

The Effects of Cultural Competency at San Antonio Regional Hospital Through CHIPS

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Chronic conditions have major increases in the global population annually. Long term illness is detrimental to one's health specially when it is not being properly treated. When healthcare support teams lack understanding of cultural beliefs, norms, and religious views, they miss out on who their patients are as individuals and not just their illness. Consequently, taking away from other important factors which have a major role in patients' lives. Failing to take patients' other life factors into account when treating them, will lead to comorbidity of worsening existing illnesses and being susceptible to additional diseases. Drawing from my experiences interning with the Community Health Improvement Program (CHIPS) at San Antonio Regional Hospital (SARH), this paper examines multiple factors which had significant effects on patient outcomes who have chronic conditions. Attributed to a lack of cultural competency training implications at SARH. This paper will analyze the importance of cultural competency training and how they are effective when working with diverse populations at SARH. As a result, training will improve patient health outcomes and provider to patient communication. Additionally, the information from this paper will provide recommendations on how to provide effective cultural competency training at SARH for patients of diverse ethnic backgrounds.

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Introduction

Living in the most diverse state, Californians face inequalities, racial injustices, and socioeconomic prejudice which play sustainable factors attributed to healthcare disparities. Oftentimes Black, Indigenous, People of Color (BIPOC) patients lack receiving treatments, leading to death or near-death experience due to foreseen neglect. Subsequently, the neglect generated additional health problems for BIPOC communities, as their health problems advanced additional complications and even faced death. Moreover, there are death and complications which could've been avoided with adequate response time and care.

The Community Health Improvement Program CHIPS was designed to help the adult population of Upland California and surrounding areas manage their chronic conditions, through educating them on different diets, medications, and resources. Additionally, patients must first be admitted to the Emergency Room (ER) three times or more within six months to be considered eligible. An issue occurred with supervisors and coaches lacking cultural awareness, professionalism, ethics, and basic human respect. Unnecessary comments occurred multiple times throughout weekly meetings regarding certain patients. Thus, exemplifying how cultural differences affect providers' treatment plans when they are not understanding of patients'; lifestyles. Leading to a domino effect of more harm than benefits as providers give patients of different backgrounds one set treatment plan. Taking away from different factors patients have such as ethnicities, genetic conditions, religious views, language, access to fresh food, access to a gym and more. Patients of certain ethnic backgrounds have higher susceptibility rates to certain diseases. All while, not being properly treated with one set treatment plan. As providers are aware of one set treatment plan not working as race, diet, environment, and other factors have greater effects.

This paper will examine how race, ethnicity, chronic conditions, and socioeconomic status (SES) play crucial roles in patients'; health outcomes. Focusing on two chronic conditions

type 2 diabetes and hypertension which were the most prevalent diseases at CHIPS. Additionally, the internship pertains to both the subfield of public administration through SARH and CHIPS organizational structure. In addition, public policy through the lack of healthcare policies in cultural competency training across the United States. As we examine the lack of cultural awareness within the organization and lack of existing policies for cultural training in healthcare which affect minority populations in the United States. The purpose and relevance to each subfield in political science is to have set policies on mindful practices which includes BIPOC communities in healthcare. Ultimately, to help providers and educators' relationship when speaking and assessing patients of different backgrounds at CHIPS. Background on Organization.

The history of why CHIPS was created was due to patients misusing the Emergency Room (E.R.) for medication refills, routine blood work and other minor problems. SARH guidelines, of an actual emergency are classified as a patient not being able to breath, see, is bleeding profusely, has become unconscious, or is experiencing discoloration. Shany, one of my previous supervisors, proposed the idea of CHIPS to the hospital. Her intent was to reduce the number of non-emergency E.R. visits. Thus, leading her intent to also save the hospital and insurance companies millions of dollars annually as the program continues.

Additionally, CHIPS serves adults who've met the requirements of three E.R. admissions within a six-month period without having a classified emergency. Another requirement is to reside in the surrounding areas of the hospital such as the Inland Empire or San Bernardino County. Patients must be at will to be admitted in the program which ensures patients are aware of requirements, are complying and can leave at any time. Ultimately, these requirements are to better contribute to positive results for patients to thrive with their conditions. Through patient engagement, program understanding, and goals patients set for themselves with the help of coaches.

CHIPS is a non-profit organization which

receives proceeds from SARH and insurance companies. SARH is a public benefit corporation governed by the board of Trustees. Board members are composed of different actors including doctors with different specialties, professors, and other professions. Though the board has withheld long-standing members, there was no information provided regarding elections or term requirements. Moreover, funding sources come from several entities such as the government, donors, insurance companies, and investors. Some investors choose to remain private or anonymous for undisclosed reasons. Non-disclosure agreements are legal documents with terms and conditions for both parties to follow for an amount of time. Therefore, making all the information private, and not following governmental structures rather, follow local private contracts.

