Summer 6-12-2008

Synthesis of Data to Develop Cultural Competency Training for Telehealth Nurses Providing Outbound Disease Management Programs to Hispanic Patients.

Barbara L. Kreinbring
Augsburg College

Synthesis of data to develop cultural competency training for telehealth nurses providing outbound disease management programs to Hispanic patients.

Barbara L. Kreinbring

Augsburg College

Augsburg College
Department of Nursing
Master of Arts in Nursing Program
Thesis or Graduate Project Approval Form

This is to certify that **Barbara L. Kreinbring** has successfully defended her Graduate Project entitled **"Synthesis of data to develop cultural competency training for telehealth nurses providing outbound disease management programs to Hispanic patients"** and fulfilled the requirements for the Master of Arts in Nursing degree.

Date of Oral defense June 12, 2008.

Committee member signatures:

Advisor: Susan K Nash Date 06-12-08

Reader 1: Ruth C. Ernstedt Date 06-12-08

Reader 2: Lynda K. Matte Date 06-12-08

Abstract

Telehealth nurses deliver disease management programs to culturally diverse populations, including Hispanic patients. Disease management programs focus on chronic conditions such as diabetes, which are increasing in prevalence. The CDC predicts that the number of Hispanic people with diabetes will rise nearly six-fold by 2050. The nurses who deliver these programs via the telephone need training focused on culturally competent care. The purpose of this project is to review and synthesize information in order to develop cultural competence training for telehealth nurses providing disease management programs to Hispanic patients.

Acknowledgements

I'd like to thank Sue Nash, my project advisor, who provided great advice and support during this process. She was patient and encouraging. Thank you to Linda Matti for agreeing to be one of my readers; I appreciate her willingness to do this for me. Thank you to Ruth Enestved for being a wonderful teacher and advisor. I'd also like to thank my family for their support. Finally, thank you to Augsburg College for offering this program.

Table of Contents

Chapter 1 Introduction

Purpose of the Field Project

Over the last twenty years, health care in America has gone through a transformation. This transformation includes the current technology boom, an increase in life expectancy, and advances in research which continually alter medical treatment (Nosek, 2004). Globalization also has had an impact on health care. Major health care providers have both created the change and responded to the change.

These changes in health care delivery and the population to be cared for have an impact on nursing care. Many major medical centers and most health plans have had to develop strategies to reach more people in cost effective ways. One way to meet these needs is develop telehealth departments in response to this changing health care environment. Through telehealth a nurse can provide remote monitoring, education, follow-up evaluation, analysis of device data, remote interventions, pain management, family support, wound care, and multidisciplinary care in an innovative way leveraging the use of remote telecommunications technologies (Grady & Schlacta-Fairchild, 2007). Telehealth departments may include units that provide acute symptom triage, case management, pregnancy advice, and disease management services. These departments can reach millions of people who are spread across the United States. These clients represent a cross section of the country in that they are different ages, have varying educational backgrounds and are from different countries of origin (Borchers & Kee, 1999).

This project will focus on the telephonic disease management programs offered by Mayo Clinic Health Solutions. The disease management programs are sold to

employers and health plans as a benefit to their members. Members with chronic conditions such as diabetes or heart failure are identified and enrolled in a program by a registered nurse via the telephone. The member and the nurse schedule appointments for phone calls where they assess the needs of the member, create a care plan and then work on the components of the care plan.

The nurses who deliver care via the phone need cultural competence training to provide effective nursing care. Some organizations offer general cultural competence training that meets some of the needs of the telehealth nurses. A review of course outlines from several major health care centers reveals these general cultural competence courses do not offer specific information about the use of the telephone as a health care delivery tool for people of differing backgrounds. These health care centers include:

- Harvard
- Kaiser Permanente
- Mayo Clinic
- University of California San Francisco

The purpose of this project is to review and synthesize information in order to develop cultural competence training for telehealth nurses providing disease management programs to Hispanic patients. The project will also reveal issues related to the telephone as the delivery method of care to a specific group.

Significance of Project

Mercer calculated that in 2005 67% of large employers in the United States offer their employees one or more disease management telephonic programs ("Disease Management in Large Employers," n.d.). The Centers for Medicare and Medicaid

Services (CMS) also adopted telehealth for Medicare and Medicaid population. Starting October 1, 2001, CMS authorized payment for Medicare recipients for telehealth initiatives (Department of Health & Human Services, 2003). Disease management programs are currently a series of demonstration programs for Medicare populations (Center for Medicare & Medicaid Services, 2002). The Center for Medicaid and State Operations endorsed disease management in 2004 as

> an exciting opportunity to significantly improve the care delivered to Medicaid beneficiaries with chronic conditions. It has emerged in both the public and private sector as a strategy to bring the benefits of care coordination techniques honed in managed care organizations (MCOs) to populations and regions that traditionally have not had access to those comprehensive capitated systems. (Department of Health & Human Services, 2004, para. 1)

Disease management companies typically offer programs for diabetes, cardiovascular disease, and respiratory diseases such as asthma and COPD (Boston Consulting Group, 2006). These conditions are considered health risks for minority populations. By 2050 officials from the Centers for Disease Control and Prevention in Atlanta estimate the number of US citizens with chronic conditions will double (CDC, 2008). The number could climb if the rate of obesity among Americans continues to rise. Researchers predict minorities will face the greatest burden. While the number of whites with diabetes will double, the number of African-Americans with diabetes is expected to triple by 2050. The number of Hispanics with diabetes is likely to rise nearly six-fold. Limited understanding of disease progression and frustration with disease management contribute to the clinical challenge of meeting the rising type 2 diabetes epidemic in

America, according to the Diabetes Roundtable (Diabetes TEAM, 2006). While diabetes is just one of the conditions addressed by telephonic disease management services the growth in prevalence and the challenges this presents for Hispanics may represent a larger issue.

