AAPCHO
ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS

Report

Community Health Center Strategies for Diabetes Prevention for Asian Americans

April 2024

Introduction

Asian Americans (AAs) are uniquely and disproportionately impacted by type 2 diabetes.[1] According to the Centers for Disease Control and Prevention (CDC), crude total prevalence of diabetes among AAs is the second highest of all racial groups.[2] Further, the rate of undiagnosed diabetes among AAs is the highest when compared to all other racial and ethnic groups.[2] Screening guidelines for diabetes do not take into account that most AAs become prediabetic and diabetic at lower body weights and lower body mass index (BMI) than other racial and ethnic groups.[3,4]

Diabetes screening, treatment, and management pose distinct challenges for AAs due to cultural, linguistic, and socioeconomic factors.[5,6] Therefore, interventions for diabetes in AAs must be culturally- and linguistically-responsive.[7,8]

Culturally-Tailored vs. Culturally-Responsive: What is the Difference?

Though these terms are not new, language and how we use it are ever-evolving. These and other terminology (e.g. cultural competence, cultural relevance, cultural sensitivity) are often used interchangeably despite notable differences. Cultural tailoring is often utilized for community-based or medical interventions, while cultural responsiveness is often cited among educational practices. The Association of Asian Pacific Community Health Organizations (AAPCHO) does not claim to be the authority on the definitions, however, for the purposes of this publication, we will use the following definitions and uses for these terms.

Culturally-Tailored - an intervention that is designed or adapted for specific cultural and linguistic needs and preferences at a population level. Culturally-tailored interventions assume shared cultural characteristics among a group (e.g. Chinese, Burmese, Indo Fijian, etc.). [9,10]

Culturally-Responsive - a combination of practices, attitudes, and materials that inform a mindset which centers culture, identity, and historical/individual context. Culturally-responsive programming views individual assets, culture, and identity (e.g. including race, ethnicity, and language) and adapts to individual needs. [11,12,13]

A note on cultural humility. There is no single term or phrase that can encompass what it means to fully acknowledge and embrace the rich culture and history of all AA subgroups. Cultural humility combines self-reflection, examination of privilege, and non-judgement to enhance cross-cultural interactions. Advancing cultural humility as a practice can interrupt patterns that perpetuate structural inequities. The practice of cultural humility can prepare health center staff at all levels to be flexible, take responsibility for mistakes, and remain open to learning and adapting as language evolves.[14]

Background

AAs are the fastest-growing racial and ethnic group, including over 50 ethnicities with over 100 languages spoken.[15] AAs are people whose ethnic, cultural, and/or ancestral origins are from the continent of Asia. Though many federal data sets and research studies group them together, AAs are not a monolith. Lack of data on specific AA subgroups results in misleading and overgeneralized information and resources. Specific data (e.g. Bangladeshi, Burmese, Chinese, Filipino, Hmong, Japanese, Lao, etc.) is crucial for identifying disparities and supporting the development of culturally-tailored resources.[16]

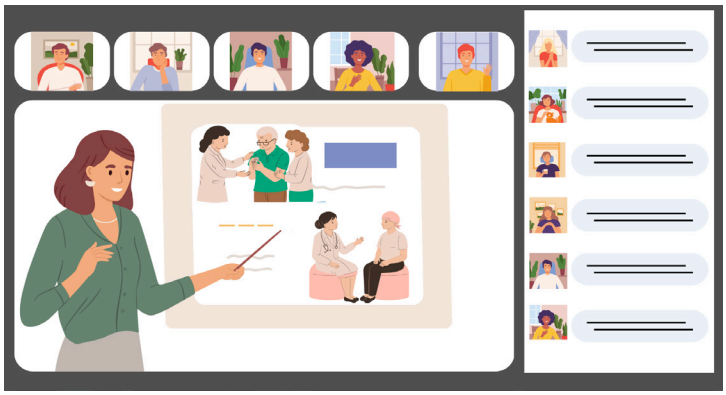
Currently, there is no singular agreed upon definition of the individual subgroups within the AA diaspora. Ethnic and national identity are ever-evolving processes of self-determination and self-identification.[17] AAPCHO does not claim to understand the various political, social, and familial complexities of ethnic identity. Nor does AAPCHO intend to assign names or meaning to individuals or groups.