CHIPS organizational structure has a mix of hierarchy which begins with the doctor at the head of the team, the next tier is supervisors Shany and Ashely followed by the marketing personnel and student interns. CHIPS structure is heavily centralized around patient engagement who work closely with students which report back to the clinical team. Making the structure a mix of hierarchy and decentralized specifically when it is time for case reviews. Case reviews are composed of a medical care team consultant from the medical director, nurse, social worker, students interns, inputs, and suggestions for the patient's health model plan. Reoccurring once on a weekly basis reporting how well patients are either progressing or regressing. Meetings help strategize new methods to achieve patient goals and plan for future steps. When a patient is not doing well according to their set goals, they may need to restart by creating new goals. After thorough review some patients will be terminated from the program when it has been determined by CHIPS to not be the best fit for them. Termination is a group decision, but the final say comes from the top of the hierarchy of the medical team. Depending on specifics around the case it is done collectively with the director, nurse and social worker having the final say on what is best for the patient.

CHIPS recently made the change of not requiring specialized personnel to be a part of the team. Before April 2024, student interns were required to be college students in a specific field of study. Now, anyone can join the program and volunteer without meeting previous requirements. When I first joined CHIPS in May 2023 it was required for volunteers to be college students. Specific to their field of study such as nursing, psychology, business, and other fields of study were allowed to intern as well. Some students are coaches or nursing interns which have separate roles. Such as, calling patients who were recently discharged from the E.R. with follow up questions. Shay's role is to interview new interns, enroll patients, attend meetings, organize orientation and follow SARH guidelines. Ashely has the same responsibilities as Shany, in addition to providing resources for patients and interns. Resources for patients are provided via websites and numbers. Don from marketing works more with SARH providing CHIPS with news, insights and insurance companies updates as well. He attends CHIPS meetings but most of his work is focused on SARH. Lastly, the medical director attends case reviews to provide medical advice, works for SARH and attends orientation. Overall, all actors at CHIPS have the same purpose to help each other and patients in different ways based on their roles. Depending on what patients need, we provide resources with finding providers, help with insurance companies, food banks and other divisions of social services. By providing patients with additional resources outside of healthcare we help them meet basic needs. As many patients are scared, shy, or ashamed to ask for help they trust us to provide them with the right resources.

CHIPS success rates are measured through data which is compiled into an annual community benefit report. Reports are presented at SARH to improve and change guidelines for future program continuation. Shany is the one who writes and presents the report to the hospital. I was not given access to view this report as our supervisor is the one completing the report. Therefore, I am not aware of data in the report and what measurements are being recorded.

There is no public evidence on display for

anyone to view CHIPS measurements to ensure objectives are being met. However, there are multiple measurements which guarantee CHIPS is meeting its objectives but are not available for the public due to Patient Information (PI), and state laws preventing the disclosure of sharing PI. publicly. Information is available only to certain members of CHIPS and SARH with special access. Information is limited due to confidentiality following Health Insurance Portability and Accountability (HIPAA) guidelines. HIPAA is a federal law which must be always upheld at facilities who manage patient information. Funding sources have specific contracts called non-disclosure agreements including HIPAA and Health Services Advisory Group (HSAG) which have to be honored and followed. Overall, there are objectives being met and measures for success rates but are not public due to federal laws and signed contracts. Preventing the publication of patient information to the public as it is a safety and legal concern.

CHIPS receives monthly and weekly lists of patients who qualify for the program from SARH. They are received and processed by both supervisors who conduct phone screenings. Phone screenings give patients a better understanding of CHIPS and determine eligibility. Once patients are eligible and agree to be enrolled in CHIPS they will be matched and assigned to a coach who will work with them for a few months. During this time patients get to ask questions, set goals and meet with their coaches on their own time. Meetings can be done by a phone call or scheduled home visit or a mix of the two. Patient charting is done via Electronic Health Record (EHR) software which requires access based on roles and responsibilities limiting use to avoid HIPAA violations. CHIPS maintains HIPAA by discussing patient information during case reviews. After case reviews no one discusses the cases unless our supervisors ask us about patients privately. Additionally, accessing EHR, charting and viewing data metrics is conducted in the CHIPS office only to maintain HIPAA. Non-disclosure agreements, including HSAG, are legal outcomes which do not get reported to the legislature since SARH is a community-based

organization.

Internship Experience

My role at CHIPS was a bilingual health coach working closely with White and Hispanic patients helping address non-medical issues. My responsibilities throughout the internship were scheduling appointments, conducting satisfaction calls, answering the phone, leaving messages, attending weekly meetings, and proofreading Spanish handouts. In addition to helping with administrative and other tasks which require my assistance. Being a bilingual coach meant I had more responsibilities to attend to. Helping was an important and necessary part of my role. As there were many Spanish speaking patients who had difficulty understanding what their doctors told them. Many staff at SARH are not fluent in Spanish & interpreters would speak Spanish differently than what patients were used to. Oftentimes, leaving important information out of translation which made patients feel interpreters took away from their courage to ask questions that were important to them. As well as, missing out on crucial information that can help or worsen their condition if not properly following their physicians' orders. Making language an additional factor to check for comprehensive understanding with coaches to check for patients'; understanding of crucial information.

SARH headquarters are in Upland, California where the main and first hospital was opened in 1907. SARH has since expanded with satellite offices, across the Inland Empire and San Bernardino County area. Additional beds were added to the hospital since the COVID-19 pandemic. CHIPS is a satellite office which was currently based in Rancho Cucamonga but is now in Upland.

