International Journal of Nursing and Health Care Research
Scollan-Koliopoulos M. Int J Nurs Health Care Res 8: 1614
www.doi.org/10.29011/2688-9501.101614
www.gavinpublishers.com

Review Article

Understanding Emergency Department Utilization by African Americans for Routine Diabetes Care: Are We Asking the Right Cultural Questions?

Melissa Scollan-Koliopoulos*

Dr. Susan L. Davis RN and Richard J. Henley College of Nursing, Sacred Heart University, Fairfield Connecticut USA

***Corresponding author:** Melissa Scollan-Koliopoulos, Dr. Susan L. Davis RN and Richard J. Henley College of Nursing, Sacred Heart University, Fairfield Connecticut USA

Citation: Scollan-Koliopoulos M (2025) Understanding Emergency Department Utilization by African Americans for Routine Diabetes Care: Are We Asking the Right Cultural Questions? Int J Nurs Health Care Res 8:1614. DOI: https://doi.org/10.29011/2688-9501.101614

Received Date: 20 January 2025; **Accepted Date:** 29 January, 2025; **Published Date**: 03 February, 2025

Abstract

Introduction: The emergency department is a source of routine care for many African Americans. Afrocentric cultural characteristics may serve as a better proxy than race for understanding preferences for emergency department use over primary care for diabetes management. **Methods:** A literature review was conducted including key terms related to transitional healthcare, emergency department recidivism, Afrocentric cultural characteristics, racism and health disparities, and diabetes in African Americans. An example of tailoring talking points using Afrocentric cultural characteristics is proposed using Jone's TRIOS Model, a Afrocentric Self-enhancing and Protective Theory. **Results:** The literature includes evidence to support a complex explanation for emergency department use by African Americans. Cultural characteristics that are self-enhancing and protective may explain preferences for emergency department care of diabetes. Cultural characteristics such as temporality, rhythm, improvisation, orality, and spirituality may drive a preference for emergency care. **Conclusion:** Tailoring care by using talking points consistent with cultural framing and culturally tailored diabetes education that is theoretically modelled has the potential to be delivered in the emergency department as a possible means of preventing recidivism, and risk for hospital readmissions.

Keywords: Afrocentric culture; Emergency department; Readmissions; Diabetes care; Race

Introduction

Race is a social construct that has been embedded in the foundation of the U.S. healthcare system for 400 years by flawed assumptions regarding race as a biologic proxy perpetuating disparities in healthcare [1]. Healthcare disparities can be linked to deficiencies in cultural competence and ethnocentric bias influencing care decisions [2], and systemic racism [3]. Notions of cultural competence may paradoxically contribute to systemic racism if flawed cultural assumptions become over assimilated into care models [2]. This is especially true if race is utilized as a proxy for culture resulting in oversimplified decision-making that is conflated by racial phenotypic categories [1] contributing to inequitable care [4]. One area where race is a robust predictor of health disparities is in emergency department utilization for primary, routine, or chronic disease care where it is associated higher mortality [5]. The purpose of this review is to propose the use of cultural characteristics to deliver tailored healthcare interventions without regard for race or ethnicity as a proxy. When tailoring healthcare interventions, use of culture-specific theories may be a potential remedy for reducing healthcare disparities.

This report addresses the clinical implications of integrating a nursing theory with a cultural psychological characteristic theory in the context of diabetes care. Afrocentric cultural characteristics

can be incorporated into diabetes self-management education with the potential to reduce the risk of hospital readmissions. An attempt to operationalize Leininger's [6] general cultural care model by adding Afrocentric constructs from Jone's [7]TRIOS model of *Self-enhancing and Protective Afrocentric Cultural Characteristics* for the purpose of diabetes self-management education was undertaken. The aim of this paper is to demonstrate a method for augmenting a nursing theory with a specific cultural characteristic theory intended to operationalize cultural competence at the bedside.

Background

In the United States, non-Hispanic African Americans are 60% more likely to be diagnosed with diabetes compared to Non-Hispanic Caucasians [8]. Essentially, 13% of African Americans over the age of 18 are diagnosed with diabetes. Furthermore, once diagnosed, African Americans are unequally affected by complications, such as retinopathy, renal disease, and lower-extremity amputations [8]. There are 114.1 per 100,000 hospital admissions for uncontrolled hyperglycemia by African Americans [8]. It is not uncommon for African Americans seek primary diabetes care in the emergency department [9], which potentially increases the likelihood of a hospital readmission. African Americans have a higher likelihood of being readmitted to the hospital after discharge compared to white individuals [10]. For 79% of the hospitalization rates in African Americans risk factors or social determinants of health failed to explain variance in differences in all cause readmissions [10].