Concurrent with the expansion of telehealth programs is a nursing shortage in the United States. Current working conditions have contributed to the shortage (Buerhaus, 2002). Professional organizations such as the Joint Commission on Accreditation of Healthcare Organizations and the American Academy of Nursing are searching for solutions to the shortage (McNeil, 2003). A 2004-2005 survey asked an international sample of nurses working with telehealth technologies how and why telehealth could combat the nursing shortage. The nurses responded by saying telehealth could keep them in nursing longer due to physical limitations, offers them improved access to the information they need to care for patients, and improves their ability to reach more people while wasting less time (Grady & Schlachta-Fairchild, 2007). The use of technology in telehealth programs is considered an important step in improving conditions and perhaps helping address the nursing shortage issues.

Nursing Theorist

Madeleine Leininger's Culture Care Diversity and Universality Theory guides this project and cultural competence is a central theme for this project. A training program will be effective when nurses have culturally based knowledge of their clients and use culturally based interventions for their care. Madeleine Leininger's interest in cultural dimensions of human care and caring led to the development of her theory of

culture care in the 1950's and 1960's. The focus of Leininger's theory is care that she believes to be inextricably linked with culture (Leininger, 1991). She defines culture as 'the learned, shared, and transmitted values, beliefs, norms, and life ways of a particular group that guides their thinking, decisions, and actions in patterned ways" (Leininger, 1991, p. 47). The purpose of the culture care theory is as follows:

> to discover human care diversities and universalities in relation to worldview, social structure and other dimensions cited, and then to discover ways to provide culturally congruent care to people of different or similar cultures in order to maintain or regain their well-being, health or face death in a culturally appropriate way. (Leininger, 1991, p. 39)

Leininger's Sunrise Model/Enabler (Leininger, 1991) is used to guide the development of a training program for telehealth nurses on how to provide meaningful disease management care over the telephone to Hispanic patients. In her model the upper half of the rising sun shows the components of social structure and cultural dimensions that influence care through language and environment. Social structure factors include education, economics, politics, legal issues, kinship, religion or spirituality, technology, philosophy of life, gender beliefs, and class differences (Leininger & McFarland, 2006, p. 14). These diverse factors must be understood as they directly or indirectly influence health and wellbeing (Leininger & McFarland, 2006, p.14). The study of these dimensions using Leininger's theory leads to a holistic view of patients and therefore culturally congruent care (Leininger, 1991).

The components of the upper half influence the lower half of the sun, which are the folk, professional, and nursing systems. The folk constructs from the lower half of the model are also referred to as the emic or insider's cultural knowledge. Professional or nursing views are the etic, which is the outsider's view (Leininger & McFarland, 2006).

The emic component will come from resources in literature that have documented cultural knowledge of Hispanic culture. The truths from literature are collected to help explain care and culture phenomena within their world (Leininger & McFarland, 2006). Leininger's ethnonursing guidelines for collecting information on lifeways and factors that influence health and or wellbeing will be utilized to select culturally relevant information. Data from literature review will help uncover embedded detail and complex information about culture and care meanings that are often well below the surface (Leininger & McFarland, 2006). Once collected the data are then considered for factors related to care meaning. Care diversity is a component of Leininger's model that allows for different patterns, values, lifeways and symbols to be considered when providing beneficial care to individuals (Leininger & McFarland, 2006). The data is also analyzed for similarities or commonly shared phenomena. Culture care universality is another key construct in Leininger's theory and it refers to:

> the commonly shared or similar culture care phenomena features of human beings or a group with recurrent meaning, patterns, values, lifeways, or symbols that serve as a guide for caregivers to provide assistive, supportive, facilitative, or enabling people care for healthy outcomes. (Leininger & McFarland, 2006, p.16)

This project will look for the diverse and the culturally similar data regarding the use of the telephone as a method of delivering healthcare to Hispanic patients in order for the care to be meaningful and therapeutic.

The professional nursing, or etic knowledge will be considered when developing educational programs for the disease management team. The medical knowledge about the diseases being addressed as well as professional beliefs about illness and health must be incorporated in the model. Factors within the etic information will include the design of the disease management programs, expected outcomes of the intervention and the reason they are being offered to a particular group.

This project will collect and review information about Hispanic culture and previous research about the use of the telephone as a healthcare delivery model for people who are Hispanic and synthesize this information utilizing Leininger's Sunrise model in order to have the information needed to develop a training program for disease management nurses.

Chapter 2 Review of Relevant Literature

Need for the Project

This project will synthesize information to be used in the development of training for nurses providing care via the telephone to Hispanic patients. The need for culturally congruent care and cultural competence training is well documented. In 2003, the Institute of Medicine identified cultural competence training of health professionals as a potential strategy to improve care and to reduce health disparities between ethnic minorities and whites (IOM, 2003). Racial and ethnic minorities currently constitute more than 25% of the nations population, yet only 10% of employed registered nurses in the United States are from racial/ethnic minority backgrounds (US Dept of Health & Human Services, 2001). Nurses who have differing racial or ethnic background from their clients may lack inherent emic knowledge that impacts their ability to provide culturally congruent care

Nurses who have been identified as good transcultural nurses have been found to be empathetic, caring, open, and flexible. They have a positive attitude toward cultural differences and have a genuine interest in learning from the client about the client's culture (Price, et al., 2005). Talabere (1996) states that openness, appreciation of another's perspective, holistic communication, genuine interest, and a nonjudgmental attitude are central to cultural sensitivity. When a culturally aware nurse develops mutually agreeable health goals with a patient from another culture, a kind of cultural synergy occurs, resulting in care that is "meaningful, satisfying and beneficial to clients" (Leininger, 1991, p. 155).

