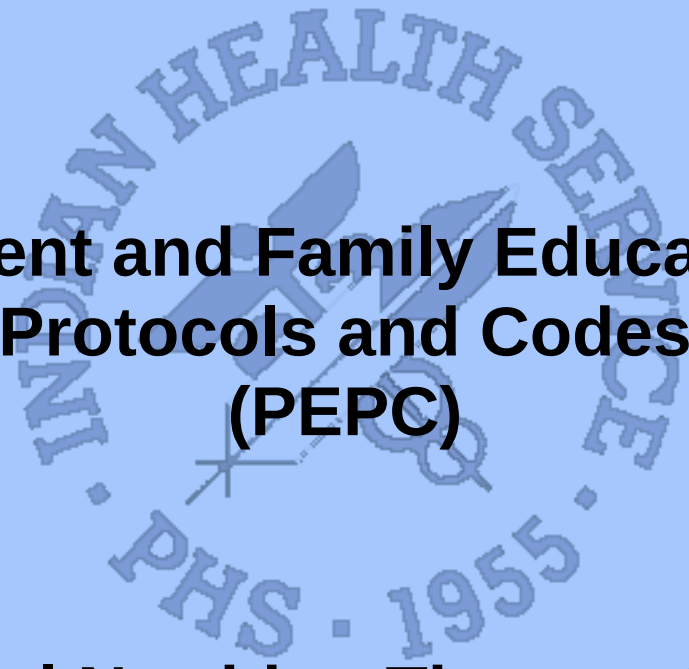
INDIAN HEALTH SERVICE



Patient and Family Education Protocols and Codes (PEPC)

Medical Nutrition Therapy Codes

11th Edition
January 2005

FOREWORD

The PEP-C (Patient Education Protocols and Codes committee) has diligently worked to add all protocols that were requested by providers or departments. We hope that you find codes helpful in documenting your patient education. Some of the codes found in this book will be used in ORYX and GPRA as indicators. Please consult your local SUD to see which indicators your site has chosen. More information about these topics can be obtained from Mary Wachacha or Mike Gomez. They are both in the IHS e-mail system.

As co-chairs of this committee we would like to sincerely thank all the members and guests of this committee. As usual they spent long hours preparing for the committee meeting and even longer hours in committee. They all deserve our appreciation. Without these dedicated committee members this would not be possible. We would also like to thank Mary Wachacha, IHS Chief of Health Education. Without her vision none of this would be possible. We would like to recognize Liz Dickey, R.N. for her part in envisioning an easier way to document education. We would like to thank Juan Torrez for his assistance in formatting and ensuring consistency in our document. We would like to thank all the programs in IHS for their dedication to the documentation of patient and family education. Finally, we are indebted to our colleagues in the Indian Health Service for their support, encouragement and input.

If you have new topics or codes you would like to see in future editions of the Patient Education Protocols and Codes please let us know. Submissions are requested and encouraged!!! Please e-mail submissions or mail them on floppy disk, in Word or Word Perfect format. Please try to follow the existing format as much as possible and as much as possible use mnemonics (codes) that are already in existence. The submissions will be reviewed by the committee and may be changed extensively prior to their publication for general use. New submissions should be sent to:

Michale Ratzlaff, M.D. or Kelton H. Oliver, M.D.
PEP-C
Alaska Native Medical Center
4315 Diplomacy Drive
Anchorage, Alaska 99508
mdratzlaff@southcentralfoundation.org

kholiver@southcentralfoundation.org

Kelton Oliver, M.D. and Michale Ratzlaff, M.D.
Co-Chairs, National Patient Education Protocols Committee

FOREWORD TO THE 11TH EDITION OF THE PATIENT EDUCATION PROTOCOLS

The current membership of the National IHS Patient Education Protocols Committee:

Committee Co-Chair
CDR Kelton Oliver, MD
Family Practice
Alaska Native Medical Center (AK)
kholiver@southcentralfoundation.org

Committee Co-Chair
CDR Michale Ratzlaff, MD
Pediatrician
Alaska Native Medical Center (AK)
mdratzlaff@southcentralfoundation.org

Cecilia Butler, RD, MS, CDE
Dietician
Santa Fe Indian Hospital (NM)
cbutler@abq.ihs.gov

CAPT Susan Dethman, MS, RD, CDE, CHES
Public Health Nutritionist
Wewoka IHS Clinic (OK)
Susan.Dethman@ihs.gov

Dar Buena-Suerte Goodman, RN
Ambulatory Care Nurse Manager
Yakama Indian Health Center (WA)
dbuena@yak.portland.ihs.gov

LCDR Christopher C. Lamer, Pharm.D., BCPS, NCPS, CDE
Pharmacist
Cherokee Service Unit (NC)
Chris.lamer@ihs.gov

LCDR Sharon L. John, RN, BSN, BA.
Clinical Nurse Specialist
Warm Springs Health and Wellness Center (OR)
sjohn@wsp.portland.ihs.gov

Linda Lucke, R.N., B.S.N.
Quality Management Coordinator
Blackfeet Service Unit (MT)
Linda.lucke@mail.ihs.gov

Michelle Ruslavage, R.N., B.S.N., C.D.E.
Diabetes Nurse Educator
Claremore Indian Hospital (OK)
Michelle.ruslavage@ihs.gov

Bonnie Smerud, R.N.
Quality Management Coordinator
Red Lake Service Unit (MN)
Bonnie.Smerud@ihs.gov

Sonya Vann, R.N., B.S.N., B.A.
ICU Unit Manager
WW Hastings Hospital (OK)
Sonya.vann@mail.ihs.gov

Mary Wachacha, Chief
IHS Health Education Program
Rockville, MD
mwachach@hqe.ihs.gov

IMPORTANT CHANGES IN THE 11TH EDITION

CHEMICAL DEPENDENCY CHANGE: The mnemonic CD for Chemical Dependency has been changed to AOD —Alcohol and Other Drugs. The change from the mnemonic CD to AOD was at the request of the Behavioral Health Program. Questions/concerns about this change should be addressed to Jon Perez, Director, IHS Behavioral Heath Program or Denise Grenier, OIT BH representative. For the short-term, "CD" will remain a viable mnemonic but will eventually become obsolete in RPMS and totally replaced by AOD. We suggest you begin using the new AOD term now.

TABLE OF CONTENTS

Use and Documentation of Patient Education Codes

Why Use the Codes?

Use of the codes helps nurses, physicians and other health care providers to document and track patient education. While it is frequently desirable to spend 15, 30 even 60 minutes making an assessment of need, providing education and then documenting the encounter, the reality of a busy clinical practice often requires us to do this in a more abbreviated fashion. The codes allow the educator a quick method of documenting that education took place during a given patient visit. The codes are then transferred to the health summary which informs everyone using the chart that a given patient received education on specific topics. The codes are limited in that they do not detail the exact nature of the education. However, using these codes consistently will show the pattern of education provided and encourage subsequent health professionals to do the appropriate follow-up. For instance, a typical health summary for a diabetic patient might show the following history of patient education:

07/19/04 DM-Nutrition, poor understanding, 10 min. (Provider Initials) GS: Pt. will include 5 veg/fruit/day

10/27/04 DM-Foot care, good understanding, 7 min. (Provider Initials)GM: Pt included 5 veg/fruit/day

11/07/04 DM-Exercise, good understanding, 15 min. (Provider Initials) GS: Pt. will walk 5 dys/wk/30 min.

A reasonable interpretation of this summary tells you that this patient is trying to understand management of their diabetes.

SOAP Charting and the Codes

Use of the codes *does not* preclude writing a SOAP note on educational encounters. Whenever a health professional spends considerable time providing education in a one-on-one setting, that visit should be recorded as an independent, stand-alone visit. The primary provider can incorporate the educational information into their SOAP note and use the code to summarize the visit and get the information onto the health summary. If the patient sees both a physician and a nurse during the same visit and the nurse completes a lengthy educational encounter, two PCC forms should be used— one for the physician visit and one for the nursing visit. In that particular case the patient had two primary care encounters during the same day.

How to Use the Codes

The Medical Records and Data Entry programs at each site determine where patient education will be entered on the PCC and other facility forms. Medical Records and Data Entry will also determine how the patient education is recorded. You should check with your Medical Records and Data Entry staff to determine how they would like your facility to document patient education. Using a stamp, over-printing on the PCC or the use of "education flow sheets" is discouraged for all disciplines and all sites. All education should be documented directly onto the PCC, PCC+ and in the Electronic Health Record.

The educator should document the education using the following steps:

1. Log onto the PCC, PCC+ or Electronic Health Record or document the education on the PCC Group Preventive Services Form
2. Circle "Patient Education" in the section marked "Medications/Treatment/Procedures/Patient Education"
3. If using the PCC+ or the Electronic Health Record, Patient Education is located in specific sections of the PCC+ and Electronic Health Record.
4. Begin your documentation by entering the appropriate:
    - STEP ONE: Write down the appropriate ICD-9 code, disease, illness or condition for which you are providing the education.
    - STEP TWO: Enter the education topic discussed (e.g. complications, nutrition, hygiene).
    - STEP THREE: Determine the patient's level of understand of the education provided and enter as good- (G), fair (F), or Poor (P).
        - If the patient refuses the education encounter, you document this refusal by writing an (R) for refused.
        - If you are providing education in a group (not an individual one-on-one encounter), the education provided is documented as (GP) for Group education. A "group" is defined as more than one person. Documenting with the Group (Gp) mnemonic indicates that the group member's level of understanding was not assessed.
    - STEP FOUR: Enter the amount of time spent educating the patient. Use specific time amounts rounded off to the minute, i.e., 3 minutes, 17 minutes.
    - STEP FIVE: Initial your entry so that you can get credit for the education provided.
    - STEP SIX: Lastly, each provider is able to encourage the patient to participate in the determination of their personal health by setting a goal for themselves. This capability is the last item documented at the end of the educational encounter. The provider assists the patient in setting a

"plan of action" for themselves to aid in the improvement of their health. This is documented by using (GS) for Goal Set; (GM) for Goal Met; and (GNM) for Goal Not Met. Upon the documentation of the setting of a Goal, each subsequent health care provider can refer to the "Health Summary" and look under the "Most Recent Patient Education" to review any goals set by the patient.

OBJECTIVE	DEFINITION	MNEMONIC
Goal Set	• State a plan; • State a plan how to maintain at least one _____; • Write a plan of management; • Plan to change ___; • A plan to test _____(blood sugar); • Choose at least one change to follow _____; • Demonstrate ____ and state a personal plan for _____; • Identify a way to cope with _____;	GS
Goal Met	Behavior Goal Met	GM
Goal Not Met	Behavior Goal Not Met	GNM

The PCC Coders can only select "Good, Fair, Poor, Group or Refused" for the level of understanding. Remember, this section is meant for speedy documentation of brief educational encounters. If you wish to write a more lengthy narrative, please do so, on a separate PCC form using the codes to simply summarize your note. On inpatient PCCs each entry must be prefaced by a date.

Recording the Patient's Response to Education

The following "Levels of Understanding" can be used in the PCC system:

Good (**G**):	Verbalizes understanding Verbalizes decision or desire to change (plan of action indicated) Able to return demonstrate correctly
Fair (**F**):	Verbalizes need for more education Undecided about making a decision or a change Return demonstration indicates need for further teaching
Poor (**P**)	Does not verbalize understanding Refuses to make a decision or needed changes Unable to return demonstrate
Refuse (**R**):	Refuses education
Group (**Gp**):	Education provided in group. Unable to evaluate individual response

Documenting Patient Education (Forms)

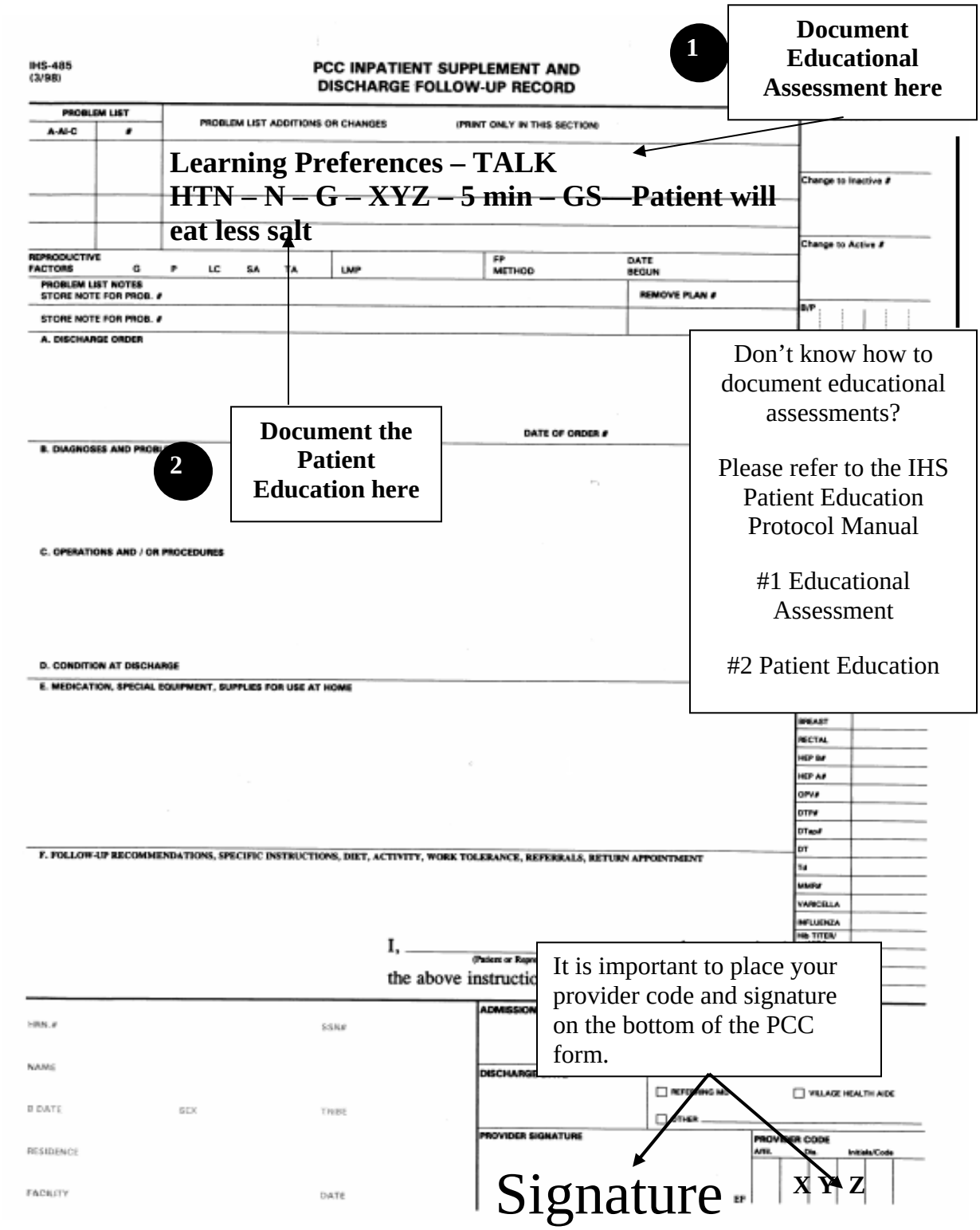


Figure 1: ***Documenting Patient Education on the PCC Inpatient Supplement and Discharge Follow-Up Record form.***

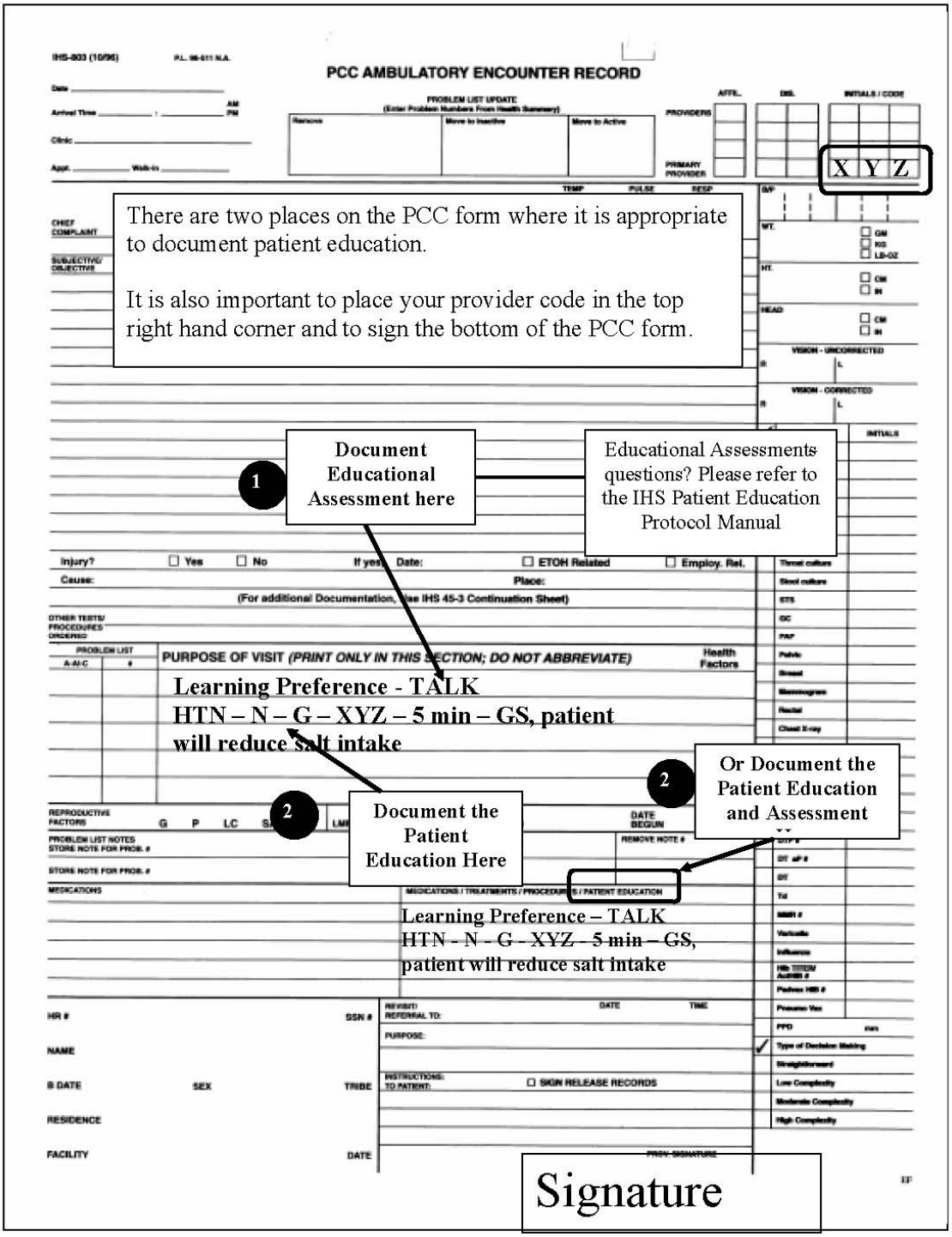
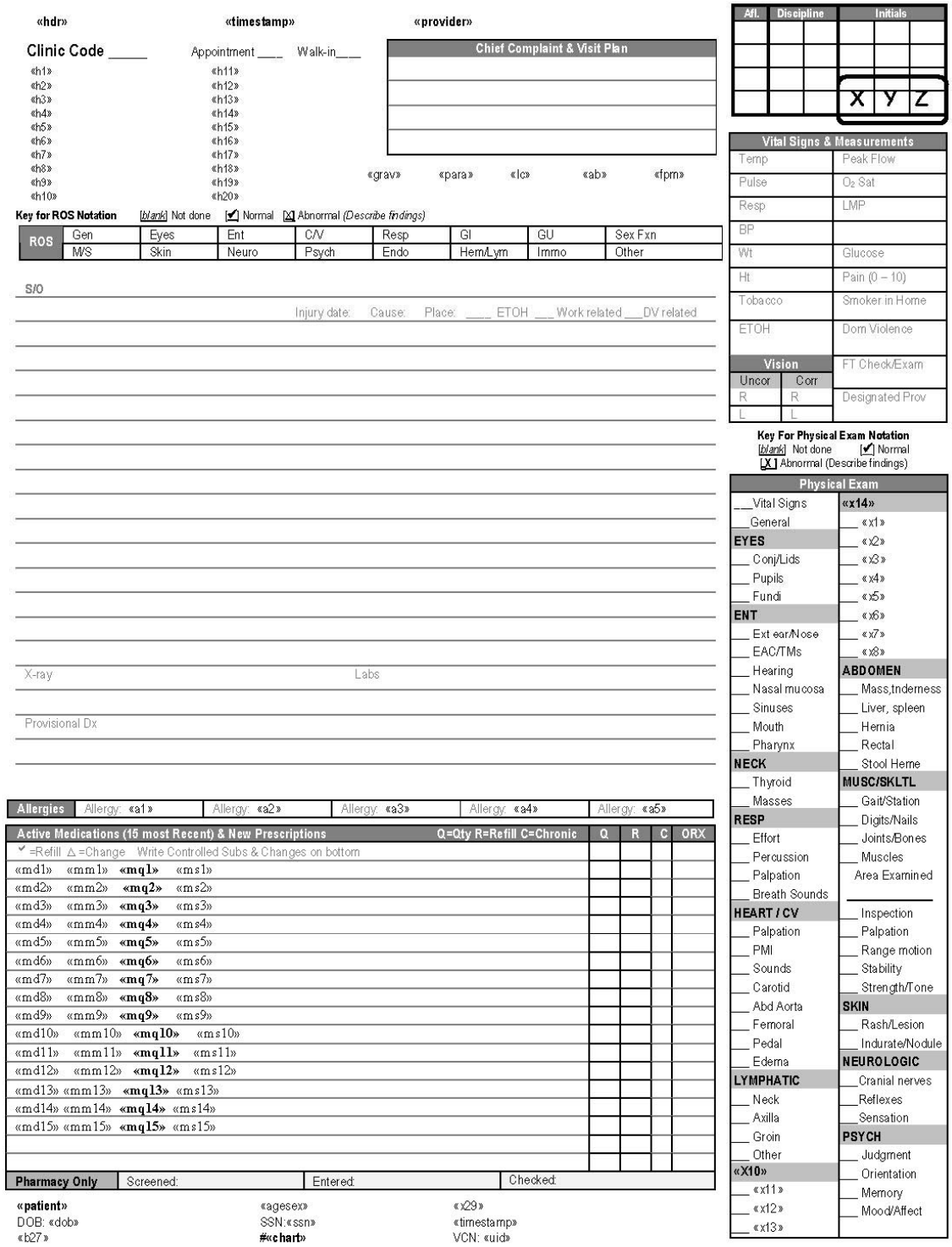


Figure 2: Documenting Patient Education with the PCC Ambulatory Encounter Record form



«hdr» «timestamp» «provider»

Clinic Code _____ Appointment ___ Walk-in___

«h1» «h11»
«h2» «h12»
«h3» «h13»
«h4» «h14»
«h5» «h15»
«h6» «h16»
«h7» «h17»
«h8» «h18»
«h9» «h19»
«h10» «h20»

Chief Complaint & Visit Plan

«grav» «para» «lc» «ab» «fpm»

Afl. | Discipline | Initials — X Y Z

Vital Signs & Measurements

Temp	Peak Flow
Pulse	O_2 Sat
Resp	LMP
BP	
Wt	Glucose
Ht	Pain (0 – 10)
Tobacco	Smoker in Home
ETOH	Dom Violence
Vision: Uncor / Corr	FT Check/Exam
R / R	Designated Prov
L / L	

Key for ROS Notation [blank] Not done [✓] Normal [X] Abnormal (Describe findings)

ROS								
	Gen	Eyes	Ent	C/V	Resp	GI	GU	Sex Fxn
	M/S	Skin	Neuro	Psych	Endo	Hem/Lym	Immo	Other

S/O

Injury date: Cause: Place: ____ ETOH ___ Work related ___DV related

X-ray Labs

Provisional Dx

Key For Physical Exam Notation
[blank] Not done [✓] Normal
[X] Abnormal (Describe findings)

Physical Exam

___Vital Signs	«x14»
___General	___«x1»
EYES	___«x2»
___Conj/Lids	___«x3»
___Pupils	___«x4»
___Fundi	___«x5»
ENT	___«x6»
___Ext ear/Nose	___«x7»
___EAC/TMs	___«x8»
___Hearing	ABDOMEN
___Nasal mucosa	___Mass,tnderness
___Sinuses	___Liver, spleen
___Mouth	___Hernia
___Pharynx	___Rectal
NECK	___Stool Heme
___Thyroid	MUSC/SKLTL
___Masses	___Gait/Station
RESP	___Digits/Nails
___Effort	___Joints/Bones
___Percussion	___Muscles
___Palpation	Area Examined
___Breath Sounds	_____
HEART / CV	___Inspection
___Palpation	___Palpation
___PMI	___Range motion
___Sounds	___Stability
___Carotid	___Strength/Tone
___Abd Aorta	SKIN
___Femoral	___Rash/Lesion
___Pedal	___Indurate/Nodule
___Edema	NEUROLOGIC
LYMPHATIC	___Cranial nerves
___Neck	___Reflexes
___Axilla	___Sensation
___Groin	PSYCH
___Other	___Judgment
«X10»	___Orientation
___«x11»	___Memory
___«x12»	___Mood/Affect
___«x13»	

Allergies | Allergy: «a1» | Allergy: «a2» | Allergy: «a3» | Allergy: «a4» | Allergy: «a5»

Active Medications (15 most Recent) & New Prescriptions — Q=Qty R=Refill C=Chronic	Q	R	C	ORX
✓=Refill △=Change Write Controlled Subs & Changes on bottom				
«md1» «mm1» **«mq1»** «ms1»				
«md2» «mm2» **«mq2»** «ms2»				
«md3» «mm3» **«mq3»** «ms3»				
«md4» «mm4» **«mq4»** «ms4»				
«md5» «mm5» **«mq5»** «ms5»				
«md6» «mm6» **«mq6»** «ms6»				
«md7» «mm7» **«mq7»** «ms7»				
«md8» «mm8» **«mq8»** «ms8»				
«md9» «mm9» **«mq9»** «ms9»				
«md10» «mm10» **«mq10»** «ms10»				
«md11» «mm11» **«mq11»** «ms11»				
«md12» «mm12» **«mq12»** «ms12»				
«md13» «mm13» **«mq13»** «ms13»				
«md14» «mm14» **«mq14»** «ms14»				
«md15» «mm15» **«mq15»** «ms15»				

Pharmacy Only | Screened: | Entered: | Checked:

«patient»
DOB: «dob»
«b27»

«agesex»
SSN: «ssn»
#«chart»

«x29»
«timestamp»
VCN: «uid»

Figure 3: Documenting Patient Education on a PCC+ form, page 1

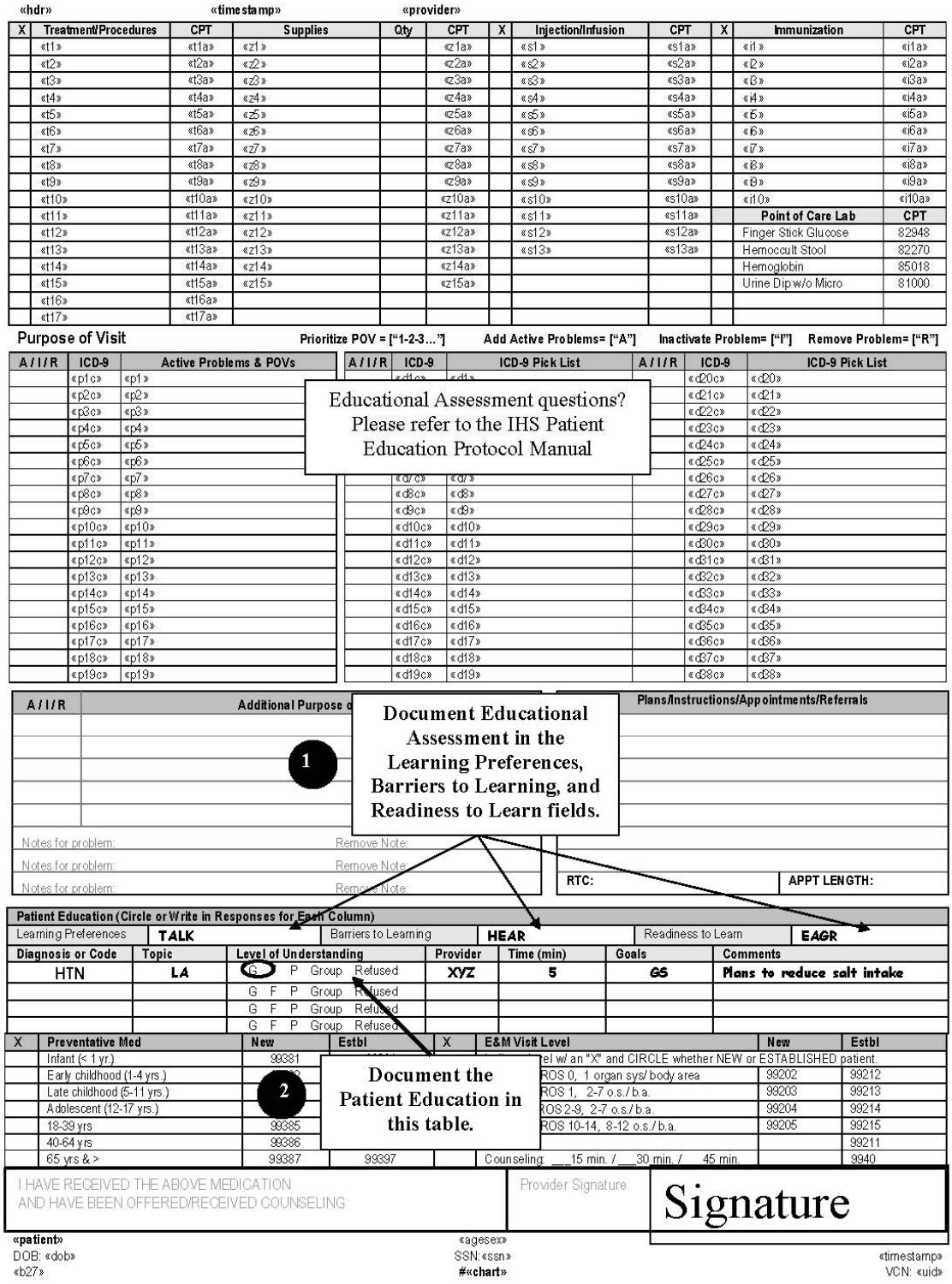
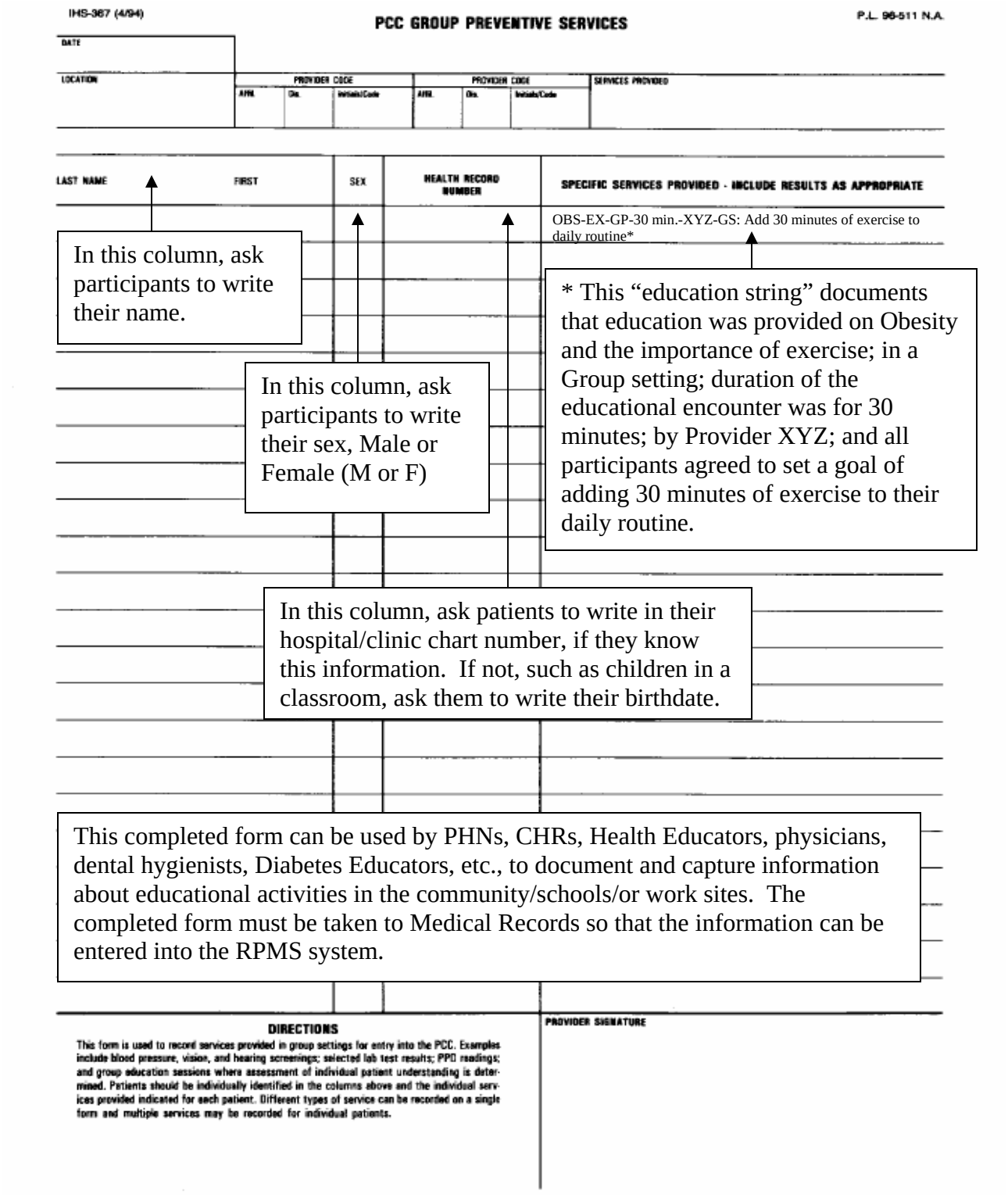


Figure 4: Documenting Patient Education on a PCC+ form, page 2

This form is used by all healthcare workers providing education in the community, schools, work sites, etc.