Racial and Cultural Bias, Perceived Racism, and Hospital Readmissions

Psychosociocultural factors are associated with 30-day readmissions among younger adults with myocardial infarctions [11]. Despite awareness of social determinants of health and systematic racism contributing to readmissions, few interventions other than discharge planning and follow-ups after discharge successfully decrease readmissions in older African Americans [12]. African Americans may be subject to bias due to preconceived notions of culture and healthcare preferences [3]. African Americans are adversely affected by systematic racism which may be influenced by preconceived notions of culture and bias [3]. When care decisions are determined based on race, it will have been based off judgements that are homogenizing as opposed to individualizing care. Incorporating culture-based knowledge into protocols and/or care delivery heuristics has the potential to prevent perpetuating bias based on preconceived notions based on race. Basing healthcare judgements on race can be both automatic and systematic. Systemic racism in healthcare is an important construct because it may be an antecedent to emergency department recidivism [2]. Racism via unequal access to resources and opportunity is a fundamental social determinant to race-based health inequality [13] leading to disparities in health.

Black race is categorically a predictor of relative Emergency Department (ED) over-use and death in the ED [5]. Emergency department recidivism is an important topic because it serves as a gateway to 30-day hospital readmissions [14]. Several factors have been identified as antecedents to Emergency Department (ED) recidivism, including discharge failure, defined as an ED return within 72 hours or more, poor compliance, or lack of comprehension of healthcare provider instructions [15]. Yet, by some estimates, those of black race are generally less likely to receive an appropriate hospital admission, which may also lead to repeated ED recidivism [5].

Cultural Competency, Disparities in Diabetes Care Amongst African Americans

Access and resources to prevent hospitalization in those recently discharged may help eliminate the emergency department as a routine source of non-emergent care. However, individuals would need to trust that the healthcare system is fully evaluating their needs without undermining their efforts to seek care. A prerequisite to establishing trust is cultural competency [9]. Cultural competency promotes feelings of protection and psychological safety. However, psychological safety can only emerge if one recognizes the power imbalance healthcare institutions juxtapose on the African American community [16]. Psychological safety requires power-shifting as a prerequisite to engaging people into full participation in healthcare decision-making. Discharge planning provides a timely opportunity to promote engagement with deliberate cultural-connecting to individuals. For example, culturally tailored education using talking points from a valid tool may facilitate cultural brokering. Cultural brokering has the potential to promote holistic healthcare in diabetes-affected individuals [17].

According to the U.S. Department of Health and Human Services (USDHHS), Office of Minority Health (2021), non-Hispanic African Americans are 60% more likely to be diagnosed with diabetes compared to Non-Hispanic Caucasians. Essentially, 13% of African Americans over the age of 18 are diagnosed with diabetes [8]. Furthermore, once diagnosed, African Americans are unequally affected by complications, such as retinopathy, renal disease, and lower-extremity amputations. There are 114.1 per 100,000 hospital admissions for uncontrolled hyperglycemia by African Americans [8]. It is not uncommon for African Americans seek primary diabetes care in the emergency department [9].

One long-standing assumption regarding emergency department over-use by African Americans has been mistrust [9]. Arnett et al. [9] indicates that when medical mistrust is accounted for,

the emergency department-as-usual source of care for problems like diabetes is eliminated as a cause of disparities in health-care utilization [9]. Reasons for healthcare disparities in readmission rates formulates before entry through the hospital doors with pre-hospital care by race in-concordant providers as a predictor. Of concern, most pre-hospital EMS providers are White with little more than 8% of paramedics representing a Black racial identity [18]. Furthermore, hospital-destination and/or admission decisions may be due to insurance status, whereby the insured are diverted to hospitals in higher socioeconomic communities [18]. This is relevant because research shows that pre-hospital emergency medical service providers are more likely to transport Black or Hispanic individuals to a safety-net hospital despite insurance status [18].

Medicare and private insurance-covered Blacks of non-Hispanic race account for the higher readmission rates when compared to non-Hispanic Whites [19]. Fortunately, hospital readmission reduction programs are effective and evidence suggest that Medicaid and the uninsured account for less readmissions when offered interventions to reduce hospitalization [19]. African Americans are less likely than White Americans to use a primary care provider for their usual source of care [20] which may lead to emergency department recidivism following a hospital discharge. Insurance coverage has positive effects on predicting a reduction in disparities in healthcare [21]. However, research has also shown that insurance factors are not an isolated reason why people choose to use the emergency room as opposed to primary care. In fact, the emergency department has been shown to be preferred by some because of the notion that it is a higher level or quality than primary care, has easier access, and may be less expensive depending upon reimbursement factors [22]. Patient perception of value may be what drives emergency department recidivism over primary care preferences in those who are recently discharged from the hospital. Nonetheless, in the Kangovi, et al. [25] study, those with higher emergency department utilization also had more social instability and disability at higher rates than low utilizers did [22].