The lessons, resources, and recommendations in this publication are focused on AA populations.* Though this publication uses the term AA broadly, we acknowledge the distinctness of the individual ethnic subgroups included in the AA diaspora.

**Data on Native Hawaiians and Pacific Islanders (NH/PIs) are often included within the AA monolith, though NH/PIs experience distinct barriers, successes, and outcomes in health. Alternative and future AAPCHO publication(s) will highlight the specific barriers, challenges, successes, and assets for diabetes prevention among NH/PI populations.*

Learning Collaborative Model

Over a three-year period, AAPCHO hosted three consecutive diabetes prevention learning collaboratives (LCs). LCs convened subject matter experts, community health center (CHC) staff, and other community-based organizations (CBOs). AAPCHO aimed to identify resources, considerations, promising practices, and tools for CHCs to prevent diabetes among AA patients. This publication spotlights key topics, lessons learned, and practical strategies shared during LCs. The lessons distilled from this collective effort provide invaluable insights, guide future strategies, and contribute to evolving promising practices.



Each LC session offers a combination of presentations, breakout groups, ongoing dialogue among participants, and homework.

Structure/Framework of LCs

The LC model emphasizes small group size, bi-directional learning, and follow-up components that make LCs unique and impactful. LCs facilitate ongoing learning, sustainable improvement, and open communication. They serve as an instrumental space for collectively addressing the unique challenges of diabetes prevention in AA communities.

CHC staff participated in three consecutive LCs over three years. The purpose of this model was to maintain long-term engagement among LC participants. Each LC had four sessions and focused on a different modality or intervention with subject matter expert guest speakers. Speakers outlined ways to modify existing practices for different AA subgroups. Each year's LC built on the previous year's themes.

From left to right, year 1, year 2, and year 3 of the Learning Collaboratives.

- Year 1 focused on foundations, insights, and strategies. Participants' homework outlined a plan to implement strategies in their CHCs.
- In Years 2 and 3, returning speakers explored evolving strategies. Participants shared challenges and successes with implementing strategies from previous years. New speakers shared alternative and emerging strategies for CHCs to implement.
- This approach allows CHCs to build on lessons learned, promote continuous feedback, and facilitate sustainable quality improvement.

The LC model values the expertise and contributions of both speakers and participants. Facilitators, speakers, and participants introduced fresh perspectives to promote holistic and community-centric diabetes care.

This framework fostered continuous learning and collaboration. After each LC, AAPCHO provided continued technical assistance and training to support CHCs in their efforts. This ongoing exchange highlighted CHC commitment to continuously improving diabetes care.

Lessons Learned

AAPCHO, guest speakers, and LC participants revealed insights and barriers that shape the landscape of diabetes within AA populations. Themes across the three years shed light on the key strategies for tailoring diabetes prevention approaches to address unique challenges faced by AAs. The following lessons, resources, and practical tools were shared by both speakers and participants.

1. Importance of Disaggregated Data

Historical research and data collection methods in the United States aggregate, or combine, all AAs into a single category. Until 2006, national data sets included all AAs within the "other" race category.[18] Today, there is still no national standard for reporting or collecting disaggregated race and ethnicity data.[19]

Aggregated data oversimplifies the experiences of diabetes among AAs and hides distinctions between subgroups. When age-adjusted, national diabetes data sets show AAs as the second lowest prevalence among all racial groups.[20] However, there are major differences in diabetes prevalence and impacts both within the AA monolith and in comparison to other racial and ethnic groups. For example, Chinese, Korean, and Japanese populations have lower rates of diabetes compared to non-Hispanic Whites.[21] Whereas South Asian, Hmong, and Filipino populations have some of the highest incidence and prevalence rates of diabetes compared to all other racial and ethnic groups.[22,23,24,25,26] This is confusing and erases the unique health experiences of smaller racial and ethnic subgroups.

