

**Case Management Teaching
Methods and Strategies
For
Native Americans**

By: Eguolo George

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Professor: Rosalyn Forbes, RN, MS, HNBC

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When dealing with patient's delicate health issues and needs, the case manager is a vital tool for coordinating health care. According to Certified Case Manager (CCM) credential, it defines case management as "a collaborative practice that assess, plans, implements, coordinates, monitors, and evaluates the options and services required to meet client's health and human services. It's characterized by advocacy, communication, resource management ... and cost effective interventions and outcomes" (Powell, 2010, p. 4). The duties of the case manager is to serve the patient and to create a seamless care plan at all aspects of their care from the minute they are admitted to after they move to another phase of care either inside another facility or in the community. An essential aspect of case management that is of interest is the teaching methods and strategies needed for a particular cultural group. The Native American culture is part of the small minority that has strong roots in the American land. Their harsh historical background has shaped them into the very small population that exists today. The case manager would have to uniquely tailor a teaching plan that is cultural sensitive and fits seamlessly into their particular life style.

For the case manager to create teaching strategies and methods for a patient who is of Native American descent, understanding their culture is one of the important steps in the initial assessment of the client. In the United States, there are over 5.2 million people classified as American Indian, Alaska Native, or combination of one of the with another racial group according to Minority Health in 2010. They only make 1.7 percent when comparing their population to all of the racial groups represented in the United States. To be classified as a Native American, the people have ancestral origins in North, South, or Central America. They also maintain their tribal affiliations or attachments to this cultural group. The same report shows only 22 percent of Native Americans live on reservations or other types of land entrusted

to them. The majority of the population lives in metropolitan areas, which is 60 percent of the people. There are 565 federally recognized tribes and 100 state recognized tribes. There are still tribes that are not officially recognized by either state or federal.

A tribe that is known federally is able to receive benefits in health and education. The government agency in charge of such benefits is Indian Health Service (IHS). This aide is helping about 1.9 Americans who live mainly on reservations or rural areas. They usually populate 36 states in western US and Alaska. Not everybody who receives these benefits live in these parts of the US. “Thirty-six percent of the IHS service area population resides in non-Indian areas, and 600,000 are served in urban clinics” (*U.S. Department of Health and Human Resource 2012*). These people in urban communities don’t usually have access to hospitals or other health care facilities. They also are most likely to have little healthcare options and poor health. Those 600,000 people stated earlier who receive HIS through urban clinics is a testament of the programs IHS emplaced to serve these population outside the reservations. This has started since 1972. Today there are 41 sites located in cities in the US. The programs provide medical services, dental services, community services, alcohol and drug abuse prevention, education and treatment, AIDS and sexually transmitted disease education and prevention services, mental health services, nutrition education and counseling services, pharmacy services, health education, optometry services, social services, and home health care.

Even though there is some help created to service the Native Americans, they still suffer from many social, economic, physical and mental issues. In looking at highest education acquired, they fall below the average of other minorities. Minority Health reports from U.S. Department of Health and Human Resource the following statistics: 77 percent age 25 and over

have at least high school diploma compared to 90 percent non Hispanic Whites; 13 percent age 25 and over have at least a bachelor's degree compared to 31 percent of non-Hispanic Whites; and 67,600 age 25 and over have at least an advanced graduate degree (i.e., master's, Ph.D., medical, or law). Economically, the average family makes \$44,347 compared to \$68,390 for non-Hispanic Whites. The average number of Native Americans living at poverty level is 28 percent, which is higher than the 9 percent of non Hispanic Whites who are at the same level. Native Americans and Alaskan Natives have a high rate of no health insurance benefits or underinsured. Minority health reports in 2009, 36 percent had private health insurance coverage. 30 percent relied on Medicaid coverage. And 33 percent had no health insurance coverage. Native American has a high prevalence of major health issues such as heart disease, cancer, unintentional injuries (accidents), diabetes, and stroke. They are at high risk for mental health, suicide, obesity, sudden infant death syndrome (SIDS), teenage pregnancy, liver disease, and hepatitis. The major causes for such poor health are cultural barriers, geographic isolation, inadequate sewage disposal, and low income.