Strategies that Prevent Recidivism after Hospital Discharge

The purpose of the emergency department discharge process is to communicate with and educate patients, support post-emergency department discharge care, and coordinate care with other provider and services [15]. The primary responsibility for the coordination of the emergency department discharge process is commonly a nursing or social work function.

Culturally competent communication may facilitate engagement and health-care decision making and is associated with improved treatment outcomes [23]. Yet only 60% of patients can describe their diagnosis and 26% feel discharge instructions are unintelligible [24]. Evidence-based discharge education must include medication reconciliation, patient education, and communication to outpatient providers [25].

Considering Preferences for Routine Sources of Care

African American's perceptions of health, medical and pharmacologic complexity, health behaviors, and care access have been observed as predictors of healthcare utilization [26] against a backdrop of systemic and structural racism accounting for mistrust of healthcare providers. Paradoxically, one may expect that utilizing the emergency department due to mistrust of primary care would reinforce feelings of mistrust and perceived racism and/or discrimination in healthcare. However, it is possible that the emergency department is perceived as protective because it fits better with the protective coping styles identified as Afrocentric in America. For example, temporality and improvisation.

Perhaps, we need to move beyond the race and ethnicity proxy that depicts a deficit model and look at the ways in which protective cultural characteristics contribute to healthcare utilization. There is a call to reduce emergency department use using transitional care programs. Yet a study by Parast, et al. [33], showed Blacks and Hispanics felt they received better care than Whites in the emergency department, possibly reinforcing utilization. The finding is surprising, yet another example of how race and ethnicity is used to tell a story without consideration for cultural values or preferences [27]. Does the possibility exist to provide lower-costing integrated and ancillary primary services in the emergency department to meet healthcare preferences while preventing unnecessary hospitalization [28]?

Emergency Department Recidivism for Diabetes Management

Approximately, 40% of the admissions for hyperglycemia occur in low-income populations [29]. A useful descriptive secondary analysis of data from a one-year randomized controlled trial showed that diabetes related distress scores, higher HbA1c, lower adherence to medication, lower education level, and low scores on neuropsychological functioning predicted emergency department use. Yet, income was not a predictor, implying economic factors may not predict access [30].

Similar to failed assumptions regarding income and insurance status, some authors show that limited primary care access is not the antecedent to emergency department utilization. In a study by Yan, et al., [39], hospital readmissions due to hyperglycemia following hospital discharge by retrospective chart review showed that precipitant causes of hyperglycemia were reduced, including infection, alcohol use or coronary syndrome [31]. Largely, medication and/or insulin non-compliance and underdosing of medication were the primary causes, representing 35.8 and 28.9% of the sample respectively [31]. The authors conclude that better discharge instructions may help. Interestingly, the bulk of

the sample had a primary care physician. All the subjects had a sentinel visit, defined as a visit prior to hyperglycemia for any reason within 14 days of the emergency department visit requiring admission [31].

There are few evidence-based interventions describing specific diabetes education interventions during discharge planning in the hospital or emergency department. Diabetes education in the emergency department has been shown to be effective at improving retainable knowledge scores [32]. Most nursing research that incorporates diabetes education into hospital readmission prevention has occurred in the context of care transitions from inpatient to home. Effective interventions to reduce readmissions and recidivism include a focus on follow-up care, reducing medication errors, and delay of care [33].

Methods

A thorough literature review was conducted to determine which interventions are effective at reducing emergency department utilization for diabetes care. An extensive literature search reviewing PubMed, google scholar, and specific diabetes and emergency medicine journals reveal no specific nursing interventions that incorporate diabetes-specific communication or education to improve the discharge process in the emergency department or hospital.

Results

There are gaps in the literature regarding how to deliver culturally competent nursing interventions using tailored communication. The assumption is that nurses do provide diabetes education, yet we do not have established effect sizes published to unequivocally state what interventions work. A systematic review of culturally tailored interventions by nurses demonstrated a lack of cultural competency training lending to weakness in the interventions. Nurses may desire to deliver respectful and appropriately tailored cultural care, but difficulty training healthcare providers remain [34].

Afrocentric Culturally-Competent Healthcare

In trying to envision what Afrocentric culturally competent care could look like, a survey of literature was conducted and revealed inconsistency and inappropriate usage of race, ethnicity, and Afrocentric values. However, [35] utilized a measure of Afrocentrism to understand healthcare utilization with the findings showed a context of protective factors against racism [35, 36]. The factors identified by [35] included unity, self-determination, collective work and responsibility, cooperative economics, purpose, creativity, and faith which are considered to be a code of conduct for daily life [35].

