

TUBERCULOSIS CASE MANAGEMENT FOR NURSES

LEADERSHIP SKILLS OF THE NURSE CASE MANAGER

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INTRODUCTION

Case management is a competency involving specific skills and knowledge. This module provides an overview of these skills. Because case management requires multidisciplinary collaboration and coordination of services for patients from diverse cultures, the nurse case manager must have an understanding of what constitutes culturally competent care and must possess effective team-building and conflict-resolution skills. In addition, this module addresses the importance of appropriately delegating responsibility to other team members and methods of assessing and improving adherence.

LEARNING OBJECTIVES

After the completion of this learning module, you will be able to:

- 1) Explain the importance of cultural awareness
- 2) List techniques for delivering culturally competent patient care
- 3) Identify the elements of team building
- 4) Define different types of conflict
- 5) Discuss conflict-resolution techniques
- 6) Describe the process of delegation
- 7) Explain the importance of assessing patient adherence
- 8) Name variables to be considered when assessing patient adherence
- 9) Identify strategies for improving patient adherence

CULTURAL COMPETENCY

Healthcare providers have the opportunity to interact with people from various ethnic and cultural backgrounds. Differences in personal appearance, behavior, communication patterns, values, and beliefs must not be viewed as obstacles to communication, but rather, as opportunities for the healthcare worker to learn and grow personally while providing healthcare that is culturally appropriate. National health statistics indicate that culturally inappropriate care and lack of understanding of cultural differences may negatively affect health outcomes (Lester, 1998). Therefore, it is imperative for the nurse case manager to become culturally competent and also guide other members of the healthcare team towards cultural competency.

What is cultural competency? It is “the ability of a system, agency, or individual to respond to the unique needs of populations whose cultures are different from that of the dominant or mainstream society” (Lester, 1998, p 31). A culturally competent system acknowledges cultural differences and incorporates appropriate care at the policy, provider, and consumer levels. Transcultural nursing utilizes the nursing process of assessment, planning, intervention, and evaluation to provide care and education that is based on cultural values, beliefs, symbols, references, and lifestyles of people from diverse backgrounds (Lester, 1998).

The first step towards cultural competency includes an exploration of personal feelings and reactions to individual or group differences. It is important to realize that an individual’s values and beliefs reflect only a single point of reference. If not viewed in this way, differences may cause internal and/or interpersonal conflict such as prejudice, ethnocentrism, and stereotyping.

Taylor (1998) suggests that the biggest barrier to cross-cultural communication is prejudice, which manifests itself as an aversion or a hostile attitude towards an individual based solely on that person’s membership in a particular group. Prejudicial thinking is neither rational nor logical and is often subconscious. The nurse case manager must first explore his/her attitudes to discern areas of prejudicial thinking. The goal is to increase awareness of prejudices, since an awareness of personal feelings of prejudice is a prerequisite for achieving cultural competency. Stereotyping closely parallels prejudice. It is an exaggerated belief associated with a particular group of people. Attitudes, assumptions, and judgments about individuals are made based on such factors as their ethnicity or cultural background. These generalizations are not based in fact but are frequently perpetuated despite contradictory evidence.

The comfort zone that envelops the familiar can influence the ability to communicate with people who are different. Culture influences the way people communicate including the use of facial expressions, gestures, and body language as well as through written and oral communication. One example is personal space, the area surrounding a person’s body. This includes both space and objects. An awareness that personal space is important in various ways to different people helps establish appropriate physical distance during interactions.

Developing cultural competence is an educational process. It is important to have an understanding of different conceptions of illness and healing when providing health care to culturally and ethnically diverse populations. Culture defines what is appropriate behavior to exhibit during significant life events such as puberty, pregnancy, birth, disease, and death. These cultural models of acceptable behavior often persist throughout life and have far-reaching effects on the expected behaviors of individuals and delivery of health care. An example is the designation of “spokesperson” when a family member is ill. In some cultures adult males are the only persons who communicate with the healthcare provider.