Disaggregated race and ethnicity data unveils specific health disparities among smaller racial and ethnic subgroups that are often hidden in aggregated data sets.[27] Disaggregated diabetes data gives a more comprehensive understanding of prevalence and risk among specific groups within the broader AA category.[28]

MASALA Case Study: Across all three years, Alka Kanaya, MD shared about the Mediators of Atherosclerosis in South Asians Living in America (MASALA) study. MASALA is the first longitudinal study that sheds light on health issues within United States-based South Asian populations. One finding from MASALA is elevated risk of type 2 diabetes among South Asians.[29] Dr. Kanaya stressed the significance of disaggregating data to tailor interventions to the unique challenges faced by different AA subgroups.

LC participants emphasized how breaking down data by specific countries of origin and ethnicities within the AA category provided detailed insights into the diverse nature of diabetes risk in CHCs.

When it came to collecting disaggregated data in their CHCs, participants reported challenges with:

- Lack of standards with disaggregated data collection,
- Issues with electronic health record (EHR) settings to collect this data, and
- Patient/provider concerns about privacy, confidentiality, and how race/ethnicity data would be used.

This recurring theme underscored the significance of disaggregated data for informing culturally-tailored diabetes prevention strategies. Despite the challenges noted by LC participants, it is important to prioritize disaggregated data to effectively address the diverse health needs of AA communities.

2. Culturally-Tailored Diabetes Screening

More than one quarter of AAs living with type 2 diabetes and prediabetes are undiagnosed.[30] Culturally-tailored diabetes screening and testing would reveal and close this gap. Patients, providers, and the general public must be aware of AA-specific screening factors for diabetes.[31] Diabetes research that is disaggregated by race shows that fat distribution differs between AA populations compared to other racial and ethnic groups.[32] This research also demonstrated that AAs may develop diabetes at lower body weights than other racial and ethnic groups, challenging uniform screening criteria.[3]

Screen at 23 Culturally-Tailored Screening Case Study:

George King, MD and Runhua Hou, MD from the Joslin Diabetes Center, highlighted the higher rate of type 2 diabetes among AAs.[6] They recommended Screen at 23, a national diabetes screening initiative specifically designed for AA populations. The Screen at 23 approach involves testing AA individuals with a lower cutoff of BMI 23 instead of the conventional BMI 25.

Screen at 23 - this includes background information of the Screen at 23 initiative, in-language handouts, other implementation resources, and more.

Asian American Diabetes Initiative AA BMI Calculator - this calculator was designed specifically for the lower BMI cutoff points for AA adults and includes a chart for the healthy range of BMIs among AA adults.

LC guest speakers discussed the importance of culturally-tailored screening for improved outcomes in diabetes prevention. Beyond screening, speakers emphasized that genetic factors alone do not determine diabetes risk and different subgroups may respond differently to medications. They also shared additional preventive measures applicable to all racial groups.

Lastly, participants of this session shared patient, organization, and systems-level strategies for CHCs to improve culturally-responsive diabetes screening.

Patient-level strategies:

- Provide in-language patient education materials
- Deliver patient education classes for self-management
- Offer drive-through or walk-up screening and A1C testing

Organization-level strategies:

- Enhance provider education on culturally-tailored screening methods
- Hire multilingual and multicultural staff in health centers
- Apply for grant funding to prevent chronic disease among racialized communities

Systems-level strategies:

- Extend patient education efforts through media and community-based partnerships
- Expand outreach efforts into AA communities
- Track diabetes care and outcomes as organizational quality improvement measures
- Create a repository of resources for CHCs to share with the AA communities they serve

Culturally-tailored diabetes screening approaches, such as Screen at 23, helps to close the gap in diagnosing diabetes among AA populations. By implementing patient, organizational, and systems-level strategies, CHCs can enhance diabetes prevention and reduce disparities in care among AA communities.