This is important because we are beginning to pay attention to the role of institutional racism in health outcomes. The paper complements the idea of incorporating [7] Jone's TRIOS psychological theory of culture into culturally competent care [7,35]. The TRIOS theory is about self-enhancement and self-protection [7]. The theory has been used to move beyond the race and ethnicity proxy toward psychological safety in healthcare to prevent disparities. [37]. Cultural appreciation is needed to provide equitable and appropriate care. Key to this is recognition of the power structures in healthcare. Safe care can only be defined by patients and the community from the cultural perspective, and not the institution itself [16]. Communities decide what is culturally competent and acceptable for those receiving care. It is not something that can be broken down in a Cartesian sort of way into binary variables of black or white. The overarching hypothesis being that African Americans are a multidimensional cultural group. To speak of African Americans in a singular way is equivalent to racial categorization and it is flawed.

According to Curtis, et al. [16] cultural characteristics continually evolve and adapt [16]. Therefore, interventions based on cultural characteristics will need to be continuously amended. The primary purpose of adaptation that occurs within African Americans is culturally shaped by the need for self-enhancement and self-protection to overcome racism [36].

TRIOS (time, rhythm, improvisation, orality, and spirituality) are proposed as a way of adapting and innovating despite dehumanization of oppression and racism [7]. The TRIOS model can be utilized to understand healthcare needs and utilization, guide interventions, and promote health. Ambitiously, the TRIOS model maybe used to promote feelings of psychological safety thus contribute to closing the gaps in healthcare disparities. Scollan-Koliopoulos, Rapp, & Bleich [46] found an association between statements about diabetes that were Afrocentrically tailored and illness representations of diabetes (Table 1) [37]. This study indicated the potential to package talking points that could be used by nurses to supplement their discharge education.

Regarding Diabetes Self-Care
Spirituality
Belief in God or a greater power can help deal with diabetes care.
Belief in a higher power is important for taking care of diabetes.
Sometimes, you just have to put your diabetes in the hands of a higher power.
There is a higher force that directs the path of diabetes.
Pray or consult with a someone with shared spiritual beliefs before making a major decision about diabetes.
In most every aspect of diabetes, spiritual beliefs can be a source of strength.
There are forces that influence diabetes that can't always be easily explained.
Improvisation
Things may not go as planned with diabetes care, so devise another plan right on the spot.
Be able to figure out almost any situation affecting diabetes care.
Diabetes care goal disruptions, can be figured out and achieved anyway.
Diabetes care styles are personal that is all my own.
Orality
Laughter about diabetes often holds us all together.
It's important to maintain harmony when taking care of diabetes.
Personal identity is very important when caring for diabetes.
Rhythm
If someone is on the attack about diabetes care, I don't have to struggle about not knowing what to do.
My experiences with diabetes are "real" when I tell someone about them.

Adapted from Scollan-Koliopoulos, Rapp, & Bleich, (2012)

Table 1: Tailored talking points to promote protective cognitions.

The TRIOS theory has the potential to explain preferences for emergency departments for routine care by African Americans. For example, improvisation and coming up with real-time solutions as opposed to planning may be a protective coping style. Albeit more costly, the emergency department is concordant with improvisation and comes with less access restrictions than the typical primary care practice.

Operationalizing Cultural Care Theoretical Models

Leininger's [6] model of nursing cultural care (CCM) and Jones' [7] theory of psychological self-enhancing and protective Afrocentric cultural characteristics can be used concurrently to create psychological safety during nursing care provision [6,7]. The CCM by Leininger includes culture care preservation and maintenance; accommodation and negotiation; repatterning and restructuring to generate culturally congruent care.

The goal of Leininger's Cultural Care Model (CCM) [6] is to promote culturally congruent care by nurses [6]. One tenant of the CCM is that cultural care is the recognition of accommodation or negotiation. People of a particular culture adapt to or negotiate with others in the healthcare culture to attain a shared goal of optimal health. This seems especially relevant to African American communities where trust is at stake. Another construct is cultural care repatterning or restructuring. This is the therapeutic actions taken by culturally competent nurses to help a patient modify health behaviours toward beneficial outcomes while maintaining respect for one's culture [6].

The specific cultural characteristics from any specific culture could be operationalized by transposing the variables onto the CCM. In the case of Jones' TRIOS Model, the Afrocentric cultural characteristics are time, rhythm, improvisation, orality, and spirituality. Table 2 depicts the Afrocentric cultural characteristics of TRIOS as defines by Jones [7]. TRIOS is operational in that a measure was developed with a valid and reliable factor analysis and internal consistency reliability tests based on a sample of 1,415 respondents [7]. Scollan-Koliopoulos, Bleich, & Rapp [37] adapted the TRIOS measure to include statements specific to the context of diabetes self-care [37].