Appendix 1 suggests interview questions that will help the nurse case manager gather essential cultural data. These questions address cultural and ethnic identity, beliefs about health and illness, approaches to caring for the sick, and specific practices used for treatment or cure of an illness.

Cultural competence requires behavioral flexibility on the part of the healthcare provider. It is important to effective leadership to make a thorough cultural assessment, using it to alter the plan of care if necessary, so that all patients are treated with dignity and respect for their culture.

TEAM BUILDING

Another feature of leadership is the nurse case manager's skill at team building. Case management cannot be done in isolation. To be successful, the case management process should always include the team of individuals who are involved in various aspect of patient care. This group may include professionals, paraprofessionals, and others from the community. Regardless of the composition of the team, each person plays a role in the patient's plan of care and, therefore, has an effect on the treatment outcome.

The strength of case management lies with the team as a whole, not the case manager or any one team member. It is important that the team functions cohesively, always moving towards the over-all goals or identified outcomes of patient care. Teamwork takes practice, smart coaching, and problem resolution. Nurse case managers must develop the skills necessary to build and lead the team. A discussion of the many aspects related to effective team building follows (Herman & Reichett, 1998, Cesta, Tahan & Fink, 1998, & Weinstein et al. 1998).

One person must head up the team. The team manager is responsible for the outcomes of the case management process. When programs establish a team with more than one leader, such as the nurse case manager and the physician as the head of the team, accountability becomes confusing and fragmented. This negatively affects anticipated outcomes and may cause conflict. The nurse case manager's role should be identified and clearly communicated to the team members, others in the healthcare system, and the patient.

Team goals must be established and clarified. Whenever possible, all team members should participate in establishing the goals of patient care. If this is not feasible, then once goals have been identified, they should be discussed with all team members. Although members of individual disciplines may have a specific focus in the plan of care, the nurse case manager must be skilled in identifying divergent goals and utilizing appropriate conflict-resolution strategies to bring unification to the team and avoid conflict. Goals should be identified at the onset of patient care and reviewed at specific intervals.

The role of each member must be clear and well defined. If team members do not understand or accept their roles, teamwork will be jeopardized and interpersonal conflicts can occur. Every role should have identified boundaries with lines of authority and job descriptions of each team member should be reviewed by the nurse case manager to confirm that team members work within the scope of the agency's internal standards. The nurse case manager should have knowledge of the licensure standards as well as any external factors, (e.g., union requirements and contracts, etc.) which may have an effect on an individual's job performance. As head of the team, the nurse case manager is responsible for ensuring that the role of each team member is:

- Clearly defined
- Understood
- Accepted by the team
- Within the scope of the individual's ability and authority

Team members must understand the application of policies and procedures. Inservice training to review policies and procedures can prevent problems. This training includes internal and external standards of practice, specific procedures, and personnel policies. Failure to adhere to policies, procedures and standards of practice will interfere in the team process and patient care outcomes. For example, problems occur when there are high rates of absenteeism among certain team members because other members of the team will have to carry the workload of the absent team member. If this happens frequently not only will teamwork suffer, but anger and conflict may result.

Building interpersonal relationships among team members is critical for an effective team. The nature of these relationships will either make the team a success or contribute to its failure. The nurse case manager must be skilled in interpersonal relationships, open communication, problem solving, and conflict resolution. Case management is successful when all parties are satisfied with the outcome. Building team spirit and fostering job satisfaction are important to the case management process. Successful teamwork affects not only patient care, but each team member as well.

UNDERSTANDING AND RESOLVING CONFLICT

The successful outcome of patient care depends not only on the medical treatment, but also on the nurse case manager's ability to handle conflict during the patient's course of treatment. Nurse case managers must address conflict involving patients, members of other disciplines, as well as others in the community who are involved in the patient's care. Conflict may be perceived, felt, or expressed. It can occur at four levels (Dove, 1998):

- 1) **Intrapersonal conflict** refers to internal struggles in an attempt to clarify values, wants, or needs.
- 2) **Interpersonal conflict** occurs when two or more individuals display contrasting values.
- 3) **Intragroup conflict** results when members of a group exhibit contrasting values, goals, ideas, or beliefs.
- 4) **Intergroup conflict** arises between two or more groups of people, departments or organizations having contradictory beliefs, goals, or needs.