IHS-367 (4/94)

PCC GROUP PREVENTIVE SERVICES

P.L. 86-511 N.A.

DATE

LOCATION

PROVIDER CODE (AFIL. | Dis. | Initials/Code)

PROVIDER CODE (AFIL. | Dis. | Initials/Code)

SERVICES PROVIDED

LAST NAME	FIRST	SEX	HEALTH RECORD NUMBER	SPECIFIC SERVICES PROVIDED - INCLUDE RESULTS AS APPROPRIATE
				OBS-EX-GP-30 min.-XYZ-GS: Add 30 minutes of exercise to daily routine*

In this column, ask participants to write their name.

In this column, ask participants to write their sex, Male or Female (M or F)

* This "education string" documents that education was provided on Obesity and the importance of exercise; in a Group setting; duration of the educational encounter was for 30 minutes; by Provider XYZ; and all participants agreed to set a goal of adding 30 minutes of exercise to their daily routine.

In this column, ask patients to write in their hospital/clinic chart number, if they know this information. If not, such as children in a classroom, ask them to write their birthdate.

This completed form can be used by PHNs, CHRs, Health Educators, physicians, dental hygienists, Diabetes Educators, etc., to document and capture information about educational activities in the community/schools/or work sites. The completed form must be taken to Medical Records so that the information can be entered into the RPMS system.

DIRECTIONS

This form is used to record services provided in group settings for entry into the PCC. Examples include blood pressure, vision, and hearing screenings; selected lab test results; PPD readings; and group education sessions where assessment of individual patient understanding is determined. Patients should be individually identified in the columns above and the individual services provided indicated for each patient. Different types of service can be recorded on a single form and multiple services may be recorded for individual patients.

PROVIDER SIGNATURE

INPATIENT EDUCATION FORM

READINESS TO LEARN
(RL Code)

Eager to Learn	**RL-EAGR**
Receptive	**RL-RCPT**
Unreceptive	**RL-UNRC**
Pain	**RL-PAIN**
Severity of Illness	**RL-SVIL**
Not Ready	**RL-NOTR**
Distraction	**RL-DSTR**

Assessed each teaching session

PATIENT'S RESPONSE TO EDUCATION (Level of UNDERSTANDING)

GOOD (G) - Verbalized understanding. Verbalizes decision to change (plan of action indicated) able to demonstrate correctly.
FAIR (F) - Verbalizes need for more education. Undecided about making a decision or change. Return demonstration indicates need for further teaching.
POOR (P) - Does not verbalize understanding. Refuses to make a decision or needed changes. Unable to return demonstration.
REFUSED (R) - Refuses education.
GROUP (GP) – Group taught

LEARNING PREFERENCES (LP Code)
Assessed Yearly
If Assessed Today, Today's Date:

Talk (one-on-one)	**LP-TALK**
Video	**LP-VIDO**
Group	**LP-GP**
Read	**LP-READ**
Do/Practice	**LP-DOIT**

BARRIERS TO LEARNING - BAR (Assessed Annually); If Assessed Today, Date Assessed:
Check those that apply:

- ☐ No Barriers **BAR-NONE**
- ☐ Doesn't read English **BAR-DNRE**
- ☐ Interpreter Needed **BAR - INTN**
- ☐ Social Stressors **BAR-STRS**
- ☐ Cognitive Impairment **BAR-COGI**
- ☐ Blind **BAR-BLND**
- ☐ Fine Motor Skills **BAR-FIMS**
- ☐ Hard of Hearing **BAR-HEAR**
- ☐ Deaf **BAR-DEAF**
- ☐ Visually Impaired **BAR-VISI**
- ☐ Values/Beliefs **BAR-VALU**
- ☐ Emotional Impairment **BAR- EMOI**

List measures taken to address above barriers:

Comments: ____

DATE	PATIENT EDUCATION ICD-9 CODE DISEASE STATE, ILLNESS OR CONDITION	(Check box to refer to Progress Notes) EDUCATION TOPIC	PROVIDER INITIALS OR PROVIDER CODE	READINESS TO LEARN CODE (RL)	LEVEL OF UNDER-STANDING CODE	PERSON TAUGHT	TIME	GOAL SET GOAL MET GOAL NOT MET	CPT CODE
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			
		™		EAGR RCPT UNRC PAIN SVIL NOTR DSTR		PATIENT OTHER			

Patient Identification **Providers please sign on back of form**

White – Chart Yellow- Billing Pink- Data Entry

INPATIENT EDUCATION FORM

Signature:	Initials/Provider code:	

White – Chart Yellow- Billing Pink- Data Entry

Reimbursement for Patient Education

Preventive Medicine Services

Evaluation and Management (E&M) CPT Coding and ICD-9 Diagnostic Coding

Reimbursement for Patient Education

To properly document and receive reimbursement for patient education services, it is important to provide enough document to substantiate accurate CPT Procedural Coding and ICD-9 Diagnostic Coding. These two types of codes are mandatory to properly complete the claim forms that will be submitted to third party payers.

For CPT Coding, the reimbursement of patient education would fall under the Evaluation and Management (E&M) Codes based on *Time*. *Time* is a factor in clinical encounters. The most common and most important element that *'Time'* becomes a factor is when counseling dominates the visit (i.e. patient education).

"In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (fact-to-face time in the office or other outpatient setting, floor/unit time in the hospital or nursing facility), *Time* is considered the key or controlling factor to qualify for a particular level of E/M services.

The following codes are used to report the preventive medicine evaluation and management of infants, children, adolescents and adults. The extent and focus of the services will largely depend on the age of the patient.

If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier '-25' should be added to the Office/Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.

An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported. The "comprehensive" examination of the Preventive Medicine Services codes 99381-99397 is NOT synonymous with the "comprehensive" examination required in Evaluation and Management codes 99201-99350.

Codes 99381-99397 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination. (Refer to codes 99401-99412 for reporting those counseling/anticipatory

guidance/risk factor reduction interventions that are provided at an encounter separate from the preventive medicine examination.)

If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of *Time* of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care."

In practice, this means that if you document spending >50% of a 15 minute visit in counseling (education), you get a 99213 code even if you don't ask a single question or touch the patient. Similarly, >50% of a 25 minute encounter gets you 99214. IHS providers do provide patient education and counseling but most sites are neglecting to charge for these services. We either do not document the actual time spent or the content of the counseling. Certainly the private sector charges for these services.

Definition: Discussion with patient when 50% or more of the total physician face to face time of the encounter includes:

- Results of diagnostic tests or impressions
- Prognosis
- Risk and benefits of treatment options
- Instructions for care at home and follow-up with physician/other provider of care
- Importance for compliance with treatment plan
- Risk factor education, e.g., diet, exercise
- Patient and Family Education regarding disease and or the disease process

Documentation Requirements:

- Total face to face time is the basis for code selection
- 50% or more of the encounter is counseling
- Documentation of the total time of the encounter and the counseling Time
- Document a summary of the counseling performed
- Document any history or exam that was performed

Coordination of Care

Definition: When 50% of more of the total time of the encounter includes:

- Establishing and/or reviewing patient's record
- Documenting in the patient's medical record
- Communication with nursing staff, other physicians or health professionals and/or patient's family
- Scheduling treatment, ordering testing and/or x-rays

Important Aspects concerning Reimbursement for PATIENT EDUCATION

- Third Party claims should be processed for Medicare Part B eligible patients. Medicare Part A does not reimburse for these services
- Each site should contact their local payers and research the billing rules and regulations of ALL third party payers to determine if they will reimburse for patient education services.
- You must identify (the education provided) and routinely document the services and have PCC Data Entry enter the information by using the appropriate CPT code
- Identify who provided the service i.e., physician, PHN, FNP, PA, RD
- Education may be covered by an alternate resource as part of their plan coverage
- Use those CPT codes that are related to education
- "Incident To" services are billable

Documentation of Evaluation and Management (E/M) Services

- Three Key Components:
  - history
  - examination
  - medical decision making
- Other Components:
  - Counseling
  - Time (may use to determine Office Visit level if > 50% of time is spent in face-to-face counseling)

BRIEF Sample - Office Visits, Established Patients

CODES	99211	99212	99213	99214	99215
History	Not Required	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Exam	Not Required	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Decision Making	Not Required	Straight Forward	Low	Moderate	High
Time	5 Minutes	10 Minutes	15 Minutes	25 Minutes	40 Minutes

New Patient: Initial preventive medicine evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk facto reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures

Established Patient: Periodic preventive medicine reevaluation and management of an individual including a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory /diagnostic procedures

PROCEDURAL TERMINOLOGY	
CPT Codes	**Description of Procedure**
G0108	Diabetes Education – Group Education
G0109	Diabetes Education – Individual Education
97802	Medical Nutrition Therapy (MNT)
97803	Hospital-Observation/In-Patient
97804	Hospital-Observation/In-Patient
99201	Office Visit, New Patients-Office or other outpatient
99202	Office Visit, New Patients-Office or other outpatient
99203	Office Visit, New Patients-Office or other outpatient
99204	Office Visit, New Patients-Office or other outpatient
99205	Office Visit, New Patients-Office or other outpatient
99211	Office Visits, Established Patients-Office of other outpatient
99212	Office Visits, Established Patients-Office of other outpatient
99213	Office Visits, Established Patients-Office of other outpatient
99214	Office Visits, Established Patients-Office of other outpatient
99215	Office Visits, Established Patients-Office of other outpatient
99218	Hospital-Observation/In-Patient
99219	Hospital-Observation/In-Patient
99220	Hospital-Observation/In-Patient
99381	Preventive Medicine – New Patient Infant Age under 1 year
99382	Preventive Medicine – New Patient Early childhood (age 1 through 4 years)

PROCEDURAL TERMINOLOGY	
CPT Codes	**Description of Procedure**
99384	Preventive Medicine – New Patient Adolescent (age 12 through 17 years)
99385	Preventive Medicine – New Patient 18 – 39 years
99386	Preventive Medicine – New Patient 40 – 64 years
99387	Preventive Medicine – New Patient 65 years and over
99391	Preventive Medicine – Established Patient early childhood (age 1 to 4 years)
99392	Preventive Medicine – Established Patient - late childhood (age 5 to 11 years)
99393	Preventive Medicine – Established Patient - adolescent (age 12 to 17 years)
99394	Preventive Medicine – Established Patient - 18 – 39 years
99395	Preventive Medicine – Established - 40 – 64 years
99396	Preventive Medicine – Established - 65 years and over
99397	Preventive Medicine – Established - 65 years and over
99401	Preventive Medicine Evaluation and Management counseling and/or risk factor reduction intervention(s) provided to a New or Established Patient
99402	Preventive Medicine-Evaluation and Management New and Established approximately 30 min.
99403	Preventive Medicine-Evaluation and Management New and Established approximately 45 min
99404	Preventive Medicine-Evaluation and Management New and Established approximately 60 min.
99411	Preventive Medicine Counseling/Education and/or risk factor reduction intervention(s) provided to individuals in a ***group*** setting (separate procedure); – Established Patients approximately 30 minutes.
99412	Preventive Medicine Counseling/Education and/or risk factor reduction intervention(s) provided to individuals in a *group* setting (separate procedure); – Established Patients approximately 60 minutes.

The ICD-9 Diagnostic codes will be used for coding diagnoses that support the provision of these educational services. Below are major codes identified that can be used for guidance.

ICD-9 DIAGNOSTIC CATEGORIES	
ICD9 Code Range	**Name of Category**
V65.3	Dietary surveillance and counseling
V65.40	Counseling NOS
V65.41	Exercise Counseling
V65.42	Counseling on Substance use/abuse
V65.43	Counseling on Injury Prevention
V65.44	HIV counseling
V65.45	Counseling on other STDs
V65.49	Other specified counseling
V65.5	Person with feared complaint in whom no diagnosis was made
V65.8	Other reasons for seeking consultation
V65.9	Unspecified reason for consultation

Diabetes Curriculum Education

What are the Diabetes Curriculum Education Codes?

The Diabetes Education Curriculum Codes (DMC) are a VERY specific set of codes that follow the IHS Diabetes Curriculum, "Balancing Your Life and Diabetes." These IHS diabetes education codes are meant to be used by persons who are familiar with the IHS Diabetes Curriculum, "Balancing Your Life and Diabetes."

If you are providing Diabetes Education and your site is *not* using the IHS "*Balancing Your Life and Diabetes"* curriculum, use the DM codes found in the main set of patient education codes. Only sites using the IHS "*Balancing Your Life and Diabetes"* should use the DMC (Diabetes Mellitus Curriculum) codes. If you are not sure which codes or curriculum your site should document with, check with your local Diabetes Coordinator

Diabetes Curriculum Education Codes

DMC—Diabetes Mellitus

DMC-ABC KNOWING YOUR NUMBERS (ABC)

OUTCOME: The individual/family will be able to identify target goals for A1c, blood pressure and blood fat levels.

STANDARDS:

ABC-1	Verbalize one reason for measuring A1c.
ABC-2	State the target A1c goal for blood sugar control.
ABC-3	Identify current A1c.
ABC-4	State two ways to reach or maintain their A1c goal.
ABC-5	Verbalize one reason for measuring blood pressure.
ABC-6	State the target for blood pressure control.
ABC-7	Identify current blood pressure.
ABC-8	State two ways to reach or maintain a target blood pressure.
ABC-9	Verbalize one reason for measuring blood fats.
ABC-10	State the target goals for target blood fats
ABC-11	Identify at least one current blood fat level.
ABC-12	List two or more ways to reach or maintain target blood fat goals.
ABC-13	State where to get help to improve their ABC numbers.
ABC-GS	State or write a plan to reach or maintain at least one of the ABC numbers.
ABC-GM	Behavior goal met (follow-up)
ABC-GNM	Behavior goal unmet (follow-up)

DMC-AC ACUTE COMPLICATIONS

OUTCOME: The individual/family will understand acute complications and self-care actions to take to prevent or treat acute complications.

STANDARDS:

LOW BLOOD SUGAR

AC-1 Define low blood sugar.
AC-2 Discuss two or more causes of low blood sugar.
AC-3 List two or more symptoms of low blood sugar.
AC-4 State two or more actions to take when feeling symptoms of low blood sugar.
AC-5 State two or more actions to prevent low blood sugar.

HIGH BLOOD SUGAR

AC-6 Define high blood sugar.
AC-7 State two or more causes of high blood sugar.
AC-8 List two or more symptoms of high blood sugar.
AC-9 Discuss two or more actions to take when the blood sugar is high.
AC-10 State two or more actions to prevent high blood sugar.

SICK DAY MANAGEMENT

AC-11 Explain how blood sugar is affected during illness.
AC-12 State two or more things to do to manage blood sugar when sick.
AC-13. Identify two or more food and drink choices to use when sick.
AC-GS State or write a plan to use for low blood sugar, high blood sugar, and sick day management.
AC-GM Behavior goal met (follow-up)
AC- GNM Behavior goal unmet (follow-up)

DMC-BG BEHAVIORAL GOALS (MAKING HEALTHY CHANGES)

OUTCOME: The individual/family will have a basic knowledge of the process of behavior change and goal setting.

STANDARDS:

BG-1 State in simple terms what a goal is.
BG-2 Discuss personal habits.
BG-3 Identify desirable behavioral changes.
BG-4 Describe the process for making personal change.
BG-GS State or write a plan to change one or more behaviors.
BG-GM Behavior goal met (follow-up)
BG-GNM Behavior goal unmet (follow-up)

DMC-BGM BLOOD SUGAR MONITORING, HOME

OUTCOME: The individual/family will understand the importance of blood sugar monitoring, know how to use the meter, and make personal blood sugar monitoring plan.

STANDARDS:

BGM-1 Explain that people with diabetes use a meter to learn how much sugar is in the blood.
BGM-2. List benefits of checking blood sugar.
BGM-3 State target blood sugar ranges to decrease risk for complications.
BGM-4 Discuss personal blood sugar goals.
BGM-5 State when to check blood sugar.
BGM-6 Discuss proper technique for checking blood sugar. (To include maintenance, support services)
BGM-7 Demonstrate how to record results correctly.
BGM-8 Discuss benefits of bringing meter and logbooks to clinic visits.
BGM-9 State proper disposal of sharps.
BGM-10 State how to get supplies to check blood sugar.
BGM-GS State or writes a plan to check blood sugar.
BGM-GM Behavior goal met (follow-up)
BGM-GNM Behavior goal unmet (follow-up)

DMC-CC CHRONIC COMPLICATIONS (PREVENTING AND TREATING DIABETES COMPLICATION)

STAYING HEALTHY WITH DIABETES

OUTCOME: The individual/family will understand the prevention and treatment of long-term complications of diabetes.

STANDARDS:

CC-1 State that controlling blood sugar lowers the chance of getting diabetes complications.
CC-2 Identify two or more factors that increase the risk of complications.
CC-3 State two or more long-term complications of diabetes

RETINOPATHY

CC-4 Describe retinopathy in their own words.
CC-5 List at least two or more ways to prevent or delay eye disease.
CC-6 Discuss how eye disease is treated.

HEART DISEASE

CC-7 Define heart disease in their own words.
CC-8 List at two or more ways to prevent or delay heart disease.
CC-9 Discuss how heart disease is treated.

NEPHROPATHY

CC-10 Define nephropathy in their own words.
CC-11 List at two or more ways to prevent or delay kidney disease.
CC-12 Discuss how kidney disease is treated.

NEUROPATHY

CC-13 Define neuropathy in their own words.
CC-14 List two or more to prevent or delay nerve damage.
CC-15 Discuss how nerve damage is treated.(To include pain management)

SEXUAL HEALTH AND DIABETES

CC-16 Discuss in simple terms how diabetes and high blood sugars may impact intimacy/sexuality.
CC-17 List two or more ways to prevent or delay sexual health problems.
CC-18 Discuss how sexual health problems are treated.
CC-19 Discuss ways to talk about sexual concerns with significant others and members of the health care team.

PERIODONTAL

CC-20 Describe periodontal disease in their own words.
CC-21 List at two or more ways to prevent or delay gum/teeth problems.
CC-22 Discuss how periodontal disease is treated.

SUMMARY

CC-23 Describe the need for all people with diabetes to get yearly tests, exams, and immunizations.
CC-24 Identify their risk factors for diabetes complications.
CC-GS State or write at least one behavior change that will help lower their risk for diabetes complications.
CC-GM Behavior goal met (follow-up)
CC-GNM Behavior goal unmet (follow-up)

DMC-DP DISEASE PROCESS (WHAT IS DIABETES)

BALANCING YOUR LIFE AND DIABETES

OUTCOME: The individual/family will have a basic understanding of the definition, pathophysiology, and treatment of Type 2 diabetes.

STANDARDS:

DP-1 Provide a simple definition for diabetes in their own words
DP-2 Discuss the differences between Type 1 and Type 2 diabetes.
DP-3 Explain how the body normally uses food.
DP-4 List two or more risk factors for developing diabetes.
DP-5 Describe the impact of insulin resistance in diabetes.
DP-6 List two or more signs or symptoms of high blood sugar.
DP-7 State the range for normal fasting blood sugar.
DP-8 State a normal blood sugar range one to two hours after a meal.
DP-9 Explain that high blood sugar can cause damage to the nerves and blood vessels in the eyes, heart, kidneys, and feet.
DP-10 List two or more diabetes self-care actions necessary to reach target blood sugar goals.
DP-GS State or write one change to make for diabetes self-care.
DP-GM Behavior goal met (follow-up)
DP-GNM Behavior goal unmet (follow-up)

DMC- EX EXERCISE (MOVING TO STAY HEALTHY)

OUTCOME: The individual/family will understand the relationship of physical activity in achieving and maintaining blood sugar control by making a personal physical activity plan.

STANDARDS

EX-1 List two or more benefits of regular physical activity.
EX-2 State effects of physical activity on blood sugar.
EX-3 Discuss kinds of physical activity.
EX-4 Discuss time and frequency for physical activity.
EX-5 Discuss simple ways to measure intensity of physical activity.
EX-6 Discuss medical clearance issues for physical activity.
EX-7 List one or more ways to stay safe during physical activity.
EX-GS State or write a personal plan for physical activity.
EX-GM Behavior goal met (follow-up)
EX-GNM Behavior goal unmet (follow-up)

DMC-FTC FOOT CARE (TAKING CARE OF YOUR FEET)

OUTCOME: The individual/family will understand the importance of foot care for people with diabetes.

STANDARDS:

FTC-1 State one or more reasons to check feet every day.
FTC-2 Identify two or more risk factors for foot problems.
FTC-3 List two or more daily self-care action to prevent foot problems.
FTC-4 Describe how to cut toenails correctly.
FTC-5 Describe two or more things to look for when choosing proper footwear.
FTC-6 State two or more signs and symptoms of foot and skin infections.
FTC-7 State the reason for routine foot exams at each clinic visit and yearly foot screening.
FTC-GS Demonstrate a personal foot exam and state a personal foot care plan.
FTC-GM Behavior goal met (follow-up)
FTC-GNM Behavior goal unmet (follow-up)

DMC-M DIABETES MEDICINE- OVERVIEW AND DIABETES PILLS

DMC-IN DIABETES MEDICINE - INSULIN

OUTCOME: The individual/family will understand their medicine regiment.

SECTION 1: OVERVIEW

M-1 Discuss the role of diabetes medicines in the overall diabetes treatment plan
M-2 State two or more reasons for adding or changing diabetes medicines
M-3 State the importance of checking blood sugar more often when medicines are changed
M-4 State the importance of taking medicines as prescribed.
M-5 State two or more guidelines for when to contact a health care provider for medicine.
M-6 Discuss the role of alternative treatments for diabetes and how they affect blood sugar (including herbal, traditional healing methods, and over-the-counter medicines).

SECTION 2: DIABETES PILLS

M7 State the name of their diabetes pills, how much to take, when to take them, how they work, and possible side effects.
M-GS State or write a personal plan for taking their diabetes pills.
M-GM Behavior goal met (follow-up)
M-GNM Behavior goal unmet (follow-up)

SECTION 3: INSULIN

IN-1 Discuss how insulin works to control blood sugar in persons with Type 2 diabetes.
IN-2 Describe the type of insulin they use, the name of the insulin, how it works, how much to take, and when to take it.
IN-3 Identify insulin injection sites.
IN-4 Demonstrate proper technique for withdrawing and injecting insulin.
IN-5 Discuss proper storage of insulin.
IN-6 Discuss proper disposal of insulin syringes and other sharps.
IN-7 Discuss the major side effect of taking insulin.
IN-GS State or write a personal plan for taking insulin.
IN-GM Behavior goal met (follow-up)
IN-GNM Behavior goal unmet (follow-up)

DMC-MSE MIND, SPIRIT AND EMOTION

OUTCOME: The individual/family will understand the emotional impact of diabetes on their personal lives.

STANDARDS:

MSE-1 Express feelings about having diabetes.
MSE-2 Discuss one or more ways diabetes has affected his/her life and/or the lives of their family members and significant others.
MSE-3 Identify their support person(s).
MSE-4 Share past experiences in dealing with health or other kinds of problems.
MSE-5 Explain the body's response to stress.
MSE-6 Discuss ways to handle stress.
MSE-GS State or write one way to handle a stressful situation.
MSE-GM Behavior goal met (follow-up)
MSE-GNM Behavior goal unmet (follow-up)

DMC-N NUTRITION (BASICS OF HEALTHY EATING)

OUTCOME: The individual/family will understand the basics of healthy eating.

STANDARDS:

SECTION 1: INTRODUCTION TO HEALTHY EATING

N-1 Describe the effect of food on diabetes.
N-2 State that healthy food choices are good for the person with diabetes and their whole family.
N-3 Describe how timing and consistency of food can help people with diabetes reach their target blood sugar goals.
N-4 Describe the effect of portion sizes on blood sugar.
N-5 State that eating less sugar and fat can help lower blood sugar.
N-6 State how keeping a record of food eaten can help people with diabetes reach their target blood sugar goals.

SECTION 2: BASICS OF HEALTH EATING

N-7 State two or more benefits of healthy food choices for the person with diabetes.
N-8 Record a day's meal onto a food record.
N-9 Discuss the basic food groups.
N-10 Identify the food groups high in carbohydrates and recognize their efforts on blood sugar.
N-11 State that weight loss can help people with diabetes reach their target blood sugar goals.
N-12 Discuss how to find reliable resources for nutrition facts and answers to questions.
N-GS State or write a personal plan for making healthy food choices.
N-GM Behavior goal met (follow-up)
N-GNM Behavior goal not met (follow-up)

SECTION 3: HEART HEALTHY EATING

N-13 State that hearth healthy food choices are good for the person with diabetes and their whole family.
N-14 Identify foods that increase the risk for heart disease.
N-15 Identify foods that can decrease risk for heart disease.
N-16 Identify two or more ways to choose foods to lower the risk of heart disease.

DMC-N-FL NUTRITION (SESSION 1: INTRODUCTION TO FOOD LABELS)

OUTCOME: The individual/family will understand the basics of food labels.

STANDARDS

FL-1 Identify at least 4 items of information on a food label, including serving size, total calories, and amounts of carbohydrate and fat.
FL-2 State that ingredients on the food label are listed in the order of the amount from greatest to least.
FL-3 Define the words "free", "low", "reduced/less" and "light/lite" on the food label.
FL-4 Describe how to use the food label to make healthy food choices.
FL-GS State or write a person plan for using food labels.

DMC-N-CC NUTRITION (SESSION 2: INTRODUCTION TO CARBOHYDRATE COUNTING)

OUTCOME: The individual/family will understand the basics of carbohydrate counting.

STANDARDS

CC-1 Describe carbohydrate counting in simple terms.
CC-2 Identify the carbohydrate food groups and list 2 or more foods in each group.
CC-3 Define a serving size of carbohydrate food.
CC-4 State 2 or more benefits of using carbohydrate counting to reach and stay at target blood sugar goals.
CC-5 Identify the number of carbohydrate serving needed at each meal.
CC-GS State or write a personal plan for carbohydrate counting.

DMC-N-EL NUTRITION (SESSION 3: INTRODUCTION TO EXCHANGE LISTS)

OUTCOME: The individual/family will understand the basics of exchange lists.

STANDARDS

EL-1 Describe exchange lists in simple terms.
EL-2 Identify the exchange lists
EL-3 Identify 2 or more foods in each exchange list.
EL-4 Define one exchange.
EL-5 Describe 2 or more benefits of using exchange lists to make healthy food choices.
EL-GS State or write a personal plan for using exchange lists.

DMC-N-FS NUTRITION (SESSION 4: INTRODUCTION TO FOOD SHOPPING)

OUTCOME: The individual/family will understand the basics of food shopping.

STANDARDS

FS-1 Identify 2 or more sources of food.
FS-2 Identify 2 or more ways to choose healthy food when shopping.
FS-3 Make a shopping list that includes healthy food choices.
FS-4 Identify 2 or more ways to save money when buying healthy food.
FS-GS State or write a personal plan for food shopping.

DMC-N-HC NUTRITION (SESSION 5: INTRODUCTION TO HEALTHY COOKING)

OUTCOME: The individual/family will understand the basics of healthy food preparation.

STANDARDS

HC-1 Describe 2 or more ways to use less sugar in cooking.
HC-2 Describe the use of sugar substitutes in cooking.
HC-3 Describe 2 or more ways to use less fat in cooking.
HC-4 Describe 2 or more ways to use less sodium in cooking.
HC-5 State 2 or more ways to safely handle food during preparation and storage.
HC-GS State or write a personal plan for cooking.

DMC-N-EA NUTRITION (SESSION 6: GUIDELINES FOR EATING AWAY FROM HOME)

OUTCOME: The individual/family will understand the basics of healthy eating away from home.