An example of culture repatterning to western diabetes care was reported in a multicenter study that utilized Jone's [7] TRIOS (temporality, rhythm, improvisation, orality, spirituality) measure of cultural characteristics to tailor diabetes talking points [7,37] The talking points predicted diabetes illness representations using Leventhal's self-regulation model [37]. Illness representations (commonsense model) are views on timeline, causes, symptoms, controllability, and consequences of specific illnesses [38]. Race and ethnicity alone did not predict illness representations [37].

TRIOS- protective and self-enhancing cultural characteristics
Time: Past, present, and future. Time is slow-moving, practical derived from tasks and behaviors as opposed to being prescribed by them. Past-present is most relevant and many African languages have no term for "future".
Rhythm: Recurring patterns of behavior set in time. Internal response to the rhythmic patterns of the external world. People are linked to their environment in a dynamic way.
Improvisation: Socially and spiritually integrative and personally expressive. This is a goal-oriented means of creative problem-solving.
Orality: Story-telling, naming, singing, drumming for socialization and cultural transmission. Connecting the present to the past.
Spirituality: Most central to African origin Forces beyond human beings act with effect in the world. Not all causes are material or knowable, as opposed to the European-derived materialistic individualism.
Taken from Jones, (2003)

Table 2: Depiction of Afrocentric cultural characteristics of TRIOS.

This means race and ethnicity alone are inadequate to assess illness representations. Illness representations are strong predictors of diabetes self-management and glycemic control in the literature. Illness representations are the timeline, causes, symptoms, consequences, and controllability of an illness and/or its treatment [37]. This article supports the need for a study using cultural characteristics to tailor talking points to promote behavior change or self-management. The article showed moderate relationships at three sites suburban and urban, upper socioeconomic and lower socioeconomic participants, the range was somewhat representative [37].

Looking Reducing Hospital Readmissions through a Cultural Lens

When evaluating a preference for emergency department use through a cultural lens, Afrocentric protective and self-enhancing psychological and cultural characteristics [7] may play a key role. Cultural characteristics, such as TRIOS (temporality, rhythm, improvisation, orality, and spirituality have been shown to predict views of diabetes as being threatening or not [37]. Those with higher Afrocentric cultural characteristics or TRIOS, were more likely to view diabetes as less threatening [37]. Viewing diabetes as less threatening could result in more emergency department use if people are less engaged in self-care practices as a result, or result in more use if perceived as threatening and requiring of intervention. No studies report on whether diabetes being viewed as a threat predicts emergency department usage or hospital readmissions. However, a possible cultural explanation of how perception of threat interacts with culture and hospital emergency department recidivism or readmission may be that given temporality, rhythm and improvisation, individuals may feel the timeliness of care is of value. More studies are needed to better understand how Afrocentric cultural characteristics contribute to differences in emergency department use based on the perception of diabetes as threatening or not.

Clinical Implications

The research is telling us that African Americans and many Hispanic [27]. Americans prefer to use the emergency room for routine care and seem to feel they have a good experience doing so. In fact, African and Hispanic Americans felt they experience better communication in the emergency department than White Americans [27]. Additionally, despite discussions of post-emergency department follow-up care, individuals return an average of three times within 6-months [27] and cite not having the follow-up source of care and being encouraged to use the emergency department as opposed to no care [27]. However, could the Afrocentric and Carribean-centric cultural characteristic of orality explain the perceptions of communication satisfaction? Could rhythm and temporality and improvisation explain the preference and satisfaction with emergency department care? Cultural characteristics may explain the preference for use of immediate care resources [5]. The problem is that in a true emergency triage scores are inaccurate, and mortality is high for Black individuals [5]. It is unclear if chronic use of the emergency department for routine care or racist assumptions result in deprivation of appropriate care. Additionally, from a socioeconomic perspective, routine use of the emergency department for chronic disease care is costly and strains the system that is intended for triaging acute emergencies and critical illness.

ED Discharge Planning and Recidivism Models

Discharge planning is evidenced to work to reduce emergency department readmissions. The Agency for Healthcare Research and Quality (2014) (AHRQ) proposes use of an environmental scan and an analytical framework for examining the emergency department discharge process [15]. The framework is useful for guiding practice and for identifying root cause of discharge failures. Embedded into the framework are specific conditions, risk assessment for discharge failure, and population-specific interventions for success. Barriers and resource allocation are considerations. It is in the population-specific interventions that culturally tailoring of interventions would be delivered [15].

Clinical Implications of Culturally Tailoring Care Models

Cultural trauma is a phenomenon that moves understanding of health disparities from a racialized medicine perspective to a resource and social deprivation/loss conceptualization [39]. When race is used as the primary marker of understanding health disparities or is used to determine interventions, even if the intention is ethically beneficent to reduce disparities, their poses a risk of inequality [40]. As opposed to recruiting individuals for health promotion interventions based on race or ethnicity and assuming singularity in preferences (ie. everyone is similar in views), homogenization can be reduced by measuring cultural characteristic strength as a predictor of healthcare access and outcomes.