3. Multidisciplinary Care Models

Multidisciplinary care models bring together healthcare providers and professionals from different fields to improve patient care. Multidisciplinary teams can leverage the expertise across specialties to inform prevention, diagnosis, and management of diabetes. These teams can also support patients across multiple treatment areas, improving whole-person care.[33]

Multidisciplinary Care Teams Case Study: Across the three years, Robert P. Marlin, MD, PhD, MPH, Sarah Bradshaw, NP, MSN, and Narin Paul, PharmD, RPh from Lowell Community Health Center shared successes from their multidisciplinary care model with the Metta Health Center. This model is a workflow for referrals and addressing social drivers of health.

Providers at Lowell Community Health Center's Metta Health Center refer patients to see a clinical pharmacist for diabetes education and care in the patients' preferred language. Community health worker (CHW) diabetes care navigators support patients beyond the clinic walls through direct follow up and support of non-clinical needs.

Collaborative teams from Lowell's Metta Health Center include providers, clinical pharmacists, diabetes care navigators, and CHWs.

This innovative model combines culturally-responsive care with in-language materials and patient care navigation in the patient's preferred language. Promising practices include offering resources for transportation; financial assistance for medications, food, and other needs; and patient education to support diabetes management.

Sessions addressed:

1. Challenges in implementing diabetes screening protocols, such as EHR barriers,
2. Promising practices, including culturally-tailored messaging, educational support tools, and adapted curriculum, and
3. Practical strategies like the referral workflows, and in-language patient education and support.

The Metta Health Center/Lowell Community Health Center partnership showcases how working together improves diabetes care. This model was developed with Massachusetts Delivery System Reform Incentive Payment (DSRIP) program funding for healthcare delivery transformation.

LC participants shared the importance of these models in solving problems and promoting a holistic approach to care. Examples of support that CHWs and other patient care navigators can provide included:

- Insurance navigation,
- Referrals to address social drivers of health needs, and
- Bridging language and cultural gaps between the patient and CHC.

Multidisciplinary teams increase collaboration among all providers involved in patient care. This approach promotes more continuity of care and improves patient outcomes by breaking down barriers.

4. Community and Peer Support Strategies

Community engagement in the process of program planning, implementation, and evaluation improves diabetes care and management outcomes.[34] Community-level feedback and investment ensure that programs are patient-centered. This collaborative approach fosters a sense of empowerment and ownership in one's community that leads to increased program involvement and sustainability. In diabetes prevention programs (DPPs), community and peer support play a crucial role in fostering social connections, providing emotional support, and facilitating behavior change.[35]

Community and Peer Supports Case Study: Mililani Leui, MPH showcased community-based lifestyle change programs that utilize CHWs, in-language resources, and culturally-responsive materials. The Pacific Islander Diabetes Prevention Program (PI-DPP) emerged as an important community-driven intervention focused on a tailored approach to address the unique challenges faced by PI communities in managing diabetes. PI-DPP emphasizes community engagement to enhance diabetes prevention and management. The program supports building infrastructure of local organizations to deliver culturally-tailored interventions.[36]

LC participants shared additional promising practices for DPPs including:

- Building partnerships with local CBOs,
- Implementing online versions of the trainings and coursework, and
- Leveraging CHWs/case managers to support DPP participants in the post-intensive period to sustain lifestyle changes.

5. Culturally-Responsive Lifestyle Interventions

The relationship between food, culture, and health is deeply intertwined.[37] Food insecurity can increase the risk of diabetes, hypertension, and other chronic conditions.[38] Food prescription programs are initiatives where healthcare providers prescribe nutritious foods as a part of patient treatment plans. Providers who acknowledge the significance of access to cultural and ancestral foods can offer more personalized dietary recommendations that can improve health outcomes.[39]

Food prescription programs provide patients with nutritious foods that align with their specific dietary needs and health conditions.

Food as Medicine Case Study:
Nancy Chen, PhD highlighted the complexities of food and culture, emphasizing the need for a foundational understanding of food as identity and nutrition. Dr. Chen shared how dietary practices intertwine with health in diverse social and cultural settings. Food prescription programs provide patients with nutritious foods that align with their specific dietary needs and health conditions.