Nursing literature shows extensive research has been done regarding addressing diversity in healthcare, and specifically how to effectively address the delivery of effective care to Hispanic patients. In addition to Madeleine Leininger's culture care theory, Josepha Campinha-Bacote has developed a culturally competent model of care (1998). The components Campinha-Bacote's (1998) model include cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire. Campinha-Bacote describes cultural competence as a process in which the nurse continuously strives to work effectively within the cultural context of the client, the emphasis being the process wherein the nurse sees themselves as becoming culturally competent rather than being culturally competent (Campinha-Bacote & Munoz, 2001).

Leuning and colleagues have further developed standards for transcultural nursing practice (Leuning, Swiggum, Wiegert, & McCullough-Zander, 2002). They developed standards based on Leininger's culture care theory and Campinha-Bacote's model of cultural competence. This work takes the principle of culturally congruent care and develops standards that provide criteria for evaluating nursing care. The standards also can be a tool for teaching and learning, they can increase the public's confidence in the nursing profession and will advance the field of transcultural nursing (Leuning, Swiggum, Wiegert, & McCullough-Zander, 2002).

A review of nursing literature indicates caring for the Hispanic population is a significant health care concern. Publication of the 2000 Census clearly documented that people of Hispanic origin are the fastest growing minority population in the United States. According to the latest census figures, one out of every seven individuals living in the United States is of Hispanic descent, accounting for 41.3 million Hispanics. It is

projected that, by the year 2050, individuals of Hispanic origin and/or ancestry will surpass 85,000,000 or 25% of the U.S. population. A significant percentage of individuals of Hispanic descent living in the United States are poor and disadvantaged and suffer from a variety of psychosocial and medical problems (Anez, Paris, Bedregal, Davidson, & Grilo, 2005).

A CINAHL search for research using the terms cultural competence and Hispanic from 1996 to 2006 revealed 79 results. The 79 research articles fell into two major categories, the first being research that identifies the need to providing culturally competent care to Hispanic patients in specific situations (ED, elderly orthopedic patients, etc) and the second being situations where specific interventions were implemented and their outcomes were assessed.

The use of the telephone as a delivery method of nursing care is documented in the literature. There were 567 research articles on telehealth in peer reviewed journals from 1996 to 2006. The CINAHL literature search for research pertaining to any combination of the three areas of cultural competence, Hispanic culture and telehealth revealed no overlap using the same search criteria, but altering the topic to cultural competence revealed 981 research articles. A combination of the two searches showed there were no articles addressing both issues. By adding the word Hispanic and using the same criteria the search revealed 1317 entries. Combining telehealth and Hispanic revealed no research articles that addressed both topics.

A different approach was taken for the search and the word telephone was used rather than telehealth. A search of the literature revealed 4059 research articles in peer reviewed journals from 1996 to 2006. When this search was combined with the

Hispanics search, results revealed 45 resulting journal articles. A complete review of the 45 articles found that only 2 of them pertained to the use of the telephone to deliver care to Hispanic populations. The majority of the remainder of the articles referenced the telephone as a mechanism for surveying populations. The first article was *Developing and evaluating a radio-linked telephone helpline for Hispanics* (Anderson & Huerta, 2000). It showed that Hispanics utilized an after-hour nurse triage line for health care advice. The second article was *Standardized telephonic case management in a Hispanic heart failure population: an effective intervention* (Riegel, Carlson, Glaser, Kopp, & Romero, 2002). This article showed that a Hispanic group responded in the same manner to telephonic case management as the non-Hispanic group following hospitalization for heart failure. Acute care resource use was lowered as effectively in Hispanic patients as non-Hispanic patients. Both articles indicate that the use of the telephone is effective for Hispanics.

A CINAHL search was conducted to look for the use of Leininger's theory to build training for nurses beyond nursing school. A search was done using Leininger and curriculum. This revealed eight research articles, none of which pertained to the development of a nursing training program. Nursing Education was used instead of curriculum and this resulted in 203 results. These focused on curriculum used in nursing schools or for nurses who themselves come from a diverse background. Many articles also addressed the concept of caring as part of nursing education, using Leininger because of her focus on caring. Several results also addressed caring for patients from specific diverse groups, but not how to educate nurses to care for them.

Nursing and health care research clearly provides a wealth of information about telehealth and its emergence as an important delivery model, about culturally competent care and the importance of providing training to health care professionals, and about the Hispanic culture. This information will provide a solid base on which to build a training program for disease management nurses who provide care to Hispanic patients. The information will be synthesized and used to build a training program that will augment an existing general cultural competence program. The training program will be implemented in the fall of 2008 in conjunction with the implementation of a new disease management client and the subsequent staff training that occurs at that time. The major drawback will be understanding the efficacy of the project. Further research will be needed to draw conclusions.