STANDARDS

EA-1 Identify 2 or more things that can affect a person's food choices when eating away from home.
EA-2 Identify 2 or more ways to plan ahead for healthy food choices when eating away from home.
EA-3 Identify 2 or more ways to make healthy food choices when eating away from home.
EA-GS State or write a personal plan for eating away from home.

DMC-N-AL NUTRITION (SESSION 7: GUIDELINES FOR THE USE OF ALCOHOL)

OUTCOME: The individual/family will understand the basics of using alcohol with diabetes.

STANDARDS

AL-1 State 2 or more ways alcohol can affect a person with diabetes.

AL-2 State 2 or more guidelines for the use of alcohol.

AL-3 State 2 or more situations when it is important not to drink alcohol.

AL-GS State or write a personal plan for the use of alcohol.

DMC-N-D NUTRITION (SESSION 8: GUIDELINES FOR EVALUATING DIETS)

OUTCOME: The individual/family will understand the basics of evaluating diets.

STANDARDS

D-1 Describe "dieting" in simple terms.
D-2 Describe how to know if a diet is healthy.
D-3 Identify 2 or more problems that may happen with an unhealthy diet.
D-4 Discuss how to find reliable resources for nutrition facts and answers to questions about dieting.
D-GS State or write a personal plan for choosing a healthy diet.

DMC-PG PREGNANCY

DMC-PG-DM SESSION 1: PREGNANCY, DIABETES AND YOU: FIRST STEPS TO A HEALTHY

OUTCOME: The individual/family will understand the definition of pregestational and gestational diabetes.

STANDARDS:

DM-1 Describe personal feelings about pregnancy and diabetes.
DM-2 State in own words the difference between pre-gestational and gestational diabetes.
DM-3 State the target blood sugar goals for pregnancy.
DM-4 Describe the need for frequent care and follow-up during pregnancy.
DM-5 Identify 2 or more resources for support during pregnancy.
DM-GS State or write a personal plan for care during pregnancy.

DMC-PG-N SESSION 2: HEALTHY EATING DURING PREGNANCY

OUTCOME: The individual/family will understand the basics of healthy eating during pregnancy.

STANDARDS

SECTION 1: BASICS OF HEALTHY EATING DURING PREGNANCY

N-1 Identify the effect of carbohydrate foods on blood sugar during pregnancy.

N-2 Identify 2 or more healthy food choices to reach target blood sugar goals during pregnancy.

N-3 Describe a healthy eating pattern during pregnancy which includes several small meals and snacks throughout the day.

N-GS State or write a personal plan for using food choices to reach target blood sugar goals and/or manage common nutritional concerns of pregnancy.

SECTION 2: HEALTHY EATING FOR COMMON CONCERNS DURING PREGNANCY

N-4 Describe 1 or more ways to check for healthy weight gain during pregnancy.
N-5 Describe 2 or more ways to relieve nausea, constipation, and heartburn during pregnancy.
N-6 Describe 1 or more ways to manage milk intolerance during pregnancy.
N-7 Describe the use of sugar-free sweeteners during pregnancy.
N-8 Describe the proper use of vitamins and supplements during pregnancy.
N-GS State or write a personal plan for using food choices to reach target blood sugar goals and/or manage common nutritional concerns of pregnancy.

DMC-PG-PA SESSION 3: MOVING TO STAY HEALTHY DURING PREGNANCY

OUTCOME: The individual/family will understand the impact of physical activity on blood sugar during pregnancy.

STANDARDS

PA-1 List 2 or more benefits of physical activity during pregnancy.
PA-2 Identify 2 or more kinds of physical activity safe for pregnancy.
PA-3 Identify 2 or more things to do to keep physical activity safe during pregnancy.
PA-GS State or write a personal plan for physical activity during pregnancy.

DMC-PG-M SESSION 4: MEDICINE DURING PREGNANCY

OUTCOME: The individual/family will understand their medicine regimen.

STANDARDS

M-1 Describe the use of insulin during pregnancy.
M-2 Describe the use of diabetes pills during pregnancy.
M-3 Discuss the use of prescription, over-the-counter, and herbal medicines, as well as traditional practices, during pregnancy.
M-GS State or write a personal plan for the use of medicine during pregnancy.

DMC-PG-BGM SESSION 5: HOME BLOOD SUGAR MONITORING DURING PREGNANCY

OUTCOME: The individual/family will understand the importance of blood sugar monitoring to reach and stay at target blood sugar goals.

STANDARDS

BGM-1 State target blood sugar goals to decrease the chance for problems for the mother and baby.
BGM-2 State when to check blood sugar during pregnancy.
BGM-3 Demonstrate how to use a logbook during pregnancy.
BGM-GS State or write a personal plan to check blood sugar at home during pregnancy.

DMC-PG-C SESSION 6: STAYING HEALTHY DURING PREGNANCY

OUTCOME: The individual/family will understand the care needed to prevent potential problems for mother and baby.

STANDARDS

C-1 Describe 2 or more things the mother can do for self-care to reach target blood sugar goals during pregnancy.
C-2 State 2 or more potential problems for the mother during pregnancy.
C-3 Describe 2 or more potential problems for the baby if the mother's blood sugar is high during pregnancy.
C-4 Describe 2 or more tests, procedures, or examinations needed during pregnancy.
C-5 State 2 or more guidelines for when to talk with a health care provider during pregnancy.
C-GS State or write a personal plan to reach target blood sugar goals during pregnancy.

DMC-PG-PP SESSION 7: STAYING HEALTHY AFTER DELIVERY

OUTCOME: The individual/family will understand the continued self-care needs after delivery.

STANDARDS

PP-1 Identify 2 or more self-care needs after delivery of mothers with diabetes during pregnancy.
PP-2 Describe 2 or more things women with pre-gestational diabetes can do to manage diabetes after delivery.
PP-3 Describe 2 or more things women with gestational diabetes can do to prevent or delay diabetes after delivery.
PP-4 State 2 or more benefits of breastfeeding.
PP-5 State or write a personal plan for diabetes self-care after delivery.

DMC-PPC PRE-PREGNANCY COUNSELING

OUTCOME: The woman with diabetes and her significant other/family will understand the need for blood sugar control prior to pregnancy.

STANDARDS:

PPC-1 Describe the need to reach target blood sugar goals before becoming pregnant.

PPC-2 Identify two or more ways to reach target blood sugar goal before becoming pregnant.

PPC-3 State that insulin injections may be needed to reach target blood sugar goal before becoming pregnant.

PPC-4 State two potential problems for baby if pregnancy occurs while the mother's blood sugar is high.

PPC-5 State two potential problems for mother during pregnancy.

PPC-6 State the need to use birth control until ready to become pregnant.

PPC-7 State the need to seek early prenatal care.

PPC-8 State the need to avoid tobacco, alcohol, and drugs before and during pregnancy.

PPC-9 Identify community resources to support families before, during, and after pregnancy.

PPC-GS State or write a personal plan to prepare for pregnancy.

PPC-GM Behavior goal met (follow-up)

PPC-GNM Behavior goal unmet (follow-up)

GDM—Gestational Diabetes

GDM-BG BEHAVIORAL GOALS (MAKING HEALTHY CHANGES)

OUTCOME: The individual/family will have a basic knowledge of the process of behavior change and goal setting.

STANDARDS:

BG1 State in simple terms what a goal is.
BG2 Discuss personal habits.
BG3 Identify what the patient may want to change.
BG4 Describe the process for making personal change.
BG50 Write one behavior change plan.
BG51 Behavior goal met (follow-up)
BG52 Behavior goal unmet (follow-up)

GDM-BGM BLOOD SUGAR MONITORING, HOME

OUTCOME: The individual/family will understand the importance of blood sugar monitoring, know how to use the monitor and make personal blood sugar monitoring plan.

STANDARDS:

BGM1 Explain that blood is tested to learn how much sugar is in the blood.
BGM2 List benefits of testing blood sugar.
BGM3 State blood sugar ranges to decrease risk for complications.
BGM4 State personal blood sugar goals.
BGM5 State when to test blood sugar.
BGM6 Demonstrate proper testing of blood sugar. (To include maintenance, support services)
BGM7 Demonstrate how to record results correctly.
BGM8 Discuss benefits of bringing meter and logbooks to clinic visits.
BGM9 State proper disposal of insulin syringes and other sharps.
BGM10 States how to get blood sugar testing supplies.
BGM50 Writes a plan to test blood sugar.
BGM51 Behavior goal met (follow-up)
BGM52 Behavior goal unmet (follow-up)

GDM-C COMPLICATIONS

OUTCOME: The woman with gestational diabetes and her significant other/family will understand the relationship between high blood sugars and adverse outcomes of pregnancy.

STANDARDS:

C1 Discuss 2 complications for mom if blood sugars are high during pregnancy.
C2 Discuss 2 complications for baby if blood sugars are high during pregnancy.
C3 Describe the how to monitor fetal movement (kick counts).
C4 Discuss how to control blood sugar during pregnancy.
C5 Discuss 2 things she can do to help prevent or control diabetes after delivery.
C50 Write a personal plan to control blood sugar during pregnancy.
C51 Behavior goal met (follow-up)
C52 Behavior goal unmet (follow-up)

GDM-DP DISEASE PROCESS

OUTCOME: The woman with gestational diabetes and her significant other/family will understand diabetes self care management during pregnancy.

STANDARDS:

DP1 Define in simple terms gestational diabetes.
DP2 State blood sugar goals for pregnancy.
DP3 Describe feelings about diabetes and pregnancy.
DP4 Describe self-care management during pregnancy.
DP50 Write a personal plan for self care management during pregnancy.
DP51 Behavior goal met (follow-up)
DP52 Behavior goal unmet (follow-up)

GDM-EX EXERCISE (PHYSICAL ACTIVITY AND PREGNANCY)

OUTCOME: The woman with gestational diabetes and her significant other/family will have a safe physical activity plan to follow during pregnancy.

STANDARDS:

EX1 Describe a safe physical activity plan for pregnancy.
EX2 List 3 guidelines to follow for a safe exercise program.
EX50 Write a physical activity plan to use during pregnancy.
EX51 Behavior goal met (follow-up)
EX52 Behavior goal unmet (follow-up)

GDM-FU FOLLOW-UP

OUTCOME: The individual/family will understand the importance of routine follow-up in diabetes treatment and management.

STANDARDS:

FU1 Discuss the importance of regular medical appointments and education to prevent or delay the complications of diabetes.
FU2 States at least 3 standards of diabetes care.
FU3 States the local process to use to make appointments for clinical, education and other services for people with diabetes.
FU50 Writes or states a personal plan for follow-up visits.
FU51 Behavior goal met (follow-up)
FU52 Behavior goal unmet (follow-up)

GDM-L PATIENT INFORMATION LITERATURE

OUTCOME: The individual/family receives information about diabetes self-care management.

STANDARDS:

L1 Provided with diabetes self-care management information.
L2 Provided information about local resources to promote health.

GDM-N NUTRITION (MEAL PLANNING IN PREGNANCY)

OUTCOME: The woman with gestational diabetes and her significant other/family will be able to make a personal plan for nutritional needs during pregnancy.

STANDARDS:

N1 Discuss in simple terms carbohydrate foods.
N2 Discuss 2 or more healthy eating changes to control blood sugar during pregnancy
N3 Discuss importance of consistent timing of meals and snacks.
N50 Write a personal plan for making nutrition changes during pregnancy.
N51 Behavior goal met (follow-up)
N52 Behavior goal unmet (follow-up)

General Education Codes

Guidelines For Use

These general education codes were developed in response to the ever-expanding list of patient education codes. The following 18 codes are education topic modifiers which can be used in conjunction with any ICD-9 diagnosis to document patient and family education. The following list is NOT exhaustive, nor is it intended to be.

This newer, more general system is used in essentially the same way as the specific codes, except that instead of having a patient education diagnosis code the provider will simply write out the 1) diagnosis or condition, 2) followed by the education modifier, 3) level of understanding, 4) write your Provider Initials, 5) Time spend providing the education, and 6) finally write down if the patient set a goal for them selves using GS for Goal Set, GM for Goal Met, and GNM for Goal Not Met. For example:

Head lice - TX - P - <provider initials>10 min. – GS: Pt. will wash bed linens

This would show up on the health summary under the patient education section as:

Head lice - treatment - poor understanding, 10 minutes ,, <Provider Initials> Goal Set: Patient will wash bed lines.

If education on more than one topic on the same diagnosis is provided these topics should be written on a separate line in the Patient Education section of the PCC, PCC+ and Electronic Health Record.:

For example:

Head lice - P - P - <provider initials>10 min. – GS: Pt. will wash bed linens
Head lice - TX - G - <provider initials>7 min. – GS: Pt. will wash bed linens
Impetigo - M, FU - G - <provider initials>GS: Pt. will practice good hygiene by not sharing items.

This would show up on the health summary under the patient education section as:

Head lice - prevention - poor understanding10 min. – GS: Pt. will wash bed linens
Head lice - treatment - good understanding 7 min. – GS: Pt. will wash bed linens
Impetigo - medications, follow-up - good understanding: Pt. will practice good hygiene by not sharing items.

Please note that for reimbursement, the Education MUST have an associated ICD-9 diagnosis code. These codes must still be documented in the patient education section of the PCC, PCC+ or on the EHR. The levels of understanding have not changed and are **G=good, F=fair, P=poor, R=refused, and Gp=group.**

The committee would like to thank Lisa Hakanson, R.D. for her suggestion that resulted in this addition.

General Education Topics

AP - ANATOMY AND PHYSIOLOGY

OUTCOME: The patient and/or family will have a basic understanding of anatomy and physiology as it relates to the disease state or condition.

STANDARDS:

1. Explain normal anatomy and physiology of the system(s) involved.
2. Discuss the changes to anatomy and physiology as a result of this disease process or condition, as appropriate.
3. Discuss the impact of these changes on the patient's health or well-being.

C - COMPLICATIONS

OUTCOME: The patient and/or family will understand the effects and consequences possible as a result of this disease state/condition, failure to manage this disease state/condition, or as a result of treatment.

STANDARDS:

1. Discuss the common or significant complications associated with the disease state/condition.
2. Discuss common or significant complications which may be prevented by full participation with the treatment regiment.
3. Discuss common or significant complications which may result from treatment(s).

DP - DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms and prognosis of his/her illness or condition.

STANDARDS:

1. Discuss the current information regarding causative factors and pathophysiology of this disease state/condition.
2. Discuss the signs/symptoms and usual progression of this disease state/condition.
3. Discuss the signs/symptoms of exacerbation/worsening of this disease state/condition.

EQ - EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) proper use and care of home medical equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed home medical equipment.
2. Discuss types and features of home medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of home medical equipment, participate in return demonstration by patient/family.
4. Discuss signs of equipment malfunction and proper action in case of malfunction.
5. Emphasize safe use of equipment, i.e., no smoking around O_2, use of gloves, electrical cord safety, and disposal of sharps.
6. Discuss proper disposal of associated medical supplies.

EX - EXERCISE

OUTCOME: The patient/family will understand the relationship of physical activity to this disease state, condition or to health promotion and disease prevention and develop a plan to achieve an appropriate activity level.

STANDARDS:

1. Explain the normal benefits of a regular exercise program to health and well-being.
2. Review the basic exercise or activity recommendations for the treatment plan.
3. Discuss the relationship of increased physical activity or limited physical activity as applicable to this disease state/condition.
4. Assist the patient/family in developing an appropriate physical activity plan.
5. Refer to community resources as appropriate.

FU - FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

HM - HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of their disease process and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer emergency room visits, fewer hospitalizations, and fewer complications.
3. Explain the use and care of any necessary home medical equipment.

HY - HYGIENE

OUTCOME: The patient will recognize good personal hygiene as an aspect of wellness.

STANDARDS:

1. Discuss hygiene as part of a positive self image.
2. Review bathing and daily dental hygiene habits.
3. Discuss the importance of hand-washing in infection control.
4. Discuss the importance of covering the mouth when coughing or sneezing.
5. Discuss any hygiene habits that are specifically pertinent to this disease state or condition.

L - PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the disease process or condition.

STANDARDS:

1. Provide patient/family with written patient information on the disease state or condition.
2. Discuss the content of patient information literature with the patient/family.

LA - LIFESTYLE ADAPTATIONS

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of the disease state or condition or to improve mental or physical health.

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over - diet, exercise, safety and injury prevention, avoidance of high risk behaviors, and full participation with treatment plan.
2. Emphasize that an important component in the prevention or treatment of disease is the patient's adaptation to a healthier, lower risk lifestyle.
3. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

M - MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of full participation with medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

N - NUTRITION

OUTCOME: The patient will understand the need for balanced nutrition and plan for the implementation of dietary modification if needed.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to the specific disease state/condition.
4. Emphasize the importance of full participation to the prescribed nutritional plan.

P - PREVENTION

OUTCOME: The patient/family will understand that healthy lifestyle behaviors can reduce the risk of developing diseases, conditions, or complications.

STANDARDS:

1. List lifestyle habits that increase the risk for the onset, progression, or spread of a specific disease/condition.
2. Identify behaviors that reduce the risk for the onset, progression, or spread of a specific disease/condition, i.e., immunizations, hand washing, exercise, proper nutrition, use of condoms.
3. Assist the patient in developing a plan for prevention.

PRO - PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure, including indications, complications, and alternatives, as well as possible results of non-treatment.

STANDARDS:

1. Discuss the indications, risks, and benefits for the proposed procedure.
2. Explain the process and what to expect after the procedure.
3. Explain the necessary preparation, i.e., bowel preps, diet instructions, bathing.
4. Discuss pain management as appropriate.
5. Emphasize post-procedure management and follow-up.

S - SAFETY

OUTCOME: The patient/family will understand principles of injury prevention and plan a safe environment.

STANDARDS:

1. Explain that injuries are a major cause of death.
2. Discuss the regular use of seat belts and children's car seats, obeying the speed limit, and avoiding the use of alcohol and/or drugs while in a vehicle.
3. Assist the family in identifying ways to adapt the home to improve safety and prevent injuries, i.e., poison control, secure electrical cords, fire prevention.
4. Discuss injury prevention adaptations appropriate to the patient's age, disease state, or condition.
5. Identify which community resources promote safety and injury prevention. Provide information regarding key contacts for emergencies, i.e., 911, Poison Control, hospital ER, police.

TE - TESTS

OUTCOME: The patient/family will understand the test(s) to be performed including indications and its impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the meaning of test results.

TX - TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available based on the specific disease process, test results, and individual preferences.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
2. Discuss the treatment plan including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of adhering to the treatment plan, including scheduled follow-up.
4. Refer to community resources as appropriate.

MNT—Medical Nutrition Therapy

****For Use By Registered Dieticians Only****

Medical Nutrition Therapy (MNT) is the use of specific nutrition interventions based on standardized guidelines that incorporate current professional knowledge and research to treat an illness, injury, or condition. Nutrition interventions are determined on an assessment that includes a review and analysis of medical and diet history, biochemical and anthropometrics measures. MNT plays a key role thought out the life cycle of an individual and integrates in the continuum of care in all levels of practice.

The Dietetic Practitioner, also referred to as a Registered Dietitian (RD), is the professional uniquely qualified to provide MNT.

Registered Dietician: An individual who has completed the minimum of a baccalaureate degree granted by a U.S. regionally accredited college or university or foreign equivalent, has met current minimum academic requirements and completed a pre-professional experience, and has successfully completed the Registration Examination for Dietitians. All RDs must accrued 75 hours of approved continuing professional education every 5 years to maintain Registration through the Commission on Dietetic Registration.

EDUCATION NEEDS ASSESSMENT CODES

INDIAN HEALTH SERVICE
EDUCATION NEEDS ASSESSMENT CODES

LP - Learning Preference	**Mnemonics**
1. -Talk	LP-TALK
2. -Video	LP-VIDO
3. -Small Group	LP-GP
4. -Read	LP-READ
5. -Do/Practice	LP-DOIT
RL - Readiness to Learn	
6. -Eager	RL-EAGR
7. -Receptive	RL-RCPT
8. -Unreceptive	RL-UNRC
9. -Pain	RL-PAIN
10. -Severity of Illness	RL-SVIL
11. -Not Ready	RL-NOTR
12. -Distraction	RL-DSTR
BAR - Barriers to Learning	
13. -No Barriers	BAR-NONE
14. -Doesn't Read	BAR-DNRE
15. -Interpreter Needed	BAR-INTN
16. -Cognitive Impairment	BAR-COGI
17. -Fine Motor Skills Deficit	BAR-FIMS
18. -Hard of Hearing	BAR-HEAR
19. -Deaf	BAR-DEAF
20. -Visually Impaired	BAR-VISI
21. - Blind	BAR-BLND
22. - Emotional Impairment	BAR-EMOI
23. -Social Stressors	BAR-STRS
24. -Values/Belief	BAR-VALU

BAR—Barriers to Learning

BAR-BLND BLIND

OUTCOME: The patient states or demonstrates the inability to see, or the patient's inability to see is documented.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine any adaptive technique or equipment that could accommodate the deficit.
3. Determine if patient can read Braille.

BAR-COGI COGNITIVE IMPAIRMENT

OUTCOME: The patient states or demonstrates an inability to comprehend new information, or, the patient has a documented cognitive impairment problem.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine adaptive approaches to learning that can be utilize.
3. Plan with patient/family how to reinforce basic information and skills needed for self care.

BAR-DEAF DEAF

OUTCOME: The patient states or demonstrates the inability to hear, or, the patient's inability to hear is documented.

STANDARDS:

1. Assess the type of deafness (cause by such as accident, illness or disease).
2. Determine any adaptive technique or equipment that could accommodate the deficit.
3. Assess Sign language ability and as needed obtain a sign interpreter.
4. Assess ability to lip read, as appropriate, speak directly facing patient and move lips distinctly while speaking.
5. Determine if patient can communicate through writing.
6. Assess and document the on-set of deafness.

BAR-DNRE DOESN'T READ

OUTCOME: The patient states or demonstrates an inability to read, or the patients' inability to read English is documented.

STANDARDS:

1. Ask patient/family if patient reads English.
2. Ask patient/family if patient reads in their primary language. If yes, what language is that?
3. Assess patient's English literacy level (English may be a second language).
4. Provide appropriate written materials.
5. Plan with patient/family about approaches to learning other than reading.

BAR-EMOI EMOTIONAL IMPAIRMENT

OUTCOME: The patient's ability to learn is limited due to an emotional impairment.

STANDARDS:

1. Assess the type and degree of emotional impairment, i.e., mood disorder, psychotic symptoms, acute stress, anxiety, depression.
2. Provide the minimum amount of information needed with simple written information for reinforcement.
3. Refer to Mental Health for assessment and intervention.
4. Plan with patient/family how to reinforce basic information and skills needed for self care.

BAR-FIMS FINE MOTOR SKILLS DEFICIT

OUTCOME: The patient states or demonstrates fine motor skills impairment, like checking blood sugars or measuring medications, or, the patient has a documented fine motor skills deficit.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine any adaptive technique or equipment that could accommodate the impairment.

BAR-HEAR HARD OF HEARING

OUTCOME: The patient states or demonstrates a problem with hearing, or, the patient's hearing impairment is documented.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine any adaptive technique or equipment that could accommodate the impairment.
3. Assess ability to lip read, as appropriate, speak directly facing patient and move lips distinctly while speaking.
4. Determine if patient can communicate through writing.

BAR-INTN INTERPRETER NEEDED

OUTCOME: For patients who do not readily understand spoken English, an Interpreter is made available.

STANDARDS:

1. Identify the patient's primary language.
2. Determine their preferred language.
3. As appropriate, obtain an interpreter.

BAR – NONE NO BARRIERS

OUTCOME: The patient/family has no apparent barriers to learning.

STANDARDS:

1. Through interview and /or observation, determine or rule out any barriers that may affect ability to learn.

BAR-STRS SOCIAL STRESSORS

OUTCOME: The patient's ability to learn is limited due to social stressors.

STANDARDS:

1. Assess acute and on-going social stressors (e.g., family separation and conflict, disease, divorce, death, alcohol/substance abuse, domestic violence).
2. Provide the minimum amount of information needed with simple written information for reinforcement. As appropriate defer additional education until crisis is over.
3. Refer to social services or mental health for assessment and/or subsequent referrals.
4. Set-up a date for follow-up assessment as indicated.

BAR-VALU VALUES/BELIEF

OUTCOME: Define what is meant by "value" and "belief." Identify differences in patients and provider's values and beliefs.

Note: There is frequently a discrepancy between what patients value and believe versus what providers think is important (about self-care issues). Initiate open dialogue with the patient. Discuss differences and establish common ground on what the patient is willing to do concerning their health.

Value - A principal, standard, or quality regarded as worthwhile or desirable to the client.

Belief - Something believed or accepted as true by the client.

STANDARDS:

1. Attempt to verbalize the difference(s).
2. Ask questions to clarify patients prospective.
3. Try to identify areas of agreement.
4. Address areas for which there is agreement.
5. Discuss the concept of Locus of Control with patient. Which statement below best describes how the patient sees his/her ability to affect his/her health?
   a. I can control my life/health through my own effort
   b. My doctor/family member/friends control my life/health
   c. I am powerless to affect my life/health

BAR-VISI VISUALLY IMPAIRED

OUTCOME: The patient states or demonstrates difficulty with vision, or the patient's visual impairment is documented.

STANDARDS:

1. Assess the type and degree of impairment.
2. Determine any adaptive technique or equipment that could accommodate the deficit.
3. Determine if patient can communicate through writing.

LP—Learning Preference

LP-DOIT DO/PRACTICE

OUTCOME: The patient/family will understand that by doing or practicing a new skill is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, "In what way or ways do you learn best?"

LP-GP SMALL GROUP

OUTCOME: The patient/family will understand that participating in small groups is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, "In what way or ways do you learn best?"

LP-READ READ

OUTCOME: The patient/family will understand that reading is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, "In what way or ways do you learn best?"

LP-TALK TALK

OUTCOME: The patient/family will understand that talk is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, "In what way or ways do you learn best?"

LP-VIDO VIDEO

OUTCOME: The patient/family will understand that viewing videos is their preferred style of learning new information.

STANDARDS:

1. Review the most common styles of adult learning (talk/discussion, watching & doing, group discussion, watching videos, reading)
2. Explain that every individual is unique and will have their own method or preference(s) in how they receive new information.
3. Ask the patient/family, "In what way or ways do you learn best?"

RL—Readiness to Learn

RL-DSTR DISTRACTION

OUTCOME: The patient is unable to learn because of distractions.

STANDARDS:

1. Acknowledge that the environment contains distractions to learning such as noise or young children.
2. Determine any action that could negate or minimize the distraction.
3. Consider deferring educational session until stimuli causing distraction is no longer an issue.

RL – EAGR EAGER TO LEARN

OUTCOME: The patient/family understands or demonstrates a level of eagerness to learn at the beginning of an educational encounter.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Ask the patient/family for their attention to the subject matter.
3. Observe their response to your request or to your presentation of the subject matter.

RL – RCPT RECEPTIVE

OUTCOME: The patient/family understands or demonstrates a receptive level of readiness to learn at the beginning of an educational encounter.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Ask the patient/family for their attention to the subject matter.
3. Observe their response to your request or to your presentation of the subject matter.

RL-PAIN PAIN

OUTCOME: The patient understands or demonstrates through the use of body language a certain level of pain.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Assess their level of pain. Does the patient require pain medication? If so, when was their last dose administered?
3. If appropriate, ask the patient for his/her attention to the subject matter.
4. Observe his/her response to your request or to your presentation of the subject matter.
5. Consider deferring or terminating the educational session if the patient is experiencing a high level of pain or is being medicated for pain.

RL-SVIL SEVERITY OF ILLNESS

OUTCOME: The patient/family will be unable to gain new knowledge due to a condition or severity of illness that would impair or prevent learning.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Assess the severity of their illness. Consider their level or "alertness."
3. Determine if family is available to assist with the patients care. Assess the family's readiness to learn.
4. If appropriate, ask the patient/family for their attention to the subject matter.
5. Observe their response to your request or to your presentation of the subject matter.
6. Consider deferring or terminating the educational session if the patient is experiencing complications from the illness that may distract the family's attention.

RL-UNRC UNRECEPTIVE

OUTCOME: The patient/family understands or demonstrates an unreceptive level of readiness to learn at the beginning of a teaching encounter.

STANDARDS:

1. Plan your educational encounter at the most opportunistic and appropriate time during the patient/family's care.
2. Ask the patient/family for their attention to the subject matter.
3. Observe their response to your request or to your presentation of the subject matter.
4. Ask or suggest to patient/family if they would like to meet at another time for education session.

A

ABD—Abdominal Pain

ABD-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of abdominal pain and understand that they will return for additional medical care if symptoms of complication occur.

STANDARDS:

1. Explain that some possible complications are acute hemorrhage, sustained hypotension and shock, perforation of a viscous, and infections such as bacteremia.
2. Explain that complications may be prevented with prompt treatment with appropriate therapy.
3. Advise the patient/family to report increasing-pain, persistent fever, bleeding, or altered level of consciousness immediately and seek immediate medical attention.

ABD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand some possible etiologies of abdominal pain.

STANDARDS:

1. Discuss various etiologies for abdominal pain, i.e., appendicitis, diverticulitis, pancreatitis, peritonitis, gastroenteritis, bowel obstruction, ruptured aneurysm, ectopic pregnancy, and inflammatory bowel disease, as appropriate.

ABD-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Explain circumstances/examples that should prompt immediate medical attention.
3. Discuss the procedure for obtaining follow-up appointments.
4. Emphasize that appointments should be kept.

ABD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about abdominal pain.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding abdominal pain.
2. Discuss the content of the patient information literature with the patient/family.

ABD-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and proper use of medication.

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Emphasize the importance of maintaining strict participation to the medication regimen.
3. Encourage the patient to carry a list of current medications.

ABD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ABD-N NUTRITION

OUTCOME: The patient/family will understand how nutrition might affect abdominal pain.

STANDARDS:

1. Discuss, as appropriate, that some foods might exacerbate abdominal pain.
2. Review this list of foods.

ABD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the management of abdominal pain.

STANDARD:

1. Discuss, as appropriate, that some foods might exacerbate abdominal pain.
2. Explain that pain medications should be utilized judiciously to prevent the masking of complications.
3. Advise the patient to notify the nurse or provider if pain is not adequately controlled or if there is a sudden change in the nature of the pain.
4. Caution the patient to take pain medications as prescribed, and not to take over-the-counter medications in conjunction with prescribed medications without the recommendation of the provider.
5. Explain that short term use of narcotics may be helpful in pain management as appropriate.
6. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
7. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
8. Explain non-pharmacologic measures that may be helpful with pain control.

ABD-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in the treatment of abdominal pain.

STANDARDS:

1. Discuss that uncontrolled stress may increase alcohol and other drug use and interfere with treatment.
2. Emphasize the importance of seeking professional help as needed to reduce stress.
3. Discuss the various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Talking with people you trust about your worries or problems
    d. Setting realistic and meaningful goals
    e. Getting enough sleep
    f. Making healthy food choices
    g. Regular physical activity
    h. Taking vacations
    i. Practicing meditation
    j. Self-hypnosis
    k. Using positive imagery
    l. Practicing relaxation methods such as deep breathing or progressive muscular relaxation
    m. Spiritual or cultural activities.
4. Provide referrals as appropriate

ABD-TE TESTS

OUTCOME: The patient/family will understand tests to be performed, the potential risks, expected benefits and the risk of non-testing.