Food prescriptions support individuals with chronic health conditions to gain access to customized food resources, educational guidance, and ongoing support. Beyond food prescriptions, CHCs should provide resources tailored for AA populations, address cultural and linguistic considerations, and implement screening initiatives like Screen at 23.

Some examples of food prescription programs include the Community Health Trust of Pajaro Valley VeggieRx program, the Community Clinic of North West Arkansas's Community Supported Agriculture (CSA) program, and the Hmong American Farmers Association "Farmshare to Care" CSA program. These initiatives support the concept of food as medicine and emphasize that access to nutritious food is essential for managing chronic conditions like diabetes.

Eating familiar cultural and ancestral foods supports physical, mental, and emotional health.[40] Integrating a culturally-tailored diet plan that incorporates patients' preferred cultural and ancestral food traditions can foster improved adherence that leads to better health outcomes.

Culturally-Tailored Food Resource Case Study: Chihiro Sato and Julia Li from the Joslin Diabetes Center Asian American Diabetes Initiative (AADI) highlighted data from DPPs that suggest the impact of lifestyle changes on diabetes prevention. They shared how diet, exercise, stress, and sleep can have a more significant impact on diabetes prevention than medical or medicinal interventions.[6]

Specifically, they explored how the Traditional Asian Diet (TAD) incorporates anti-inflammatory, high antioxidant, and healthy gut microbiome foods.

Promising practices included:

- AA-specific dietary guidelines
- Culturally-tailored recipes
- Ideas and tools to increase daily physical activities
- In-language handouts and manuals
- Education for providers and patients on AA-specific screening initiatives like Screen at 23

AADI promoted multiple free tools that they have created to support CHC patients and providers with diabetes prevention and management strategies.

Your Meal Plan Toolkit - includes food record handouts, eating out healthy tips, how to read a food label, tips for finding a culturally-responsive dietitian, and more!

Pan-Asian Recipes - includes AA-specific recipes and a 10-day menu for TAD.

Physical Activities Toolkit - includes exercises, activities to burn calories, how to form a walking club, and more!

Drag n' Cook - includes an interactive meal planning tool that shares nutritional content and includes Pan-Asian ingredients.

Tips for Managing Diabetes Toolkit - includes AA-specific risk factors for diabetes and pre-diabetes, a diabetes care checklist for AAs, and more!

Happiness and Health Toolkit - includes strategies for supporting mental health, reducing stress, seeking support from a specialist, and more!

AA-Specific Lifestyle Intervention Case Study:
Winston Wong, MD, MS, FAAFP and David Lee Hawks from the National Council of Asian Pacific Islander Physicians (NCAPIP) highlighted the direct and indirect effects of implementing AA-specific screening protocols and interventions.

NCAPIP and the AADI worked together to develop the RISE framework for a culturally-tailored intervention for AAs. RISE consists of seven steps in four categories: **Reduce** unhealthy foods, **Increase** healthy ones, importance of **Sleep**, and importance of **Exercise**.

Handout for providers: RISE to Avoid, Control, and Reverse Diabetes and Prediabetes in Asian Americans

Slide deck for patients: RISE to Avoid, Control, and Reverse Diabetes and Prediabetes in Asian Americans

The connection between food, culture, and health shows the importance of promoting culturally appropriate dietary interventions for diabetes prevention. Throughout the LCs, speakers and participants shared effective strategies for implementing culturally-responsive dietary changes:

- Partner with food distribution programs and then educate people about the available foods and how to incorporate them into their meals,
- Suggest making small changes to diet over time. For example, instead of switching completely from white rice to brown rice, try mixing them together,
- Understand the importance of family dynamics in dietary changes and get the whole family involved in making healthier choices,
- Emphasize moderation and balance in food consumption, coupled with exercise,
- Any approaches should be adapted based on community needs and preferences and avoid a one-size-fits-all approach, and
- Strengthen connection to cultural food traditions.

Community activities that foster connection to culture, tradition, and community can support overall health and wellness as well as diabetes prevention.