Chapter 3 Methodology

Development of the Training Course Data

The literature review revealed the significance of the health needs of the Hispanic population in the United States. Initial research has shown the telephone to be an effective delivery method for providing care (Anderson & Huerta, 2000; Riegel et al. 2002). The importance of culturally congruent care is also well documented (Campinha-Bacote, 1998; Leininger, 1991; Leuning et al., 2002). Leininger's culture care theory will guide the synthesis of information about Hispanic culture and culturally congruent care into a training course for disease management nurses providing care to Hispanic patients.

The existing core cultural competence training program is augmented with specific training designed for the disease management nurses. Information in the literature regarding Hispanic culture and communication style, as well as information regarding successful use of the telephone to deliver care, was used to create cultural competence training for the disease management nurses. In Leininger's sunrise model this is the emic component. The training incorporates contextual information about Hispanic culture and communication about health.

The first part of the course will assimilate information about Hispanics and Hispanic culture. Hispanics are a large, heterogeneous group with ancestry from many different geographic locations, including Spain, Central and South America, Africa, the Middle East and some of the Caribbean islands (Anez, et al., 2005). They also have a wide range of cultures, ethnicities, socioeconomic backgrounds, customs, and education.

A majority of the Hispanic population shares a common language, Spanish or Castellano. In addition to the shared language are cultural elements that bind some Hispanic groups together. These cultural elements or concepts are not necessarily unique to Hispanics but are thought to play an important role in the life of people of Hispanic origin (Anez, et al., 2005).

Communication competency is enhanced by understanding core cultural concepts that guide behavior. Understanding core concepts can help avoid inappropriate and ineffective cultural interactions. Two resources were used for core communication concepts in this training course. They were Comas-Diaz (1996) and Lindsley and Braithwaite (1999). There were several similarities between authors, as well as some differences. The concepts they describe are summarized in the following tables:

Table 1

Summary of Core Communication Concepts of Hispanic Culture; Comaz-Diaz

Concept	Description
Familisimo	Family Orientation
Personalisimo	Personal rather than institutional relationship
Respeto	Respect; mutual and reciprocal defense
Confianza	Trust and intimacy in a relationship
Dichos	Popular sayings
Fatalisimo	Fatalism
Controlarse	Conscious control of negative affect
Aguantarse	Ability to withstand stressful situations

Sobreponerse	Self-suppression

Table 2

Summary of Core Communication Concepts of Hispanic Culture; Lindsley and Braithwaite

Concept	Description
Confianza	Trust
Simpatia	Good communication
Palanca	Power affiliated from connections
Estabilidad	Stability
Manana	Tomorrow, sometime in the future

The creation of tables to summarize information may lead to oversimplification of cultural constructs. Just two authors have emphasized different constructs within the Hispanic community that impact communication. Family relationships, trust and how decisions are made are common themes from both sources. The training for disease management nurses highlights the importance of these constructs and provides basic information about each. Examples of how this information can be used in practice will be given during the training and additional resources will be listed for those interested in further study.

The delivery of health care is a form of communication, and culture is a powerful, enduring and invisible shaper of our communication behavior (Andersen, 2003). As such, another component of the training that is part of the emic component of

Leininger's sunrise model is communication context, or the degree to which communication is explicit and verbal or implicit and nonverbal (Andersen, 2003). High context communication is one where most of the information is either internalized or in the physical context. Low context communication is the opposite; messages are explicit via verbal communication. Understanding these differences is important if the parties communicating have different contexts. It may also change the meaning of receiving health care if the telephone is the delivery method for people who rely on non-verbal cues.

In the situation of a health care call center in the Midwest most of the nurses come from North American, German or Scandinavian backgrounds and therefore are low context; whereas people from Hispanic cultures are high context cultures (Andersen, 2003). For the low context cultures talking is the prevalent form of communication. High context cultures rely on non-verbal communication and values verbal communication less than low context cultures. Gestures and body language seem inconsequential until we fully consider the amount of information that we communicate without words. Positive feelings are often communicated through social gestures among the Hispanic population (Comaz-Diaz, 1996). The use of the telephone as the single source of communication will impact the meaning of the conversation.

The final section of the training will review the etic components of Leininger's model. Leininger (1991) intended the Sunrise Model to be used 'as a cognitive map to orient and depict the influencing dimensions, components, facets, or major concepts of the theory with an integrated view of these dimensions" (p. 49). The lower half of the

model includes folk systems, nursing care and professional systems (p. 43). Professional nursing care refers to "formal and explicit cognitively learned professional care knowledge and practices obtained generally through educational institutions" (p. 14). The nurses that provide disease management care must have a minimum of five years clinical experience before being eligible for this position. They receive orientation to delivering the programs that include information about diseases, such as asthma, diabetes and cardiac disease, as well as information about evidence based best practice, health benefit design and access to health care.

This knowledge of the health care system and nursing practice can be compared to traditional Hispanic systems and folk beliefs. The Hispanic family is more inclined to resort to home remedies to treat illness than is the general US population as a whole (Olsen & Frank-Stromborg, 1993). Folk medicine is an important aspect of health for Hispanics (Zaldivar & Smolowitz, 1994). Complementary healers, such as curanderos (general healers), sobadores (bone-setters), and brujos (witches), may be involved in the care of Hispanic patients (Zaldivar & Smolowitz, 1994). Self-care and complementary care is often practiced and may be inconsistent with Western recommendations that are fundamental for the disease management nurses. The training program will include examples of the options available to the Hispanic patient from multiple professional sources.