These conflicts exist in all organizations, occurring when individuals or groups experience differences in beliefs, values, and goals that place them in opposition. Such differences may lead to misunderstanding, frustration, and anger. In addition, stress from outside the team (e.g., personal life), or from within (e.g., staffing shortage, difficult patients) may cause behaviors that lead to conflict. Conflict can suppress individual and team growth and negatively affect the quality of healthcare services. Although conflict is usually uncomfortable, it is not always detrimental. Conflict, when evaluated and resolved by the nurse case manager, can actually result in higher levels of achievement, professional and team growth, creativity, and satisfaction of all members.

What factors influence the patient outcome when conflict arises within the healthcare team? The answer to the question lies in the understanding and management of conflict. If the nurse case manager is able to identify destructive conflict, determine its underlying cause, and use problem-solving techniques to resolve issues, then satisfactory outcomes for all individuals can occur (Dove, 1998).

There are several strategies for conflict resolution and the success or failure of the outcome will be dependent upon the strategy chosen. Marquis & Huston (1996, p 338) discuss various ways in which conflict is managed by individuals and groups and state that "the optimal goal in resolving conflict is creating a win-win solution for all involved."

Compromising or negotiation requires that each team member gives up something in the process. To be successful, each member must commit to equal sacrifice. If the compromise lacks equality, one group or individual is likely to perceive he/she has given up more than the other.

Competition always results in a win-lose situation. If conflict is resolved in this manner, one individual/group competes for success at the expense of the other. The losing individual/group may feel frustrated and angry about the outcome. This approach is used when one team member has more knowledge or information about a situation or when the nurse case manager must make a quick or unpopular decision.

Cooperating is the opposite of competition. The use of this strategy requires that an individual or group allows the other to “win” in an effort to resolve the conflict. This sacrifice leaves one faction of the team with a “you owe me” attitude. Smoothing is the art of encouraging team members to focus on areas of agreement rather than opposition. This strategy is effective in removing or reducing the emotional component of the conflict. Both sides can feel that they have “won.” However, smoothing never addresses the cause of the conflict or problem. It is effective in resolving minor problems, but can add additional layers on larger, complex issues.

Avoiding is a strategy in which all team members agree to ignore the problem, even though they recognize that conflict exists. This approach is often used to resolve minor problems, when the conflict is likely to resolve itself over time, or when the cost of resolution outweighs the benefits. Nurse case managers should encourage this strategy when the problem can be solved at a higher level or by structural or policy changes.

Collaboration requires team members to use assertive cooperation to resolve the conflict. With this approach, individual issues or goals are set aside and problem-solving techniques are used to establish new, common goals. While this may be a lengthy process, it is most useful in solving complex problems and where there is no superior/subordinate relationship.

The resolution strategy should be based upon the cause of the conflict. A clear understanding of the problem obtained from open communication with those involved, a review of all factors influencing the conflict, and an objective analysis of the entire situation will help determine the cause. Team members should be encouraged to discuss conflict with each other without repercussions, and a private place should be provided for this discussion. Individuals should be encouraged to work out their differences prior to outside intervention. When conflict or potential conflict has been identified, the nurse case manager should decide on the most appropriate resolution strategy or be able to guide team members in selecting a strategy. In summary, the nurse case manager should be aware of different conflict-resolution approaches and their likely consequences.