Beyond diet, multiple lifestyle changes can support diabetes prevention. Healthy sleeping habits, physical activity, and stress reduction can all support patients in preventing or managing diabetes.[41,42,43] Social isolation and loneliness have negative impacts on health outcomes.[44] Social connection is vital to both mental and physical health; connection to one's community is healing. A study by Martino et al. reported decreased cardiovascular mortality, controlled blood sugar levels, and maintained healthy BMI after increases in social connection.[45]

LC participants provided valuable insights about the integration of mental health into diabetes care. They emphasized the importance of holistic wellbeing and identified potential places of impact beyond the health center walls. Discussions highlighted the need to address stress and mental health for patients, caregivers, health center staff, and the broader community.

Culturally-responsive programs that incorporate multiple lifestyle changes provide patient-driven solutions. The goal of lifestyle interventions should be to improve overall quality of life with a focus on functionality and building confidence to sustain changes.[46] Collaborative, community-centered approaches are critical for addressing health disparities and improving diabetes prevention among AA populations.

Recommendations and Research

AAPCHO recommends the following priority areas to build CHC capacity to support AA patients with diabetes prevention. Please note that these are based on the insights, strategies, and promising practices from the LCs and that this is not an exhaustive list. For further resources and information, please refer to Appendix A.

1. Disaggregate race and ethnicity data to uncover disease disparities between AA subgroups

- Collect standardized race and ethnicity data across health centers
  - Uniform data collection of detailed race and ethnicity data can identify strengths, opportunities, and gaps in care.[47]
- Seek training and technical assistance on how to collect detailed race and ethnicity data and to identify unique health characteristics that exist between subgroups
  - Many health centers will need support to understand how to collect disaggregated race and ethnicity data.[48,49] Incorporate funding for this support into CHC budgets.
- Leverage disaggregated data to cultivate, expand, or enhance culturally-tailored programs
  - Many funders rely on existing scientific research and data to choose their awardees, despite research funding that is often disproportionately distributed.[50,51] Collecting detailed data at CHCs can create informed research, facilitate funding, and highlight needs among AA subgroups.

2. Implement culturally-responsive screening for diabetes

- Educate providers on culturally-responsive strategies to serve AA patients
  - Continuing education and skills-based training on the principles and concepts of cultural humility can help staff and providers navigate multicultural communities more effectively.[14,52]
- Conduct patient outreach and education about screening factors specific to AA populations
  - Interpreters, translation services, and multilingual and multicultural staff from the community can all support the creation and implementation of resources and services.[53,54]
- Provide in-language educational materials and outreach
  - Many ethnic groups have an oral language tradition. Health education materials, public service announcements, and other messaging should be offered in a variety of formats, including visual and audio.[55]

Leverage partnerships with local ethnic media such as radio and tv broadcast to disseminate messages to a larger audience.

3. Explore multidisciplinary care teams to support patients with diabetes

- Hire, train, and sustain multicultural and multilingual staff from the community
  - Multilingual and multicultural CHC staff can more easily build relationships and establish trust with patients.[56]
- Improve communication with other community providers (e.g. pharmacists, holistic healers, therapists, dentists, etc.) to support whole-person care
  - Integrated care models enhance continuity of care and provide a 'no wrong door' entry point to patients.[57]
- Employ CHWs to provide patient engagement, outreach, and support
  - CHWs and other non-clinical support staff can meet patients' social drivers of health needs and help patients navigate complex health and social service systems.[58,59]

4. Forge partnerships with culturally-specific community organizations

- Leverage shared outreach efforts across in-person, digital, audio, and print media
  - Each AA subgroup has unique health beliefs, cultural history, language, and socioeconomic background. Ensure that outreach and educational campaigns use culturally-relevant images and messages.[52]
- Engage community members in the creation, implementation, and sustainability of DPPs
  - Community-based participation in all aspects of DPP planning and delivery will ensure that strategies are rooted in and responsive to community needs. Shared goals will promote long-term commitment and overall success of the program.[60]
- Partner with trusted community leaders and messengers from AA-specific groups to deliver diabetes prevention strategies and health education
  - Shared outreach efforts can leverage existing relationships to communicate information to a wider audience.[61]

Health centers can forge partnerships with local AA language schools, houses of worship, and other established community-based organizations.