A training course will be designed for disease management nurses that include the major dimensions and interrelated components of Leininger's Sunrise Model. Every disease management nurse will receive the training annually and it will be delivered in

small group sessions via a PowerPoint presentation (Appendix). The session will be informal and include time for discussion. Additional handouts and reference material will be provided to the nurses. The efficacy of the program will be determined by a post test and by quality monitoring of actual calls.

Chapter 4 Findings

Evaluation of cultural competency training

The purpose of the nurse training is to improve the care given to Hispanic patients participating in a disease management telephonic program. This project collected information about Hispanic culture and previous research about the use of the telephone as a healthcare delivery model for people who are Hispanic and synthesized this information utilizing Leininger's Sunrise model in order to have the information needed for a training program for disease management nurses. Leininger's Sunrise Model provides a framework for analyzing whether the training includes all important aspects of culturally competent care. The theory offers a strong foundation for the daily operations of nursing units and direct client care (Leininger, 2006). This type of training brings theory into action.

Training will be offered to the nurses during a one hour classroom session utilizing lecture and discussion. The efficacy of the training will be assessed using three categories of evaluation. Each category of evaluation addresses different aspects of course assessment and uses a variety of evaluation methods and approaches.

The first type of evaluation will be formative evaluation for course content and design. Participants of the training will be asked to assess the training for relevance and usefulness to their practice as disease management nurses. They will be asked to give feedback on time allocated for the training, perceived completeness of the course, and understandability of the information. Finally, they will be asked whether the training was balanced and whether it lacked bias.

The second course evaluation will be process evaluation. Process evaluation will measure knowledge gains; reinforcement of existing knowledge; and increase in feelings of self-efficacy and motivation immediately post training. The training will include objectives, an informal pre-test that will also serve as a course outline, and a post test. The post test will measure actual retention of information, as well as assessing self-efficacy gained during discussion. The nurses will also be asked whether they intend to change their practice, and whether the training reinforced existing knowledge. The Sunrise model can also be used to help nurses reflect on the decisions and care.

Both of these types of evaluation are important, but perhaps the outcome evaluation is the most important as it reflects actual practice changes. Liu (2004) found the evaluation of training effect showed that most training programs improved participants' knowledge significantly following immediate evaluation. However, most of the studies showed limited effects on nurses' behavioral changes in clinical practice (Liu, 2004). Therefore actual adoption of the information into practice is the final evaluation. Utilizing the current process of evaluating actual calls with members by either live audit or listening to recorded calls, nurse supervisors will incorporate measures related to the training into the audit. The call analyses will be shared with the nurses providing a feedback loop for their practice on the telephone. Staff nurses also listen to their own calls to evaluate then for quality and are encouraged to bring forward samples of calls to share with the team. The overall goal of call analysis is to create a safe environment where the nurses can discuss the calls that went well, as well as the calls that didn't go well and utilize them as learning opportunities for self and the team.

Overall success of the training from all three evaluation measures will provide important information to the management team. The outcomes will provide an opportunity to reflect critically on the training, how it was perceived and whether it resulted in culturally competent care on the telephone. The training can be revised as needed and the management team can assess expanding this type of training for other cultural competence needs.

Chapter 5 Discussion

The implications for nursing care are significant. Leininger (2006) has predicted that health care will become increasingly multicultural. There is an overall globalization of nursing and health care resulting in the need to move from a unicultural to a multicultural mode of operation. (Leininger & McFarland, 2006). The Department of Health and Human Services, Office of Minority Health has created CLAS (Culturally and Linguistically Appropriate Services) standards that it expects healthcare services to meet. This is intended to reduce disparities in healthcare. Among these expected skills is the ability to provide culturally sensitive and competent care with all clients (Leininger & McFarland, 2006). Advanced practice nurses will likely experience increasing need for staff training to meet the needs of this diverse population as cultural competence becomes more important.

Simultaneously nursing is experiencing new ways of delivering care, such as care over the telephone. The complexities increase and in order to meet staff and patient needs nursing leaders will need a broad, comprehensive and culturally based theory in order to expand their worldview and to be sensitive to global or transcultural view of administrative activities (Leininger & McFarland, 2006).

The ability to deliver culturally competent care has implications for retaining patients and in the case of disease management programs, clients who pay for the service. Providing culturally competent care to Hispanic patients over the phone is important for the financial success of disease management programs. According to Leininger, nursing leadership with a unicultural view face challenges because consumers and employees

expect services to be responsive to their needs and not treat all consumers in similar ways (2006). She further reinforces that more attention needs to be given to different ways of providing culture care services by nursing administration (2006). Buying decisions by payers are based on the ability to meet the needs of all of the members needing care. Many payers are sophisticated in their buying decisions and ask for proof thatmultilingual staff is available at the least ("Disease Management in Large Employers," n.d.).

The Hispanic population is growing rapidly in the US and it is estimated they will account for 25% of the population by 2025 (IOM, 2003). By the middle of the 21st century, the minority population will almost equal the size of the non-Hispanic white population (Shi, 1999). The increasing racial/ethnic diversity in the United States will create both challenges and opportunities for health care delivery. According to Shi (1999), significant differences exist across racial and ethnic groups in the United States in health status and minorities face barriers to accessing health care. Numerous studies have indicated that minorities receive less ambulatory, hospital, and disease-specific care than whites and experience greater barriers in their interaction with the medical care system (Shi, 1999). Utilizing the telephone potentially allows access to more patients, including Hispanics, thus reducing health inequities. The combination of culturally competent care delivered via the telephone may reduce barriers to care.