DELEGATION IN NURSING PRACTICE

In the course of a patient's treatment for TB, it may become necessary for the nurse case manager to delegate responsibility to others. Therefore, nurse case managers must develop the ability to delegate properly. Delegation is "transferring to a competent individual, the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for delegation" (National Council of State Boards of Nursing, 1995). When a nurse delegates, he/she not only assigns a particular task, but also delegates some of the decision making regarding the execution of that task. In the delegation process, the nurse is responsible for assessing the patient's particular circumstances and ascertaining the competence of the person to whom a task is delegated.

Crucial components of delegation include:

- Supervision
- Monitoring
- Evaluation
- Follow-up by the delegating nurse

The professional nursing functions of assessment, evaluation, and nursing judgement are **never** delegated.

The person who accepts the delegation is accountable for his/her actions in carrying out the task, and the nurse case manager is accountable for appropriate delegation. For example, if an LPN/LVN administers the wrong medication or an improper dose, the LPN/LVN is accountable for the error, but the RN is accountable for delegating the task to a person who was not competent to perform the task.

The National Council of State Boards of Nursing (NCSBN) offers the following "*Five Rights of Delegation*" as rules for nurses to follow when delegating a task (1995):

- **Right Task** – The task is one that can be delegated as determined by the specific patient care situation
- **Right Circumstances** – The patient setting is appropriate, resources are available, and other relevant factors are considered
- **Right Person** – The right person is delegating the right task to the right person
- **Right direction/communication** – The task is clearly and concisely described, including its objectives, limits, and expectations
- **Right Supervision** – There is appropriate monitoring, evaluation, intervention (as necessary), and feedback

ASSESSING AND IMPROVING ADHERENCE

Many variables affect a patient's adherence to treatment. The nurse case manager must assess the following variables regularly:

- **Patient variables** include a wide variety of factors, which may be individual or specific to a cohort of patients who have common lifestyles, similar cultural backgrounds, or shared interests
- **Treatment variables** related to medication and duration of treatment
- **Disease or disorder variables** such as coexisting medical conditions
- **Organizational variables**, often overlooked by healthcare providers, can influence patient adherence by the quality of services provided

Appendix 2 lists examples of these variables for the nurse case manager to consider. Assessment data may be obtained from team members and by interviewing, listening, and observing the patient's behavior during the course of TB treatment.

The assessment of adherence requires knowledge of these variables and a review of the following indicators:

- Standards of adherence (e.g., monthly adherence rate)
- Self-reporting by patient
- Behavioral measures
- Clinical outcome

Assessment of adherence should be conducted at regular monthly intervals or at clinic or physician visit. However, it may be necessary to evaluate a patient's treatment adherence more frequently to avoid gaps in treatment. Episodes of nonadherence should be identified as soon as possible and discussed with the patient and team members to establish the necessary interventions.

To assess DOT adherence, use the standards for adherence established by the state TB control program or set by individual health departments or healthcare facilities. The DOT adherence rate is calculated by dividing the number of documented days that the patient was observed taking medication by the number of available days in the month and multiplying by 100. Weekends and holidays should not be counted in the denominator as days available for DOT unless DOT is provided 7 days a week and on holidays.

$$\frac{\text{\# of documented observed days}}{\text{\# of available days for observation}} \times 100 = \text{adherence rate } \underline{\hspace{2cm}} \%$$

The denominator may vary depending on the month and circumstances that arise. There are possible exclusions from the denominator. For example, if a patient is hospitalized during the month, the numbers of days in the hospital are subtracted from the number of days DOT would have been available. DOT is not calculated during a patient's hospitalization because, in a hospital setting, all medications should be administered under observation. However, it is important for the nurse case manager to become familiar with hospital practices in his/her area to ensure that TB medications are not left with the patient to self-administer during the hospitalization. Other exclusions from the denominator are planned and agreed upon days when a patient may be unavailable for DOT, such as vacation or conflicting appointments, and days when medications are withheld for medical reasons. If the patient must miss DOT, the nurse case manager should ensure that the patient has enough medication for self-administration, and that he/she is knowledgeable about the medication actions, administration, dosages, and side effects.