STANDARDS:

1. Explain that diagnostic testing may be required to determine the etiology of the pain so appropriate therapy can be initiated.
2. Explain the tests that have been ordered.
3. Explain the necessary benefits and risks of the tests to be performed. Explain the potential risk of refusal of the recommended test(s).
4. Inform the patient of any advance preparation for the test, i.e., nothing by mouth, enemas.

ABD-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be prescribed including the risk and benefits of the treatments or the risk of non-treatment

STANDARDS:

1. List the possible therap(ies) that may be indicated for the treatment of abdominal pain.
2. Briefly explain each of the possible treatment options. Discuss the risk(s) and benefit(s) of the proposed treatment(s).
3. Explain the risk(s) of non-treatment of abdominal pain.

AOD—Alcohol and Other Drugs

AOD-C COMPLICATIONS

OUTCOME: The patient/family will understand how to avoid the complications of alcohol and other drug (AOD) abuse/dependence and develop a plan to slow the progression of the disease by full participation with a prescribed daily program.

STANDARDS:

1. Review the short and long term effects that AODs have on the body.
2. Discuss the progression of use, abuse, and dependence.
3. Review the effects of AOD abuse/dependence on the lifestyle of the individual, the family, and the community.

AOD-CCA CONTINUUM OF CARE

OUTCOME: The patient/family will understand the importance of integrated Continuum of Care in the treatment of AOD use disorders.

STANDARDS:

1. Discuss with patient/family the concept of Continuum of Care in the treatment of AOD use disorders including the pre-treatment, treatment, sobriety maintenance, follow-up, and relapse prevention phases.

2. Provide assistance and advocacy to the patient/family in obtaining integrated Continuum of Care services.

AOD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)

2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.

3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.

4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.

5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.

6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

AOD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the disease process of AOD abuse and addiction and understand the stages of change.

STANDARDS:

1. Review the current medical information, including physical, psycho-social, and spiritual consequences of the patient's specific AOD abuse/dependency.
2. Discuss the diagnosis of AOD abuse/dependence and provide an opportunity to recognize the disease process of abuse and dependence.
3. Explain the stages of change as applied to the progression of AOD abuse/dependence, i.e., pre-contemplation, contemplation, preparation, action, and maintenance.
4. Discuss the role of the family/support system in the recovery process and an AOD-free lifestyle.
5. Assist the patient/family in developing a plan for healthy and AOD-free lifestyle.

AOD-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity for a healthy and AOD-free life style and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Discuss the benefits of regular physical activity, i.e., reduced stress, weight maintenance, improved self image, and overall wellness.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

AOD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will understand the importance of utilizing available AOD resources to maintain a healthy and AOD-free lifestyle.

STANDARDS:

1. Provide patient/family with appropriate patient information (including literature and/or website addresses) to facilitate understanding and knowledge of AOD issues.
2. Discuss the content of patient information with the patient/family.

AOD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand that alcohol and other drug (AOD) use disorder is a chronic disease, which can be treated.

STANDARDS:

1. Discuss the patient's AOD abuse/dependence and the impact on the patient/family lifestyle.
2. Discuss the patient's perceptions which promote AOD abuse/dependence and mechanisms to modify those perceptions and associated behaviors.
3. Discuss relapse risk of AOD abuse and the need to utilize family, cultural/spiritual and community resources to prevent relapse.
4. Explain that the patient/family and the care team will develop a plan to modify behavior that may precipitate the use of AOD.

AOD-M MEDICATIONS

OUTCOME: The patient/family will understand and fully participate the medication regimen.

STANDARDS:

1. Review the mechanism of action of the prescribed medication.
2. Discuss important or common side-effects of the prescribed medications.
3. Emphasize the importance of taking medications as prescribed, i.e., avoiding overuse, under use or misuse.
4. Review OTC medications (e.g., cough syrup) that contain ETOH/drug additives and the signs/symptoms of intentional/unintentional ingestion.

AOD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

AOD-N NUTRITION

OUTCOME: The patient/family will understand the importance of nutritionally healthy food choices in the recovery process of AOD-use disorders.

STANDARDS:

1. Review patient's current eating habits and how these habits might be improved with a healthy eating plan.
2. Refer to a registered dietician, when appropriate, for a comprehensive nutritional assessment and meal plan.

AOD-P PREVENTION

OUTCOME: The patient/family will understand the dangers of AOD-use disorders to promote a healthy and AOD- free lifestyle.

STANDARDS:

1. Emphasize awareness of risk factors associated with AOD abuse and dependence, such as experimentation with alcohol and other drugs, binge drinking, and family history of AOD abuse and dependence.
2. Discuss the impact of comorbid conditions and psychosocial stressors on AOD abuse and dependence.
3. Discuss how AOD abuse and dependence adversely affects the patient, family and community.

AOD-PLC PLACEMENT

OUTCOME: The patient/family will understand the recommended level of care/placement as a treatment option for AOD-use disorders.

STANDARDS:

1. Explain the rationale for the recommended placement based on patient/family preference, level of need, court order, safety, eligibility, availability and funding.
2. Explain that the purpose of placement is to improve mental or physical health and to ensure a safe and supportive environment for recovery from AOD-use disorders.
3. Discuss alternative placement or treatment options if recommended placement is declined or unavailable.
4. Discuss patient/family fears and concerns regarding placement and provide advocacy and support during the placement process.

AOD-SCR SCREENING

OUTCOME: The patient/family will understand the process of screening for alcohol and other drug related issues to determine an individual's need for further evaluation and referral.

STANDARDS:

1. Discuss with patient/family the initial reason for the referral for AOD screening and obtain informed consent for the screening as needed.
2. If referring to another provider for screening, explain the referral process for AOD screening and provide assistance with a referral contact as needed.
3. Explain the screening results to the patient/family and the indications for additional referrals or treatment.

AOD-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in the treatment of AOD abuse and dependence.

STANDARDS:

1. Discuss that uncontrolled stress may increase alcohol and other drug use and interfere with treatment.
2. Emphasize the importance of seeking professional help as needed to reduce stress.
3. Discuss the various stress management strategies which may help maintain a healthy AOD-free lifestyle. Examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Talking with people you trust about your worries or problems
    d. Setting realistic and meaningful goals
    e. Getting enough sleep
    f. Making healthy food choices
    g. Regular physical activity
    h. Taking vacations
    i. Practicing meditation
    j. Self-hypnosis
    k. Using positive imagery
    l. Practicing relaxation methods such as deep breathing or progressive muscular relaxation
    m. Spiritual or cultural activities.
4. Provide referrals as appropriate

AOD-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered and any necessary consent as needed.
2. Explain the indications, benefits and risks of the test to be performed, as appropriate, including the consequences of refusal.
3. Explain how the test relates to the course of treatment.
4. Explain the necessary preparation for the test, including appropriate collection or preparation.
5. Explain the meaning of the test results, as appropriate, and the implications for care.

AOD-WL WELLNESS

OUTCOME: The patient/family will understand factors that contribute to wellness.

STANDARDS:

1. Assist the patient/family to identify an AOD-free supportive social network
2. Encourage the patient/family to participate in AOD free family, social, cultural/spiritual and community activities.
3. Discuss the associated health risks with AOD abuse/dependence, i.e., including sexually transmitted infections, unplanned pregnancies, family dysfunction, acute illness, exacerbation of chronic health problems.
4. Explain that AOD use increases the risk of injury, i.e., motor vehicle crashes, falls, assaults.

AL—Allergies

AL-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the physiology of allergic response.

STANDARDS:

1. Review anatomy and physiology as it relates to the patient's disease process and its relationship to the patient's activities of daily living.
2. Explain that allergic response is a collection of symptoms caused by an immune response to substances that do not trigger an immune response in most people, i.e., food allergies; hay fever; allergy to mold, dander, dust, drug allergies.
3. Explain that symptoms vary in severity from person to person.
4. Explain that allergies are common. Heredity, environmental conditions, numbers and types of exposures, emotional factors (stress and emotional upset can increase the sensitivity of the immune system), and many other factors indicate a predisposition to allergies.
5. Explain that allergies may get better or worse over time and that new allergies may appear at any time.

AL-FU FOLLOW-UP

OUTCOME: The patient/family will recognize the importance of routine follow-up as an integral part of health care and maintenance.

STANDARDS:

1. Discuss the importance of routine follow-up by the primary provider, registered dietician and community health services as applicable.
2. Assess the need for any additional follow-up and make the necessary referrals.

AL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information on allergy reaction.

STANDARDS:

1. Provide the patient/family with written patient information literature on allergies.
2. Discuss the content of the patient of the patient information literature with the patient/family.

AL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand what lifestyle adaptations are necessary to cope with their allergy(s).

STANDARDS:

1. Assess the patient and family's level of acceptance of the disorder.
2. Review the lifestyle areas that may require adaptations; i.e., diet, physical activity, avoidance of environmental allergens/triggers.
3. Explain that treatment varies with the severity and type of symptom.
4. Emphasize that avoidance of the allergen is the best long-term treatment, particularly with allergic reaction to foods or medications.

AL-M MEDICATION

OUTCOME: The patient/family will understand the goals of drug therapy, the side effects of the medications and the importance of fully participating in the medication regimen.

STANDARDS:

1. Review the mechanism of action for the patient's medication.
2. Discuss the proper use, benefits and common side effects of the patient's prescribed medications. Review signs of possible medication toxicity as indicated.
3. Emphasize the importance of taking medication as prescribed.

AL-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

AL-N NUTRITION

OUTCOME: The patient/family will understand that a true food allergy is an immune response with a reaction usually within two hours.

STANDARDS:

1. Discuss the importance of avoiding known food allergens. If the allergen is not known, the patient/family can use the elimination diet to discover what is causing the reaction.
2. Encourage the patient/family to keep a food diary to record reactions.
3. Emphasize the importance of reading all food labels. Instruct the patient/family as necessary.
4. Refer to dietitian for assessment of nutritional needs and appropriate treatment as indicated.

AL-TE TESTS

OUTCOME: The patient/family will understand the testi(s) to be performed and possible results.

STANDARDS:

1. Explain that testing may be required to determine if symptoms are an actual allergy or caused by other problems.

2. Explain the testing procedure to the patient/family
3. Discuss the possible results of testing with the patient/family.
4. Emphasize that history is important in diagnosing allergies, including whether the symptoms vary according to the time or the season and possible exposures that involve pets, diet changes or other sources of allergens.
5. Explain allergies may alter the results of some lab tests.

ALZ—Alzheimer's Disease

ALZ-DP DISEASE PROCESS

OUTCOME: The patient/family/caregiver will understand the definition of Alzheimer's and treatment options available specific to the patient's diagnosis.

STANDARD:

1. Explain that Alzheimer's disease is a degenerative brain disorder and is more common in older adults.
2. Explain that Alzheimer's destroys the chemical acetylcholine which is responsible for memory and cognitive skills.
3. Explain that as the disease progresses, nerve cells in several brain areas shrink and die and the brain itself shrinks as the wrinkles along its surface become smoother.
4. Discuss signs and symptoms and usual progression of the disease due to dementia:
    a. Impaired memory and thinking
    b. Disorientation and confusion
    c. Misplacing things
    d. Impaired abstract thinking
    e. Trouble performing familiar tasks
    f. Change in personality and behavior
    g. Poor or decreased judgment
    h. Inability to follow directions
    i. Problems with language or communication
    j. Impaired visual and spatial skills
    k. Loss of motivation or initiative
    l. Loss of normal sleep patterns
    m. Increasing agitation
    n. Irrational violent behavior and lashing out
    o. Late stage loss of ability to swallow
5. Explain that the cause is unknown and nothing can be done to prevent the disease. Encourage a healthy lifestyle and habits that prevent dementia (limit alcohol intake, stop smoking, eat well, exercise).
6. Discuss the importance of maintaining a positive mental attitude.

ALZ-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the importance of full participation in the treatment plan and follow up.

STANDARDS:

1. Explain the importance of obtaining referrals for contract health services when appropriate.
2. Explain that test(s) required by private outside providers need coordination with Indian Health physicians.
3. Discuss the process for making follow up appointments with internal and external providers.
4. Discuss individual responsibility for seeking and obtaining third party resources.
5. Discuss the importance of keeping follow up appointments and how this may affect outcome.
6. Discuss the possible need for a patient advocate to maintain follow-up activities.

ALZ-HM HOME MANAGEMENT

OUTCOME: The patient/family/caregiver will understand home management of Alzheimer's and develop a plan for implementation, as well as the coordination of home health care services to assure the patient receives comprehensive care.

STANDARDS:

1. Explain the home management techniques necessary based on the status of the patient. Explain that these home management techniques may change as the disease progresses.
2. Discuss ways to minimize confusion:
   a. Limit changes to the physical surroundings.
   b. Encourage full participation to daily routines.
   c. Maintain orientation by reviewing the events of the day, date and time.
   d. Simplify or reword statements.
   e. Label familiar items.
3. Explain that medications must be given as prescribed.
4. Explain the importance of being patient and supportive.
5. Discuss ways of providing a safe environment. **Refer to ALZ-S**.
6. Explain the importance of supervising the patient during bathing and eating. Discourage leaving the patient alone for extended periods.
7. Encourage assistance with activities of daily living as appropriate.
8. Explain the benefits of increased physical activity (strength, endurance, heart fitness, increased energy, improvement in sleep and mood and mental functioning). Advise family/caregiver to consult with a health care provider prior to beginning an exercise program for the patient. Explain that factors such as bone disease, heart condition or balance problems may limit or restrict activities.

ALZ-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family/caregiver will receive written information of Alzheimer's disease and organizations that assist in the care of patients with this disease.

STANDARDS:

1. Provide written information about diagnosis to the patient/family/caregiver.
2. Review the content of patient information literature with the patient/family/caregiver.
3. Advise of any agency or organization that can provide assistance and further education such as support groups.

ALZ-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family/caregiver will understand some of the necessary lifestyle adaptations to improve overall quality of life.

STANDARDS:

1. Discuss lifestyle behaviors that the care giver may be able to help the patient with, such as diet, increased physical activity, and habits related to the risks of the disease.
2. Encourage full participation in the treatment plan.
3. Explain the importance of the patient adapting to a lower risk, healthier lifestyle.
4. Review community resources available to assist the patient in making changes. Refer as appropriate
5. Explain that over the course of the disease, lifestyle adaptations will require frequent adjustments.

ALZ-LW LIVING WILL

OUTCOME: The patient/family will understand the process of making a living will and its role in maintaining a sense of control in the patient's medical care and decisions.

STANDARDS:

1. Explain that in most cases patients with Alzheimer's disease will predictably lose the capacity to make their own decisions and a living-will will be able to express the patient's desires prior to the loss of decision making abilities.
2. Review the option of Advanced Directives/ Living Will with the patient and his/her family. Explain treatment options and answer questions in a manner the patient/family will understand.
3. Refer to appropriate services to assist the patient in making a living will, i.e., Social Services, Clergy, Lawyer.
4. **Refer to ADV**.

ALZ-M MEDICATIONS

OUTCOME: The patient/family/caregiver will understand the choice of medication to be used in the management of Alzheimer's disease.

STANDARDS:

1. Explain the medication regimen to be implemented.
2. Explain the medications to be used including dose, timing, adverse side effects: drug-food, drug-drug interactions
3. Explain that Alzheimer medications are generally well tolerated, although troublesome side effects sometimes occur, i.e., nausea, vomiting, diarrhea, weight loss.
4. Explain that the medications may slow the progression of the disease, but are not a cure.
5. Emphasize that regular reassessment of these medications is crucial.
6. Discuss the importance of consulting a healthcare provider prior to starting new medications, including OTCs, herbal, or traditional remedies.
7. Discuss the use of all medications with your healthcare provider or pharmacist.

ALZ-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
    a. Assessment of the nutrition related condition.
    b. Identification of the patient's nutritional problem.
    c. Specific nutrition intervention therapy plan.
    d. Evaluation of the patient's nutritional care outcomes.
    e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ALZ-N NUTRITION

OUTCOME: The patient/family/caregiver will receive nutritional assessment and counseling.

STANDARDS:

1. Assess the patient's current nutritional level and determine an appropriate meal plan.
2. Review normal nutritional needs for optimum health.
3. Explain the importance of serving small, frequent meals and snacks. Encourage offering finger foods that are easy for the patient to handle.
4. Discourage the use of caffeine.
5. Discourage force feeding the patient.
6. Advise serving high calorie foods first. Offer favorite foods.
7. Advise offering a variety of food textures, colors, and temperatures.
8. Discourage foods with little or no nutritional value, i.e., potato chips, candy bars, cola.
9. Encourage walking or light exercise to stimulate appetite.
10. Explain that a the disease progresses the patient will often lose the ability or forget to eat, tube feeding may be an option.
11. Refer to registered dietician as appropriate.

ALZ-PLC PLACEMENT

OUTCOME: The patient/family will understand the recommended level of care/placement as a treatment option.

STANDARDS:

1. Explain the rationale for the recommended placement based on patient/family preference, level of need, involuntary placement, safety, eligibility, availability and funding.
2. Explain that the purpose of placement is to improve mental or physical health and to ensure a safe and supportive environment for continued care.
3. Discuss alternative placement or treatment options if recommended placement is declined or unavailable.
4. Discuss patient/family fears and concerns regarding placement and provide advocacy and support.

ALZ-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family/caregiver will understand the importance of injury prevention and make a plan to implement safety measures.

STANDARDS:

1. Explain the importance of body mechanics in daily living to avoid injury, i.e., proper lifting techniques for lifting the patient.
2. Assist the patient/family/caregiver in identifying ways to adapt the home to improve safety and prevent injuries, i.e., remove throw rugs, install bars in tub/shower, secure electrical cords, install ramps.
3. As appropriate, stress the importance of mobility assistance devices, i.e., canes, walkers, wheel chairs, therapeutic shoes.
4. Discuss the current/potential abuse of alcohol or drugs.
5. Discuss the need to secure medications and other potentially hazardous items.
6. Emphasize the importance of NEVER smoking in bed or never smoking alone.
7. Discuss the potential for elder abuse/neglect (including financial exploitation) and ways to identify abuse/neglect. Refer as appropriate.
8. Explain the need to secure the patient's financial resources as they may be unable to make wise financial decisions.
9. Discuss that as the disease progresses, constant supervision will be necessary.
10. Discuss that patients may wander and alarms on doors and windows may be necessary.

ALZ-SM STRESS MANAGEMENT

OUTCOME: The patient/family/caregiver will understand the importance of stress management in the management of Alzheimer's disease.

STANDARDS:

1. Explain that uncontrolled stress can result in a worsened outcome for the patient, as well as the caregiver.
2. Explain that effective stress management may help improve the patient's sense of health and well-being.
3. Discuss various stress management strategies for the caregiver and the patient, such as maintaining a healthy lifestyle. Some examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Talking with people you trust about your worries and problems
    d. Setting small attainable goals
    e. Getting enough sleep
    f. Maintaining a healthy diet
    g. Exercising regularly
    h. Practicing meditation
    i. Using positive imagery
    j. Spiritual and cultural activities
    k. Utilizing support groups
    l. Utilizing respite care

ALZ-TE TESTS

OUTCOME: The patient/family/caregiver will understand the conditions under which testing is necessary and the specific test(s) to be performed.

STANDARDS:

1. Explain that there is no definitive test for Alzheimer's disease. A definitive diagnosis can only be made after death at autopsy when an examination of the patient's brain may show tell tale signs of changes associated with Alzheimer's.
2. Explain that diagnosis may be made through medical, psychiatric and neurological evaluation. Ruling out other factors for the dementia is necessary to make a diagnosis.
3. Explain that other conditions may mimic Alzheimer's. Some examples are: depression, head injury, certain chemical imbalances, or effects of some medications.

ALZ-TX TREATMENT

OUTCOME: The patient/family/caregiver will understand the focus of the treatment plan will be on the quality of life.

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family/caregiver in the development of the treatment plan.
2. Explain that regular visits to a healthcare provider are a crucial part of the treatment plan and the importance of starting treatment early.
3. Explain that physical activity, good nutrition, and social interaction are important for keeping Alzheimer's patients as functional as possible.
4. Explain the importance of a calm, safe and structured environment.
5. Explain that an appropriate drug regimen can sooth agitation, anxiety, depression, and sleeplessness and may help boost participation in daily activities.
6. Emphasize the importance of reassessing the level of daily functioning, mental status, mood and emotional state of the patient. Discuss the importance of assessing the status of the caregiver(s).
7. Explain that there is no cure and it is important to maintain a positive mental attitude.
8. **Refer to EOL.**

AN—Anemia

AN-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of untreated anemia.

STANDARDS:

1. Explain that failure to fully participate in the prescribed therapy will result in a chronic lack of oxygen, possibly producing signs and symptoms such as chronic or severe fatigue, chronic dyspnea, inability to concentrate, irritability, depression, anxiety, tachycardia and susceptibility to infection.
2. Explain that if tissues don't receive enough oxygen, the body will compensate by increasing heart rate and cardiac output.

AN-DP DISEASE PROCESS

OUTCOME: The patient/family will understand anemia, the specific cause of the patient's anemia and its symptoms.

STANDARDS:

1. Explain that anemia describes a condition in which the concentration of hemoglobin is too low. This may be the result of decreased number of red blood cells, abnormal red blood cells, abnormal hemoglobin molecules or deficiency of iron or other essential chemicals.
2. Explain that the kidneys, bone marrow, hormones and nutrients within the body work in cooperation to maintain the normal red blood cell count.
3. Explain that there are several categories of abnormal conditions that cause anemia: (Discuss those that pertain to this patient)
    a. Lack of dietary iron, vitamin B12, or folic acid
    b. Hereditary disorders of the red blood cells, such as Sickle Cell Anemia or thalassemia
    c. Disorders involving the bone marrow or spleen which inhibit red blood cell formation or destroy red blood cells
    d. Blood loss from the GI tract or other organ as a result of disease or trauma
    e. Kidney disease which may result in decreased production of red blood cells
    f. Thyroid or other hormonal diseases
    g. Cancer and/or the treatment of cancer
    h. Medications
    i. Anemia of chronic disease
4. Explain that when the body's demand for nutrients, including iron, vitamin B12 or folic acid, isn't met, the body's reserves can be rapidly depleted and the nutrients will not be available to produce red blood cells. Fewer circulating red blood cells cause both hemoglobin concentration and the blood's oxygen-carrying capacity to decrease. Consequently, the patient may develop signs and symptoms of anemia.
5. Explain that the body's demand for iron will increase after blood loss, with certain medications and at certain life stages, such as infancy, adolescence and in women during pregnancy.
6. Explain that symptoms of anemia may include fatigue, headache, lightheadedness, tachycardia, anxiety, depression, exertional dyspnea and angina.

AN-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up and will develop a plan to manage their anemia and keep follow-up appointments.

STANDARDS:

1. Emphasize that the treatment plan and full participation to it are the responsibility of the patient.
2. Stress the importance of keeping follow-up appointments and continuing the prescribed therapy even after the condition improves.

AN-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information regarding the specific type of anemia and its treatment.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding the specific type of anemia and its treatment.
2. Discuss the content of the patient information literature with the patient/family.

AN-M MEDICATIONS

OUTCOME: The patient will understand the importance of their prescribed medications and will fully participate in the medication treatment plan.

STANDARDS:

1. Explain that iron replacement therapy is necessary to correct iron-deficiency anemia and oral iron is prescribed most often. It is the safest and most effective treatment. Discuss that iron should be taken as prescribed. Explain that an overdose of iron can be lethal. Emphasize the importance of keeping iron out of the reach of children.
2. Explain that iron injections, which are not as easy, safe or effective, may be necessary if oral iron is not tolerated.
3. Explain that in order to restore total body iron stores a minimum course of iron therapy of three months is usually indicated.
4. Instruct the patient not to take antacids, calcium supplements, dairy products, eggs, whole grain breads, tea or coffee, soy products or wine within 1 hour of taking oral iron. These substances as well as some others interfere with the absorption of iron.
5. Review the proper use, benefits, and common side effects of iron or any other medications prescribed to treat the specific anemia.
6. Review the clinical effects expected with these medications.

AN-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

AN-N NUTRITION

OUTCOME: The patient/family will understand the role dietary modification plays in treating anemia and develop an appropriate plan for the necessary dietary modifications.

STANDARDS:

1. Explain that diet can be a contributing factor in the disease process if it includes insufficient iron, vitamins and protein to meet the body demands during stages of life when requirements are increased.
2. Explain that diet alone usually cannot treat anemia, but plays an important role in therapy.
3. Encourage the patient to include foods rich in protein, vitamins and iron in the diet.
4. Explain that ascorbic acid (vitamin C) helps the body absorb iron. Instruct the patient to eat plenty of fruits and vegetables and drink fruit juice in place of sodas. If vitamin C supplementation is desirable vitamin C and iron should be taken at the same time.
5. Explain that anorexia and sore mouth often accompany anemia. If this is a problem, suggest frequent, small meals of easily digested food and the avoidance of hot spicy foods.
6. Discuss that pica (the ingestion of dirt or other non-food substances) may be both a symptom and a cause of anemia.

AN-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s), as well as the risks, benefits, alternatives to the proposed procedure(s) and associated factors affecting the patient.

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
3. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

AN-TE TESTS

OUTCOME: The patient/family will understand the possible tests that may be performed.

STANDARDS:

1. Explain that blood test(s) (i.e., hemoglobin, hematocrit, iron studies, hemoglobin electrophoresis) in conjunction with a thorough history and physical exam are necessary to diagnose anemia.
2. Explain that further tests, including a bone marrow exam, may be necessary to determine the type and cause of the anemia.
3. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
4. Explain that a complete blood count will be necessary to evaluate hemoglobin levels and detect physical/chemical changes in red blood cells or hemoglobin molecules.
5. Explain that periodically during treatment, blood counts must be obtained to assess the patient's degree of recovery.

AN-TX TREATMENTS

OUTCOME: The patient/family will understand the possible treatments that may be performed based on the test results.

STANDARDS:

1. Explain that treatment for anemia depends on the cause and severity.
2. Explain that a treatment plan including a diet of iron-rich foods and iron replacement is necessary to treat iron-deficiency anemia and B12 injections treat

pernicious anemia. Other anemias are treated by treating the specific cause of the anemia.

3. Explain that the treatment of severe anemia may include transfusions of red blood cells.
4. Explain that once the hemoglobin levels return to normal, therapy for iron-deficiency anemia should continue for at least 2 months to replenish the body's depleted iron stores.
5. Explain that some anemias require long-term or lifelong treatment and others may not be treatable.

ACC—Anticoagulation

ACC-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of anticoagulation therapy and/or failure to follow medical advice in the use of anticoagulation therapy.

STANDARDS:

1. Explain that failure to follow medical advice in anticoagulation therapy may result in a blood clot or uncontrollable bleeding.
2. Explain that even with correct dosing, disease processes that cause problems with clotting may have devastating outcomes including stroke, uncontrollable bleeding, deep venous thrombosis or death, etc.
3. Emphasize the importance of immediately seeking medical attention for unexplained bruising or bleeding, pain in the legs or chest, severe headache, confusion, dizziness or changes in vision, etc.

ACC–DP DISEASE PROCESS

OUTCOMES: The patient will understand what causes a blood clot, the risks of developing blood clots, and methods to prevent the formation of blood clots.

STANDARDS:

1. Review the causative factors as appropriate to the patient.
2. Review lifestyle factors which may put the patient at risk of developing a blood clot.
3. Discuss the patient's specific condition, including anatomy and pathophysiology as appropriate.
4. Discuss the signs and symptoms of active clotting or over-anticoagulation.

ACC–FU FOLLOW-UP

OUTCOMES: The patient/family will understand the importance of follow-up and make a plan to make and keep the follow-up appointments.

STANDARDS:

1. Emphasize the importance of follow-up care to adjustment medications and prevent complications.
2. Encourage full participation in the treatment plan and acceptance of the diagnosis.
3. Explain the procedure for obtaining follow-up appointments.

ACC–HM HOME MANAGEMENT

OUTCOMES: The patient/family will understand what lifestyle adaptations are necessary to cope with the patient's specific disorder and how diet and activity will interact with anticoagulation therapy.

STANDARDS:

1. Assess the patient/family's level of acceptance of the disorder.
2. Emphasize the importance of avoiding dangerous or hazardous activities while receiving anticoagulation therapy.
3. Review the areas that may require adaptations, i.e., diet and physical activity.

ACC–L LITERATURE

OUTCOMES: the patient/family will receive written information regarding anticoagulation therapy.

STANDARDS:

1. Provide the patient/family with written patient information literature on anticoagulation therapy.
2. Discuss the content of the patient information literature with the patient/family.

ACC–LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient/family will understand what lifestyle adaptations are necessary to cope with the patient's specific disorder and how diet and activity will interact with anticoagulation therapy.

STANDARDS:

1. Assess the patient/family's level of acceptance of the disorder.
2. Emphasize the importance of avoiding dangerous or hazardous activities while receiving anticoagulation therapy.
3. Review the areas that may require adaptations, i.e., diet and physical activity.

ACC–M MEDICATIONS

OUTCOMES: The patient will understand the goal of medication therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Review the patient's medication. Reinforce the importance of knowing the medication, dose, and dosing interval of medications.
2. Review common and important side effects, signs of toxicity, and drug/drug and drug/food interactions of medications.
3. Explain that some over-the-counter medications or herbal products can alter the effect of the anticoagulation therapy.
4. Emphasize that a health care provider must be consulted prior to starting any new medications (prescription, OTC, or herbal) while receiving anticoagulation therapy.

ACC-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ACC–N NUTRITION

OUTCOMES: The patient/family will understand the effect of various foods in relation to their anticoagulation therapy.

STANDARDS:

1. Explain the importance of a consistent diet while receiving anticoagulation therapy.
2. Explain how various foods may interact with the patient's medication to alter coagulation.
3. Explain how various foods may alter the results of laboratory tests.

ACC–S SAFETY AND INJURY PREVENTION

OUTCOMES: The patient/family will understand the risks associated with anticoagulation therapy and the measures that must be taken to avoid serious adverse effects.

STANDARDS:

1. Discuss the risks associated with anticoagulation therapy, i.e., bleeding, stroke, adverse drug reactions.
2. Inform the patient/family to seek immediate medical attention in the event of an adverse reaction resulting from anticoagulation therapy.
3. Discuss the importance of informing all health care workers of anticoagulation therapy.
4. Emphasize the importance of avoiding dangerous or hazardous activities while receiving anticoagulation therapy to prevent the risk of serious adverse effects (bleeding).

ACC-TE TESTS

OUTCOME: The patient/family will understand the test(s) proposed, the risk(s) and benefit(s) of the test(s) and the risk/benefit of non-performance of the testing. The patient/family will further understand that it is extremely important to have regular testing while on anticoagulation therapy.