The assignments I worked on which lead me to the issue this paper will focus on were case reviews, resource list, patient data, and patient satisfaction calls. During case reviews coaches expressed frustrations of not understanding patients' language, lack of understanding patients diets and customs. These gaps lead to cycles of frustration and confusion with patients and

coaches not being able to understand or complete additional work with patients. Supervisors were aware of these frustrations when it came to the lack of comprehending diverse ideology around food, cultures, and medications. Multiple coaches verbalized their concerns on separate occasions with different patients on effective communication. Our supervisor advised us to “push through it” or reassign patients to take on other patients. Alluding to the problem not being resolved but rather managed by being passed around the room but not making a solution for the program. There were insufficient times throughout training on everything attributing to coaches feeling guilty for not understanding different cultures to provide a better understanding for themselves to help their patients reach their goals thoroughly.

The resource list contained information on housing, food, mental health, and other resources in the Inland Empire. Which provided coaches options for additional support to patients inquiring about the resource information. Further on, patient satisfaction calls were used to evaluate how well CHIPS worked with patients by providing feedback to coaches on program improvement. Response ratings were split as half patient’s believed outcomes were good and the other half believed they received nothing helpful from CHIPS. Those who had a positive response believed coaches were effective and appreciated all their hard work to improve their conditions and understanding for a manageable life. The other half felt they did not like their health coaches or got nothing out of CHIPS. The ratings were used to give an additional thanks to coaches who worked well with patients. As well as work harder to improve on specific areas patients felt coaches lacked to better improve for future patients and coaches. After reviewing patient demographics, I noticed Social Economic Status (SES), location and race attributed to patients’ success in CHIPS. Demographic information reflected access to fresh produce, parks, gyms and understanding on educational materials White patients had, compared to other ethnicities. Not to mention, Upland and SARH office locations have higher populations of White neighborhoods. Opposed

to BIPOC patients which had worse results compared to when they began the program.

Regression came from BIPOC patients facing financial strains, immigration status, lack of access to healthy foods, feeling shame for seeking government assistance and not using the standard American diet used at CHIPS. The standard White American diet was not useful to all patients as not everyone shares the same culture and is not a “one size fit all”; diet we can keep giving to everyone. Patients felt information sheets about the standard White American diets did not match their ethnic foods. Leading patients to disregard information sheets and kept eating how they wanted because the diet did not match their culture. Limiting and taking away potential for the BIPOC community at CHIPS, to achieve their health goals the same as White patients can.

Literature Review

Further on, this paper will analyze previous research which examined gaps, trends, and findings in four core areas. These areas will be from different scholarly articles containing a mixed methodology approach using both quantitative and qualitative data, consisting of statistical analysis, cross sectional studies, scales, and case studies. The four presented themes will be on different perspectives of racism and prejudice in healthcare, to BIPOC disparities, effective diets for type two diabetes and mindful practices for providers. As well as, present four arguments on different topics of the themes and how it is applied or failed to be applied. To collectively find a better approach on how to improve provider to patient relationships. As well as evaluate past policies and gaps in current cultural competency training in the United States. Racism and Prejudice in Healthcare

We must analyze the literature review with the concept of discrimination and prejudice in healthcare. Discrimination will occur whether it is done consciously or unconsciously (Chandra, et al, 2010). In the article by Chandra, et al, “Identifying Provider Prejudice in Healthcare” scholars add patient care becomes affected by providers’ biases, beliefs, prejudice, and stereotypes. Affecting patients’ ability to progress

due to inadequate treatments from being received and experiencing long wait times. Scholars found; patients of non-minority groups received treatments when they were at three months of an illness. Meanwhile, minority patients experienced the opposite treatment and instead they regressed since providers treated them at a five-month mark. Providers increased their treatment time to 2 months further instead of treating them at the same time as majority patients. A consequence of this type of prejudice is minority patients will have an increased marginal return rate due to the bad experience (Chandra, et al, 2010). Another form of bias occurs when providers put too much or too little weight on race and gender or misinterpret other patient characteristics at the time of determining appropriateness (Chandra, et al, 2010). Further on, scholars believe obtaining a measurable test for providers will represent major effects caused by racial bias. An argument made on what the best way would be to measure bias from some providers' standpoint was divided. As some providers felt this measurement was not appropriate for their work. All while other providers agreed on being measured on racial bias. An additional view, on this measurement was yes, there will be results, but some providers feel they will not change as their bias is who they are and will continue to work in such a way. Past scholars mentioned the article measuring racial bias with patient actors. This method would be expensive and problematic in healthcare as it can be seen as health fraud for having actors instead of real patients. Not to mention, hospitals would not want to pay actors to participate as providers would not be interested as they are not real patients to examine. Another method presented for provider measurements was Implicit Association Tests (IAT) used to assess cases of prejudice in how providers treat similar patients from different demographic backgrounds (Chandra, et al, 2010). The test represented a conscious awareness of providers selecting treatments for certain races. There was not a reason provided for why providers willingly neglected certain patients in the experiment.