Along with its potential for reducing barriers to care, telehealth nursing also has its challenges (Grady & Schlachta-Fairchild, 2007). Current issues include reimbursement for services provided, licensure and liability concerns, privacy and confidentiality issues, and ensuring quality of care (Grady & Schlachta-Fairchild, 2007). There is an absence of consistent, comprehensive reimbursement policies for telehealth

(Artinian, 2007). Partial Medicare reimbursement for telehealth services was authorized in the Balanced Budget Act of 1997(Artinian, 2007). Reimbursement policies will also require standards of documentation, for purposes of audit and quality review, and separation of technology costs (e.g., networks, databases, servers, and personnel to maintain them) from services costs (e.g., physician and nurse care manager time) (Shea, et al, 2002). The narrow scope of reimbursement may limit the expansion of telehealth programs. In order for telehealth services to thrive, expanded reimbursement is critical (Artinian, 2007).

In addition to guidelines, it is important to be aware of telehealth legal issues. An important question has been whether nursing care administered electronically over a distance is actually the practice of nursing (Artinian, 2007). According to the Boards of Nursing, "Nursing practice occurs at the point a nurse uses the knowledge, skill, judgment, and critical thinking that are inherent in nursing education and that are authorized through the nursing license" (Artinian, 2007, p.). Nurse-patient telehealth interactions are based on nursing knowledge, skill, judgment, and critical thinking and therefore do fall under the practice of nursing (Artinian, 2007). The legal environment in which the medical and nursing professions are credentialed, licensed, held accountable, disciplined, and insured for malpractice are largely based on individual state laws (Shea, et al., 2002). There are differences among states in almost all these areas. There are limitations resulting from state-based licensure that may impede the electronic delivery of health care services across state boundaries (Shea, et al., 2002).

Finally, the Health Insurance Portability and Accountability Act of 1996 raises the issue of privacy concerns for patients engaging in telehealth care (Artinian, 2007). The use of the telephone alone may not pose issues related to privacy, but many disease management programs include in-home visits and the use of technology in the form of monitoring devices (Demeris & Courtney, 2006). Therefore de-identification of personal information and information security are features of disease management programs (Demeris & Courtney, 2006). The concept of extending care into the home via the telephone or other technology presents significant issues for nursing leadership to consider.

Chapter 6 Conclusions, Recommendations, Reflections

The three main concepts of the paper are all important concepts for healthcare today. The first is care of Hispanic patients who are a growing minority; the second is the emergence of telehealth nursing and the final is the importance of culturally congruent care. The literature review for all three suggests that each is becoming increasingly important. Initial research shows that the telephone is an effective delivery mechanism for care (Anderson & Huerta, 2000; Riegel et.al., 2002). The focus of this paper is on the synthesis of information related to all three and the subsequent development of a training program for nurses providing disease management programs via the telephone to Hispanic patients.

Telehealth is a growing field of healthcare delivery (Shea, et al., 2002). Several factors have contributed to its growth, including the ability to facilitate access to care, the growing number of older adults living in the community and their need for frequent monitoring, increased patient care demands on healthcare providers, improved telephone systems, decreasing technology costs, the potential for saving the patient and provider substantial dollars, expanded public and private reimbursement for distance care, and the shift toward patient-centered healthcare (Shea, et al., 2002). The growth of telehealth may also relate to its potential to improve nurse staffing issues. If telehealth care can help nurses manage their caseloads more efficiently, thus contributing to greater job satisfaction, nurse retention rates and issues related to the nursing shortage may improve.

More research is needed to understand the efficacy of the telephone for Hispanic populations. Cultural concepts related to communication and beliefs in health need to be

explored to understand how they impact the efficacy of care delivery using the telephone. Hispanic culture is a low context culture while most nurses in the United States come from high context cultures. Subtle differences between Hispanic heritage will also potentially have an impact on efficacy of training. This training will consider the group Hispanic as a whole, yet there are many nuances and differences between different groups (Anez et al., 2005). The literature search documented barriers to care for Hispanic populations (IOM, 2003; Shi, 1999). This is particularly important in providing services to first generation Latino clients who are faced with a multitude of barriers to mainstream care (Shi, 1999). What are the issues related to care of second or third generation Hispanics? This is another nuance not addressed in this training but one that will become more and more relevant as time passes and there are more generations to care for.

Nurses could spend considerable time delving deeper and deeper in to the similarities and differences between cultures and populations, and how they may impact the delivery of care. This raises the question of how much detail and training is enough? What is the tool set that each nurse needs given the challenge that each nurse is not going to know the details of every cultural need of each patient? Focus should be on culturally competent care for all populations, with training that builds a tool set that allows for a caring and effective interaction with each patient. Training on dominant culture as well as minority cultures should place emphasis on competent care and not on the minority.

Leininger's Culture Care Theory and Sunrise Model provided the nursing framework for synthesizing the information utilized for the training. In what way does the theory of Culture Care contribute to differentiated nursing practice? Will programs,

such as this disease management program, differentiate themselves by utilizing the Sunrise Model and other frameworks such as the proposed standards for transcultural nursing developed by Leuning, et al. (2002)?

There may be barriers to the adoption and implementation of telehealth nursing. Inadequate integration of telehealth services into overall healthcare delivery poses one potential barrier. Research has demonstrated the value of human touch in caring for specific populations (Shea, et al., 2002). Physical closeness is conceived to be an embodiment of caring in nursing (Demeris & Courtney, 2006). Therapeutic touch has been found to be one of the highest ranked hospice interventions on both effectiveness and frequency of use (Shea, et al., 2002). Telehealth nursing interactions lack human touch and therefore the implications of loss of touch within these interactions may be a barrier.