STANDARDS:

1. Discuss the importance of regular laboratory testing in the management of anticoagulation therapy. Explain that this testing is necessary to appropriately adjust the medication as applicable.
2. Explain the risk/benefit ratio of testing vs. non-testing.

ASM—Asthma

ASM-C COMPLICATIONS

OUTCOME: The patient/family will understand how to prevent complications of asthma.

STANDARDS:

1. Discuss that the most common complications of asthma are exacerbation or infection. These complications often result from failure to fully participate with treatment regimens (i.e., medications, peak flows) or from exposure to environmental triggers or infections.
2. Emphasize early medical intervention for minor URIs, fever, cough, and shortness of breath can reduce the risk of complications, hospitalizations, E.R. visits, and chronic complications of the disease.
3. Stress the importance of fully participating in the treatment plan. Explain that failure to fully participate with the treatment plan may result in permanent scarring of the lungs.

ASM-DP DISEASE PROCESS

OUTCOME: The patient will understand the etiology and pathophysiology of asthma.

STANDARDS:

1. Review the anatomy and physiology of the respiratory system.
2. Discuss common triggers of asthma attacks, i.e., smoke, animal dander, cold air, exercise.
3. Explain that asthma is a chronic inflammatory disease and must be treated on a long-term ongoing basis.
4. Explain the various aspects of an asthma attack, including airway inflammation (swelling), mucus production, and constriction of airway muscles.
5. Explain that asthma is an atopic condition and may occur in combination with other atopic illnesses, i.e., nasal allergy. Explain that control of these concomitant illnesses may be necessary to control the asthma.

ASM-EQ EQUIPMENT

OUTCOME: Refer to outcomes for **ASM-NEB**, **PF**, **MDI**, and **SPA**.

STANDARDS:

1. **Refer to ASM-NEB, PF, MDI, and SPA.**

ASM-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
2. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
3. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
4. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
5. Discuss medical clearance issues for physical activity.
6. Discuss that exercise is a common trigger of asthma attacks and that inhalers or other medications may be necessary before engaging in athletic activities. Explain that for persons with severe asthma, exercise may need to be limited until the asthma is under better control.

ASM-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of regular follow-up and will strive to keep scheduled appointments.

STANDARDS:

1. Discuss the importance of regular follow-up care in the prevention of complications and adjustment of medications.
2. Encourage full participation with the treatment plan. Assess the patient's understanding of the treatment plan and acceptance of the diagnosis.
3. Provide positive reinforcement for areas of achievement.
4. Refer to community resources as appropriate.
5. Emphasize the importance of consistent peak flow measurement and charting of these measurements. Emphasize the importance of bringing peak flow charts to clinic visits as they assist in management of the asthma.

ASM-HM HOME MANAGEMENT

OUTCOME: The patient and/or family will understand the home management of their disease process and make a plan for implementation.

STANDARDS:

1. Discuss home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer emergency room visits and fewer hospitalizations.
3. Emphasize the importance of consistent peak flow measurement and charting of these measurements. Emphasize the importance of bringing peak flow charts to clinic visits as they assist in management of the asthma.
4. Emphasize the importance of correctly using inhalers and other medications as prescribed.
5. Identify and avoid environmental triggers (i.e., cigarette smoke, stress, environmental smoke, pollen, mold, dust, roaches, insecticides, paint fumes, perfumes, animal dander, cold air, sulfites, aspirin) as appropriate for the patient.

ASM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about asthma.

STANDARDS:

1. Provide the patient/family with written patient information literature on asthma.
2. Discuss the content of the patient information literature with the patient/family.

ASM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of asthma and prolong life.

STANDARDS:

1. Discuss which lifestyle changes the patient has the ability to change: cessation of smoking, dietary modifications, weight control, treatment participation, and exercise.
2. Re-emphasize how complications of asthma can be reduced or eliminated by such changes.
3. Review the community resources available to help the patient in making such lifestyle changes.
4. Identify and avoid environmental triggers (i.e., cigarette smoke, stress, environmental smoke, pollen, mold, dust, roaches, insecticides, paint fumes, perfumes, animal dander, cold air, sulfites, aspirin) as appropriate for the patient.

ASM-M MEDICATIONS

OUTCOME: The patient and/or family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed medication regimen.

STANDARDS:

1. Review the patient's medications. Reinforce the importance of knowing the drug, dose, and dosing interval of medications.
2. Review common side effects, signs of toxicity, and drug interactions of medication(s).
3. Discuss the difference between fast relief and long-term control metered dose inhalers.
4. Explain the difference between maintenance and rescue drugs.
5. Emphasize full participation and explain how effective use of medications can facilitate a more active life style for the asthma patient.
6. Emphasize the importance of consulting with a health care provider before using any OTC medication.

ASM-MDI METERED-DOSE INHALERS

OUTCOME: The patient will be able to demonstrate correct technique for use of MDIs and understand their role in the management of asthma.

STANDARDS:

1. Instruct and demonstrate steps for standard or alternate use procedure for metered-dose inhalers and ways to clean and store the unit properly.
2. Review the importance of using consistent inhalation technique. **Refer to ASM-SPA.**

ASM-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ASM-N NUTRITION

OUTCOME: The patient/family will understand nutritional factors that may effect or trigger asthma.

STANDARDS:

1. Discuss that some foods may affect asthma. Common triggers are milk products, egg products, wheat products, and other.
2. Refer to a registered dietician as appropriate.

ASM-NEB NEBULIZER

OUTCOME: The patient will be able to demonstrate effective use of the nebulizer device, discuss proper care and cleaning of the system, and describe its place in the care plan.

STANDARDS:

1. Describe proper use of the nebulizer including preparation of the inhalation mixture, inhalation technique, and care of equipment.
2. Discuss the nebulizer treatment as it relates to the medication regimen.

ASM-PF PEAK-FLOW METER

OUTCOME: The patient will be able to demonstrate correct use of the peak-flow meter and explain how its regular use can help achieve a more active lifestyle.

STANDARDS:

1. Discuss use and care of the peak flow meter as a tool for measurement of peak expiratory flow rate (PEFR) and degree of airway obstruction. Discuss peak flow zones in management of airway disease.
2. Explain how monitoring measurement of PEFR can provide an objective way to determine current respiratory function.
3. Emphasize how a regular monitoring schedule can help determine when emergency care is needed, prevent exacerbations through early intervention, and facilitate a more active lifestyle.
4. Explain that charting of peak flow values daily and bringing the chart to clinic visits will assist the provider in assessing the patient's current asthma control and in adjusting medications accordingly.

ASM-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. Smoldering cigarette, cigar, or pipe
   b. Smoke that is exhaled from active smoker
   c. Smoke residue on clothing, upholstery, carpets or walls
2. Discuss harmful substances in smoke
   a. Nicotine
   b. Benzene
   c. Carbon monoxide
   d. Many other carcinogens (cancer causing substances)
3. Explain the increased risk of illness in the asthma patient when exposed to cigarette smoke either directly or via second-hand smoke.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the asthma patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car.

ASM-SPA SPACERS

OUTCOME: The patient will be able to demonstrate the correct use of spacers and understand their importance in delivery of medications.

STANDARDS:

1. Instruct and demonstrate proper technique for spacer use.
2. Discuss proper care and cleaning of spacers.
3. Explain how spacers improve the delivery of inhaled medications.

ASM-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Discuss the necessity, benefits and risks of the test to be performed, as appropriate, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Discuss the meaning of the test results, as appropriate.

ASM-TO TOBACCO (SMOKING)

OUTCOME: The patient and/or family will understand the dangers of smoking in the asthma patient and develop a plan to cut back or stop smoking.

STANDARDS:

1. Explain the increased risk of illness in the asthma patient when exposed to cigarette smoke.
2. Encourage smoking cessation. If the patient is unwilling to stop smoking, emphasize the importance of cutting back on the number of cigarettes smoked in an effort to quit or minimize increased risk of illness or hospitalization.
3. **Refer to TO**.

ADD—Attention Deficit Hyperactivity Disorder

ADD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the nature of the disorder that is categorized into two diagnostic criteria: inattention and/or hyperactivity-impulsivity. The disorder usually manifests itself in childhood and continues into adulthood.

STANDARDS:

1. Discuss the current theories of the causes of attention deficit disorder:
   a. Neurological: Brain damage
   b. Neurotransmitter Imbalances: Dopamine, Norepinephrine, Serotonin - likely but not proven
   c. Environmental toxins: lead, prenatal exposure to cigarette smoke and alcohol
   d. Dietary Substances: Food additives, sugar, milk - not supported by most research
   e. Genetics
   f. Environmental Factors: Parenting and social variables
2. Discuss the three types of attention deficit disorder: Predominately Inattentive, Predominately Hyperactive/Impulsive or a combination of both.
3. Discuss the problems associated with attention deficit disorder: academic achievement, learning disabilities, health problems, social problems, and, sleep problems.
4. Discuss the prognosis for attention deficit disorder.

ADD-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept. Discuss prescription medications and how follow-up relates to the ability of the patient to get refills of medications.

ADD-GD GROWTH AND DEVELOPMENT

OUTCOME: The patient/family will understand that the growth of children with ADD/ADHD needs to be monitored closely.

STANDARDS:

1. **Refer to ADD-N.**

ADD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about ADD/ADHD.

STANDARDS:

1. Provide patient/family with written patient information literature on the ADD/ADHD.
2. Discuss the content of patient information literature with the patient/family.

ADD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family have an increased understanding of the factors that contribute to better outcomes for ADD Children and Adults.

STANDARDS:

1. Explain that the treatment of ADD requires family involvement in an ongoing fashion.
2. Discuss that effective therapy often requires restructuring home, community and school environments.
3. Explain that use of multiple, consistent, persistent interventions are necessary for a good outcome.
4. Discuss the need to advocate for, not against the child.
5. Discuss the importance of positive reinforcement for good behaviors and support of self esteem.
6. Discuss the effects of parental stress and marital problems on children. Further discuss that ADD may exacerbate parental stress and marital problems. Explain that these problems should not be ignored and that appropriate help should be sought as soon as the problem is identified.

ADD-M MEDICATION

OUTCOME: The patient/family will understand the importance of fully participating with a prescribed medication regimen, if applicable

STANDARDS:

1. Review the proper use, benefits and common side effects of the prescribed medication.
2. Discuss drug and food interactions with prescribed medication.
3. Briefly review the mechanism of action of the medication if appropriate.
4. Explain that the medication should be stored in a safe place to avoid accidental overdoseage.

ADD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ADD-N NUTRITION

OUTCOME: The patient/family will understand nutritional requirements for the child with ADD/ADHD and will plan for adequate nutritional support.

STANDARDS:

1. Explain that the hyperactive child will often burn more calories than age-matched peers and will require additional caloric intake for adequate growth.
2. Discuss that many medications used for ADD/ADHD suppress appetite. Timing of medication may need to be adjusted to optimize hunger at mealtimes.
3. Explain that children with ADD are distractible and may need to be reminded to eat.

ADD-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed to diagnose ADD/ADHD.

STANDARDS:

1. Discuss the test(s) to be performed to diagnose ADD/ADHD. Answer the patient/family questions regarding the testing process.
2. Refer to Behavioral Health or other community resources as appropriate.

ADD-TX TREATMENT

OUTCOME: The patient/family will understand that the four components of treatment of ADD symptoms are based on biologically-based handicaps.

STANDARDS:

1. Discuss that the therapy for ADD is multifactorial and may consist of:
   a. Parent Education
   b. Behavior Management and Behavior Therapy
   c. Educational Management
   d. Medication Therapy

ATO—Autoimmune Disorders

ATO-C COMPLICATIONS

OUTCOME: The patient/family will understand how to lessen the complications of their particular immune disorder.

STANDARDS:

1. Review the common complications associated with the patient's disease.
2. Review the treatment plan with the patient/family. Explain that complications are worsened by non-participation with the treatment plan.

ATO-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the patient's particular Autoimmune Disease process.

STANDARDS:

1. Discuss the pathophysiology of the patient's autoimmune disorder and how it may affect function and lifestyle.
2. Explain that treatments are highly individualized and may vary over the course of the disease.
3. Explain that outcome varies with the specific disorder. Most are chronic, but many can be controlled with treatment.
4. Explain that symptoms of autoimmune disease vary widely depending on the type of disease. A group of very non-specific symptoms often accompany autoimmune disease. Review these symptoms with the patient.
    a. Tires easily
    b. Fatigue
    c. Dizziness
    d. Malaise
    e. Fever, very low grade temperature elevations
5. Explain that specific autoimmune disease results in either destruction of an organ or tissue or increase in size of an organ or tissue.

ATO-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of routine follow-up as an integral part of health care and maintenance.

STANDARDS:

1. Discuss the importance of routine follow-up by the primary provider, social services, mental health services, registered dietician, and community health services as appropriate.
2. Assess the need for any additional follow-up and make the necessary referrals.

ATO-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the patient's autoimmune disorder.

STANDARDS:

1. Provide the patient/family with written patient information literature on autoimmune disorder.
2. Discuss the content of the patient information literature with the patient/family.

ATO-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand what lifestyle adaptations are necessary to cope with the patient's specific autoimmune disorder.

STANDARDS:

1. Assess the patient's and family's level of acceptance of the disorder.
2. Refer to Social Services, Mental Health and community services as appropriate.
3. Review the lifestyle areas that may require adaptations: diet, physical activity, sexual activity, role changes, communication skills and interpersonal relationships.

ATO-M MEDICATIONS

OUTCOME: The patient/family will understand the goals of drug therapy, the side effects of the medications and the importance of fully participating with the medication plan.

STANDARDS:

1. Review the mechanisms of action for the patient's medication.
2. Discuss the proper use, benefits and common or important side effects of the patient's prescribed medications. Review signs of possible medication toxicity as indicated.
3. Emphasize the importance of taking medication as prescribed.

ATO-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ATO-N NUTRITION

OUTCOME: The patient/family/caregiver will understand the role of appropriate nutrition in the management of the patient's autoimmune disease.

STANDARDS:

1. Explain that many patients with autoimmune diseases will have altered nutritional requirements. Refer to dietitian as indicated.
2. Explain that some autoimmune diseases may become better or worse with changes in diet.
3. Review the patient's current nutritional habits. Encourage the patient/family/caregiver to keep a food diary for review.
4. Emphasize the importance of fully participating in the prescribed nutritional plan.

ATO-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in autoimmune disorders.

STANDARDS:

1. Explain that uncontrolled stress can suppress the immune response.
2. Explain that uncontrolled stress can interfere with the treatment of autoimmune disorders.
3. Explain that effective stress management may increase the number of immune cells, as well as help improve the patient's health and well-being.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from autoimmune disorders.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

ATO-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications, and the impact upon further care

STANDARDS:

1. Explain the test(s) ordered.
2. Explain the necessity, benefits, and risks of the test(s) to be performed and how it relates to the course of treatment.
3. Explain any necessary preparation for the test(s), i.e., fasting.
4. Explain the meaning of the test results, as appropriate.

ATO-TX TREATMENT

OUTCOME: The patient/family/caregiver will understand the possible treatments which will be available based upon the specific disease process, test results, and individual preferences.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
2. Discuss the treatment plan, including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan. Emphasize the importance of adhering to the treatment plan, including scheduled follow-up.
3. Refer to community resources as appropriate.

B

BF—Breastfeeding

BF-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The parent /family will understand the anatomy and physiology of breastfeeding.

STANDARDS:

1. Explain external anatomy of the breast, including the areola and nipple.
2. Explain internal anatomy of the breast, including milk glands, ducts, milk sinuses.
3. Explain the physiology of breastfeeding, including:
    a. Production of colostrums
    b. Onset of white mature milk within 3-5 days postpartum.
    c. Let down/milk ejection reflex

BF-BB BENEFITS OF BREASTFEEDING

OUTCOME: The parent/family will be able to identify benefits of breastfeeding.

STANDARDS:

1. Identify benefits for mother, including decreased risk of postpartum hemorrhage, enhanced uterine involution, decreased risk of breast cancer, delayed return of menses, improved postpartum weight loss, and bonding.
2. Identify benefits to the baby (i.e., increased IQ, improved bonding, easier to digest)
3. Identify risk reducing benefits to the baby (i.e., reduced risk of: type 1 and type 2 diabetes, obesity, food allergies, infections of mucosal membranes, and constipation).

BF-BC BREAST CARE

OUTCOME: The parent and/or family will able to identify methods to use for management of engorgement and tenderness.

STANDARDS:

1. Explain the current techniques for management of engorgement and tenderness.
2. Explain some techniques for preventing and managing sore nipples (i.e., assure correct latch-on, apply cool moist tea bags). Refer to BF-ON.
3. Explain the techniques for treating and recognizing signs of infection (mastitis):
    a. need for frequent feeding to reduce risk of breast infections.
    b. need to seek medical care if flu like symptoms (i.e., flu-like symptoms, fever, sores, or redness on breast are present.
    c. need to continue breastfeeding despite infection.
    d. reassure that the baby can continue to safely breast-feed.
4. Explain the techniques for treating and recognizing signs of infection (candida):
    a. keeping the nipples dry helps prevents thrush (i.e., change breast pads often, let nipple air dry).
    b. recognizing the symptoms of thrush (candida), including red painful nipples, characteristic cracking at base of nipple making feeding difficult for the baby. Emphasize the need for medical treatment for both mother and baby to eliminate thrush.
    c. emphasize the need to aggressively clean all items that come in contact with the mother's nipple or the baby's mouth such as clothing, pacifiers, plastic nipples, and breast pump equipment with hot soapy water.
5. Refer to a lactation consultant or other community resources, if available.

BF-BP BREASTFEEDING POSITIONS

OUTCOME: The parent/family will understand all 4 breastfeeding positions and provide a demonstration as appropriate.

STANDARDS:

1. Demonstrate the four common breastfeeding positions: cradle, modified cradle (cross-cradle), football, side-lying.
2. Discuss traits of effective positions, including baby parallel to the mom, face to face, tummy to tummy, baby held close to mother.

BF-CS COLLECTION AND STORAGE OF BREASTMILK

OUTCOME: The parent/family will understand the collection and storage of breastmilk.

STANDARDS:

1. Explain the role of manual pumps for occasional use and hospital grade electric pumps for long term use.
2. Explain that pumped breastmilk may have variable appearances and will separate if left standing and will need to be remixed by shaking the milk.
3. Explain storage recommendations for breastmilk, i.e., milk stays good in the refrigerator for 24 hours, refrigerator freezer for 1 month and deep freezer for 3 months.

BF-EQ EQUIPMENT

OUTCOME: The patient/family will understand the instructions for effective use of breast pumps and other breastfeeding equipment.

STANDARDS:

1. Discuss resources for manual and hospital grade electric pumps, including hospital, clinic, WIC, and community.
2. Discuss and demonstrate effective use of pumps.
3. Emphasize the proper use and care and cleaning of equipment.
4. Discuss any other breastfeeding equipment as appropriate.

BF-FU FOLLOW-UP

OUTCOME: The parents/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

BF-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent/family will understand the progression of growth and developmental stages of a nursing baby.

STANDARDS:

1. Explain growth and development stages common in a nursing baby, such as:
   a. bonding behaviors
   b. frequent nursing due to growth spurts
   c. eye contact with baby while nursing
   d. baby showing interest in surrounding while nursing
   e. baby gaining independence by crawling and walking
   f. reduced interest in nursing as development progresses

BF-HC HUNGER CUES

OUTCOMES: The parents/family will understand early and late hunger cues and the benefit of responding to early hunger cues.

STANDARDS:

1. Explain early hunger cues, i.e., low intensity cry, small body movements, smacking, rooting.
2. Explain late hunger cues, i.e., high intensity cry, large body movements, arched back, and distressed behavior.
3. Explain that feedings are usually more effectively accomplished at the stage when early hunger cues are being expressed.

BF-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about breastfeeding.

STANDARDS:

1. Provide patient/family with written patient information literature on breastfeeding.
2. Discuss the content of patient information literature with the patient/family.

BF-LA LIFESTYLE ADAPTATIONS

OUTCOME: The parents/family will understand life style adaptations regarding breastfeeding.

STANDARDS:

1. Discuss options for continuing to breastfeeding while separated from the baby, such as with work, school, and hospitalizations.
2. Discuss the reasons for eliminating the exposure of the baby to nicotine, including SIDS and respiratory illness. Encourage the abstinence from nicotine (smoked and chewed). If abstinence is not possible, wait at least one hour after using.
3. Discuss the potentially lethal effects for the baby if a breastfeeding mother uses recreational/street drugs (i.e., particularly drugs such as speed, crystal-meth, amphetamines).
4. Discuss that it is likely to take 2 hours for a nursing mother's body to eliminate the alcohol from the breastmilk if she has a standard serving of an alcohol containing beverage. A standard serving is typically 12 ounces of beer, one shot of liquor, or 4-5 ounces of wine.
5. Discuss options for breastfeeding in public.
6. Identify community resources available for breastfeeding support (i.e., La Leche League, WIC, community health nursing breastfeeding educators, IHS Breastfeeding Hotline 1-877-868-9473).

BF-M MATERNAL MEDICATIONS

OUTCOME: The parent/family will understand that most medications are safe during breastfeeding but that some medications are detrimental to breastfed infants.

STANDARDS:

1. Explain that most OTC and prescribed medications are safe in breastfeeding, but the breastfeeding mother should consult a health care provider before starting any new prescribed or OTC medications and/or herbal/traditional therapies.
2. Explain that there are a few substances that are harmful, including, but not limited to, recreational/street drugs, some anticonvulsants, some antidepressants, chemotherapeutic agents, radio-pharmaceuticals, etc. (Note: this information is subject to change and current resources should be consulted before counseling a patient about any medication).

BF-MK MILK INTAKE

OUTCOME: The parent/family will understand the signs of adequate milk intake.

STANDARDS:

1. Explain the feeding duration should be at least 15 minutes on each side, encouraging the baby to nurse longer as the baby desires. Feeding will take less time as the baby grows.
2. Explain the feeding frequency should be an average of every 2-3 hours, 8-10 times in 24 hours in the first weeks. Feeding will spread out as the baby grows.
3. Explain diaper change patterns in the first week beginning with a few diapers each day to at least 6-8 diapers changes in 24 hours by 1 week of age.
4. Explain transition of stool from meconium to transitional stool (brown, mushy) to breastfed stool (yellow with white seeds) when the white, mature milk comes in.

BF-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

BF-NJ NEONATAL JAUNDICE

OBJECTIVE: The family will understand the importance of monitoring for jaundice and the complications of unrecognized jaundice.

STANDARDS:

1. Explain that jaundice is the yellow color seen in the skin of many newborns which is caused by build up of bilirubin in the blood.
2. Explain that everyone's blood contains bilirubin, which is removed by the liver and that before birth, the mother's liver does this for the baby. Explain that many babies develop jaundice in the first few days after birth because it takes a few days for the baby's liver to get better at removing bilirubin.
3. Explain that the yellow skin color caused by bilirubin usually appears first in the face then moves to the chest, abdomen, arms and legs as the bilirubin level increases. Explain that the whites of the eyes may also be yellow.
4. Explain that mild jaundice is harmless but high levels of bilirubin may cause brain damage.
5. Explain that this brain damage can be prevented by treatment of the jaundice before the bilirubin level gets too high. Discuss that treatment options may include medical phototherapy or exchange transfusion.
6. Emphasize that parents should watch closely for jaundice and seek medical attention if jaundice is noticed.
7. Explain that medical personnel can check the level of bilirubin in the blood by blood tests or occasionally by a skin test.
8. Explain that all bilirubin levels must be interpreted in light of the infant's age and that term infants and older infants can tolerate higher levels of bilirubin than preterm infants and younger infants.
9. Explain that jaundice is more common in breastfed infants especially when the infant is not nursing well. Encourage nursing the infant a minimum of 8-12 times a day for the first week of life to increase milk production and keep bilirubin levels down. Emphasize that breastmilk is the ideal food for infants.

BF-N NUTRITION (MATERNAL)

OUTCOME: The parent/family will understand the foods that contribute to the nutritional well-being of breastfeeding mothers.

STANDARDS

1. Encourage consumption of same kinds of foods that are important during pregnancy.
2. Identify foods to avoid if necessary (i.e., chocolate, gas forming food, and highly seasoned foods).
3. Emphasize the increased need for water in the diet of breastfeeding mothers.

BF-ON LATCH-ON

OUTCOME: The parent/family will understand the characteristics of effective latch.

STANDARDS:

1. Identify the cues that indicate readiness to feed, i.e., wakefulness, lip smacking, and rooting.
2. Explain that effective latch on will be more successful if the baby's mouth is open wide.
3. Explain the physical traits of an effective latch (i.e., both lips out- covering at least part of the areola, with absence of chomping by baby and absence of prolonged pain for the mother).

BF-SF INTRODUCTION TO SOLID FOODS

OUTCOME: The parent/family will understand the appropriate ages to introduce various solid foods. (teach any or all of the following as appropriate to this infant/family)

STANDARDS:

1. Explain that infants should not routinely be fed foods other than breastmilk or formula prior to 4 months of age except under the advice of a healthcare provider.
2. Emphasize that, for some time after the introduction of solid foods, breastmilk/formula will still be the infant's primary source of nutrition.
3. Emphasize that foods should never be given from a bottle or infant feeder and must always be fed from a spoon.
4. Explain that infants may be fed cereal mixed with breastmilk or formula not sooner than 4 months of age. Rice cereal is generally the preferred first solid food. It is normal for an infant to take very small amounts of solid foods for several months. Discard any uneaten food after each meal.
5. Emphasize the need to wait 3-5 days between the addition of new foods to watch for adverse events from the foods.
6. Explain that pureed/or finely mashed vegetables and fruits should be started no earlier than 6 months of age.
7. Explain that some foods such as peanut butter, chocolate, eggs, strawberries, cow or goat milk and citrus should not be fed until the infant is one year of age due to the highly allergenic nature of these foods. Explain that honey and syrups may contain botulism toxin and should not be fed before one year of age.
8. Explain that infants 14-16 moths of age will have a decreased appetite and will become more picky eaters.
9. Emphasize that some foods are easy to choke on and should be avoided until 4 years of age, i.e., nuts, hard candies, gum, carrot sticks, meat on a bone, grapes, popcorn, hot dogs, unpeeled apples, slices of orange.
10. Discuss the importance of offering foods at the appropriate ages but do not insist that infants eat foods when they are not hungry:
    a. Baby knows how much to eat
    b. It is important to go along with the baby when they feel they have finished eating
    c. Some days babies eat a lot other days not as much
    d. No two babies eat the same
11. Explain how to assess readiness, an infant:
    a. who exhibits tongue thrusting is not ready to eat solids.

b. will give you cues to readiness when they open their mouths when they see something coming

c. will close lips over a spoon

d. will keep food in their mouth instead of spitting it out

e. will sit up alone without support

12. Explain that the body of knowledge regarding infant feedings has changed dramatically and advice from family/friends may no longer be appropriate; talk to your healthcare provider.

BF-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in the lactating mother.

STANDARDS:

1. Explain that uncontrolled stress may result in problems with milk let-down and reduced milk supply.
2. Explain that effective stress management may increase the success of breastfeeding.
3. Explain that difficulty with breastfeeding may result in feelings of inadequacy, low self-esteem, or failure as a mother.
4. Emphasize the importance of seeking help (i.e., lactation consultant, public health nurse or other nurse, WIC) as needed to improve breastfeeding success and reduce stress.
5. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use which may reduce the ability to breast-feed successfully.
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. recruiting other family members or friends to help with child care
    d. talking with people you trust about your worries or problems
    e. setting realistic goals
    f. getting enough sleep (e.g., sleeping when the baby sleeps if possible)
    g. maintaining a reasonable diet
    h. exercising regularly
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
7. Provide referrals as appropriate.

BF-T TEETHING

OUTCOME: The parent/family will understand teething behaviors and ways to prevent biting while breastfeeding.

STANDARDS:

1. Explain the normal stages of teething, i.e., sore swollen gums and the baby's tendency to nurse to ease discomfort.
2. Identify ways to anticipate and prevent biting in a teething baby (i.e., closely observing the baby while nursing to interrupt potential biting).
3. Explain the variety of techniques to discourage persistent biting (i.e., keeping finger poised near baby's mouth to interrupt chomping, briefly stopping the feeding, firmly say "no" and break the latch.

BF-W WEANING

OUTCOME: The parent/family will understand methods to effectively wean the child from breastfeeding.

STANDARDS:

1. Discuss reasons for weaning (i.e., including infant/child readiness, separation from mother, medication needed for mother that is contraindicated in breastfeedings).
2. Explain process of weaning, including replacing one feeding at a time with solids or milk from cup.
3. Explain managing abrupt weaning to prevent/reduce the risk of breast infections, such as pumping/expressing to comfort.
4. Explain social ways to replace breastfeeding such as reading books together at the table and playing with toys.
5. Refer to community resources as appropriate.

C

CA—Cancer

CA-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the normal function of organ(s)/site being affected by the cancer.

STANDARD:

1. Explain relationship of anatomy and physiology of the system involved and how it may be affected by this tumor.
2. Discuss changes in health of the patient as it relates to the cancer site and the potential impact on health and well being.

CA-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand that both the disease process and the therapy may have complications which may or may not be treatable.

STANDARDS:

1. Explain that cancer, depending on the primary site, size of the tumor, or degree of metastasis, and specific treatment regimens have various and diverse complications.
2. Explain that many therapies for cancer depress the immune system and that infection is a major risk.
3. Discuss that many therapies for cancer will have as a side-effect nausea and vomiting. This can often be successfully medically managed.
4. Discuss that pain may be a complication of the disease process or the therapy. **Refer to PM.**

CA-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CA-DP DISEASE PROCESS

OUTCOME: The patient/family/caregiver will understand the definition of cancer, and types affecting American Indian population and treatment options available to alleviate specific to the patient's diagnosis.

STANDARD:

1. State the definition of Cancer, the specific type, causative and risk factors and effect of primary site of the cancer and staging of the tumor.
2. Discuss signs and symptoms and usual progression of specific cancer diagnosis.
3. Discuss significant complications of treatment.
4. Explain that many cancers are curable and most are treatable. Discuss prognosis of specific cancer.
5. Discuss the importance of maintaining a positive mental attitude.

CA-EQ EQUIPMENT

OUTCOME: The patient/family will understand durable medical equipment and demonstrate proper use and care of equipment.

STANDARDS:

1. Discuss the indication for and benefits of prescribed home medical equipment.
2. Demonstrate the proper use and care of medical equipment.
3. Review proper function and demonstrate safe use of equipment.
4. Discuss infection control principles as appropriate.

CA-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the importance of fully participating in treatment regimen and to maintain activities to follow up with outside referral sources.

STANDARDS:

1. Emphasize the importance of obtaining referrals for contract health services when appropriate.
2. Explain that test(s) required by private outside providers need coordination with Indian health physicians.
3. Discuss process for making follow up appointments with internal and external providers.
4. Discuss individual responsibility for seeking and obtaining third party resources.
5. Discuss the importance of keeping follow-up appointments and how this may affect outcome.