In another article with similar arguments scholars emphasize racism constitutes a barrier

towards achieving equitable healthcare (Hamed, 2022). The result of racism affects minority patients from receiving treatments for the same condition as White patients. The article found White patients receive treatment for the same illness at the two-month mark compared to minority patients who received treatment at the five-month mark. Minority patients got sick or worsened their illness when providers could have prevented it. The outcome of minority patients who lacked treatment had higher mortality rates. While White patients had higher return rates for treatment and got better at a higher rate. Previous scientific research on various ways racism affects healthcare has grown steadily (Hamed, 2022). Overall, scholars found racism has always been a problem in healthcare and will continue to grow. As there has been limited efforts from providers who have racial bias towards how they treat patients from certain backgrounds. Scholars in both articles agree healthcare can limit bias with measurements. Some measurements were cases, patient demographics, and scales measuring racial bias affecting how fast patients are seen and treated by providers. Hamed (2022) mentioned providers do not care to avoid or limit bias which affects their ability to help meet patient's needs.

In contrast, Stanford and Pizzuto (2022) had a different stance on reasons for discrimination in healthcare. The above scholars have a narrow view opposed to above scholars who have broad reasons as to why racism in healthcare is a contributing factor. Healthcare discrimination experience is expected to be a consequential variable that explains racial/ethnic inequities in patient activation and health (Stanford and Pizzuto, 2022). Overall, all scholars agree and accept discrimination to occur in healthcare. Despite the opposed theory of why racism in healthcare occurs. Stanford and Pizzuto (2022) use existing healthcare scales to assess discrimination, which looks at patients' household income, conditions, life stressors and more. Opposed to Hamed's (2022) scale assessing providers racial bias not from a patient's standpoint. However, both Hamed and Stanford and Pizzuto (2022) agree on the importance of understanding the effects of racial/ethnic discrimination in healthcare.

Further on, Stanford and Pizzuto (2022) add on discrimination experience may be a fundamental indicator of overall healthcare quality (Stanford and Pizzuto, 2022). Patients did not improve their illness and were “confused” throughout as they felt their providers were not understanding.

All in all, the above articles highlight the theme of racial bias resulting in disparities in treatment amongst minority patients. Additionally, Chandra and Hamed agree bias and racism will always be a present factor for patients of certain backgrounds to face. Hamed (2022) findings were primarily on conscious awareness of racism from providers. While Stanford and Pizzuto (2022) scale analyzed and measured patients giving different results and not providers. Both articles agree trying to limit racial bias with measurements may improve the existing gap of treatment disparities in the country. However, Hamed (2022) does not have a strong solution for what to do when providers are aware of their bias to certain patients affecting treatment disparities. Stanford and Pizzuto (2022) article argue for the use of scales to obtain variables for patients. As variables are a clear indicator for what providers can improve on. Overall, all three articles lacked policies and strong solutions for proposals to the existing racial gaps in healthcare. As seen in scholarly articles, racism has, and will always be, a problem in healthcare, but proposing a mandated policy for all public healthcare facilities to follow can help limit these problems. As scholars show, measuring bias will help limit racism and decrease treatment disparities for minority patients. Stanford and Pizzuto (2022) emphasize the use of scales which improve patient-provider relationships. A possible policy proposal which can help aid gaps related to racism regarding health care is Mandatory Cultural Competency training done on a semi-annual basis. These articles prove the importance of having cultural competency training as bias and racism are co-occurring unconsciously and consciously.

BIPOC Disparities

Like the first theme, racism affects disparities and prejudice towards BIPOC patients in healthcare. Moreover, existing literature

addresses the divide and reasons for why White patients succeed opposed to BIPOC patients when it comes to chronic illness with the use of frameworks and scales. To begin we analyze data and gaps which lack representation for BIPOC patients in healthcare. In the United States with healthcare professionals, administrators, and policy makers information to address this public health concern (McCoy, et al, 2015). The biggest challenge is insufficient BIPOC representation on a national scale to help prevent recurring healthcare disparities. McCoy (2015) mentions a trend of gaps within the Hispanic population growing as the divide becomes wider. As more Hispanics make up California’s population there are more medical disparities occurring. As a result of the gap, Hispanics also die while waiting for treatments given too late. The literature exhibits the lack of urgency represented to the Hispanic population in the ER. Moreover, on a national level all patients are not viewed as equal. Far from equal, opposed to White patients who had the same condition with an approximate number to the Hispanic patients They did not face any disparities but were instead prioritized and treated at a faster rate without having a valid reason to be seen sooner than they were. As White patients were viewed as a priority in the waiting room while having the same condition as BIPOC patients. A visible trend for White patients was that while more Hispanics were being dispraised in the Emergency Room the lower their mortality rate went. All in all, Hispanics’ mortality rates due to lack of medical attention raises no policies or laws implemented to address this long existing systematic issue in healthcare with other ethnicities. McCoy (2015) mentions records of disparities held at Washington D.C. and other federal agency offices. Thus far, no urge was displayed for representation for policies, formulated for those who were severely affected by a loss, which could have been avoided with adequate attention. Further on, McCoy (2015) alludes to federal and state agencies using evidence to conduct their own studies on disparities, race, income, and occupation. These agencies witnessed the magnitude of these issues on a national level and its effects.