5. Offer non-medicinal, culturally-tailored lifestyle strategies

- Partner with farmers and growers to expand community access to food
  - Bridging the food insecurity gap through access, financial incentive, and nutritional education can support whole person health.[62,63]
- Increase provider awareness of cultural dietary preferences and connect patients to cultural and ancestral foods
  - Providers who understand the need for culturally-specific food access can tailor food prescriptions, vouchers, and other referrals to food programs.[38,63]

Kitchen staff at health centers, hospitals, and other medical care facilities can expand in-house meal options to meet cultural dietary preferences for AA patients.

- Promote stress reduction strategies among patients
  - Physical activity, sleep improvements, mental health support, and overall connection to community all significantly improve diabetes outcomes.[41,42,43] Expand awareness of culturally-specific programs to refer patients to.

The recommendations above are only some of the possible strategies that CHCs can use to promote diabetes prevention for AA communities. Efforts should always be patient-centered, culturally-responsive, and sustainable.

Conclusion

Over three years, the LCs sparked important discussions between guest speakers and participants. These conversations explored practical strategies CHCs have employed to improve diabetes prevention for AAs. It showcases not only the effectiveness of individual strategies but also the transformative potential when CHCs come together with a shared commitment to improve health outcomes. As these lessons ripple through different communities, they emphasize the importance of sustained collaboration, continuous education, and the integration of cultural humility into every aspect of diabetes prevention. Beyond patient strategies, they highlight the importance of recognizing each community's unique needs and adapting interventions accordingly. These insights pave the way for a future where diabetes prevention strategies for AA communities are not just informed by data and expertise but are deeply rooted in empathy, cultural understanding, and a collective dedication to health equity. The impact of these lessons extends far beyond the confines of individual LCs, shaping a new era of community-driven healthcare practices.

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Appendix B: Additional Resources

Additional Asian American Diabetes Research:

- Pharmacists Improve Diabetes Outcomes: A Randomized Controlled Trial, Journal of American Pharmacists Association, June 2022
- Knowledge Gaps, Challenges, and Opportunities in Health and Prevention Research for Asian Americans, Native Hawaiians, and Pacific Islanders: A Report From the 2021 National Institutes of Health Workshop, Annals of Internal Medicine, April 2022
- The Impact of Type 2 Diabetes in Asian Americans, U.S. Food and Drug Administration, May 2021
- Validation of the Diabetes Distress Scale in an Asian Pacific Islander Population, Hawaii Journal of Medicine and Public Health, January 2019
- DREAM (Diabetes, Research, Education, and Action for Minorities) Project, Emory University, July 2017
- Making Diabetes Self-Management Education Culturally Relevant for Filipino Americans in Hawaii, Diabetes Education, September 2008

Culturally-Tailored Resources to Support Patients:

- Our Healthy Eating Plate: Filipino/a/x and Hmong Editions, AAPCHO/MHP Salud, 2022
- How to use the AADI Healthy Eating Plate, Joslin Diabetes Center Asian American Diabetes Initiative, 2022
- Personalizing Your Plate for Your Culture, Joslin Diabetes Center, 2022
- Food, Medicine, and the Quest for Good Health, Nancy Chen, 2009
- Fasting During Ramadan with Diabetes, Joslin Diabetes Center, 2022
- Returning to Our Roots, Kokua Kalihi Valley, 2021
- Carbohydrate Counting for Traditional South Asian Foods, San Jose State University, 2014
- Diabetes Prevention and Management: A Guide for Asian Americans, Joslin Diabetes Center Asian American Diabetes Initiative, 2021
    - Japanese
    - Korean
    - Simplified Chinese
    - Traditional Chinese
- "Let's Talk About…." video series, Joslin Diabetes Center Asian American Diabetes Initiative, 2021
- ADA New Diabetes Screening Guidelines, UC San Diego School of Medicine, 2017

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