Assessment of the patient who is self-administering TB medications can be done by asking the patient directly if the medications are being taken as directed. Self-monitoring forms may be used, but their accuracy has been challenged. However, the simple act of self-monitoring and recording may serve as a reminder for the patient and thus improve adherence. Unlike DOT, self-reporting cannot be considered a true indicator of adherence and is, therefore, a less reliable assessment tool.

Behavioral measures are frequently used to assess adherence. The most commonly used methods to assess adherence to TB treatment are:

- Pill counts
- Observation of patient behaviors
- Record keeping of clinical appointments

Clinical outcome may be measured by:

- Symptom improvement such as weight gain, lessening of cough, increased appetite, and/or increased energy
- Bacteriology change from smear and/or culture positive to negative
- Chest x-ray improvement

Patients often experience symptom improvement after several weeks of treatment and may stop taking TB medications once they start to feel better. The risk of nonadherence increases with the duration of treatment. If DOT is not provided, patients must be closely monitored throughout the course of treatment for changes in their clinical status.

Nurse case management is an extremely effective strategy to enhance adherence to TB treatment. The activities of the case manager, the individualized treatment plan, the multidisciplinary team approach, and the assignment of responsibility and accountability are all factors that positively affect patient outcomes. Other measures used to improve adherence are:

- DOT
- Flexible treatment strategies
- Good patient-provider relationships
- Behavior modification
- Incentives and enablers
- Behavioral contracting
- Patient education

The nurse case manager may utilize one or more of the above strategies to improve patient adherence.

Directly observed therapy (DOT) has proven to be a highly successful strategy that can improve completion rates for tuberculosis treatment. It allows the practitioner to count the exact number of medication doses the patient has taken during the course of treatment. Often however, DOT alone is not enough to achieve adherence. Certain patient behaviors such as failing to keep appointments, taking medication before the outreach worker or nurse arrives, behaving in a hostile or argumentative manner, or refusing to swallow medication can make the DOT process difficult. These behaviors require the use of various interventions aimed at enhancing adherence. During patient assessment, the nurse case manager will need to:

- Determine the attitudes of the patient/family about DOT and the healthcare provider
- Understand the feelings of the patient regarding the anti-TB medications
- Evaluate the patient's tolerance to the medications, such as: ability to swallow medications and ingest all medications at once rather than in divided doses
- Evaluate the presence or possibility of interactions with other medications
- Ensure that the time and place for DOT administration that was originally agreed on is still convenient

Ongoing assessment will identify factors that could jeopardize the plan and unnecessarily prolong treatment. The simultaneous use of other interventions, rather than relying on DOT alone, has been shown to promote adherence.

One such adherence strategy is the use of **intermittent therapy** whereby medications are administered either 2 or 3 times a week rather than 5 to 7 times per week. This strategy is particularly useful when time is an issue for the patient, when healthcare personnel resources are limited, or if it is difficult for the healthcare provider to make daily visits.

Another treatment strategy is the use of **fixed-dose combination medication** such as Rifater® (rifampin, isoniazid, pyrazinamide/Aventis). This treatment option not only provides patients with a choice, but also guarantees ingestion of three first-line TB drugs, thereby reducing the development of multi-drug resistant TB (MDR-TB). This is particularly effective when patients feel a loss of control over their lives due to the diagnosis of TB. For some patients, receiving injections of TB medication has been shown to enhance TB treatment. However, this treatment must be used in conjunction with DOT. The nurse case manager must give careful consideration to any problems patients may encounter with injections over time. If problems occur, this strategy can easily become a deterrent to adherence.

Although the physician is responsible for developing the treatment plan and ordering the medication regimen, he/she should be able to rely on the nurse case manager to make suggestions regarding treatment strategies to improve adherence. This consultation should occur before nonadherence becomes a problem. However, the nurse case manager should have a team discussion that includes the physician, if nonadherence is identified as a problem. Other useful strategies include scheduling appointments as soon as possible after the initial diagnosis, quickly following up on missed appointments, and using of appointment reminders.