The agency conducted their own study and published it after being made aware of hospitals and patients' neglect caused by racial prejudice, withholding medical treatment due to their ethnic background, and doing nothing. Attributing to these agencies brushing away the problem and essentially allowing for the cycle to continue. As these facilities did not face any legal punishments and patients lost trust in the healthcare system. McCoy (2015) emphasizes the effects of families and individuals who were victims of medical disparities who did not return to the Emergency Room, unless they were severely sick. Due to family members not returning with a loved one or becoming additionally sick then before getting to the E.R. and being stuck with a high medical bill.

Further on, another scholarly article examining seven Kaiser clinics nationally found disparities attributed to location and lack of resources being met for BIPOC communities. As population creates demand for resources to be met for BIPOC patients to use. Schmittiel (2008) argues once basic needs are met such as language then, chronic condition scores will also improve. Giving patients better results on their assessment scales as seen with White patients who have good scores. Good scores are seven and above, bad scores are anything below a seven for this article's index measurement scale. Using the Chronic Care Model (CCM) a widely accepted framework for delivering care to patients with chronic illnesses (Schmittiel, et, al,2008). Resulted in missing out on many existing disparities not attributed to the patient's actual chronic condition. However, hospital facilities had been made aware of needed resources to better help BIPOC patients but did not urge to obtain necessary accommodations for patients. Being an added factor for their scores to be a seven and below on the scale. Schmittiel (2008) did not mention throughout the literature what the reason was besides lack of demand for population demand. Further on, Schmittiel (2008) mentions previous work briefly with subtypes covered from past research using scales but there were no gaps or arguments mentioned in detail. All in all, evidence of data scales does not correlate with hospitals as they

do not push for policies to meet real solutions for BIPOC communities with high demands. Especially, BIPOC communities as they are minorities throughout several states not receiving proper resources attributing to low scores on chronic conditions scales.

Moreover, there is years of compiled evidence from different sources from both themes. As all scholars mention the long-standing systematic history of disparities and racism in BIPOC communities. No previous framework, scale, or data results towards achieving possible solutions for BIPOC communities nationally. Politically there have not been policies pushing to advocate for BIPOC rights in healthcare. Given the failure of federal and state level agencies doing anything for patients or hospitals with all the documented evidence they are equally responsible as providers and hospitals. Additionally, McCoy (2015), alludes these agencies are a reason for this systemic problem of medical disparities being promenade for BIPOC communities nationwide. Schmittiel (2008) also agrees BIPOC disparities are attributed to environmental factors, population, and lack of demand for resources. Overall, McCoy (2015) did not mention solutions to fix long existing systemic problems in healthcare, although did provide insight on California's disparities in the Emergency Room. Schmittiel (2008) provides insight on why BIPOC patients score lower than White patients on scales not attributing to race but rather attributing to hospital lack of resources and representation for BIPOC communities. Such as, language barriers making it difficult to understand the root of patients' conditions.

Effective Diets for Type Two Diabetes

Further on, the following theme of effective diets and type two diabetes explores the importance of certain cultural diets and etiology of the condition. Khazrai (2014) states diabetes is the most prevalent illness globally with an expected number of people diagnosed to be 552 million globally. Attributing lifestyle and medication therapy to be two main factors to getting diagnosed with the condition. There is no definite consensus on how to treat this disease with recommended therapies (Khazrai, et, al,

2014). Among the fields, there are agreements on diabetes being the most common illness globally and no exact way on how to cure it for everyone despite many treatment options Khazari (2014) mentioned. An effective diet Khazari (2014) mentions to be the Mediterranean diet, which is vegan, vegetarian, and overall affordable. The American Diabetes Association has made several recommendations regarding medical nutrition therapy of diabetes (Khazrai, et, al, 2014). Many dietary regimens are available for patients with type 2 diabetes to choose from, according to personal taste and cultural tradition (Khazrai, et, al, 2014). It is important to provide a tailor-made diet wherever possible to maximize the efficacy of the diet on reducing diabetes symptoms and to encourage patient adherence (Khazrai, et, al, 2014). As previously stated, other providers must work one on one with patients to be effective on their health journey and not give them generic information which does not fit their cultural needs. Overall, Khazrai (2014) highlights recommendations for providers and other actors in healthcare to push for individually working with patients for the best results possible. Associations have statistics facts made that push for recommendation but do not have set policies on the recommendations made. Khazrai (2014) does not mention a reason for healthcare workers advocating for policies. However, we can assume healthcare professionals fear politics or policies as it can be unethical to speak on in their field of work, having lawyers represent healthcare facilities.

Another scholar agrees, diabetes is the most common and complex disease to treat but argues it is based solely on etiology and not medication or diet like Khazrai (2014) mentioned. Etiology of T2DM is complex, associated with irreversible risk factors such as age, genetic, race, and ethnicity and reversible factors such as diet, physical activity, and smoking (Sami, et, al, 2017). Sami (2017) analyzes more factors than Khazrai (2014) did while analyzing the greater aspects of the condition. Khazrai (2014) examines the importance of diet while Sami (2017) analyzes diet and a sedentary lifestyle solely. Sami (2017) examines more studies and facts in his study