CA-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand home management of cancer process and develop a plan for implementation. The patient/family/caregiver will understand the coordination of health care services to assure the patient receives comprehensive care.

STANDARDS:

1. Explain the home management techniques necessary based on the status of the patient. Explain that these home management techniques may change on a day to day or week to week basis.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources as appropriate. Refer to hospice care as appropriate.
4. Refer to support groups as appropriate.

CA-L LITERATURE

OUTCOME: The patient/family/caregiver will receive written information of cancer and organizations that assist in the care of patients with cancer such as the American Cancer Society.

STANDARDS:

1. Provide written information about specific cancer diagnosis to the patient/family/caregiver.
2. Review content of patient information literature with patient/family/caregiver.
3. Advise of any agency or organization that can provide assistance and further education such as support groups.

CA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will attempt to make necessary lifestyle adaptations to prevent or delay the onset of complications or to improve overall quality of life.

STANDARDS:

1. Review lifestyle behaviors the patient has control over such as diet, exercise, and habits related to risk of disease.
2. Encourage full participation with treatment plan.
3. Emphasize importance of the patient adapting to a lower risk, healthier lifestyle.
4. Review community resources available to assist the patient making changes. Refer as appropriate.

CA-M MEDICATIONS

OUTCOME: The patient/family will understand choice of medication to be used in management of cancer disease.

STANDARDS:

1. Explain medication regimen to be implemented. **Refer to PM.**
2. Explain medication to be used including dose, timing, adverse side effects including drug-food interactions.
3. Explain affects of chemotherapy such as hair loss, nausea, vomiting and altered immune status.
4. Caution on the administration of live vaccines to self and family as appropriate. Discuss the implications of immunization advantages and disadvantages.

CA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CA-N NUTRITION

OUTCOME: The patient, family/caregiver will receive nutritional assessment and counseling. Patient will understand the need for a well balanced nutritional plan.

STANDARDS:

1. Assess patient's current nutritional level and determine an appropriate meal plan.
2. Discuss ways the meal plan can be enhanced to decrease nausea and vomiting, or other complications associated with the therapy or the disease process.
3. Explain that medications may be provided to enhance appetite, decrease adverse effects of therapy or the disease process to assist in maintenance of proper nutrition.
4. Review normal nutrition needs for optimum health.
5. Discuss current nutritional habits and assist in developing a plan to implement the prescribed nutritional plan.
6. Discuss the patient's right to decline nutritional support.

CA-P PREVENTION

OUTCOME: The patient/family will have awareness of risk factors associated with the development of cancer and be able to access health activities.

STANDARDS:

1. Explain that the use of tobacco is a major risk factor for many and diverse types of cancer.
2. Discuss the need to use sunscreens or reduce sun exposure.
3. Discuss reduction to exposure of chemicals as appropriate.
4. Discuss other preventive strategies as currently determined by the American Cancer Society.
5. Discuss the importance of health surveillance and routine health maintenance and recommended screening procedures for a patient of this age/sex, i.e., PAP smears, colonoscopy, BSE, TSE, PSA.
6. Emphasize the importance of early detection of cancer in cancer cure. Encourage the patient to come in early if signs of cancer (i.e., unexpected weight loss, fatigue, GI bleeding, new lumps or bumps, nagging cough or hoarseness, change in bowel or bladder habits, changes in warts or moles, sores that don't heal) are detected.

CA-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM.**
2. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain or nausea and vomiting.
3. Explain non-pharmacologic measures that may be helpful with pain control.

CA-REF REFERRAL

OUTCOME: The patient/family will understand referral and contract health services process and will make a plan to follow-up with contract health services.

STANDARDS:

1. Emphasize that referrals to outside providers by Indian Health Service primary providers typically will be processed by Contract Health Services.
2. Explain the procedure for the referral to the private sector is usually based on a priority system and/or waiting list.
3. Explain that coverage by insurance companies and Medicare/Medicaid packages will be utilized prior to contract health service funds in most cases. The Indian Health Service is a payer of last resort.
4. Discuss the rules/regulations of Contract Health Services.
5. Refer as appropriate to community resources for Medicaid/Medicare enrollment, i.e., benefits coordinator, social services. **Refer to EOL-LW.**
6. Discuss the importance of follow-up care and the requirement to notify contract health services of any future appointments and procedures by the private sector. **Referrals are for one visit only**, unless otherwise specified. Future and/or additional referrals must be approved prior to the appointment.

CA-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in cancer.

STANDARDS:

1. Explain that uncontrolled stress can result in a worsened prognosis in cancer patients.
2. Explain that effective stress management may help reduce the morbidity and mortality associated with cancer, as well as help improve the patient's sense of health and well-being.
3. Discuss various stress management strategies such as maintaining a healthy lifestyle. Some examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
4. Provide referrals as appropriate.

CA-TE TESTS

OUTCOME: The patient /family will understand the conditions under which testing is necessary and the specific test(s) to be preformed, technique for collecting samples and the expected benefit of testing and any associated risks. The patient/family will also understand alternatives to testing and the potential risks associated with the alternatives, i.e., risk of non-testing.

STANDARDS:

1. Explain that tests may be necessary for diagnosis or staging of cancer and follow-up therapy. Discuss the procedure for the test to be performed, the benefit expected and any associated risks.
2. Explain the alternatives to the proposed test(s) and the risk(s) and benefits(s) of the alternatives including the risk of non-testing.
3. Explain any preparation for testing that is necessary, i.e., NPO status, bowel preps.

CA-TX TREATMENT

OUTCOME: The patient/family will understand the difference between palliative and curative treatments; and understand that the focus of the treatment plan will be on the quality of life rather than quantity of life.

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of a treatment plan.
2. Explain what signs/symptoms should prompt an immediate call to the provider.
3. Explain the difference between palliative and curative treatments.
4. Explain that treatments may prolong the patient's life and improve the quality of life by increasing patient comfort or curing of the disease process.
5. Discuss therapies that may be utilized including chemotherapy, surgical debulking or removal of tumor and radiation therapy as appropriate.
6. Explain that various treatments have their own inherent risks, side effects and expected benefits. Explain the risk/benefit of treatment/non-treatment.

CVA—Cerebrovascular Disease

CVA-C COMPLICATIONS

OUTCOME: The patient/family will understand how to prevent the complications of cerebrovascular disease.

STANDARDS:

1. Discuss common complications of cerebrovascular disease, i.e., loss of function, loss of speech, confusion, loss of independence.
2. Discuss the importance of following the prescribed treatment plan including physical therapy, medications and rehabilitation in maximizing potential.

CVA-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CVA-DP DISEASE PROCESS

OUTCOME: The patient will understand cerebrovascular disease and its symptoms.

STANDARDS:

1. Explain that cerebrovascular disease is the result of the buildup of plaque in the interior wall of the arteries of the brain.
2. Review the factors related to the development of cerebrovascular disease - smoking, uncontrolled hypertension, elevated cholesterol, obesity, uncontrolled diabetes, sedentary lifestyle, increasing age, and male sex. Emphasize that a history of coronary artery disease greatly increases the risk of cerebrovascular disease and vice-versa.
3. Review the signs of cerebrovascular disease, i.e., weakness, numbness, confusion, slurred speech, episodes of "blacking out."
4. Explain that the symptoms of cerebrovascular disease occur when the brain is deprived of oxygen.
5. Differentiate between temporary ischemic attack (the temporary loss of oxygen to the brain) and "stroke" (a permanent loss of oxygen to the brain resulting in permanent damage and loss of function).
6. Explain that sometimes only a physician, through test interpretation, may be able to differentiate between TIA and stroke.
7. Emphasize that a TIA is a significant warning sign which may be a precursor to a stroke and permanent loss of function. Any TIA or similar symptoms should prompt immediate medical evaluation.
8. Emphasize that effects of a stroke are often reversible with early intervention and appropriate rehabilitation. Refer as appropriate.

CVA-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) proper use and care of medical equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed medical equipment to be used during the hospital stay and/or at home after discharge.
2. Discuss and/or demonstrate proper use and care of medical equipment; participate in return demonstration by patient/family.
3. Emphasize infection control principles and the safe use of equipment.

CVA-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adhering to a treatment regimen, be able to identify appropriate actions to take for symptoms indicating life-threatening ischemia, and will make a plan to obtain and keep appropriate follow-up appointments.

STANDARDS:

1. Discuss the individual's responsibility in the management of cerebrovascular disease.
2. Review treatment plan with the patient, emphasizing the need for keeping appointments, fully participating with medication therapy, adhering to dietary modifications, and maintaining an appropriate activity/rest balance.
3. Review the symptoms which should be reported, i.e., symptoms more frequent or occurring during rest, symptoms lasting longer.

CVA-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of status post stroke patients and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer falls, fewer emergency room visits, fewer hospitalizations and fewer complications.
3. Explain the use and care of any necessary home medical equipment.

CVA-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the cerebrovascular disease.

STANDARDS:

1. Provide patient/family with written patient information literature about cerebrovascular disease.
2. Discuss the content of patient information literature with the patient/family.

CVA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to maintain optimal health.

STANDARDS:

1. Emphasize that the most important component in the prevention and treatment of cerebrovascular disease is the patient's adaptation to a healthier, lower risk lifestyle.
2. Discuss lifestyle adaptations that may reduce further risk of TIA and/or stroke and improve the quality of life (cease all use of tobacco products, control hypertension and elevated cholesterol through medications, diet and exercise, lose weight as indicated, control diabetes, and increase activity as prescribed by the physician).

CVA-M MEDICATIONS

OUTCOME: The patient will understand the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medications.
2. Emphasize the importance of maintaining strict participation in the medication regimen.

CVA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CVA-N NUTRITION

OUTCOME: The patient/family will understand how to control cerebrovascular disease through weight control and diet modification and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between diet and cerebrovascular disease, hypertension, elevated cholesterol, and obesity.
3. Provide lists of foods that are to be encouraged and avoided. Refer to dietitian or other local resources as available.
4. Assist in developing an appropriate diet plan to achieve optimal weight and cholesterol control.
5. **Refer to LIP**.

CVA-P PREVENTION

OUTCOME: The patient/family will understand ways to prevent CVA.

STANDARDS:

1. Discuss that prevention of cerebrovascular disease is far better than controlling the disease after it has developed.
2. Explain that consuming a diet low in fat, and controlling weight, lipid levels and blood pressure will help to prevent CVA.
3. Discuss that persons with uncontrolled diabetes and uncontrolled hypertension and uncontrolled dyslipidemia are more likely to develop CVA. Stress the importance of controlling these disease processes. **Refer to DM, HTN, LIP, OBS.**

CVA-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient and/or appropriate family member(s) will understand the importance of injury prevention and implement of safety measures.

STANDARDS:

1. Explain to patient/family members the importance of body mechanics and proper lifting techniques to avoid injury.
2. Assist the family in identifying ways to adapt the home to improve safety and prevent injuries, i.e., remove throw rugs, install bars in tub/shower, secure electrical cords.
3. Stress importance and proper use of mobility devices, i.e., cane, walker, wheel chair.

CVA-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in cerebrovascular disease.

STANDARDS:

1. Explain that uncontrolled stress can contribute to increases in blood pressure, which increases the patient's risk for stroke.
2. Explain that uncontrolled stress can interfere with the treatment of cerebrovascular disease.
3. Explain that effective stress management may help prevent progression of cerebrovascular disease, as well as help improve the patient's health and well-being.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from cerebrovascular disease.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

CVA-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed, the risk(s)/benefit(s) of the test(s) and the risk(s) of refusal of the test(s).

STANDARDS:

1. Explain the test ordered, i.e., CT, MRI, angiography.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.

CVA-TX TREATMENTS

OUTCOME: The patient/family will understand the possible treatments that may be performed based on the test results.

STANDARDS:

1. List the possible procedures that might be utilized to treat the arterial blockage, i.e., angioplasty, carotid endarterectomy.
2. Briefly explain each of the possible treatments.
3. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of diagnostic tests.

CP—Chest Pain

CP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand some possible etiologies of chest pain.

STANDARDS:

1. Discuss various etiologies for chest pain, i.e., cardiovascular, pulmonary, musculoskeletal, gastrointestinal.
2. Explain that diagnostic testing may be required to determine the etiology.

CP-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Explain the use of equipment utilized to monitor the patient.
2. Explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
3. Emphasize, as necessary, that electrodes and sensors must be left in place in order for the equipment to function properly.
4. Encourage the patient/family to ask questions if they have concerns regarding equipment readings.
5. Emphasize the importance of not tampering with any medical equipment.

CP-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments and fully participate with instruction given for recurrence of chest pain.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Explain circumstances /examples that should prompt immediate medical attention.
3. Discuss the procedure for obtaining follow-up appointments.
4. Emphasize that appointments should be kept.

CP-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about chest pain.

STANDARDS:

1. Provide the patient/family with written patient information literature on chest pain.
2. Discuss the content of patient information literature with the patient/family.

CP-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and proper use of medications.

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Emphasize the importance of maintaining strict participation to the medication regimen.
3. Encourage the patient to carry a list of current medications with them.

CP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CP-N NUTRITION

OUTCOME: The patient/family will understand how nutrition might affect chest pain.

STANDARDS:

1. Discuss as appropriate that some foods might exacerbate chest pain.
2. Refer to a registered dietician as appropriate.

CP-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in chest pain.

STANDARDS:

1. Explain that uncontrolled stress may cause chest pain or increase the severity of other conditions which cause chest pain. **Refer to CAD, GAD.**
2. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as inappropriate eating, all which can contribute to causes of chest pain.
3. Explain that effective stress management may help reduce the frequency of chest pain, as well as help improve the health and well-being of the patient.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. becoming aware of your own reactions to stress
   b. recognizing and accepting your limits
   c. talking with people you trust about your worries or problems
   d. setting realistic goals
   e. getting enough sleep
   f. maintaining a reasonable diet
   g. exercising regularly
   h. taking vacations
   i. practicing meditation
   j. self-hypnosis
   k. using positive imagery
   l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   m. spiritual or cultural activities
5. Provide referrals as appropriate.

CP-TE TESTS

OUTCOME: The patient/family will understand tests to be performed, the potential risks, expected benefits and the risk of non-testing.

STANDARDS:

1. Explain tests that have been ordered.
2. Explain the necessary benefits and risks of tests to be performed. Explain the potential risk of refusal of recommended test(s).
3. Inform patient of any advance preparation for the test, i.e., NPO status.

CHN—Child Health – Newborn (0-60 Days)

CHN-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of keeping routine well child visits.

STANDARDS:

1. Discuss that well child visits are important to follow growth and development, screen for disease and update immunizations.
2. Inform the patient/family of the timing of the next well child visit.
3. Discuss the procedure for making appointments.

CHN-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent(s) will have a basic understanding of a newborn's growth and development.

STANDARDS:

1. Discuss the various newborn reflexes.
2. Explain the limits of neuromuscular control in newborns.
3. Review the myriad of "noises" newborns can make and how to differentiate between normal sounds and signs of distress.
4. Review the limited wants of newborns— to be dry, fed and comfortable.
5. Discuss the other newborn aspects— sleeps about 20 hours, may have night and day reversed, colic and fussiness, knows mother better than father.

CHN-I INFORMATION

OUTCOME: Parents/family will understand newborn health and wellness issues.

STANDARDS:

1. Bowel habits
   a. Discuss the difference in frequency, consistency, texture, color, and odor of stools of breast or bottle fed newborns. Stress that each newborn is different.
   b. Review constipation. Strongly discourage the use of enemas or homemade preparations to relieve constipation.
   c. Review diarrhea protocols -- clear liquids, when to come to the clinic.
   d. Discuss normal I/O (7-8 wet and/or dirty diapers by the 4th to 5th day of life).
2. Stress the dangers of fever (>101 degrees Fahrenheit) in the newborn period and the importance of seeking immediate medical care. **Refer to NF**.
3. Discuss that rectal temperature is a reliable method of temperature measurement in newborns.
4. Discuss the option of circumcision and care of the circumcised and uncircumcised penis.
5. Discuss newborn hygiene, i.e., bathing, cord care, avoidance of powders.
6. Discuss symptoms of jaundice and icterus and when to seek medical care.
7. Discuss the immunization schedule and when the infant should receive his/her first immunization. **Refer to IM**.
8. Discourage use of medications in the newborn period.

CHN-L PATIENT INFORMATION LITERATURE

OUTCOME: The parent/family will receive written information about child health issue.

STANDARDS:

1. Provide patient/family with written patient information literature on child health issue.
2. Discuss the content of patient information literature with the patient/family.

CHN-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CHN-NJ NEONATAL JAUNDICE

OBJECTIVE: The family will understand the importance of monitoring for jaundice and the complications of unrecognized jaundice.

STANDARDS:

1. Explain that jaundice is the yellow color seen in the skin of many newborns which is caused by build up of bilirubin in the blood.
2. Explain that everyone's blood contains bilirubin, which is removed by the liver and that before birth, the mother's liver does this for the baby. Explain that many babies develop jaundice in the first few days after birth because it takes a few days for the baby's liver to get better at removing bilirubin.
3. Explain that the yellow skin color caused by bilirubin usually appears first in the face then moves to the chest, abdomen, arms and legs as the bilirubin level increases. Explain that the whites of the eyes may also be yellow.
4. Explain that mild jaundice is harmless but high levels of bilirubin may cause brain damage.
5. Explain that this brain damage can be prevented by treatment of the jaundice before the bilirubin level gets too high. Discuss that treatment options may include medical phototherapy or exchange transfusion.
6. Emphasize that parents should watch closely for jaundice and seek medical attention if jaundice is noticed.
7. Explain that medical personnel can check the level of bilirubin in the blood by blood tests or occasionally by a skin test.
8. Explain that all bilirubin levels must be interpreted in light of the infant's age and that term infants and older infants can tolerate higher levels of bilirubin than preterm infants and younger infants.
9. Explain that jaundice is more common in breastfed infants especially when the infant is not nursing well. Encourage nursing the infant a minimum of 8-12 times a day for the first week of life to increase milk production and keep bilirubin levels down. Emphasize that breastmilk is the ideal food for infants.

CHN-N NUTRITION

OUTCOME: The parent/family will understand the various methods of feeding a baby in order to ensure good nutrition and adequate growth.

STANDARDS:

1. Encourage breastfeeding as the healthy way to feed infants. Explain that infants grow appropriately on formula when breastfeeding is not an option. **Refer to BF**.
2. Discuss that solids are not needed until 4-6 months of age.
3. Discourage the use of cereals added to formula except when specifically recommended by the health care provider.
4. Emphasize that nothing should be given from the bottle but formula, breastmilk, water, or electrolyte solutions, i.e., no caffeinated beverages or other soft drinks.
5. Review formula preparation and storage of formula and/or breastmilk as appropriate.
6. Review proper technique and position for bottle feeding, i.e., no propping of bottles.

CHN-PA PARENTING

OUTCOME: The parent/family will cope in a healthy manner to the addition of a new family member.

STANDARDS:

1. Discuss the common anxieties of new parents.
2. Review some of the changes of adding a new baby to the household.
3. Review the sleeping and crying patterns of a new baby.
4. Emphasize the importance of bonding and the role of touch in good emotional growth.
5. Emphasize that fatigue, anxiety, and frustration are normal and temporary. Discuss coping strategies.
6. Discuss sibling rivalry and some techniques to help older siblings feel important.
7. Review the community resources available for help in coping with a new baby.

CHN-S SAFETY AND INJURY PREVENTION

OUTCOME: The parent/family will understand principles of injury prevention and plan to provide a safe environment.

STANDARDS:

1. Review the dangers of leaving a newborn unattended. Discuss the need to require ID from people presenting themselves in an official capacity.
2. Stress the use of a properly secured, rear facing car seat EVERY TIME the newborn rides in a vehicle. The car seat should be in the middle of the back seat of the vehicle.
3. Discuss the requirement of a NTSB approved car seat. Not all infant carriers are approved for use in automobiles.
4. Discuss the dangers posed by--open flames, closed-up cars, siblings, plastic bags, tossing the baby in the air, second-hand cigarette smoke and shaken-baby syndrome.
5. Illustrate the proper way to support a newborn's head and back.
6. Explain that SIDS is decreased by back or side-lying and by not smoking in the home or car.
7. Stress the importance of carefully selecting child-care settings to assure child safety.
8. Discuss the importance of keeping a hand on the infant when he/she is lying on any surface over floor level to avoid falls.
9. Discuss the dangers posed by hot liquids, too hot bath water, microwaving baby bottles, and cigarettes or open flames.

CHN-SF INTRODUCTION TO SOLID FOODS

OUTCOME: The parent/family will understand the appropriate ages to introduce various solid foods. (teach any or all of the following as appropriate to this infant/family)

STANDARDS:

1. Explain that infants should not routinely be fed foods other than breastmilk or formula prior to 4 months of age except under the advice of a healthcare provider.
2. Emphasize that, for some time after the introduction of solid foods, breastmilk/formula will still be the infant's primary source of nutrition.
3. Emphasize that foods should never be given from a bottle or infant feeder and must always be fed from a spoon.
4. Explain that infants may be fed cereal mixed with breastmilk or formula not sooner than 4 months of age. Rice cereal is generally the preferred first solid food. It is normal for an infant to take very small amounts of solid foods for several months. Discard any uneaten food after each meal.
5. Emphasize the need to wait 3-5 days between the addition of new foods to watch for adverse events from the foods.
6. Explain that pureed/or finely mashed vegetables and fruits should be started no earlier than 6 months of age.
7. Explain that some foods such as peanut butter, chocolate, eggs, strawberries, cow or goat milk and citrus should not be fed until the infant is one year of age due to the highly allergenic nature of these foods. Explain that honey and syrups may contain botulism toxin and should not be fed before one year of age.
8. Explain that infants 14-16 moths of age will have a decreased appetite and will become more picky eaters.
9. Emphasize that some foods are easy to choke on and should be avoided until 4 years of age, i.e., nuts, hard candies, gum, carrot sticks, meat on a bone, grapes, popcorn, hot dogs, unpeeled apples, slices of orange.
10. Discuss the importance of offering foods at the appropriate ages but do not insist that infants eat foods when they are not hungry:
    a. Baby knows how much to eat
    b. It is important to go along with the baby when they feel they have finished eating
    c. Some days babies eat a lot other days not as much
    d. No two babies eat the same
11. Explain how to assess readiness, an infant:
    a. who exhibits tongue thrusting is not ready to eat solids.

b. will give you cues to readiness when they open their mouths when they see something coming

c. will close lips over a spoon

d. will keep food in their mouth instead of spitting it out

e. will sit up alone without support

12. Explain that the body of knowledge regarding infant feedings has changed dramatically and advice from family/friends may no longer be appropriate; talk to your healthcare provider.

CHN-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define “passive smoking”, ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls
2. Discuss harmful substances in smoke:
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances)
3. Explain the increased risk of illness in infants when exposed to cigarette smoke either directly or via second-hand smoke.
4. Discuss that infants who live in home where someone smokes in the home are three times more likely to die of SIDS than infants who do not live in a home in which someone smokes.
5. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
6. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
7. Encourage smoking cessation or at least never smoking in the home or car.

CHI—Child Health – Infant (2-12 Months)

CHI-FU FOLLOW UP

OUTCOME: The patient/family will understand the importance of keeping routine well child visits.

STANDARDS:

1. Discuss that well child visits are important to follow growth and development, screen for disease and update immunizations.
2. Inform the patient/family of the timing of the next well child visit.
3. Discuss the procedure for making appointments.

CHI-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent(s) will understand the biologic and developmental changes and achievements during infancy and provide a nurturing environment to achieve normal growth and development.

STANDARDS:

1. Review the expected weight and height changes.
2. Review the improvements in neuromuscular control--visual acuity and motor control.
3. Discuss psycho-social development--prevalence of narcissism and acquisition of trust.
4. Discuss cognitive development--active participation with the environment fosters learning.
5. Review adaptive behaviors:
    a. Smiles by 8 weeks.
    b. Show interest in environment by 3 months.
    c. Laughs by 4 months.
    d. Is very personable by 6 months.
    e. Says “mama” and “dada” by 6 months.
    f. Imitates by 8 months.
    g. Plays peek-a-boo, patty-cake by 10 months.

CHI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about child health issue.

STANDARDS:

1. Provide patient/family with written patient information literature on child health issue.
2. Discuss the content of patient information literature with the patient/family.

CHI-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CHI-N NUTRITION

OUTCOME: The parent(s) will understand the changing nutritional needs of an infant.

STANDARDS:

1. Discuss the schedule for introducing solids and juices at 4-6 months of age, and how to accomplish first spoon feeding. Explain that solids should not be fed from a bottle or infant feeder but from a spoon.
2. Review breastfeeding and discuss current information on the use of vitamin and iron supplements when breastfeeding.
3. Review formula preparation and storage and proper technique and position for bottle feeding (no propping bottles in bed).
4. Discuss age appropriate intake (ounces/day) and stress the dangers of overfeeding.
5. Discuss weaning, transition from bottle to cup. Emphasize the effects of "baby bottle tooth decay".
6. Discuss waiting 3-4 days between additions of new foods to identify food allergies.
7. Discuss as appropriate the recommendations for fluoride supplementation in non-fluoridated water areas. (Currently no fluoride supplementation is recommended for infants under 6 months of age.)
8. Explain the dangers of giving honey before the age of one year. (infantile botulism)
9. Emphasize the importance of avoiding food that are easy to choke on, i.e., nuts, hard candy, gum.
10. Emphasize the importance of observing the child while eating to reduce the risk of choking.
11. Emphasize the importance of having the child remain seated while eating to reduce the risk of choking.

CHI-PA PARENTING

OUTCOME: The parent(s) and family will adapt in a healthy manner to the growth and development of the infant.

STANDARDS:

1. Discuss how home life is beginning to settle down. Encourage the parents to find some time to nurture their relationship.
2. Review basic nurturing skills: spending time with the infant, continued importance of touch, involving father in care and nurturing.
3. Discuss age appropriate disciplinary techniques as increasing mobility increases the risk of injury (i.e., distraction for the 6 month old).
4. Encourage stimulation of the infant (auditory, tactile, visual).
5. Encourage sibling participation in care of the infant.
6. Discuss the role of a bedtime routine and comfort objects such as stuffed animals or blankets as appropriate to the age of the infant.
7. Stress importance of regular well child care and immunizations.
8. Review the community resources available for help in coping with an infant.

CHI-S SAFETY AND INJURY PREVENTION

OUTCOME: The parent(s) will understand principles of injury prevention and plan a safe environment.

STANDARDS:

1. Explain that accidents are a major cause of death.
2. Emphasize the importance of a properly fitting car seat correctly installed, rear facing until one year of age and the correct place in the car (currently the middle of the back seat for the youngest child).
3. Stress that the infant's increasing mobility requires additional vigilance to the dangers of aspiration, suffocation, falls, poisonings, burns, motor vehicle crashes and other accidents.
4. Explain that walkers are a source of serious injury and often delay walking.
5. Explain that SIDS is decreased by back or side lying and by not smoking in the home or car.
6. Child-proof the home. **Refer to WL-S**.
    a. Keep hot liquids, cigarettes and other hot objects out of the infant's reach and cover outlets to avoid burns, i.e., turn pot handles to the back of the stove and use back burners preferentially.
    b. Review choking hazards and the importance of keeping small objects out of the child's reach.
    c. Review drowning and the importance of never leaving the child unattended in the bath and keeping toilet lids down and bathroom doors closed.
    d. Emphasize the importance of child locks on cabinets and keeping potentially dangerous substances and objects out of the child's reach.
    e. Emphasize the importance of keeping electrical cords and other wiring out of the reach of children. Small children will chew and pull on electrical cords and wiring.
7. Emphasize the importance of carefully selecting child-care settings to assure child safety.

CHI-SF INTRODUCTION TO SOLID FOODS

OUTCOME: The parent/family will understand the appropriate ages to introduce various solid foods. (teach any or all of the following as appropriate to this infant/family)

STANDARDS:

1. Explain that infants should not routinely be fed foods other than breastmilk or formula prior to 4 months of age except under the advice of a healthcare provider.
2. Emphasize that, for some time after the introduction of solid foods, breastmilk/formula will still be the infant's primary source of nutrition.
3. Emphasize that foods should never be given from a bottle or infant feeder and must always be fed from a spoon.
4. Explain that infants may be fed cereal mixed with breastmilk or formula not sooner than 4 months of age. Rice cereal is generally the preferred first solid food. It is normal for an infant to take very small amounts of solid foods for several months. Discard any uneaten food after each meal.
5. Emphasize the need to wait 3-5 days between the addition of new foods to watch for adverse events from the foods.
6. Explain that pureed/or finely mashed vegetables and fruits should be started no earlier than 6 months of age.
7. Explain that some foods such as peanut butter, chocolate, eggs, strawberries, cow or goat milk and citrus should not be fed until the infant is one year of age due to the highly allergenic nature of these foods. Explain that honey and syrups may contain botulism toxin and should not be fed before one year of age.
8. Explain that infants 14-16 moths of age will have a decreased appetite and will become more picky eaters.
9. Emphasize that some foods are easy to choke on and should be avoided until 4 years of age, i.e., nuts, hard candies, gum, carrot sticks, meat on a bone, grapes, popcorn, hot dogs, unpeeled apples, slices of orange.
10. Discuss the importance of offering foods at the appropriate ages but do not insist that infants eat foods when they are not hungry:
    a. Baby knows how much to eat
    b. It is important to go along with the baby when they feel they have finished eating
    c. Some days babies eat a lot other days not as much
    d. No two babies eat the same
11. Explain how to assess readiness, an infant:
    a. who exhibits tongue thrusting is not ready to eat solids.

b. will give you cues to readiness when they open their mouths when they see something coming

c. will close lips over a spoon

d. will keep food in their mouth instead of spitting it out

e. will sit up alone without support

12. Explain that the body of knowledge regarding infant feedings has changed dramatically and advice from family/friends may no longer be appropriate; talk to your healthcare provider.

CHI-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls
2. Discuss harmful substances in smoke:
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances)
3. Explain the increased risk of illness in infants when exposed to cigarette smoke either directly or via second-hand smoke.
4. Discuss that infants who live in home where someone smokes in the home are three times more likely to die of SIDS than infants who do not live in a home in which someone smokes.
5. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
6. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
7. Encourage smoking cessation or at least never smoking in the home or car.

CHI - W WEANING

OUTCOME: The parent/family will understand methods to effectively wean the child from breastfeeding or bottle.

STANDARDS:

1. Discuss appropriate reasons for weaning the infant from breastfeeding or bottle. **Refer to ECC-P, OM-P.**
2. Explain readiness signs of weaning that the infant may display.
3. Explain the process of weaning, i.e., replace one feeding at a time with solids or cup.
4. Explain social ways to replace breastfeeding or bottle-feeding, i.e., reading books together, playing with toys, cuddling together.
5. Explain that infants should be weaned from the bottle by 12 months of age.
6. Refer to community resources as appropriate.

CHT—Child Health – Toddler (1-3 Years)

CHT-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of keeping routine well child visits.

