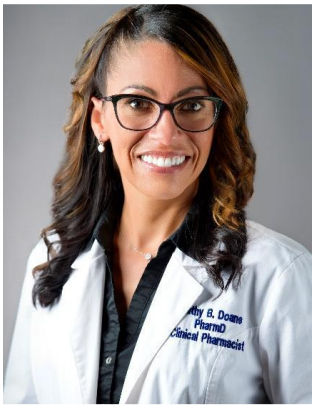
ADCES Inclusion Spotlight



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Inclusion Council Board Liaison

1. What interested you about the Inclusion Council?

I was drawn to the Inclusion Council because of the opportunity to help ensure that every ADCES member feels seen, valued, and represented. Inclusion is essential to building a strong professional community and an effective healthcare system.

As someone born and raised in Puerto Rico, I have witnessed how cultural background, language, and lived experience influence how individuals engage with healthcare systems and professional environments. These experiences have shaped my understanding that inclusion is foundational to trust, collaboration, and equity in care delivery.

In diabetes care, these principles are especially critical given the complexity of self-management and the diversity of patient needs. Patients bring varied cultural perspectives, health literacy levels, socioeconomic circumstances, and personal priorities that directly influence their ability to engage in care. In my practice as a pharmacist and diabetes care and education specialist, I have consistently seen that when care is culturally responsive and patient-centered, engagement improves and outcomes become more sustainable.

Serving as Board Liaison to the Inclusion Council offers a meaningful opportunity to support efforts that embed inclusion into organizational strategy, education, and practice. I am particularly committed to elevating underrepresented voices and contributing to ADCES' continued growth as an organization that reflects both its members and the communities they serve.

2. Why is inclusion meaningful in your own practice when serving patients?

Inclusion is meaningful in my practice because it directly influences how I assess patient needs and tailor diabetes care plans that are realistic, relevant, and sustainable.

In daily practice, I care for individuals with diverse cultural backgrounds, levels of health literacy, financial circumstances, and competing life demands. These factors shape how patients interpret medical guidance and determine what is feasible within their daily lives. Recognizing this allows me to move beyond standardized recommendations and instead deliver care that is individualized and context-driven.

To better understand these realities, I use open-ended, patient-centered communication to identify barriers that may not be immediately apparent. This includes exploring challenges such as medication affordability, dietary habits shaped by culture or family structure, limited access to healthy food options, and competing responsibilities such as work or caregiving. These conversations often reveal critical insights that would otherwise be missed.

This approach shifts the clinical interaction from directive instruction to collaborative problem-solving. Over time, it strengthens trust, improves engagement, and supports more effective self-management because care plans are built around the patient's lived experience rather than assumptions.

3. Why should inclusion be important to others in the specialty? Do you have any anecdotes to share that may be helpful to those working to be more inclusive in their work?

Inclusion should be a priority for all professionals in diabetes care because it directly impacts communication, trust, and clinical outcomes. Given that diabetes management relies heavily on daily self-management, the effectiveness of any treatment plan depends on how well it aligns with a patient's real-world circumstances.

In practice, I have consistently observed that small but intentional shifts in communication can significantly improve engagement and uncover barriers that are not immediately obvious. These may include cost-related medication challenges, food insecurity, competing responsibilities, cultural dietary patterns, or limited health literacy. Without an inclusive approach, these factors can easily be overlooked, resulting in care plans that are difficult to implement or sustain.

One question I routinely use is, *"What matters most to you when managing your diabetes?"* This reframes the conversation from assumption-based guidance to patient-driven priorities, allowing for more meaningful and individualized care planning.

For example, I worked with a patient whose diet consisted primarily of potatoes and other starchy vegetables across two main meals. His blood glucose levels were elevated, and the initial recommendation focused on reducing these foods without adjusting his medication regimen. However, further discussion revealed significant financial constraints that limited his ability to purchase non-starchy vegetables. In addition, he lacked familiarity with how to prepare them in a practical way.

By identifying these barriers, we were able to implement a more supportive and sustainable plan. We coordinated with our care manager to connect the patient with grocery assistance programs for which he qualified. In parallel, we provided education on selecting, preparing, and incorporating non-starchy vegetables into his meals in a realistic and culturally appropriate manner.

Over time, these changes resulted in improved glycemic control. As his dietary patterns became more balanced and sustainable, I was able to reduce and eventually de-prescribe medications rather than intensify therapy.

This experience reinforces how inclusion-driven care—grounded in understanding a patient's lived reality—can meaningfully improve outcomes and support more appropriate clinical decision-making. I encourage all clinicians to intentionally integrate inclusion into their approach to diabetes care, as it has the potential to profoundly impact a person's health, emotional well-being, financial stability, and many other aspects of daily life.