attributing to diabetes being more complex and not as simple as Khazrai (2014) writes it to be in his literature. However, both scholars analyze leading risk factors for developing microvascular and macrovascular complications (Sami, et al, 2017). Sami (2017) examines 3000 years ago of ancient Egyptians and Indians, illustrating some clinical features very similar to what we now know as prehistoric diabetes. Which mentions diabetes to be an old condition across many cultures no one has answers to theories or cures from centuries ago. The only occurrence is stakeholders have similar challenges worldwide. In addition, over 18 poor developing nations had even less knowledge and worse growing rates of diabetes. Since diabetes is something, stakeholders have control over, the only way to manage it is by the way we eat. Moreover, another scholar states the opposite as, good nutrition still does not guarantee someone's immunity to be diabetes free due to other factors such as, gender differences, environment, and genetics. Making it pointless to keep pushing for better policies on better food standards. However, European nations do not agree with Sami (2017) argument. As they strongly disagree and will keep advocating for policies on better food standards, better working conditions and policies for less environmental waste. Another finding was European nations have better numbers when it comes to diabetes despite high consumption rates on sugar, carbs, and alcoholic beverages. Sami (2017) alludes to diabetes coming from many factors beyond food, gender, environment, genetics and medication. Not to mention Europe has higher numbers of White Europeans natives, with smaller numbers of minorities compared to other nations on a global scale. Taking away from smaller language barriers and cultural differences is not a big problem compared to the United States.

Mindful Practices for Providers

Moreover, the final theme of mindful practices for providers emphasizes the importance and benefits of promoting a better understanding for both parties. Burgess(2017) restates that healthcare providers hold implicit racial and

ethnic biases that may contribute to healthcare disparities as seen in the first two themes. Restating what past scholars stated was there not being progress being effectively made. As little progress had been made in identifying and implementing effective strategies to address these normal but potentially harmful unconscious cognitive processes (Burgess, et al, 2017). Burgess (2017) arguing for the implementation of meditation training for healthcare providers. Stating providers need these therapeutic skills to address racial and ethnic bias. Emerging evidence suggests mindfulness practices can reduce providers' contribution to healthcare disparities through several mechanisms including: reducing the likelihood of implicit biases. Which will be activated in the mind, increasing providers' awareness of and ability to control responses to implicit biases once activated, increasing self-compassion and compassion toward patients, and reducing internal sources of cognitive load such as, stress, burnout, and compassion fatigue (Burgess, et al, 2017). This suggested approach will also benefit providers' minds and bodies to work effectively with patients to reduce racial bias. A question Burgess (2017) stated was how mindfulness and meditation practice can reduce the effects of implicit bias on patients from stigmatized groups. Burgess (2017) "habits of mind" are unconscious stereotypes of certain ethnicities such as African American providers must break out to limit racial bias and provide equity to patients. She conducted laboratory experiments conducted with non-clinicians, and meditation was shown to reduce implicit bias, assessed by Implicit Association Test (IAT), a widely used computer-based measure of unconscious bias. Her findings were meditation was effective to adults in marginalized communities for both providers and patients. Further on, explaining the science behind how the brain is clamped during this state reducing implicit bias. Burgess'(2017) work is promising but may be problematic as some providers may opt-out of this training on the basis that their religious rights are being unhinged. Some people avoid mediating because of religious beliefs and others look at meditating for religious beliefs.

Overall, providers can work around this practice and still leave gaps when it comes to provider to patient relationships.

Another scholar pulls away from meditation and focuses on the importance of building therapeutic alliances. Stating therapeutic alliance is agreeing on goals and tasks to stay on track obtaining promising outcomes. Further on, Michael (2007) states therapeutic alliance is arguably the most crucial process for critical skill processes of clinicians and using it for long term treatment. Michael (2007) states the first step to establishing therapeutic alliance is to listen to patients' sensitivity. Additionally, asking are these traditional factors really the most important? (Michael, et, al,2007). Further on, Michael (2007) mentions the process to check for not only understanding but the baseline of what is important to each patient. As these factors may change over the course of treatment with outside factors possibly affecting treatment. A great political example noted by Michael (2007) was the political alliance of the Second World War. During that time members of the alliance included the United States Britain, Canada, and Russia (Michael, et, al,2007). The alliance at the time was fundamentally strong because of trust, respect, and empathy for one another. Going back to having these same core concepts when working with patients. Having goals, communication and motivation interviews will bring out the best in both provider and patients to work harder.

Finally, the last scholar argues the need for cultural competency training stemming from the growing, diverse workforce. Which is crucial in reducing health disparities and improving health outcomes (Jorge, et al, 2017). Jorge (2017) analyzes years of data linking back to the generational long-term effects in multicultural communities. Center for Disease Control (2011), some of the most striking health disparities among multiracial and multiethnic populations include life expectancy, infant mortality, rate of birth defects, the incidence of chronic diseases such as diabetes, cardiovascular disease and mental illness, survival rates in cancer, as well as substance abuse and suicide rates (Jorge, et al, 2017). Jorge (2017) examines grand effects