STANDARDS:

1. Discuss that well child visits are important to follow growth and development, screen for disease and update immunizations.
2. Inform the patient/family of the timing of the next well child visit.
3. Discuss the procedure for making appointments.

CHT-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent(s) will understand the rapidly changing development of the inquisitive and independent toddler and plan to nurture normal growth and development.

STANDARDS:

1. Explain the toddler's intense need to explore.
2. Review appropriate ways of disciplining toddlers. Provide positive alternatives to undesirable behaviors. Toddlers often attempt to control others with temper tantrums, negativism and obstinacy. Encourage parents to be consistent in discipline.
3. Discuss toilet training methods and indicators of toilet training readiness, i.e., the ability to walk, complaining of wet or dirty diapers, asking to go to the toilet.
4. Review the importance of allowing for positive emotional growth. Touch is still important. Fears may develop during this time.
5. Review the need for good dental hygiene.
6. Discuss the need for continued well child care.

CHT-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about child health issue.

STANDARDS:

1. Provide patient/family with written patient information literature on child health issue.
2. Discuss the content of patient information literature with the patient/family.

CHT-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CHT-N NUTRITION

OUTCOME: The parent(s) will understand the nutritional needs of the toddler and the frustrations that can surround mealtime.

STANDARDS:

1. Discuss the varying levels of mastery of cups and utensils. Allow the toddler to feed him/herself.
2. Discuss the importance of eating meals as a family and providing 2-3 nutritious snacks per day. Encourage a relaxed mealtime atmosphere.
3. Review the dangers posed by continued use of the bottle beyond one year of age, i.e., baby bottle tooth decay, elongated midface, delayed speech, ear infections. **Refer to OM-P and ECC-P**.
4. Explain that most toddlers manifest a decreased nutritional need. Discuss that toddlers become fussy eaters with strong food preferences. Discuss appropriate diet (balance diet over the week -- do not struggle to balance every meal,).
5. Discuss the need for whole milk at least through 2 years of age and encourage low fat milk after the age of 2.
6. Avoid foods that are choking hazards through age 4 (unpeeled grapes, unpeeled apples, orange slices, nuts, popcorn, pickles, carrot sticks, celery sticks, hard candies and gum, wieners, chicken drum sticks, and peanut butter).
7. Encourage and model healthy choices for meals and snacks (e.g., fruit, veggies, lean meats, and whole grains). Limit foods such as candies, cookies, etc.

CHT-PA PARENTING

OUTCOME: The parent(s) will understand challenges of parenting a toddler and will continue to provide a nurturing environment for growth and development.

STANDARDS:

1. Emphasize that the toddler continues to demand much of the parent(s) time, and increasing mobility and independence requires increased supervision.
2. Discuss the common toddler behaviors that can cause parental frustration—constant demands, saying "no", struggle for autonomy, unwillingness to share, and boundless energy.
3. Discuss the parental need for sharing the toddler experience.
4. Reinforce the need for adult companionship, periodic freedom from child-rearing responsibilities, and nurturing the marital relationship.
5. Stress that weariness, frustration, and exasperation with a toddler are normal. Sometimes it is difficult to love toddlers when they are not asleep.
6. Provide stimulating activities (i.e., reading to the child, coloring with the child) as alternatives to TV watching, which should not exceed one hour per day. The attention span of a toddler is about 5-10 minutes.
7. Discuss that drinking and smoking in the presence of children may promote this behavior in the child.

CHT-S SAFETY AND INJURY PREVENTION

OUTCOME: The parent(s) will understand the principles of injury prevention and plan to provide a safe environment.

STANDARDS:

1. Review that accidents are the leading cause of death in this age group due to the toddler's increased mobility and lack of awareness of environmental dangers. Child-proof the home. Check windows and screens to assure that the toddler cannot push them out, etc.
2. Stress additional vigilance to the dangers of drowning, open flames, charcoal pans, aspiration, suffocation, falls, poisonings, animal bites, electrocution and motor vehicle crashes. **Refer to WL-S.**
3. Discuss foods which are choking hazards (unpeeled grapes, unpeeled apples, orange slices, nuts, popcorn, pickles, carrot sticks, celery sticks, hard candies and gum, hot dogs, any meat on a bone, and peanut butter).
4. Discuss other choking hazards (i.e., balloons, coins, toys that will fit inside a toilet paper roll, and latex gloves).
5. Review continued need for child safety seats in automobiles. (As of November 2004 the American Academy of Pediatrics recommends that children remain in child safety seats until the age of 8 years AND 80 pounds.)
6. Review the need for bicycle helmets when riding on a tricycle, bicycle or with a parent on a bicycle.
7. Discourage independent operation of any motorized vehicle, including electrical vehicles.
8. Review the continued need to check water temperature for baths and to never leave the child unattended when near water.
9. Discuss the use of sunscreen while outdoors. **Refer to SUN.**
10. Emphasize the importance of carefully selecting child-care settings to assure child safety.

CHT-SF INTRODUCTION TO SOLID FOODS

OUTCOME: The parent/family will understand the appropriate ages to introduce various solid foods. (teach any or all of the following as appropriate to this infant/family)

STANDARDS:

1. Explain that infants should not routinely be fed foods other than breastmilk or formula prior to 4 months of age except under the advice of a healthcare provider.
2. Emphasize that, for some time after the introduction of solid foods, breastmilk/formula will still be the infant's primary source of nutrition.
3. Emphasize that foods should never be given from a bottle or infant feeder and must always be fed from a spoon.
4. Explain that infants may be fed cereal mixed with breastmilk or formula not sooner than 4 months of age. Rice cereal is generally the preferred first solid food. It is normal for an infant to take very small amounts of solid foods for several months. Discard any uneaten food after each meal.
5. Emphasize the need to wait 3-5 days between the addition of new foods to watch for adverse events from the foods.
6. Explain that pureed/or finely mashed vegetables and fruits should be started no earlier than 6 months of age.
7. Explain that some foods such as peanut butter, chocolate, eggs, strawberries, cow or goat milk and citrus should not be fed until the infant is one year of age due to the highly allergenic nature of these foods. Explain that honey and syrups may contain botulism toxin and should not be fed before one year of age.
8. Explain that infants 14-16 moths of age will have a decreased appetite and will become more picky eaters.
9. Emphasize that some foods are easy to choke on and should be avoided until 4 years of age, i.e., nuts, hard candies, gum, carrot sticks, meat on a bone, grapes, popcorn, hot dogs, unpeeled apples, slices of orange.
10. Discuss the importance of offering foods at the appropriate ages but do not insist that infants eat foods when they are not hungry:
    a. Baby knows how much to eat
    b. It is important to go along with the baby when they feel they have finished eating
    c. Some days babies eat a lot other days not as much
    d. No two babies eat the same
11. Explain how to assess readiness, an infant:
    a. who exhibits tongue thrusting is not ready to eat solids.

b. will give you cues to readiness when they open their mouths when they see something coming

c. will close lips over a spoon

d. will keep food in their mouth instead of spitting it out

e. will sit up alone without support

12. Explain that the body of knowledge regarding infant feedings has changed dramatically and advice from family/friends may no longer be appropriate; talk to your healthcare provider.

CHT-SHS SECOND-HAND SMOKE

OUTCOME: The patient and/or family will understand the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls
2. Discuss harmful substances in smoke:
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances)
3. Explain the increased risk of illness in children when exposed to cigarette smoke either directly or via second-hand smoke, i.e., increased colds, asthma, ear infections, pneumonia.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car. **Refer to TO.**

CHT-W WEANING

OUTCOME: The parent/family will understand methods to effectively wean the child from breastfeeding or bottle.

STANDARDS:

1. Discuss appropriate reasons for weaning the infant from breastfeeding or bottle.
2. Explain readiness signs of weaning that the infant may display.
3. Explain the process of weaning, i.e., replace one feeding at a time with solids or cup.
4. Explain social ways to replace breastfeeding or bottle-feeding, i.e., reading books together, playing with toys, cuddling together.
5. Explain that infants should be weaned from the bottle by 12 months of age to decrease the risk of baby bottle tooth decay, ear infections, delayed speech, etc.
6. Refer to community resources as appropriate.

CHP—Child Health – Preschool (3-5 Years)

CHP-FU FOLLOW UP

OUTCOME: The patient/family will understand the importance of keeping routine well child visits.

STANDARDS:

1. Discuss that well child visits are important to follow growth and development, screen for disease and update immunizations.
2. Inform the patient/family of the timing of the next well child visit.
3. Discuss the procedure for making appointments.

CHP-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent will understand the growth and development of a preschool age child and plan to provide a nurturing environment.

STANDARDS:

1. Discuss characteristics such as a short attention span, imagination, high mobility and learning through play and peers.
2. Discuss the most common fears of this age; separation from parents, mutilation, immobility, the dark and pain.
3. Discuss that night terrors are a normal developmental phenomenon and they are not indicative of underlying problems.
4. Review age appropriate physical growth and development.

CHP-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about child health issue.

STANDARDS:

1. Provide patient/family with written patient information literature on child health issue.
2. Discuss the content of patient information literature with the patient/family.

CHP-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CHP-N NUTRITION

OUTCOME: The parent will understand the nutritional needs of the preschooler.

STANDARDS:

1. Review the basics of a balanced diet. Explain that serving sizes for children are smaller than for adults.
2. Encourage family meal times and healthy snacks between meals.
3. Discuss the relationships between childhood obesity and adult obesity. Relate the risk of diabetes to obesity.
4. Emphasize the importance of healthy snack foods, limit fatty foods and refined sugars, increase fresh fruits, fresh vegetables and fiber.
5. Explain the need for a structured meal time due to short attention span and high mobility.
6. Explain that this is a critical age when children form their eating habits. Encourage the parents to model eating habits that are essential to developing a healthy weight.

CHP-PA PARENTING

OUTCOME: The parent will understand the transition from toddler to school age and plan to provide a nurturing environment for is period of development.

STANDARDS:

1. Emphasize that children at this age are striving for greater independence and that in so doing they often test parental boundaries. Emphasize the importance of proper discipline.
2. Explain the need for preschoolers to have group interaction with children of similar age and gender. Explain the importance of teaching children to respect others and accept their differences. Discourage bullying and belittling behaviors.
3. Emphasize that preschool growth is at a rapid pace. Their rapidly increasing mobility and agility combined with their limited problem solving ability means that they need adult supervision.
4. Discuss the need for parental discretion as the child's vocabulary is expanding. Protect your children from language you don't want them to repeat, i.e., television, music, conversations.
5. Discuss common fears of this age and the need for parental support.
6. Discuss that drinking and smoking in the presence of children may promote this behavior in the child.

CHP-S SAFETY AND INJURY PREVENTION

OUTCOME: The parent will develop a plan for injury prevention.

STANDARDS:

1. Explain that with increasing independence children of this age are at risk for accidents. Continue vigilance to dangers of drowning, open flames, suffocation, poisonings, animal bites, electrocution and motor vehicle crashes.
2. Discourage independent operation of any motorized vehicle, including electrical vehicles.
3. Emphasize the need for protective equipment, i.e., bike helmets, knee pads, elbow pads.
4. Emphasize continued need for passenger safety devices. Children still need booster seats through 8 years of age and 80 pounds.
5. Discuss stranger safety and personal safety, i.e., private parts of their body.
6. Emphasize the importance of teaching the child how to cross the street safely.
7. Discuss the importance of teaching the child parent's name, complete address including state, complete telephone number including area code, and emergency phone numbers, i.e., 911.
8. Encourage participation in programs which photograph and fingerprint children for identification purposes.
9. Emphasize the importance of carefully selecting child-care settings to assure child safety.
10. Discuss the use of sunscreen to decrease the likelihood of skin cancer. **Refer to SUN.**

CHP-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls
2. Discuss harmful substances in smoke:
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances)
3. Explain the increased risk of illness in children when exposed to cigarette smoke either directly or via second-hand smoke, i.e., increased colds, asthma, ear infections, pneumonia.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car.

CHS—Child Health School Age (5-12 Years)

CHS-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of keeping routine well child visits.

STANDARDS:

1. Discuss that well child visits are important to follow growth and development, screen for disease and update immunizations.
2. Inform the patient/family of the timing of the next well child visit.
3. Discuss the procedure for making appointments.

CHS-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent(s) will understand the growth and development of the school-aged child.

STANDARDS:

1. Explain that this is a time of gradual emotional and physical growth. Physical and mental health is generally good.
2. Discuss that coordination and concentration improve. This allows increased participation in sports and household chores.
3. Review the increasing importance of hygiene.
4. Discuss prepubescent body changes and the accompanying emotions.
5. Review the information needed to explain menses and nocturnal emissions, as appropriate.
6. Encourage age-appropriate discussions of sexuality, birth control and sexually transmitted Infections. **Refer to CHS-SX.**

CHS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about child health issue.

STANDARDS:

1. Provide patient/family with written patient information literature on child health issue.
2. Discuss the content of patient information literature with the patient/family.

CHS-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CHS-N NUTRITION

OUTCOME: The patent(s) will understand the changing nutritional needs of a school-aged child.

STANDARDS:

1. Review the basics of a balanced diet. Teach the child to make healthy food choices. Avoid foods high in fat and sugar.
2. Encourage parents to read food and beverage labels and then make healthy choices.
3. Emphasize that high fructose corn syrup is widely used to sweeten prepared foods and beverages and contributes to obesity.
4. Discuss how childhood obesity is increasingly prevalent in school-aged children and emphasize its relationship to adult obesity and emotional well-being. Relate the risk of diabetes to obesity.
5. Discuss the child's predilection for junk food. Stress ways to improve the diet by replacing empty calories with fresh fruits, nuts and other wholesome snacks.
6. Encourage parents to model healthy nutritional habits and to eat as a family as often as possible.

CHS-PA PARENTING

OUTCOME: The parent(s) will understand the "growing away" years and make a plan to maintain a healthy relationship with the child.

STANDARDS:

1. Discuss how peer influence becomes increasingly important.
2. Review age-specific changes:
   a. Age 6: Mood changes, need for privacy
   b. Age 7-10: Increase in peer involvement. Experimentation with potentially harmful activities and substances may begin.
   c. Age 11-12: Increase in stormy behavior. Sexual maturation necessitates adequate and accurate sex education.
3. Provide stimulating activities as an alternative to watching TV, playing video games, and other sedentary activities. Sedentary activities should be limited to one hour per day.
4. Discuss the importance of listening to the school aged child and showing interest in his/her activities.
5. Emphasize the importance of knowing the child's friends and their families.
6. Discuss that drinking and smoking in the presence of children may promote this behavior in the child.

CHS-S SAFETY AND INJURY PREVENTION

OUTCOME: The parent(s) will identify safety concerns and make a plan to prevent injuries as much as is possible.

STANDARDS:

1. Review that motor vehicle crashes are the most common cause of injury and death in this age group. Encourage the use of seat belts. Child safety seats are recommended for children until they are 8 years old AND weigh 80 pounds.
2. Review traffic safety.
3. Review personal safety - approaches by strangers, sexual molestation, etc.
4. Discuss age-appropriate recreational activities. (Most children in this age group lack the coordination to operate a motor vehicle.)
5. Discuss the appropriate use of personal protective equipment when engaging in sports, i.e., helmets, knee and elbow pads for bicycling and roller blading; life vests for water sports; helmets and protective body gear for horseback riding.
6. Encourage the use of sunscreen to reduce the risk of skin cancer. **Refer to SUN.**

CHS-SHS SECOND-HAND SMOKE

OUTCOME: The patient and/or family will understand the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls
2. Discuss harmful substances in smoke:
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances)
3. Explain the increased risk of illness in children when exposed to cigarette smoke either directly or via second-hand smoke, i.e., increased colds, asthma, ear infections, pneumonia.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car. **Refer to TO.**

CHS-SX SEXUALITY

OUTCOME: The parent(s) and preadolescent will understand that children are maturing at an earlier age, necessitating education about sexual safety at an earlier age.

STANDARDS:

1. Explain the physical changes that result from increased hormonal activity. Discuss that this is happening at a earlier age and may produce an expectation of a more mature behavior which is often unrealistic.
2. Discuss that early maturity can often lead to self esteem issues (i.e., depression, isolation, unrealistic body image, eating disorders, and sexual promiscuity).
3. Discuss as appropriate the anatomy and physiology of the male/female reproductive tract. **Refer to WL-SX**.
4. Explain that as a general rule, menarche occurs within two years of thelarche (breast development).
5. Discuss the elements of a positive, nurturing interpersonal relationship versus a potentially abusive relationship.
6. Review the physical and emotional benefits of and encourage abstinence (i.e., self-respect, negating the risk of STIs, and pregnancy, dramatically reducing the risk of cervical cancer, having the first sexual encounter be in the context of a stable, loving relationship).
7. Identify the community resources available for sexuality counseling.

CHS-TO TOBACCO

OUTCOME: The patient/family will understand the dangers of tobacco or nicotine use and make a plan to never initiate tobacco use or if already using tobacco make a plan to quit.

STANDARDS:

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.
2. Explain nicotine addiction.
3. Discuss the common problems associated with tobacco use and the long term effects of continued use of tobacco, i.e., COPD, cardiovascular disease, numerous kinds of cancers including lung cancer.
4. Review the effects of tobacco use on all family members- financial burden, second-hand smoke, greater risk of fire and premature.
5. Explain dependency and co-dependency.
6. Discuss that tobacco use is a serious threat to health. If the patient is already using tobacco, encourage tobacco cessation and refer to cessation program. **Refer to TO.**

CHA—Child Health – Adolescent (12-18 Years)

CHA-AOD ALCOHOL AND OTHER DRUGS

OUTCOME: The patient/family will understand the dangers posed by use of tobacco, alcohol, street drugs or abuse of prescription drugs.

STANDARDS:

1. Explain that adolescence is a high-risk time for using drugs and other risky behaviors.
2. Describe some of the possible dangers of illicit drug use, including but not limited to:
    a. Marijuana is known to interfere with the actions of male hormones and may reduce fertility and male secondary sex characteristics.
    b. Cocaine, methamphetamine ("speed"), and other stimulant use is often associated with heart attacks, strokes, kidney failure and preterm delivery of infants.
    c. Narcotics cause sedation, constipation, and significant impairment of ability to think.
    d. All drugs of abuse impair judgment and dramatically increase the risk of behaviors which lead to AIDS, hepatitis, and other serious infections, many of which are not curable as well as increase the risk of injury
    e. Illicit drug use often results in arrest and imprisonment, creating a criminal record which can seriously limit the offender's ability to get jobs, education, or participate in government programs.
3. Explain that nicotine, found in smoke and smokeless tobacco products, is an extremely addictive drug and that almost everyone who uses tobacco for very long will become addicted. Risks of tobacco use include:
    a. Emphysema and severe shortness of breath which often will limit the patient's ability to participate in normal activities such as sports, sex, and walking short distances.
    b. Greatly increased risk of heart attacks, strokes, and peripheral vascular disease.
    c. Significant financial cost. (Smoking one pack of cigarettes per day at $3.00 per pack will cost almost $1,100.00 per year. Suggest that there a lot of things the patient may prefer to do with that much money.)
    d. Cancer of the lung, bladder, and throat (smoking) and of the lip and gum (smokeless tobacco). These tumors are typically very aggressive and often cannot be successfully treated.

4. Explain that alcohol use is a major cause of illness and death in the United States and that addiction is common. Some of the risks of alcohol use are:
    a. Significant impairment of judgment and thinking ability leading to behaviors which the patient might not otherwise engage in, such as indiscriminate sex, fighting, and use of other drugs.
    b. Liver disease, up to and including complete liver failure and death.
    c. Arrest and imprisonment for alcohol-related behaviors such as drunken driving or fighting.
    d. Loss of employment, destroyed relationships with loved ones, and serious financial problems.

CHA-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of keeping routine well visits.

STANDARDS:

1. Discuss the reasons for well visits.
2. Inform the patient/family of the timing of the next well visit.
3. Discuss the procedure for making appointments.

CHA-GD GROWTH AND DEVELOPMENT

OUTCOME: The patient/family will understand the physical and emotional changes that are a natural part of adolescence.

STANDARDS:

1. Explain that adolescence is a time of rapid body growth. This often results in awkwardness as the brain is adjusting to the new body size.
2. Discuss the natural increase in sex hormones during adolescence. Explain that this often results in an increased interest in members of the opposite sex. Encourage abstinence.
3. Explain that emotional and social maturity often do not keep pace with physical maturity. It is very important to keep open lines of communication between parents and teenagers.
4. Explain that puberty and the associated growth spurt begins and ends at an earlier age in girls than in boys.

CHA-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about adolescent health issue.

STANDARDS:

1. Provide patient/family with written patient information literature on adolescent health issue.
2. Discuss the content of patient information literature with the patient/family.

CHA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CHA-N NUTRITION

OUTCOME: The parent(s) and adolescent will relate nutrition to health promotion and disease prevention.

STANDARDS:

1. Stress the importance of reducing fats, sugars, and starch to avoid obesity and diabetes and subsequent self-image problems. Emphasize the role peers play in food intake. **Refer to WL-N**.
2. Emphasize the importance of not skipping meals, especially breakfast.
3. Discuss calcium intake, including its role in preventing osteoporosis.
4. Discuss the risk of anorexia and bulimia in adolescence. Discuss signs of these diseases as appropriate.

CHA-PA PARENTING

OUTCOME: The parent/family and adolescent will understand the transitional phase of adolescence from childhood to adulthood.

STANDARDS:

1. Discuss the teenager's changing self-image and the effect of peer pressure.
2. Stress the importance of communicating (especially LISTENING) and providing a supportive environment.
3. Discuss how fluctuating hormone levels affect emotions. Be alert for significant changes in behavior which may indicate depression.
4. Provide an environment which allows for increased independence and decision-making. Emphasize the importance of completing adequate education.
5. Encourage open lines of communication between parents and community role models.
6. Explain the importance of teaching adolescents to respect others and accept their differences. Discourage bullying and belittling behaviors.
7. Discuss that drinking and smoking in the presence of children may promote this behavior in the child.

CHA-S SAFETY AND INJURY PREVENTION

OUTCOME: The parent and adolescent will understand the principles of injury prevention and avoidance of risk behaviors.

STANDARDS:

1. **Refer to AOD and TO**.
2. Promote driving education courses and the importance of following the speed limit and other rules of the road
3. Promote use of seat belts and other personal protective equipment, i.e., helmets, knee pads, elbow pads, mouth guards.
4. Promote the safe use of all recreational vehicles (i.e., all terrain vehicles (ATVs), snow machines, boats, horses), refer to community resources as appropriate.
5. Discourage sun tanning or use of tanning beds. Encourage the use of sunscreen to decrease the risk of skin cancer. **Refer to SUN**.
6. Review personal safety strategies, i.e., sexual molestation, strangers, chat rooms.
7. Review self-destructive behaviors (suicidal gestures and comments, improper/inappropriate use of firearms, gangs, cults, hazing, alcohol and substance use/abuse).

CHA-SHS SECOND-HAND SMOKE

OUTCOME: The patient and/or family will understand the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls
2. Discuss harmful substances in smoke:
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances)
3. Explain the increased risk of illness in children when exposed to cigarette smoke either directly or via second-hand smoke, i.e., increased colds, asthma, ear infections, pneumonia.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car. **Refer to TO.**

CHA-SX SEXUALITY

OUTCOME: The parent(s) and adolescent will understand the challenges of adolescent sexual development.

STANDARDS:

1. Explain the physical changes that result from increased hormonal activity.
2. Discuss the elements of a positive, nurturing interpersonal relationship versus a potentially abusive relationship.
3. Review the need for continued information sharing regarding sexuality, birth control and STIs.
4. Discuss as appropriate the anatomy and physiology of the male/female reproductive tract. **Refer to WL-SX**.
5. Review the physical and emotional benefits of and encourage abstinence (i.e., self-respect, negating the risk of STIs, and pregnancy, dramatically reducing the risk of cervical cancer, having the first sexual encounter be in the context of a stable, loving relationship).
6. As appropriate discuss birth control and sexually transmitted infection prevention.
7. Identify the community resources available for teenage sexuality counseling.

CHA-TO TOBACCO

OUTCOME: The patient/family will understand the dangers of tobacco or nicotine use and make a plan to never initiate tobacco use or if already using tobacco make a plan to quit.

STANDARDS:

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.
2. Explain nicotine addiction.
3. Discuss the common problems associated with tobacco use and the long term effects of continued use of tobacco, i.e., COPD, cardiovascular disease, numerous kinds of cancers including lung cancer.
4. Review the effects of tobacco use on all family members: financial burden, second-hand smoke, greater risk of fire and premature death.
5. Explain dependency and co-dependency.
6. Discuss that tobacco use is a serious threat to health. If the patient is already using tobacco, encourage tobacco cessation and refer to cessation program. **Refer to TO.**

CKD—Chronic Kidney Disease

CKD-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of where the kidneys are located in the body and their function

STANDARDS:

1. Explain that there are two kidneys in the body located on either side of the spine and extend a little below the ribs.
2. Explain that the kidneys are bean-shaped organs and is about the size of a fist.
3. Explain that the kidneys receive approximately 10% of the blood that is pumped out of our heart every minute.
4. Explain that the kidneys are responsible for performing various roles in maintaining a balance of fluid and chemicals in the body. They have four basic functions:
    a. Regulation of body fluid
    b. Balance of chemicals in the body (potassium, calcium, sodium, phosphorus)
    c. Removal of waste products from bloodstream/body (urea, creatinine, phosphorus).
    d. Secretion of three hormones: Renin, which regulates blood pressure. Erythropoietin, which stimulates the bone marrow to produce red blood cells. Calcitrol (1,25 dihydroxyvitamin D3), the active form of vitamin D helps stimulate absorption of calcium by the intestine and bone.

CKD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CKD-C COMPLICATIONS

OUTCOME:

1. The patient/family will understand the complications/symptoms of untreated or progressive kidney disease.
2. The patient/family will understand the complications associated with dialysis treatment. (Please choose from the following standards as they apply to the patient's specific disease process.)

STANDARDS:

1. Explain that CKD is progressive in nature.
2. Explain that anemia is a common consequence of chronic kidney failure due to a decrease in erythropoietin production from the kidneys or there may be a lack of iron in the blood.
3. Explain how uncontrolled hypertension hurts the blood vessels in the kidneys and increases the risk for cardiovascular disease.
4. Explain how malnutrition can result from inadequate caloric and protein intake due to loss of appetite or uremia.
5. Explain how bone disease develops from a consequence of phosphorus retention and calcitriol deficiency leading to secondary hyperparathyroidism.
6. Explain that as the kidney function decreases, functional status (i.e., quality of life) may decrease and well-being may be affected.
7. Explain how CKD increases the risk for heart/cardiovascular disease.
8. Explain that as toxins build up in the blood, patient may experience symptoms of uremia, i.e., inability to think clearly, nausea, vomiting, itchiness, loss of appetite, altered smell & taste.
9. Explain that as the kidney function declines, a patient may experience weight gain from excess fluids, swollen ankles and feet, puffiness around eyes, including high blood pressure.
10. Explain that as the kidney function declines, a patient with diabetes may have changes in diabetes control and need less diabetes medications, to reduce risk for low blood sugar.
11. Explain that even with proper dialysis, patients may experience fluid imbalances; shortness of breath, unusual swelling, dizziness, etc. should prompt medical evaluation.

CKD-DIA DIALYSIS

OUTCOME: The patient/family will understand the process, risks, and benefits of hemodialysis and events that may result from refusal of hemodialysis.

STANDARDS:

1. Explain the dialysis procedure to be performed, including the risks and benefits of performing the procedure and the adverse events which might result from refusal of the procedure.
2. Explain hemodialysis:
    a. Hemodialysis is the use of an artificial filtering of blood by a machine, removing metabolic wastes and excess fluids from the body.
    b. This procedure is usually initiated three times per week. Each session is usually three to four hours at a hemodialysis center.
    c. A fistula, a surgical connection of major blood vessels, is usually placed in the arm prior to the start of dialysis. A temporary placement may be established in other sites of the body such as the neck when an emergent condition arises.
3. Discuss the expected patient/family involvement in the care required following dialysis.
4. Explain that infections are common in dialysis patients and that the patient/family should report all elevations in body temperature to the dialysis staff. Infection, particularly at the site may require immediate hospitalization for IV antibiotic therapy.
5. Explain that deviations from prescribed dietary and fluid restrictions may result in acute metabolic problems, which must be addressed by the dialysis unit.
6. Explain that even with proper dialysis, patients may experience fluid imbalances and that all shortness of breath, unusual swelling, dizziness, etc. should prompt immediate medical attention and evaluation.

CKD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand their specific type of chronic kidney disease (CKD). (Choose from the following standards that apply to this patient's specific chronic kidney disease process.)

STANDARDS:

1. Explain that chronic kidney disease is irreversible and progressive. CKD can have many causes including:
   a. Diabetic nephropathy
   b. Hypertension
   c. Glomerulonephritis
   d. Infections, urinary tract abnormalities.
2. Explain the basic pathophysiology of the specific type of CKD and its symptoms.

CKD – EQ EQUIPMENT

OUTCOME: The patient/family will understand hemodialysis and equipment used for home dialysis.

STANDARDS:

1. Explain function of hemodialysis machine and components used in filtering patient's blood.
2. Discuss types and features of medical equipment used for peritoneal dialysis.
3. Discuss proper disposal of used medical supplies.

CKD – LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/ family will strive to make the lifestyle adaptation necessary to deal with and prevent complications of the specific kidney disease and improve overall health.

STANDARDS

1. Discuss that kidney disease is different for everyone. Advice from the doctor may change if the disease continues to progress. Explain that they can participate in their own care and ask questions.
2. Review the lifestyle aspects/changes that the patient has control over – food and exercise, taking medications safely, follow-up appointments, tobacco, alcohol.
3. Explain that the patient should avoid blood draws (venipuncture), IVs and blood pressures on the non-dominant arm to protect blood vessels for potential dialysis access.
4. When discussing renal replacement therapy options, explain that people on dialysis or who have had a kidney transplant can still work. Rehabilitation is preferred.
5. Review the community resources available to assist the patient in making lifestyle changes and make referrals as appropriate.
6. Explain that kidney failure affects not only the patient but, family and friends as a major crisis. It is not uncommon for patients and their families to have feelings of fear, guilt, denial, anger, depression, and frustration but there is help available.
7. Explain that a mental health assessment might be beneficial - to allow patient to grieve through the emotional aspect (loss of kidney function). The patient may need to assess their own traditional beliefs to begin accepting dialysis treatment.

CKD - M MEDICATIONS

OUTCOME: The patient/family will understand the medications prescribed in the management of his/her kidney disease.

STANDARDS:

1. Discuss proper use, benefits, common side effects and common interactions of prescribed medication including drug/drug and drug/food interactions.
2. Explain to the patient/family that the patient's physician(s) should be contacted before starting, stopping or changing any prescription medications, over-the-counter medications or dietary supplements.
3. Explain that the doctor may tell the patient to avoid certain medications like NSAIDs.
4. Explain that phosphate binding medications are necessary for many people with kidney disease. They serve two purposes- increase calcium in bones & help reduce phosphate levels.
5. Explain that the patient's medications may change after starting dialysis (prn).
6. Emphasize the importance of bringing all medications to medical appointments.