For the case manager to be successful in a teaching plan for a Native American living in the reservations or low income urban areas there are many hurdles they have to jump to plan out the right methods. There are many obstacles that the particular patient is going through other than their health problem such as financial issues and cultural clashes. Cultural awareness allows us to see the person as more than a patient with a particular diagnosis. The case manager has to tie all parts of their lives such as educational background, economic status, beliefs systems and cultural practices, their personal views of the situation, doubts in healthcare system, historical hardships their particular tribe or family faced, etc. All of this can affect how the patient would perceive learning about more westernized interventions that they may be seen as a

loss of their culture. This population already may feel some type of way towards outsiders and may even suspect them as enemies. Also the case workers values and patient's values may clash. An example is case manager see it unprofessional to bring her own personal story for the situation but to the patient this is a part of building relationships. Openly addressing differences can be a positive take on showing respect for each others values. Trust is something that needs to be built by the case worker to allow the learner to slowly open up to the idea of collaborating during the learning/teaching process. The learner must feel that they are in control of what is occurring to them and their voice matter. Even as far as having the spiritual leader of the tribe collaborating with you on effective care that would increase positive communal support is something to add to the care plan. If culture is a big part of their lives, this definitely has to be incorporated into their teaching plan. The case manager should be aware of practices such as home remedies, traditional meals, and healing rituals. If the patients head is focused on other levels of needs such as basic needs (food & shelter) due to reservation and urban life, they need to be worked out to give the patient ability to focus on the next level of Maslow's chart. A plan can truly work if the learner is open to active participation since their feedback and actions help to shape the plan to be more effective. After fully understanding the patient's background and addressing issues that would defer learning environment, the next step is to start assessing their current knowledge of the health topic. At this day of age, access to technology and media create faster ways in which people are learning about their health issues. Also their personal experience, family/friends/neighbors experience, information sharing through word of mouth, and research on their own about how the health issue has an impact on what their views on the issue. Starting off with open ended questions facilitate a two way conversation. Here are some question examples: "Tell me what you already know about...", "What do you think/feel

about...?", "How do you like to learn best?" (ex: books, TV, one-to-one, hands on), "Who told you about...?", and "Why do you feel it's important to...?"

Once you have gathered all necessary information related to the patient and addressed issues that decrease active learning, you are now able to think of an effective teaching/learning strategy. There are three types of strategies that could be used: teacher centered, interactive, and independent. Teacher centered is the traditional way of learning, similar to a classroom setting. This includes lectures, questioning, discussion and group work. Independent learning is when the person creates his/her own teaching plan. This is a self thought method. The style of greatest interest to the case manager for teaching a Native American patient is interactive method. Within the style there are three types: problem solving (learning takes place when learner and educator identify a problem to solve), dialogical learning (two people learning at the same time through different activities), and experimental learning (two people learn by acting out real life situations in simulated environment or actual real setting). Incorporating all three styles of interactive learning with the patient and his/her family would build the foundations needed to be successful in combating any health issue.

Now a teaching plan based on the teaching strategy chosen can start. The health issue being addressed in the teaching plan is diabetes. Diabetes is one of the leading health issues for Native Americans. More half of the adults between the ages of 30 to 64 have been diagnosed with Type 2 Diabetes (Edwards, 2009, p. 1). The culture is rationally communal and looks at how individual actions have an impact on the whole community. The case manager needs to introduce new ways of how to deal with diabetes instead of seeing it as a diagnosis that tears the individual away from their culture due to lifestyle changes. A good starting point is to use a