and framework scholars missed out on. Finding these systemic problems to be known throughout medicine, research, and politics. Overall, no one from these fields does anything to close the gap; rather, stakeholders make the systemic problem adjustable, making it okay to keep existing and thriving throughout. As Jorge (2017) adds on another agency for Healthcare Research and Quality (AHRQ) considers the following groups as “priority populations” for research, policy, support, and funding: women, children, elderly, ethnic minorities, racial minorities, special needs population, urban or rural population as well as the lesbian, gay, bisexual, and transgender (LGBT) population (AHRQ, 2016). Grouping and coining the term to most people from a diverse population. Healthcare management programs play an important role in preparing the future workforce to manage diversity and eliminate health disparities by offering educational opportunities on cultural competency, inclusion, and diversity leadership in management curriculum. The University of Virginia, School of Continuing and Professional Studies (SCPS), has developed an online program to prepare healthcare management students with the leadership, communication, and cultural competency skills to improve the management of a diverse workforce and health disparities (Jorge, et al, 2017). As education is a big contributor to our providers becoming not only culturally aware but also equity in talking to patients. Additionally, providers can become more mindful through educational online programs. Which helps the overall gap in racial disparities as cultural competence is a needed program for change. The program provides mentorship, collaborative projects, awareness, and reflective learning opportunities for students to build their skills for diversity management to meet the needs of their patients (Jorge, et al, 2017). A policy proposal would be to make a course like this offered to become a part of the curriculum for medicine and public health majors as the results from students are positive when working with diverse patients.

Analysis

Further on, this Analysis section will go over different themes related to cultural competence specific to improve CHIPS training standards, setbacks, areas of improvement, and need for policies to advocate for BIPOC communities nationally. In addition to each subsection, there will be arguments with collected data from my firsthand experiences of CHIPS such as interviews, observations, journals, information sheets and patient demographic information. As well as scholarly literature to back up these observations, experiences and arguments presented throughout subsection topics.

CHIPS Training Standards

To begin with, from my own personal observation's orientation was short and brief as we only touched bases on what chronic conditions are, history of SARH and CHIPS, intervening and communicating with patients. Leaving out essentials and fundamental information such as how to communicate with patients of different backgrounds which brought up more issues. Such as, language barriers despite speaking the same language many patients were born in their homeland attributing to speaking a different dialect. As someone who doesn't speak Spanish with a dialect or accent it was oftentimes difficult to understand patients. Further on, I also conducted an interview with four health coaches three agreed language was a barrier when speaking to patients. Another factor in the need for cultural competency training was many coaches experienced frustration which later turned to burnout. As a scholar mentions, lack of appropriate training will be a recurring factor for providers. From my own experience the burnout burdened me mentally as I did not want to participate in CHIPS due to these frustrations with my own patients. My own patient at the time was leaving out crucial information, changing their story many times, and oftentimes blaming me for her own health problems. One of my supervisors, Ashely, was supportive and told me to intervene. As Michael (2007) emphasizes the benefits and effectiveness of intervening and motivational intervening.

Training Setbacks

In the interview I conducted all interviewees believed “there needs to be more done for patients of color”. Moreover, be sensitive when talking about patients during case reviews. As all interviewees felt there was lack of profession when speaking about patients during case reviews. Additionally, all interviewees believed there needs to be more done in preparing coaches as many felt like they had to “figure it out on their own”. Which should not be the case if we are receiving training and orientation. Ultimately, the scholarly articles of mindfulness “providers never stop learning”. Meaning no matter how many titles or awards a facility has, providers and agencies are never done learning as cultures are so vast. Made up of different religions, languages, ethnic groups and much more. Not to mention, ethics, cultural awareness and professionalism must always be followed. Especially when patients are not present to defend or speech on their behalf. Given CHIPS is a non-profit means they do not follow all governing policies from Congress.

Areas of Improvement

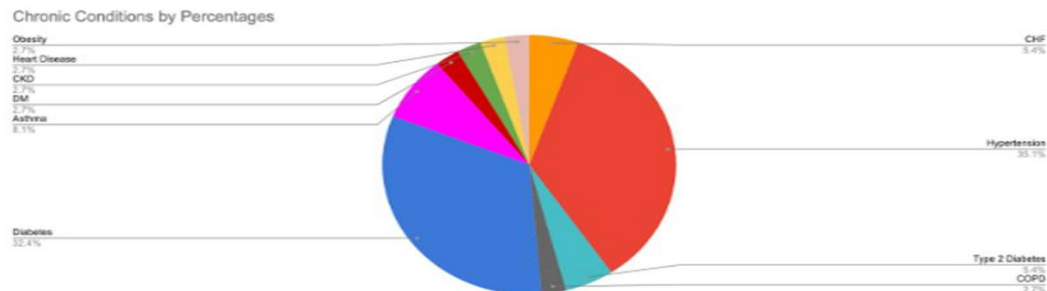
Jorge (2017) mentions the importance and effectiveness of The National CLAS Standards (Office of Minority Health, 2010). As it provides an excellent framework for education as its principal standard focuses on providing “effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs (Jorge, et al, 2017). Below are specific standards especially relevant to future healthcare managers. Standard Two Advancing and sustaining organizational governance and

leadership that promotes health equity through policy, practices, and allocated resources (Jorge, et al, 2017). Making the CLASS standards useful for any governing body of administration if it follows this system. In addition, to utilizing policies and strategies of mindfulness practices for the internship. Burgess (2017) notes the benefits are not only to close the gap of racial bias for providers but also to help providers mind and body from burnout. Further on, this is important and crucial as CHIPS stakeholders experience burnout, lack cultural awareness and have unconscious bias.

Further on, the data compiled below highlights two important problems from 2023 patients.