Accordingly, we considered that Jones [7] TRIOS, theory which is a cultural psychological trauma theory that considers the pervasive of effects of racism as a traumatizing antecedent to the formation of cultural characteristics employed by African Americans for coping with adversity [7] to better understand and tailor diabetes self-management practices [37]. Those who score stronger on orality may benefit from a story-telling intervention. Those who are stronger on spirituality characteristics may do better in a group that focuses on spirituality and universality. Temporality-strong scoring individuals may prefer less structure and check-ins when they feel the need as opposed to when they provider requests their return visit. Those scoring high on rhythm may benefit more than others from a physical or dance intervention. Improvisation may include a group where problem-solving strategies are utilized. Table 3 depicts operationalization of the nursing process, the CCM and TRIOS for a diabetes self-management education episodic visit. This is an example of how the TRIOS measure could be hypothesized to generate a culturally sensitive intervention by using talking points when a nurse is implementing Leininger's model regarding cultural values, beliefs, and lifeways [6]. Table 4 lists Afrocentric talking points adapting Jone's TRIOS measure that could potentially be utilized during discharge planning to provide diabetes-specific communication and education.

Leininger's CCM	**Jone's TRIOS**
Inquiry regarding worldview, cultural, and structural dimensions	Individual's unique improvisation and rhythm of health behavior engagement (Rhythm and Improvisation)
Assessment: When you run out of insulin, who do you pray or consult with for help in solving this problem? Do you prefer to get care for high sugar in the moment or do you plan ahead?	
Plan for accommodation & negotiation	Individual's preferences are considered with specific regard to past And present coping styles (orality and Time)
Planning: Tell me how you have managed to maintain harmony when you ran high sugars in the past?	
Assist individual with maintaining/ moderating health behaviors	Intervention is carried out collaboratively with consideration for spiritual forces at play to influence health outcomes (Spirituality, rhythm)
Intervention: What forces do you feel empower you to manage your sugar when you run out of insulin?	
Considers individual's response to intervention responded by encouraging orality	Nurse considers how individual storytelling/expression. (Orality, Improvisation and Rhythm) contribute to problem-solving.
Evaluation: Did anything disrupt your diabetes self-care goals and how did you figure your way out of the situation?	

Table 3: Use of Leininger's model used in the nursing process operationalized by Afrocentric Cultural Characteristics.

Race and ethnicity have a long history of being used as a culture-proxy to understand and explain disparities in health. However, individuals and communities are not reducible to a homogonous binary units. Despite the United States taking the lead in generating research on the causal explanations of race-based health disparities, the solutions do not robustly result in change [3]. Cultural competency must include a recognition of what shapes the characteristics and respective context shaping health views, behaviours, and healthcare utilization. Meeting patient preferences is appropriate, albeit challenging if healthcare providers do not ascertain the antecedent to the preferences. This is not obtainable using a binary proxy for a heterogenous culture that is constantly adapting to the environment.

Spirituality
"There are forces that influence your diabetes that you may not always be able to explain to your doctors."
The emergency department is a busy place. The doctors in the emergency department may not take the time to fully understand everything that affects your diabetes because they need to treat you as quickly as possible. The focus of the emergency department is treating emergencies and the doctors may not always find an 'emergency' in your diabetes care needs.
Improvisation
"When things don't go as planned with your diabetes care, it may not always be easy to devise another plan right on the spot."
Sometimes going to the emergency room just seems to make sense. It seems like an on-the-spot solution. But the emergency department takes away valuable time because care takes longer and the system is devised to care for emergencies only. You may not get all the attention you need to solve your problem completely.
Orality
"Talking about your diabetes can help maintain harmony."
When diabetes is common, runs in your family or affects your friends, it helps to talk about how you care for your diabetes. Sharing stories with others can help spread knowledge and keep diabetes real. The doctors in the emergency department may have less experience caring for diabetes than you do living it.
Rhythm
"Some patients with diabetes feel if someone is attacking them about diabetes, they struggle about what to do."
Sometimes we may feel as though our doctors are telling us the same thing again and again about how to care for diabetes. This may cause feelings of struggle and confusion. Doctors know patients do the best they can at any given moment. Having a regular primary care provider may help to have someone understand what diabetes was like for you in the past while understanding what is going on now.
These statements were created by taking Jone's TRIOS (2003) and Scollan-Koliopoulos, Rapp, & Bleich, (2003) measure and turning the statements into talking points to use as communication interventions.

Table 4: Potential tailoring talking points to deter emergency department use.