What are the future trends in telehealth? How will reliance on mobile devices and text messaging impact nursing care? What kind of nursing service needs to be developed to accommodate the needs of an increasingly culturally diverse and technically savvy population? Will telehealth be widely adopted to help reduce health disparities? Nursing has an opportunity to contribute to efforts to provide ethnically and culturally competent care and to remove or reduce the many barriers facing racial/ethnic minorities in their access to care.

Appendix

Cultural Competency Training Outline

Hispanic Patients in Disease Management Programs

I. Objectives of Training
   A. The nurse will be able to list 3 communication concepts for Hispanic patients.
   B. The nurse will be able to describe how to apply communication context to their disease management practice.

II. Outline of presentation
   A. Cultural confidence awareness model
   B. Culturally competent care
   C. Background-the need
   D. Hispanic culture
   E. Communication context
   F. Health care system
   G. Practice and discussion

III. Culturally Competence and Confidence
   A. Cultural confidence discussion and pre-test
   B. Culture- the learned, shared and transmitted values, beliefs, norms and lifeways of a particular group that guides their thinking, decisions and actions in a patterned way
      a. Madeleine Leininger

IV. Culturally Competent Care
   A. Nurses are empathetic, caring, open and flexible
   B. Nurses are open, appreciate another's perspective, holistic communication, nonjudgmental attitude
   C. It is a process

V. Background- The Need
   A. CDC predicts chronic conditions rates could double by 2050*
   B. The rate could be 6-fold for Hispanics
   C. Hispanic population has limited understanding of disease and disease progression**
   D. Hispanic the fastest growing minority population***

VI. Background- The Need
   A. 25% of population is a racial/ethnic minority; only 10% of registered nurses*
   B. Barriers to care
      a. Telephone may help overcome barriers for Hispanic patients
      b. Little is understood about the use of the telephone as a delivery method

VII. Hispanic Culture
- A. Heterogeneous group
  - a. Spain
  - b. Central and South America
  - c. Africa
  - d. Middle East
  - e. Caribbean Islands
- B. Majority speak Spanish or Castellano

VIII. Core Communication Concepts
- A. Table

IX. Core Communication Concepts
- A. Examples for discussion
- B. 55 y.o. man resists seeing his physician because he says he doesn't respect him
- C. 60 y.o. woman who isn't interested in following a diet because she says her condition is "the will of God"
- D. 30 y.o. woman who hasn't done what she had agreed to do because her husband isn't working and her father thinks she doesn't need to follow her care plan

X. Communication Context
- A. Low context communication
- B. Information is internalized
- C. North American, German, Scandinavian
- D. High context communication
- E. Messages are explicit via verbal communication
- F. Gestures and body language
- G. Hispanic
- H. Implications of communication via telephone

XI. Health Care System
- A. Traditional Western resources
- B. Folk medicine
- C. Home remedies
- D. Curanderos, sobadores, brujos

XII. Folk Medicine
- A. Examples
- B. Patient has mal de ojo, and believes the only way to lift the curse (and heal) is to pray
- C. Patient has been told they are suffering from shock (espanto) and have been given an herb to take

References

Amerson, R., & Burgins, S. (2005). Hablamos Espanol: Crossing communication barriers with the Latino population. *Journal of Nursing Education, 44*(5), 241-243.

Andersen, P. A. (2003). In Different dimensions: Nonverbal communication and culture. In L. A. Samovar & R. E. Porter (Eds.), *Intercultural communication: A reader* (pp. 239-252). Belmont, CA: Wadsworth/Thomson Learning.

Anderson, D. M. & Huerta, E.E. (2000). Developing and evaluating a radio-linked telephone helpline for Hispanics. *International Quarterly of Community Health Education, 19*(4), 341-51.

Anez, L. M., Paris, M., Bedregal, L. E., Davidson, L., & Grilo, C. M. (2005). Application of cultural constructs in the care of first generation Latino clients in a community mental health setting. *Journal of Psychiatric Practice, 11*(4), 221-230.

Artinian, N.T. (Jan-Feb, 2007). Telehealth as a tool for enhancing care for patients with cardiovascular disease. *Journal of Cardiovascular Nursing, 22*(1), 25-31.

Borchers, L., & Kee, C. (1999). An experience in telenursing. *Clinical Nurse Specialist, 13*(3), 115-118.

Brown, S. A., Garcia, A. A., Kouzekanani, K., & Hanis, C. L. (2002). Culturally competent diabetes self-management for Mexican Americans: The Starr County border health initiative. *Diabetes Care, 25*(2), 259-268.

Buerhaus, P.I., Needleman, J., Mattke, S. & Stewart, M. (Sept-Oct, 2002). Strengthening hospital nursing: preventing the estimated shortage of more than 400,000 RNs by 2020 will require recruiting many talented men and women and making long-overdue improvements in the hospital workplace. *Health Affairs, 21*(5): 123-32.

Campinha-Bacote, J. A (1999). Model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*, 38(5): 203-7.

Campinha-Bacote, J. & Munoz, C. (Mar – Apr, 2001). Cultural diversity: A guiding framework for delivering culturally competent services in case management. *Case Manager, 12*(2), 48-52.

Cariello, F. P. (2003). Computerized telephone nurse triage: An evaluation of service quality and cost. *Journal of Ambulatory Care Management*, 26(2), 124-137.