Diabetes as both scholars from the literature review section mention diabetes was the most prominent condition at CHIPS in 2023 and 2024. In addition, I found that SARH has a faulty system of taking patient demographics.

The above data does not accurately represent patients in the program. As I saw an equal amount of White and Hispanic patients. I also saw Asian and Black patients; however, I am not sure how patients identified during the E.R. intake. Another finding from the data was mix, ethnicity but and other races were not accounted for. Attributing to why there was 75.7 percent of patients from 2023 who are not labeled or chose not to identify with any race the hospital had available. As previously mentioned, there were also Asian American patients in the program, but the graph does not accurately reflect the information. Leading to our next theme of need for policies for BIPOC communities in healthcare.



Need for Policies to Advocate for BIPOC Communities Nationally

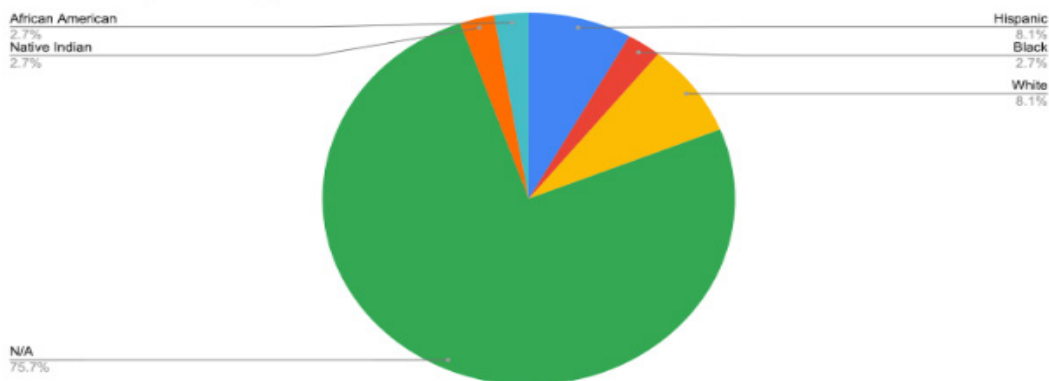
All in all, tying back from my own firsthand observations, scholar literature, interviews and patient demographics we are systematically leaving out minority groups that are becoming majority. As multiple scholars mention this racial divide in healthcare has records in Washington D.C. and nothing is being done. Instead, federal agencies are conducting their own studies and coming up with terms for this racial bias. Not addressing the need for resources or basic human rights to equity in healthcare. Scholars touch on frameworks and past policies but it is problematic as providers would not want to participate in training for multiple reasons. One reason from Burgess (2017) article would be religious bases of meditation. Another reason in this article and in other scholarly articles is cost for additional training and location. Additionally, the overall literature lacks policy making for BIPOC communities as healthcare and politics are sensitive. Lacking equal representation nationally for BIPOC communities to attempt to receive equity in representation for basic accommodations in their healthcare system. Summarizing the previously stated barriers in language, immigration status, economic and more this may be an even harder way of obtaining representation for most. Overall, representation for BIPOC communities is possible as scholarly literature states is possible but will take longer to make it to Congress due to current lack of representation and advocacy.

Conclusion

Overall, this paper explored, examined, and analyzed, significant effects on cultural awareness in healthcare for BIPOC patients with diabetes and other chronic conditions. All scholars agreed this issue has a long history nationally within healthcare and will continue to grow if no policies or representation starts now. Advocacy for BIPOC communities is not on the same level as it is for majority patients. There are proposals for measurements to limit racial bias however, these biases will continue. As providers have “set” beliefs on patients from certain backgrounds. These measurements only provide theory of racism in healthcare more but did not represent nor help BIPOC patients in any manner. Instead set policies will hold providers and healthcare facilities more accountable as there would be no way to get around the set policies. An example of a policy that advocates for patients is HIPPA. Before 1996 patients had no right to privacy in healthcare as providers and administrators would share personal and medical information to anyone. Now in 2024 if a provider does this, they will lose their licenses emphasizing the importance of privacy for providers to honor.

Overall, CHIPS can obtain an effective proposal by having interns teach additional courses during orientation. Making it mandatory to be taken for every year of being in the program. Additionally, being able to reduce health coaches stress, burnout and frustrations when working with patients they do not know much about. Another benefit is professional development of student interns learning more about other

Race/Ethnicity Percentage



ethnicities they are allowed to use outside of the organization. Another proposal for CHIPS is providing student interns with mental health days to miss a few days of volunteering. As research proves, mindfulness is important to have when working with patients. Interns should have a few days off, no questions of since the internship is not paid and gets overwhelming with other life factors. In addition, interns will have less rates of experienced burnout and will recharge to come back with a happier mood to work with patients. Mental health days will reduce unconscious and conscious bias coaches may have providing the best adequate and equal care for all despite backgrounds. Finally, the third proposal to improve CHIPS is having continuing education for all stakeholders.

Ultimately the purpose of these three policy proposals will be to implement, better work ethic, bring out leadership and measure success rates in the program. Additionally, we will help the SARH community have a better understanding of one another to limit implicit bias. As well as be an example of a majority community advocating for minority patients within to give equal treatment to prevent the divide of health disparities for BIPOC patients from growing.

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