visual/auditory aide such as very short video or reading a scenario about the topic to initiate discussion between the patient, their family/friends/community support if involved, and nurse case manager. The visual/auditory aide should be as close to Native American life and culture as possible to show case life after having diabetes. Depending on what information or myths they had on diabetes before hand from other teaching settings, this may trigger more questions they hadn't thought of asking. The case manager can now address false myths, answer truthfully about concerns, and reaffirming important information. Written information should be given to allow further reading back at home. Language should be at sixth grade reading level or less, in the patient's primary language, and in large font. There should be pictures that support the texts. All information taught during learning session should be given as simple reading material too. Learning isn't created from a onetime session. Starting education at the beginning, if possible, has a greater chance of sticking in the minds of the patient. It also allows a greater chance of revising the plan as many times possible to fit the patients mind frame and knowledge at that moment. The teaching plan is an outline that is not set in stone; it changes with the level of understanding of the patient. There can be a mixture of confusion and understanding, complete confusion or false/true understanding.

Effective teaching can only be effective through how much the patient retains. Assessing the patient for how much they took out of the sessions can be evaluated many ways. One way is asking the patient to verbally repeat what they are going to do when they have to face their health situation at home. When looking at the case of a diabetic Native American, they can state their method of checking for types of food they could eat that is either traditionally based and who they would call or what intervention to do depending on their blood sugar levels. Another way to asses is through role playing a situation that can occur in the community to see how they

would actively use their new knowledge. This could be on how to combat temptations of fast/processed food or voicing symptoms of high/low blood sugar to emergency officials through phone. Words alone are not the only way to assess effective teaching. Observing the patient doing a procedure on their own allows the patient to feel autonomy in their accomplishment and gives a chance for repetitive learning.

As part of a healthcare team, they're other disciplinarians who are creating teaching plans such as the RN, dietician, physical therapist, etc. Issues such as disease process, medical equipment, nutrition, rehabilitation activities, medication usage, medication interactions and side effects are covered by other health care workers. The case manager is responsible to making sure these areas are covered and teach in areas such as individual health insurance coverage, deductibles, co pay plans, DRGs, prescription costs, and location of pharmacies and hospitals. Also important is how the patient would be able to seek and access community resources. The patient needs to know that back home in the community they have a team that is ready to be there for them regardless if they live in remote areas or the city. As always, this teaching session can include the people in the patient's life. Health insurance coverage can be addressed by having a conversation of what they feel is covered by their insurance to see what they know. This is a daunting topic due to many policies and coverage that can be confusion to understand. Next the case manager would talk about what is actually covered, for what amount and time period. For things that are not covered, discussing alternatives in obtaining those items is also talked about for as little cost as possible. An easy to understand outline of their health insurance plan and where else they can get help for items that are not covered should be given to take home. The patient can have the best care at the hospital but the patient would be bouncing back and forth from emergency centers if there is no community based care help. To facilitate

continuation of care, the case manager should identify the programs, support team, and health facilities near the patient. There may be an IHF program near them; the Native Challenge Program for family and economic issues, tribal community programs, clinic, or community diabetic support groups that would be a positive ally in their daily struggle with diabetes and other life issues. Whether they need heat in their house or feel lost with food choices at grocery store, they must have some support systems outside their home to contact. Besides actual facilities, phone numbers that are not just general hotlines should be given for voicing any issues that arise whether it's a medical, social, or economical issue.

Using cultural competency as a case manager is one tool of taking the step to make sure the care given to the patient coincides with their views. When looking at the Native American culture, individuals may fully immerse themselves into their culture, fully adapted a more westernized view or fall somewhere in between. Not one person in the culture is going to think or behave the same. This is why just solely knowing a patient's culture isn't going to help create an individualized care plan. It can only be used as a guide. The case manager needs to gather as much information they can from all parts of the patient's life to form a personalized teaching plan. The use of interactive learning strategies to encourage active learning is a key factor to increase the likelihood of behavioral practices outside of the comforts of the hospital.

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