The adaptation to the environment would include trauma responses to chronic and systematic resource and social loss/deprivation in healthcare [40]. Using an Afrocentric cultural model, such as Jones [7] psychological enhancing and protective factors to operationalize grand nursing culture theories may result in culturally competent care that meets preferences for healthcare interventions. Future research can assess the hypothesis that those who may endorse diabetes as threatening may be more likely to have an emergency department visit within 30-days of a hospital discharge especially if they have higher scores on Afrocentric cultural characteristics in temporality, rhythm, improvisation, orality, and spirituality.

Conclusion

The research question we may need to ask is, "How can we integrate primary diabetes care and education in the emergency department more cohesively?' as opposed to how we do 'divert care'. How do we help patients who culturally prefer and respond to care in their operationalization of temporality, rhythm, and improvisation receive the real-time here and now care without using he emergency room or urgent care intended for acute care for chronic disease management? What are the alternatives from the month's out scheduled appointments? There is a need for research to test the effects of using Afrocentric tailored communication and education to promote efficient and timely chronic disease management within the safety-net hospital setting. We know

standard discharge planning can prevent readmissions and result in successful diversion within 30 days of hospital discharge but is it the long-term solution to meet culturally sensitive care and preferences? standard discharge planning. There is also a need to determine if culturally tailoring of talking points will reduce disparities in emergency department utilization and recidivism for chronic disease management.

Availability of Data and Materials

All data or materials will be shared upon reasonable request to the author

Competing Interests

There are no competing interests to declare

Funding

There was no external funding received for this project

Author's Contribution

There is only one author for this manuscript and no other cont

References

1. Wright JL, Davis WS, Joseph MM, Ellison AM, Heard-Garris NJ, et al. (2022) Eliminating race-based medicine. Pediatrics. 150: e2022057998.
2. Berger JT, Miller DR (2021) Health disparities, systemic racial, and failures of cultural competence. The American Journal of Bioethics. 21: 4-10.
3. Hamed S, Bradby H, Ahlberg BM, Thapar-Bjorkert, S (2022) Racism in healthcare: a scoping review. BMC Public Health. 22: 988.
4. Lett E, Asabor E, Beltran S, Xannon AM, Arah OA (2022) Conceptualizing, contextualizing, and operationalizing race in quantitative health science research. Annals of Family Medicine. 20:157-163.
5. Zhang X, Carabello M, Hill T, Bell SA, Stephenson R, et al. (2020) Trends of racial/ethnic differences in emergency department care outcomes among adults in the United States from 2005-2016. Frontiers Medicine. 7:300.
6. Leininger, M.M. (1991) Culture care diversity and universality: A Theory of Nursing, New York, N.Y.: National League for Nursing Press.
7. Jones JM (2003) TRIOS: A psychological theory of the African Legacy in American Culture. Journal of Social Issues. 59: 217-242.
8. U.S. Department of Health and Human Services, Office of Minority Health (2021) Diabetes and African Americans.
9. Arnett MJ, Thorpe RJ, Gaskin DJ, Bowie JV, LaVeist TA (2016) Race, medical mistrust, and segregation in primary care as a usual source of care: findings from the exploring health disparities in integrated community's study. Journal of Urban Health. 93: 456-467.
10. Okafor CM, Zhu C, Raparelli V, Murphy TE, Arakaki A, et al. (2023) Association of sociodemographic characteristics with 1-year hospital readmission among adults aged 18-55 years with acute myocardial infarction. JAMA Network Open. 6: e2255843.
11. Khera R, Jain S, Pandey A, Agusala V, Kumbhani DJ, et al. (2017) Comparison of readmission rates after acute myocardial infarction in 3 patient age groups (18 to 44, 45 to 64, and ≥65 years) in the United States. Am J Cardiol. 120:1761-1767.
12. Bhandari S, Dawson AZ, Kobylarz Z, Walker RJ, Egede LE (2023) Interventions to Reduce Hospital Readmissions in Older African Americans: A Systematic Review of Studies Including African American Patients. J Racial Ethn Health Disparities 10:1962-1977.
13. Williams DR, Cooper LA (2019) Reducing racial inequalities in health: using what we already know to take action. International Journal Environmental Research Public Health.16: 606.
14. Brennan JJ, Chan TC, Killeen JP, Castillo EM (2015) Inpatient readmissions and emergency department visits within 30 days of a hospital admission. Western Journal of Emergency Medicine.16:1025-1029.
15. Agency for Healthcare Research and Quality (AHRQ) and Johns Hopkins University, Armstrong Institute for Patient Safety and Quality. Improving the emergency department discharge process: environmental scan report (Prepared by Johns Hopkins university, Baltimore, MD, undr contract No HHSA 29020100000271.). (2014) Rockville, MD: Agency for Healthcare Research and Quality; AHRQ 14(15)-0067-EF.
16. Curtis E, Jones R, Tipene-Leach D, Walker C, Loring B, et al. (2019) Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. International Journal for Equity in Health. 18:174.
17. Luig T, Ofosu NN, Chiu Y, Wang N, Omar N, et al. (2023) Role of cultural brokering in advancing holistic primary care for diabetes and obesity: a participatory qualitative study. BMJ Open. 13: e073318.
18. Ellis J (2020) Is there systemic racism in EMS? ACEP Now. Acepnow.com/article/is-there-systemic-racism-in-ems.
19. Basu J, Hanchate A, Bierman A (2018) Racial/ethnic disparities in readmission in US hospitals: the role of insurance coverage. Inquiry. 55:46958018774180.
20. Goode P (2017) Diabetes disparities in African Americans: A cry for help to primary care providers. Journal of Health Disparities Research and Practice. 10: 61-66.
21. Hargraves LJ, Hadley J (2003) The contribution of insurance coverage and community resources to reducing racial/ethnic disparities in access to care. Health Services Research. 38: 809-829.
22. Kangovi S, Barg FK, Carter T, Long JA, Shannon R, et al. (2013) Understanding why patients of low socioeconomic status prefer hospitals over ambulatory care. Health Affairs. 32: 1196-203.
23. Vahdat S, Hamzehgardeshi L, Hessam S, Hamzehgardeshi Z (2014) Patient involvement in health care decision making: a review. Iran Red Crescent Medical Journal. 16: e12454.
24. Horwitz LI, Moriarty JP, Chen C, Foogerty RL, Brewster UC, et al. (2013) Quality of discharge practices and patient understanding at an academic medical center. Journal of American Medical Association Internal Medicine. 173:1715-1722.