Patient-provider relationships are one of the most critical factors in improving patient satisfaction and adherence. All adherence-enhancement strategies discussed in this module will be most effective in the context of a concerned, compassionate relationship with the patient who is an active participant in his/her TB treatment. The nurse case manager should initiate open discussions with the patient about the treatment plan, including responsibilities of all participants. Communication, written or oral, must be clearly understood by the patient, and the nurse should obtain feedback regarding the clarity of the communication or information.

Compassion and understanding of patients' lifestyles as well as a non-judgmental attitude are important qualities for a nurse case manager and all team members to possess. It is important to avoid criticism of patients' behaviors, to be open-minded about their beliefs and lifestyles, and to avoid imposing personal values on patients. Patients are extremely perceptive about attitudes that the healthcare provider may have concerning their lifestyles, even when they are not verbally communicated. The nurse case manager should be aware of opinions held by healthcare providers on the team, and how those opinions affect the patient's willingness to adhere to treatment. Open discussions with team members about their feelings will help avoid conflict; however, if either the patient or healthcare worker cannot work through a problem, a change in provider should be considered.

The compassionate nurse case manager should also recognize and address the patient's feelings about the disease and the resulting illness. A diagnosis of TB disease may produce fear, anxiety, and hopelessness. Often the role of the nurse case manager is to support the patient and help him/her work through these feelings. If this does not occur in the early stages of the process, these fears may cause barriers to adherence that will interfere with the nurse/patient relationship and treatment.

Incentives and enablers are tools that the nurse case manager may use to encourage positive patient behavior. Incentives are small rewards given to patients to improve and maintain adherence and provide motivation to carry out the activities necessary for treatment. Incentives must be tailored to the individual's special interests or needs and be offered according to an established policy and plan that stipulates how they will be used. The following is an example of an incentive policy:

- All patients on DOT shall receive an incentive (\$5 gift certificate to the grocery store or fast-food restaurant) every week if adherence rate is 100%.

The healthcare worker who works most closely to achieve a particular behavior should give the incentives. Incentives act as an immediate reward. If the reward is for keeping the clinic appointment, the nurse case manager may be the one to give the incentive to the patient. How the patient chooses to use the incentive should not be addressed in any way.

There should be no judgment attached to the incentive by the healthcare worker. Healthcare workers' negative attitudes about incentives may impact the effectiveness of this program. By listening and observing healthcare workers on the team, the nurse case manager will be able to determine if negative attitudes exist. The nurse case manager should encourage open dialogue and provide education regarding the use and effectiveness of incentives. If all efforts fail to change a team member's attitude about incentives, then the nurse case manager should change the manner in which the incentive is given to the patient.

Enablers differ from incentives in that they help patients to adhere to the treatment plan. An assessment, which identifies the barriers to care for individual patients and/or cohorts of patients, will determine the need and types of enablers. The nurse case manager, along with the multidisciplinary team and the patient, should determine which incentive and enabler will be most beneficial in modifying the patient's behavior. An example of an enabler is free transportation. There should be written policies and procedures as to how, when, and under what conditions the enabler is given, but these policies should be designed to allow flexibility.

Assessment of incentives and enablers and the expected behaviors of the patient should be documented in the patient's medical record. Evaluation of the expected behavior should occur regularly and may result in a change in the incentive and/or enabler during the course of TB treatment if the expected patient behavior deviates from the original plan.

Behavioral contracting is another strategy often used by healthcare providers in TB control. Contracts provide a useful means by which the patient's participation, responsibility, and accountability can be nurtured and managed. Contracts, whether written or oral, clarify treatment goals, patient and provider responsibilities, and minimize confusion. A critical feature of behavioral contracting is the benefit that accrues from the negotiation process. The patient's choice, control, and involvement are essential. The nurse case manager can utilize all these in negotiating a behavioral contract with patients. The contracting process involves concrete discussions about specific behaviors, expectations, and rewards.