Center for Medicaid & State Operations, (2004). Retrieved March 11, 2006 from http://cms.hhs.gov/smdl/downloads/smd022504.pdf

Center for Medicare & Medicaid Services, (2002). Medicare announces disease management demonstration for chronically ill. Retrieved March 11, 2006 from http://www.cdc.gov/nccdphp/publications/aag/ddt.htm

Centers for Disease Control and Prevention (2008). Diabetes, disabling disease to double by 2050. Retrieved April 2, 2008, from http://www.cdc.gov/nccdphp/publications/aag/ddt.htm

Comas-Diaz, L. (1996). Cultural considerations in diagnosis. In: F.W. Kaslow (Ed.), *Handbook of relational diagnosis and dysfunctional family patterns*. New York: John Wiley & Sons; 152-68.

Demiris, G., Oliver, D.P. & Courtney, K.L., (2006). Ethical considerations for the utilization of telehealth technologies in home and hospice care by the nursing profession. *Nursing Administration Quarterly*. 30(1), 56-66.

Department of Health & Human Services, (2003). Medicare carriers manual: Part 3. Retrieved March 11, 2006 from http://www.cms.hhs.gov/Transmittals/Downloads/R1798B3.pdf

DiabetesTEAM, (2006). Retrieved April 5, 2007 from http://www.diabetesteamsite.com/

Frusti, D. K., Niesen, K. M., & Campion, J. K. (2003). Creating a culturally competent organization: Use of the diversity competence model. *Journal of Nursing Administration*, 33(1), 31-38.

Grady, J.L. & Schlachta-Fairchild, L. (2007). Report of the 2004-2005 International Telenursing Survey. *CIN*, Sep-Oct; 25(5): 266-72.

Gustafson, D. L. (2005). Transcultural nursing theory from a critical cultural perspective. *Advances in Nursing Science*, 28(1), 2-16.

Health Resources and Service Administration Bureau of Health Professions (2001). The registered nurse population: National sample survey of registered nurses. Rockville, MD: US Department of Health & Human Services

Institute of Medicine, (2003). Unequal treatment: Confronting racial and ethnic disparities in health care. Smedley, B.D., Stith, A.Y., Nelson, A.R. (Eds). Washington, DC: National Academies Press

Leininger, M.M. (1991) *Culture Care Diversity and Universality: A Theory of Nursing*. National League of Nursing Press, New York

Leininger, M.M. & McFarland, M.R. (2006). *Culture Care Diversity and Universality: A Worldwide Nursing Theory*. Jones and Bartlett Publishers, Sudbury, Massachusetts

Leuning, C.J., Swiggum, P.D., Wiegert, H.M.B. & McCullough-Zander K. (2002). Proposed standards for transcultural nursing. *Journal of Transcultural Nursing*. Jan; 13(1), 40-6.

Lindsley, S. L. & Braithwaite, C. A. (2003). U.S. Americans and Mexicans working together: Five core Mexican concepts for enhancing effectiveness. In L. A. Samovar & R. E. Porter (Eds.), *Intercultural Communication: A Reader* (pp. 293-299). Belmont, CA: Wadsworth/Thomson Learning.

Matheson, D., Wilkins, A., & Psacharopoulos, D. (2006). Realizing the promise of disease management; Payer trends and opportunities in the United States. Boston Consulting Group.

McNeil, B. J., Elfrink, V. L., Bickford, C. J., Pierce, S. T., Beyea, S. C., Averill, C., et al. (2003). Nursing information technology knowledge, skills, and preparation of student nurses, nursing faculty, and clinicians: A U.S. survey. *Journal of Nursing Education*, 42(8), 341-349.

Nosek, L. J. (2004). Globalization's costs to healthcare: How can we pay the bill? N*ursing Administration Quarterly*, 28(2), 116-121.

Olsen, S.J. & Frank-Stromborg, M. (1993). Cancer prevention and early detection in ethnically diverse populations. *Seminars in Oncology Nursing*. Aug; 9(3), 198-209.

Price, E. G., Beach, M. C., Gary, T. L., Robinson, K. A., Gozu, A., Palacio, A., et al. (2005). A systematic review of studies evaluating cultural competence training of health professionals. *Academic Medicine*, 80(8), 578-586.

Riegel, B., Carlson, B., Glaser, D., Kopp, Z. & Romero, T.E. (2002). Standardized telephonic case management in a Hispanic heart failure population: an effective intervention. *Disease Management & Health Outcomes*. 2002; 10(4), 241-9.

Shea, S., Starren, J., Weinstock, R.S., Knudson, P.E., Teresi, J., Holmes, D., Palmas, W., Field, L,. Goland, R., Tuck, C., Hripcsak, G,. Capps, L. & Liss, D. (2002).

Columbia University's Informatics for Diabetes Education and Telemedicine (IDEATel) project: rationale and design. *Journal of the American Medical Informatics Association.* Jan-Feb; 9(1), 49-62.

Shi, L. (1999). Experience of primary care by racial and ethnic groups in the United States. *Medical Care*. 37(10), 1068-77.

Talabere, L.R. (1996). Meeting the challenge of culture care in nursing: diversity, sensitivity, competence, and congruence. *Journal of Cultural Diversity*. Summer; 3(2), 53-61.

Zaldivar, A. & Smolowitz, J. (1994). Perceptions of the importance placed on religion and folk medicine by non-Mexican-American Hispanic adults with diabetes. *Diabetes Educator*. Jul-Aug; 20(4), 303-6.