25. Goncalves-Bradley DC, Ianin NA, Clemson LM, Camron ID, Shepperd S (2016) Discharge planning from hospital. Cochrane Database Systematic Review. 2: CD000313.

26. Assari S, Smith J, Bazargan M (2020) Poor self-rated health is associated with hospitalization and emergency department visits in African American older adults with diabetes. Journal of Racial and Ethnic Health Disparities. 7: 880-887.

27. Parast L, Matthews M, Martino S, Lehrman WG, Stark D, et al. (2021) Racial/Ethnic difference in emergency department utilization and experience, Journal of General Internal Medicine. 37:49-56.

28. Caston R, Rovner B, Change AM, Hollander JE, Kelley M, et al. (2020) A randomized clinical trial of a collaborative home-based diabetes intervention to reduce emergency department visits and hospitalizations in black individual with diabetes. Contemporary Clinical Trials. 95:106069.

29. Benoit S, Hora I, Pasquel FJ, Gregg EW, Albright AL, et al. (2020) Trends in emergency department visits and inpatient admissions for hyperglycemic crisis in adults with diabetes in the U.S., 2006-2015. Diabetes Care. 43:1057-1064.

30. Rovner BW, Casten RJ (2021) Emergency department visits in African Americans with mild cognitive impairment and diabetes. Journal of Diabetes Complications. 35:107905.

31. Yan JW, Gushulak KM, Columbus MP, Hamelin AL, Wells GA, et al. (2018) Sentinel visits in emergency department patients with diabetes mellitus as a warning sign for hyperglycemic emergencies. CJEM, 20: 230-237.

32. Lewis VR, Benda N, Nassar C (2015) Successful patient diabetes education in the emergency department. The Science of Diabetes Self-management and Care.

33. Black RL, Duval C (2019) Diabetes discharge planning and transitions of care: A focused review. Current Diabetes Reviews. 15: 111-117.

34. Joo JY, Liu MF (2020) Effectiveness of culturally tailored interventions for chronic illnesses among ethnic minorities. Western Journal of Nursing Research. 43: 73-84.

35. Cokley KO (2005) Racial(ized) identity, ethnic identity, and Afrocentric values: Conceptual and methodological challenges in understanding African American identity. Journal of Counselling Psychology. 52: 517-526.

36. Jones JM, Campbell S (2011) Cultural psychology of African Americans. Online Readings in Psychology and Culture. 3.

37. Scollan-Koliopoulos M, Rapp KJ, Bleich D (2012) Afrocentric cultural values and beliefs: movement beyond the race and ethnicity proxy to understand views of diabetes. The Diabetes Educator. 38: 488-498.

38. Leventhal H, Meyer D, Nerenz D (1980). The common sense representation of illness danger. In S. Rachman (Ed.). Medical Psychology (Vol II,p.p. 7-30), New York: Pergamon Press.

39. Subica AM, Link BG (2022) Cultural trauma as a fundamental cause of health disparities. Social Science & Medicine. 292: 114574.

40. Cerdena JP, Asabar EN, Plaisime MV, Hardman RR (2020) Race-based medicine in the point-of-care clinical resource UpToDate: A systematic content analysis. Eclinical Medicine. 52: 101581.