During the course of TB treatment, the nurse case manager should continually assess whether the patient has met the terms of the contract. As part of this assessment, the nurse must determine if the patient has the necessary resources to meet the demands of the contract. It may be necessary to break down complex behavioral goals into small achievable components that progressively move the patient toward treatment objectives. Positive reinforcement should be given soon after the desired behavior is exhibited rather than at fixed intervals, and if the patient fails to live up to the terms of the contract, previously stated consequences should be employed within a specified time period. These consequences should not come as a surprise to the patient because they were part of the original contract. In addition, the patient should be made aware of any legal ramifications if nonadherence becomes an issue.

Patient education that is well planned and combined with other interventions is essential for assuring adherence. Information must be appropriate for the patient's stage of development, or level of education, literacy and current level of knowledge regarding TB. The specific needs of each patient should be taken into account during the education process. If the patient has immediate unmet needs that are a priority, the educational process will not be successful. The nurse case manager should try to deal with these needs before attempting to educate the patient about TB. If a change in behavior or lifestyle is required, the nurse case manager should assess the patient's readiness for change, cultural beliefs and values, and expectations about the disease and treatment. Patients are more likely to be adherent if they believe they have a treatable disease, understand the treatment plan, and realize the benefits of treatment.

Education is an interactive process between the patient and healthcare provider. Learning is diminished when the patient is a passive recipient of information. It is important to assess the patient's beliefs and knowledge about TB treatment before any education is provided. Based on the assessment of the patient, the nurse case manager will need to decide when, how, and who participates in the education process. Education should be provided throughout the duration of treatment in a planned, sequential manner, limiting the amount of information presented at any one visit.

Effective communication techniques and age-appropriate literature are important. Literature in the patient's primary language and at the appropriate educational level should be available so the patient can review the information at home and share it with the family members. It is not wise to assume that the patient understands all the information that has been provided. If the nurse case manager or healthcare provider cannot speak the patient's language, a medical interpreter should be used rather than a family member. Repetition or different teaching methods should be employed to reinforce concepts until the patient demonstrates understanding. Feedback and questions the patient asks indicate the need for further information. Patient education should be documented in the medical record as it occurs.

Organizational barriers often cause patients to become uncooperative with healthcare providers, making delivery of care difficult. Patient satisfaction with the healthcare system and with individual providers is important for improved adherence. Therefore, difficulties that patients encounter in the clinic or with providers should be identified and addressed by the nurse case manager. If the nurse case manager does not have authority to change the clinic system, it will be necessary to meet with the appropriate administrative staff to discuss the problems and assist in resolution. The organization of TB services will impact adherence. Some basic guidelines follow:

- The clinic should be physically safe and comfortable
- Clinic staff should be courteous, respectful, and culturally sensitive
- Interpreters must be made available
- All staff involved with patient care must hold patient information in strict confidence. A breach in confidentiality is both illegal and a great deterrent to adherence
- Documentation of patient's medical care, nursing interventions, and other services provided should be in accordance with external and internal standards
- Clinic services must be efficient and easily accessible to minimize waiting time

Professional issues cannot be overlooked when addressing adherence. Attitudes and beliefs of healthcare workers impact their ability to provide effective patient care, education, and promote adherence. The following negative attributes of healthcare workers have been associated with patient nonadherence:

- Pessimism or inertia
- Stimulus overload
- Too many obstacles
- Lack of time
- Low pay
- Low expectation of adherence

Healthcare workers' interactions with patients and the degree of motivation towards their work may be more important than the extent of technical expertise. Professional burnout, the exhaustion of strength, both physical and emotional, resulting from prolonged frustration, stress, and/or overwork, is a major problem in caring for difficult patients. Since the length of TB treatment may range from 6 months for pan-sensitive patients to between 18 to 24 months for patients with MDR-TB, the potential for professional burnout is great. For example, burnout can occur when a patient takes an unusually long time to ingest TB medication, when the worker is providing DOT in unsafe areas, or when patients are verbally hostile and abusive. In these situations, the nurse case manager should be alert for signs of burnout in team members. These signs are not always obvious but may include:

- Lack of motivation in performing necessary job-related activities
- Failure to complete tasks or assignments on time
- Frequent use of personal or sick time
- Tardiness
- Complaints of fatigue, restlessness, and apathy

Healthcare workers should be made aware of the signs of burnout and be encouraged to seek assistance. Supervisory staff must be willing to provide counseling or to refer the employee to an employee assistance program. Often, however, relieving the worker from a stressful situation, such as re-assigning a difficult patient to another nurse/outreach worker/physician, may resolve the problem. The nurse case manager who communicates regularly with the multidisciplinary team, observes closely for signs of stress and frustration, and who attempts to solve problems immediately, will be able to prevent burnout in team members.

In summary, successful patient outcomes are influenced by the nurse case manager's ability to build a cohesive team, resolve conflict and delegate appropriately. Equally important are the provision of culturally competent healthcare and an understanding of factors that contribute to patient adherence.

REVIEW QUESTIONS

SECTION REVIEW – CULTURAL COMPETENCY

- 1) Define cultural competency.
- 2) List interview questions used in a cultural assessment.
- 3) Identify ways that a nurse case manager can promote cultural competency among staff.

SECTION REVIEW – TEAM BUILDING

- 1) Name five elements of the team building process.

SECTION REVIEW – UNDERSTANDING AND RESOLVING CONFLICT

- 1) List four levels within an organization where conflict can occur.
- 2) Identify five strategies for resolving conflict.

SECTION REVIEW – DELEGATION IN NURSING PRACTICE

- 1) Define delegation.
- 2) Describe the professional nurse's responsibility in the delegation process.
- 3) What nursing functions should never be delegated?
- 4) List the critical components of the delegation process.
- 5) Describe the Five Rights of Delegation.

SECTION REVIEW – ASSESSING AND IMPROVING ADHERENCE

- 1) Describe ways that the nurse case manager can assess the patient's adherence to treatment.
- 2) List the variables that may affect adherence to TB treatment.
- 3) Name four indicators of adherence in TB treatment.
- 4) How is DOT adherence assessed?
- 5) List at least five strategies to enhance adherence to treatment.

APPENDIX 1

COMPONENTS OF CULTURAL ASSESSMENT

Cultural Identity

- Where were you born?
- Where were your parents born?
- What ethnic group do you belong to?

Health/Illness Beliefs

- What do you think caused your current illness?
- What types of things do you do to treat illness?
- What treatment(s) do you think you should receive for your illness?
- What problems will your illness cause you?
- Why do you think you got sick when you did?
- What worries you about the illness?
- How do family and/or close friends feel about your illness?

Caring Patterns

- Who cares for you when you are sick?
- Where do you go if you are sick?
- Who do you prefer to take care of you when you are sick, sad, or uncomfortable?

Rituals

- What types of food, remedies, and practices are you using to treat illness or to get well?

APPENDIX 2

VARIABLES AFFECTING ADHERENCE

Patient Variables

- Cultural beliefs about disease
- Apathy, pessimism, depression, denial
- Lack of a social support system
- Residential instability
- Lack of resources
- Dissatisfaction with healthcare provider
- Negative experiences with healthcare providers in past
- Previous history of nonadherence
- Impatience with level of progress/response to treatment
- Sensory disabilities
- Inability to follow treatment plan
- Embarrassment
- Lack of control over life

Treatment Variables

- Complexity and/or duration of treatment
- Expense of treatment
- Characteristics of medications (number of pills, side effects)
- Interaction of medication with food

Disease Variables

- Coexisting medical conditions
- Disease requiring multiple tests or complex treatment

Organizational Variables

- Inaccessibility of clinic
- Long waiting time at clinic or for clinic appointment
- Fragmented, uncoordinated services
- Inaccessible telephone system
- Lack of resources for transportation of patients

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