CKD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CKD - N NUTRITION

OUTCOME: The patient/family will understand how diet relates to kidney disease.

STANDARDS:

1. Explain that an appropriate dietary regimen is essential in the management and treatment of kidney disease.
2. Discuss that the dietary regimen will change as laboratory values and other indices change in conjunction with disease progression and treatment.
3. All kidney disease patients must meet regularly with a Registered Dietitian for ongoing medical nutrition therapy.

CKD-P PREVENTION

OUTCOME:

1. The patient/family will understand how to prevent or slow progression of chronic kidney disease (CKD).
2. The patient/family will understand how to prevent complication(s) associated with vascular access placement, i.e., AV fistula, graft, or central line catheter.

STANDARDS:

1. Discuss with patient/family the importance of treating/controlling other medical conditions associated with CKD such as adequate blood glucose control in diabetic patients, high blood pressure control, and control of elevated cholesterol.
2. Screening family members who are at high risk for chronic kidney disease.
3. Emphasize the importance of using aseptic technique with peritoneal catheter care and during exchanges.
4. Emphasize the importance of keeping the central line catheter clean, dry, and avoid touching to prevent infection.
5. Emphasize the importance of assessing vascular access, i.e., feeling for thrill, checking for numbness, bleeding, and redness.

CKD-PRO PROCEDURES

OUTCOME: The patient/family will understand the risks, benefits, and alternatives of the proposed procedure(s) to be performed.

STANDARDS:

1. Explain the specific proposed procedure(s), i.e., biopsy, fistula, graft, central catheter, or peritoneal catheter to be performed, including the risks and benefits.
2. Discuss possible alternative(s) to the proposed procedure(s), i.e., fistula, graft, central catheter, or peritoneal catheter, in the event that the proposed procedure is not recommended.
3. Discuss with patient/family the involvement of required post-operative and maintenance care following the proposed procedure(s).

CKD-TE TESTS

OUTCOME: The patient/family will have a basic understanding of the test(s) to be performed, indications, and its influence on further care.

STANDARDS:

1. Explain the specific test(s) ordered, i.e., blood urea nitrogen, creatinine, phosphorus, calcium, albumin, urinalysis, CBC.
2. Explain the necessity, benefits, and risks of the test(s) to be performed and how it relates to the course of treatment.
3. Explain any necessary preparation for the testing, i.e., fasting.
4. Explain the meaning of the test results and its impact on further treatment, as appropriate.

CKD-TX TREATMENT

OUTCOMES:

1. The patient/family will have a basic understanding of treatment plan for CKD.
2. The patient/family will have a basic understanding of the various modalities of renal replacement therapy to make an informed decision.

STANDARDS:

1. Discuss the specific treatment plan for CKD including treatment to conserve renal function and eventual need for renal replacement therapy.
2. Emphasize the importance of fully participating to medications, dietary, and lifestyle changes that may impede the rate of progression of chronic kidney disease.
3. Discuss the treatment plan with patient/family; emphasize the importance of full participation with therapeutic regimen, even if the patient is asymptomatic.
4. Explain each possible renal replacement therapy:
    a. Hemodialysis
        i. Hemodialysis is the use of an artificial filtering of blood by a machine, removing metabolic wastes and excess fluids from the body.
        ii. This procedure is normally initiated three times per week. Each session is usually three to four hours at a hemodialysis center.
        iii. A fistula, a surgical connection of major blood vessels, is normally placed in the arm prior to the start of dialysis. A temporary placement may be established in other sites of the body such as the neck when an emergent condition arises.
    b. Peritoneal dialysis
        i. Peritoneal dialysis involves an artificial filtering of the blood by a bagged solution.
        ii. This form of dialysis removes metabolic wastes and excess fluids from the body. This is done through an exchange system via osmosis to remove water and diffusion for glucose exchange/waste removal.
        iii. This procedure is preformed on a daily basis at home.
        iv. Each session is dependent on the two different types of peritoneal dialysis used.
            (1) Intermittent Peritoneal Dialysis (IPD). This is normally completed once per day using multiple bags of dialysate, (bags of glucose fluids). A partner is usually needed.

(2) Continuous Cycling Peritoneal Dialysis (CCPD). This is normally a nocturnal procedure regulated by an infusion pump administering a set amount of dialysate exchange throughout the night.

(3) Continuous Ambulatory Peritoneal Dialysis (CAPD). This procedure is performed four times per day and there is fluid in the abdomen nearly 100% of the time. A partner is not necessary for this procedure.

c. Kidney transplant

i. Kidney transplantation is completed in end stage kidney disease when the glomerular filtration rate drops to 10 mL/min.

ii. Persons older then 50 years of age with poor health or history of cancer often can not receive a transplant.

iii. Children must receive an evaluation from a pediatric renal transplant team prior to receiving a transplant or being considered as a donor.

iv. After a renal transplant, the patient has a functioning donor kidney. Medications and regular medical evaluations will usually be required to prevent rejection.

v. It is important for patients to understand that anti-rejection medication must be taken as prescribed through out their life to prevent kidney rejection. Anti-rejection medications may have very unpleasant side effects.

vi. Patients with co-morbidities leading to initial kidney failure must be instructed to follow all prescribed regimens to avoid subsequent kidney failure.

vii. There is a possibility that a donor kidney may fail or be rejected even under ideal conditions.

5. Review with the patient/family the risks and benefits of each renal replacement therapy option and the consequences of refusing treatment.

CDC—Communicable Diseases

CDC-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the disease process of communicable disease, transmission, and causative agent(s), as identified by the provider.

STANDARDS:

1. Discuss whether the infection is vaccine preventable.
2. Describe how the body is affected.
3. List symptoms of the disease and how long it may take for symptoms to appear.
4. List complications that may result if the disease is not treated.
5. List treatment options and the risks and benefits of each.

CDC-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

CDC-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of communicable diseases and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer future infections (reinfections or reinfestations), fewer emergency room visits, fewer hospitalizations and fewer complications, as well as a healthier life.
3. Explain the relationship between hygiene and infection control principles. Emphasize importance of hand washing.

CDC-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about communicable diseases.

STANDARDS:

1. Provide patient/family with written patient information literature on the communicable diseases.
2. Discuss the content of patient information literature with the patient/family.

CDC - M MEDICATION

OUTCOME: The patient/family will understand the importance of medication in the treatment of the communicable disease and make a plan to fully participate with therapy.

STANDARDS:

1. Discuss the proper use, benefits, common side effects, and food or drug interactions of the prescribed medication. Include procedure for follow-up if problems occur.
2. Explain the importance of completing the course of therapy and its role in eradicating the infection and/or decreasing the infectiousness of the communicable disease.
3. Explain, as appropriate, that failure to complete the course of antibiotics may cause the development of resistant organisms.
4. Discuss, as appropriate, the concomitant use of antipyretics.

CDC-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CDC-N NUTRITION

OUTCOME: The patient/family will understand the need for balanced nutrition and plan for the implementation of dietary modification if needed.

STANDARDS:

1. Review normal nutritional needs for optimal general health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to the specific communicable disease.

CDC-P PREVENTION

OUTCOME: The patient and/or family will understand communicability and preventive measures for communicable disease control.

STANDARDS:

1. Explain that there are vaccines or immunity against certain infections and/or diseases.
2. Explain that certain infections can be dependent upon hygiene, social and/or environmental conditions. **Refer to WL-HY.**
3. Discuss importance of hand washing in infection control in relation to food preparation/consumption, childcare, and toilet use.
4. List mode of transmission and precautions to prevent spread of disease.

CDC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM**.
2. Explain that short-term use of NSAIDS may be helpful in pain management as appropriate.
3. Explain non-pharmacologic measures that may be helpful with pain control.

CDC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as appropriate, including possible complications that may result from not having the test performed.
3. Explain how the test relates to immunization status and the course of disease treatment/prevention.
4. Explain the meaning of the test results, as appropriate.

CHF—Congestive Heart Failure

CHF-C COMPLICATIONS

OUTCOME: The patient/family will understand how to prevent complications of CHF.

STANDARDS:

1. Discuss common complications of CHF, i.e., pulmonary or peripheral edema, MI, death, inability to perform activities of daily living.
2. Discuss the importance of following a treatment plan including diet, exercise, and medications to prevent complications.
3. Discuss the importance of regular follow-up to prevent complications.
4. Emphasize early medical intervention for signs and symptoms of complications.

CHF-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CHF-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the causes and symptoms of congestive heart failure.

STANDARDS:

1. Explain that CHF results from the heart not pumping as efficiently as it should. As a result, fluids back up in the extremities (edema) and in the lungs (pulmonary congestion). This back up of fluids causes weight gain. Weight gain should be reported.
2. Explain the cause of CHF as it relates to the patient's condition, i.e., previous M.I., long-standing hypertension.
3. Review signs and symptoms of CHF, i.e., swelling, fatigue, shortness of breath, weight gain.

CHF-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment, as appropriate.
3. Discuss and/or demonstrate proper use and care of medical equipment. Participate in a return demonstration by the patient/family.
4. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
5. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
6. Emphasize the importance of not tampering with any medical device.
7. Discuss as appropriate the proper use and care and cleaning of medical equipment.
8. Discuss proper disposal of associated medical supplies.

CHF-EX EXERCISE

OUTCOME: The patient/family will understand the exercise recommendations or limitations for this patient's disease process.

STANDARDS:

1. Discuss the exercise recommendations or limitations of exercise for this patient.
2. Emphasize the importance of seeking medical advice before starting/changing any exercise program.

CHF-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of fully participating in treatment regimen and keeping all follow-up appointments.

STANDARDS:

1. Discuss the individual's responsibility in the management of CHF.
2. Encourage regular weight checks and the reporting of any sudden weight gain.
3. Explain the procedure for making follow-up appointments.
4. Review treatment plan with the patient, emphasizing the need for keeping appointments, fully participating in medication regimen, keeping to dietary modifications, and striving to maintain activity/rest balance.

CHF-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of congestive heart failure and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan. (Attain or maintain a healthy weight, eliminate tobacco use, control alcohol intake, elevate feet to reduce edema, etc.)
2. Explain the importance of following a home management plan, i.e., fewer emergency room visits, fewer hospitalizations and fewer complications, as well as a healthier life.
3. Explain the relationship between congestive heart failure and the increased risk of a MI, PE, and/or stroke.
4. Discuss the importance of avoiding communicable diseases by avoiding contact with ill persons, and by obtaining vaccination for vaccine preventable diseases.
5. Balance activity and rest.

CHF-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about congestive heart failure.

STANDARDS:

1. Provide patient/family with written patient information literature on the congestive heart failure.
2. Discuss the content of patient information literature with the patient/family.

CHF-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle adjustments necessary to maintain control of congestive heart failure and formulate an adaptive plan with assistance of the provider.

STANDARDS:

1. Discuss lifestyle changes that may reduce the symptoms of heart failure and improve quality of life. (Attain or maintain a healthy weight, eliminate tobacco use, control alcohol intake, elevate feet to reduce edema, etc.)
2. Discuss the importance of avoiding communicable diseases by avoiding contact with ill persons, and by obtaining vaccination for vaccine preventable diseases.
3. Balance activity and rest.

CHF-M MEDICATIONS

OUTCOME: The patient will understand the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefit, and common side effects of the prescribed medications.
2. Emphasize the importance of maintaining full participation in the medication regimen.

CHF-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CHF-N NUTRITION

OUTCOME: The patient will develop a plan to control CHF through weight control and sodium intake modification.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between sodium and fluid retention.
3. Emphasize the importance of a sodium-restricted diet.
4. Provide a list of foods high in sodium and emphasize the importance of reducing sodium intake. Refer to registered dietician or other local resources as available.
5. Assist in developing appropriate diet plan to achieve optimal weight and sodium control.

CHF-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in congestive heart failure.

STANDARDS:

1. Explain that uncontrolled stress can increase the severity of congestive heart failure.
2. Explain that uncontrolled stress can interfere with the treatment of congestive heart failure.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from congestive heart failure.
4. Explain that effective stress management may help reduce the severity of congestive heart failure, help prevent progression of cardiovascular disease, as well as help improve the health and well-being of the patient.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

CHF-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Discuss the necessity, benefits and risks of the test to be performed, as appropriate, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Discuss the meaning of the test results, as appropriate.

CAD—Coronary Artery Disease

CAD-C COMPLICATIONS

OUTCOME: The patient will understand how to prevent complications of coronary artery disease.

STANDARDS:

1. Discuss the common and important complications of coronary artery disease, i.e., MI, angina, and stroke.
2. Discuss the importance of following a treatment plan to include diet, exercise, and medication therapy to prevent complications.
3. Emphasize immediate medical intervention for signs and symptoms of complications, i.e., chest pain, nausea, loss of consciousness, jaw/arm pain, SOB, diaphoresis.

CAD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CAD-DP DISEASE PROCESS

OUTCOME: The patient will understand coronary artery disease and its symptoms.

STANDARDS:

1. Explain that coronary artery disease is the result of the buildup of plaque in the interior wall of the coronary artery.
2. Review the factors related to the development of coronary artery disease - uncontrolled hypertension, elevated cholesterol, obesity, uncontrolled diabetes, sedentary lifestyle, increasing age, family history of vascular disease, and male sex. Emphasize that a personal history of any vascular disease greatly increases the risk or CAD.
3. Review the signs of coronary artery disease - substernal chest pain radiating to the jaw(s), neck, throat, arm(s), shoulder(s), or back. Nausea, weakness, shortness of breath, or diaphoresis (sweating) may accompany the pain.
4. Explain that chest pain is the discomfort felt when the heart muscle is deprived of oxygen.
5. Differentiate between angina (the temporary loss of oxygen to the heart muscle) and infarction (a permanent loss of oxygen to the heart muscle resulting in permanent damage and loss of function). Emphasize that angina is an important warning sign which should prompt immediate medical evaluation.
6. Explain that sometimes only a physician, through test interpretation, may be able to differentiate between angina and myocardial infarction.

CAD-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Emphasize safe use of equipment.
7. Discuss proper disposal of associated medical supplies.
8. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
9. Emphasize the importance of not tampering with any medical device.

CAD-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
2. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
3. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
4. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
5. Discuss medical clearance issues for physical activity.

CAD-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adhering to a treatment regimen, be able to identify appropriate actions to take for symptoms indicating life-threatening ischemia, and will make a plan to obtain and keep appropriate follow-up appointments.

STANDARDS:

1. Discuss the individual's responsibility in the management of coronary artery disease.
2. Review treatment plan with the patient, emphasizing the need for keeping appointments, fully participating with medication therapy, adhering to dietary modifications, and maintaining an appropriate activity/rest balance.
3. Review the symptoms that should be reported and maintained (symptoms more frequent or occurring during rest, symptoms lasting longer, using prn medications more frequently, etc.).
4. Instruct the patient that if chest pain is not relieved after taking three doses of nitroglycerine 3-5 minutes apart, he/she should go immediately to the nearest emergency care facility. Recommend use of the local emergency transport system.

CAD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about coronary artery disease.

STANDARDS:

1. Provide patient/family with written patient information literature on coronary artery disease.
2. Discuss the content of patient information literature with the patient/family.

CAD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to maintain optimal health.

STANDARDS:

1. Emphasize that the most important component in the prevention and treatment of coronary artery disease is the patient's adaptation to a healthier, lower risk lifestyle.
2. Discuss lifestyle adaptations that may reduce further risk of myocardial infarction and improve the quality of life (cease use of tobacco products, limit stress, control hypertension and elevated cholesterol through medications, diet and exercise, lose weight as indicated, control diabetes, and increase activity as prescribed by the physician).

CAD-M MEDICATIONS

OUTCOME: The patient will understand the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medications.
2. Emphasize the importance of maintaining full participation in the medication regimen.

CAD-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CAD-N NUTRITION

OUTCOME: The patient/family will understand how to control coronary artery disease through weight control and diet modification and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between diet and coronary artery disease, hypertension, elevated cholesterol, and obesity.
3. Provide lists of foods that are to be encouraged and avoided. Refer to dietitian or other local resources as appropriate.
4. Assist in developing an appropriate diet plan to achieve optimal weight and cholesterol control.
5. **Refer to LIP**.

CAD-P PREVENTION

OUTCOME: The patient/family will understand ways to prevent CAD.

STANDARDS:

1. Discuss that prevention of coronary artery disease is far better than controlling the disease after it has developed.
2. Explain that consuming a diet low in fat, and controlling weight, lipid levels and blood pressure will help to prevent CAD.
3. Discuss that persons with uncontrolled diabetes and uncontrolled hypertension and uncontrolled dyslipidemia are more likely to develop CAD. Stress the importance of controlling these disease processes. **Refer to DM, HTN, LIP, OBS.**

CAD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that chest pain unrelieved by the prescribed regimen should be considered an emergency and prompt immediate medical evaluation.
2. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
3. Explain that short-term use of narcotics may be helpful in pain management as appropriate.
4. Explain that other medications may be helpful to control the symptoms of pain.
5. Discuss non-pharmacologic measures that may be helpful with pain control.

CAD-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s), as well as the risks, benefits, alternatives to the proposed procedure(s) and associated factors affecting the patient.

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events that might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
3. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

CAD-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in coronary artery disease.

STANDARDS:

1. Explain that uncontrolled stress can increase the severity of coronary artery disease.
2. Explain that uncontrolled stress can interfere with the treatment of coronary artery disease.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from coronary artery disease.
4. Explain that effective stress management may help reduce the severity of coronary artery disease, as well as help improve the health and well-being of the patient.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

CAD-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Explain the test ordered (ECG, echo, thallium stress test, coronary angiography).
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment.

CAD-TX TREATMENTS

OUTCOME: The patient/family will understand the possible treatments that might be performed based on the test results.

STANDARDS:

1. List the possible procedures that might be utilized to treat the coronary artery blockage, i.e., angioplasty, coronary stent, coronary artery bypass.
2. Briefly explain each of the possible treatments.
3. Explain that the patient and medical team will make the treatment decision after reviewing the results of diagnostic tests.

CRN—Crohn's Disease

CRN-C COMPLICATIONS

OUTCOME: The patient/family will understand the signs of complications of Crohn's disease and will plan to return for medical care if they occur.

STANDARDS:

1. Explain that some possible complications of Crohn's disease are stricture and fistulae formation, hemorrhage, bowel perforation, mechanical intestinal obstruction, and colorectal cancer, etc.
2. Explain that complications may be delayed, minimized or prevented with prompt treatment of exacerbation.
3. Discuss the symptoms of exacerbation that trigger the need to seek medical attention, i.e., blood in the stool, unusual drainage, unusual abdominal pain, change in frequency of stools, fever.

CRN-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CRN-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of their Crohn's disease.

STANDARDS:

1. Explain that Crohn's disease is a chronic inflammatory disease of the small intestine, usually affecting the terminal ileum at the region just before the ileum joins the colon. The etiology is unknown.
2. Explain that there is a familial tendency toward Crohn's disease and it occurs mostly in those between 15 and 35 years of age.
3. Explain that this condition interferes with the ability of the intestine to transport the contents of the upper intestine through the constricted lumen, causing crampy pains after meals.
4. Explain that chronic diarrhea due to the irritating discharge from the intestine occurs and may be accompanied by bloody stools.
5. Explain that in some patients, the inflamed intestine may perforate and form intra-abdominal and anal abscesses.
6. Explain that this condition is characterized by exacerbations and remissions that may be abrupt or insidious.

CRN-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

CRN-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the Crohn's disease.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding Crohn's disease.
2. Discuss the content of the patient information literature with the patient/family.

CRN-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen and its importance.

STANDARDS:

1. Describe the proper use, benefits, and common or important side effects of the patient's medications. State the name, dose, and time for administration as applicable.
2. Discuss any significant drug/drug or drug/food interactions, including interaction with alcohol.
3. Caution the patient/family against utilizing over-the-counter medications for constipation without consulting his/her provider.

CRN-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CRN-N NUTRITION

OUTCOME: The patient/family will understand how dietary modification may assist in the control of bowel function and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Instruct the patient/family to abstain from fresh fruits, fresh vegetables and dairy products and eat foods that are low in fats. Provide a list of foods for the patient to avoid, if available.
3. Assist the patient/family in developing appropriate meal plans.
4. Explain to the patient/family that parenteral hyperalimentation may be necessary to maintain nutrition while allowing the bowel to rest.
5. Refer to dietitian as appropriate.

CRN-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of colon disease.

STANDARDS:

1. Discuss the effects of a fatty, low fiber diet on the colon.
2. Provide and review a list of low fat, high fiber foods.
3. Assist the patient/family in meal planning that includes low fat, high fiber foods and avoids high fat, low fiber foods.
4. Explain that the etiology of Crohn's disease is unknown and there is no known prevention, but an appropriate diet may prevent or slow progression of the disease.

CRN-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Advise the patient/family to strictly follow dietary guidelines to assist in the control of crampy pain after meals.
2. Advise the patient to fully participate with medication regimen to decrease the inflammation and pain.
3. Instruct the patient in meticulous anal skin care with protective creams to prevent skin breakdown and pain.
4. Advise the patient not to use over the counter pain medications without checking with his/her provider.

CRN-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in Crohn's disease.

STANDARDS:

1. Explain that uncontrolled stress can increase constipation or diarrhea, abdominal pain, and fatigue.
2. Explain that uncontrolled stress can interfere with the treatment of Crohn's disease.
3. Explain that effective stress management may reduce the adverse consequences of Crohn's disease, as well as help improve the health and well-being of the patient.
4. Explain that stress may cause inappropriate eating which will exacerbate the symptoms of Crohn's disease. **Refer to CRN-N.**
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

CRN-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed. The patient/family will further understand the risk/benefit ratio of the proposed testing, alternatives to testing and risks of non-testing.

STANDARDS:

1. Proctosigmoidoscopy and Colonoscopy
    a. Explain that proctosigmoidoscopy and colonoscopy may be utilized to directly visualize the inside of the colon and enable biopsies to be obtained. The information from the colonoscopy may be necessary to diagnose the specific type of bowel disease.
    b. Explain that the procedure involves introducing a flexible tube through the anus and rectum.
    c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.
2. Upper gastrointestinal barium studies
    a. Explain that the upper GI barium study is an x-ray to assess the degree and extent of the disease.
    b. Explain that barium liquid will be swallowed and radiographs taken.
3. Barium Enema
    a. Explain that the barium enema is an x-ray to assess the extent of the disease, identify lesions, detect pseudo polyps, carcinoma, and strictures.
    b. Explain that barium liquid will be introduced by enema and radiographs taken.
    c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.
4. Discuss the risk/benefit ratio of testing, alternatives to testing and the risk of non-testing.

CRN-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate treatment for bowel disease and have a plan to fully participate in the treatment regimen. The patient/family will further understand the risk/benefit ratio of the proposed treatment, alternatives to treatment and the risk of non-treatment.

STANDARDS:

1. Discuss the specific treatment plan, which may include the following:
    a. A diet restricted to no fruits or vegetables, low in fats and free of dairy products.
    b. Parenteral hyperalimentation to maintain nutrition while allowing the bowel to rest.
    c. Corticosteroids, salicylates, and/or other anti-inflammatory agents to decrease inflammation.
    d. Medications to control diarrhea.
    e. Rest.
    f. Surgery to correct hemorrhage, fistulas, bowel perforation or intestinal obstruction.
2. Discuss the risk/benefit ratio of the proposed treatment, alternatives to treatment and the risk of non-treatment.

CF—Cystic Fibrosis

CF-C COMPLICATIONS

OUTCOME: The patient/family will understand common and important complications of cystic fibrosis.

STANDARDS:

1. Discuss pulmonary complications of cystic fibrosis as appropriate.
2. Discuss that cystic fibrosis may affect any part of the respiratory mucosa.
3. Discuss that exocrine pancreatic failure may cause fat malabsorption and lead to growth delay or failure.
4. Discuss that endocrine pancreatic failure may lead to glucose intolerance or insufficient insulin secretion.
5. Discuss that cirrhosis may result from severe forms of cystic fibrosis.
6. Discuss that persons with cystic fibrosis may be sterile as a result of the disease process.

CF-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

CF-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the disease process of Cystic Fibrosis.

STANDARDS:

1. Explain that cystic fibrosis is a form of genetic disorder known as an autosomal recessive. This means that to have the disease, a person must inherit a gene from both parents.
2. Explain that cystic fibrosis is a chronic and progressive disease that causes mucus to become thick, dry and sticky. This results in end organ problems especially in the lungs, pancreas, and spermatic tubules.
3. Explain that the environment, diet, exercise, or other lifestyle behaviors do not cause cystic fibrosis. The disease is not contagious and cannot be passed from one person to another except through inheritance.
4. Explain that cystic fibrosis is usually diagnosed during childhood.
5. Explain that the course of cystic fibrosis varies. Some babies show signs immediately (meconium ileus or severe respiratory problems/infections) while others may not develop symptoms for years. Some people with cystic fibrosis have a shortened life expectancy.
6. Explain the symptoms of cystic fibrosis.
7. Explain that most people with cystic fibrosis have problems with their digestive system and/or lungs. Many people have growth deficiency.
8. Explain that there is no cure for the disease but those with cystic fibrosis can live productive lives.

CF-EQ EQUIPMENT

OUTCOME: The patient/family will understand any medical equipment utilized by this patient.

STANDARDS:

1. Discuss indications for and benefits of prescribed medical equipment.
2. Discuss types and features of medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of medical equipment, participate in return demonstration by patient/family.
4. Discuss signs of equipment malfunction and proper action incase of malfunction.
5. Emphasize safe use of equipment, i.e., no smoking around O2 use of gloves, electrical cord safety, and disposal of sharps.

CF-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Emphasize that appointments should be kept.
3. Discuss the procedure for obtaining follow-up appointments.
4. Encourage genetic counseling prior to starting a family.

CF-L PATIENT LITERATURE INFORMATION

OUTCOME: The patient/family will receive written information about cystic fibrosis.

STANDARDS:

1. Provide patient/family with written patient information literature.
2. Discuss the content of patient information literature with patient/family.

CF-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
    a. Assessment of the nutrition related condition.
    b. Identification of the patient's nutritional problem.
    c. Specific nutrition intervention therapy plan.
    d. Evaluation of the patient's nutritional care outcomes.
    e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

CF-N NUTRITION

OUTCOME: The patient/family will understand the special nutritional requirements of some patients with cystic fibrosis.

STANDARDS:

1. Discuss the need for adequate calories and protein for optimal growth and development and resistance to infection.
2. Discuss as appropriate the need for pancreatic enzyme supplementation.
3. Discuss supplementation of water miscible sources of fat soluble vitamins and iron as needed.
4. Discuss supplementation of medium chain triglyceride oils as needed.
5. Discuss the need for liberal water intake, or if extra calories are needed, calorie containing fluids. Discourage intake of dehydrating beverages such as soft drinks or other caffeinated beverages.
6. Discuss that some patients with cystic fibrosis will have the need for salt supplementation.
7. Explain that if the patient is lactose intolerant, sources of calcium other than milk may be necessary. Refer to a registered dietician or physician for specific information as appropriate.
8. Discuss other aspects of nutrition support as appropriate.

CF-SHS SECOND HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking" and ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls
2. Discuss the harmful substances in smoke:
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances)
3. Explain the increased risk of illness in the patient with cystic fibrosis when exposed to cigarette smoke either directly or via second-hand smoke.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient with cystic fibrosis is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car.

CF-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Explain that the most common diagnostic test for cystic fibrosis is a sweat chloride test. Explain that this is a non-painful procedure.
2. Discuss the possible need for genetic testing of the patient and the impact on diagnosis and/or prognosis. Discuss the need for genetic testing for family members as well as the patient's present and future sexual partners and the impact on future progeny.
3. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.

CF-TO TOBACCO (SMOKING)

OUTCOME: The patient and/or family will understand the dangers of smoking in the patient with cystic fibrosis and develop a plan to cut back or stop smoking.

STANDARDS:

1. Explain the increased risk of illness in the patient with cystic fibrosis when exposed to cigarette smoke.
2. Encourage smoking cessation. If the patient is unwilling to stop smoking emphasize the importance of cutting back on the number of cigarettes smoked in an effort to quit or minimize increased risk of illness, hospitalization or premature death.
3. **Refer to TO**.

CF-TX TREATMENT

OUTCOME: The patient/family will understand and participate in the formulation of a treatment plan.

STANDARDS:

1. Explain that management varies from person to person depending on the organ systems which are involved.
2. Discuss the current treatment plan for this patient.

D

DC—Dental Caries

DC-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand that different components make up the tooth structure. The patient/family will further understand that the properties of the various components affect the susceptibility for decay.

STANDARDS:

1. Explain that enamel is a protective covering for the tooth. Discuss that the portion of the tooth that is normally seen in the mouth (crown) is covered with enamel.
2. Explain that the root of the tooth is not covered with enamel. The root of the tooth is made of dentin. Explain that dentin is a softer, more easily decayed substance.
3. Explain that the living portion of the tooth (pulp) is a sensitive structure containing the nerve and blood vessels. Decay into this portion of the tooth may cause severe pain and will kill the tooth.

DC-C COMPLICATIONS

OUTCOME: The patient/family will understand some complications/consequences of treated or untreated dental caries.

STANDARDS:

1. Explain that, by necessity, when dental caries are treated, a portion of the healthy tooth structure must also be removed. This results in a weakening of the tooth.
2. Explain that occasionally when dental caries are treated, inflammation of the pulp may occur. This insult may be reversible and result in temporary soreness of the tooth, or may be irreversible and result in infection and/or death of the tooth.
3. Explain that occasionally dental caries may result in abscess of the tooth, which may extend into a sinus or other adjacent tissues.
4. Explain that some dental caries may involve so much of the tooth structure that root canal or removal of the tooth may be necessary.
5. Explain that early tooth loss in children may cause abnormal eruption of permanent teeth. Further explain that early tooth loss of permanent teeth may result in loosening of other teeth and further tooth loss unless restorative measures are taken.

DC-DP DISEASE PROCESS

OUTCOME: The patient/family will be able to explain what dental caries are and summarize some causes as appropriate to this patient.

STANDARDS:

1. Explain that natural bacteria live in the mouth. Some bacteria are healthy and are protective. Explain that a sticky film called plaque forms on teeth and that bacteria live in the plaque.
2. Explain that some bacteria in the presence of carbohydrates will produce acids that attack the tooth structure. The acids dissolve and demineralize the tooth weakening the tooth structure. Progressive acid attacks on the tooth surface may lead to decay or dental caries.
3. Explain the various factors which may predispose a person to dental caries:
    a. Poor oral hygiene
    b. High carbohydrate diet, especially frequent consumption
    c. Children whose parents have active tooth decay
    d. Lack of fluoride
    e. Gingival recession
    f. Persons having undergone radiation therapy
    g. Genetic predisposition

DC-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular dental follow-up.

STANDARDS:

1. Explain the current recommendation for regular dental examination and professional tooth cleaning.
2. Emphasize the importance of a dental visit if any problems occur between routine dental visits.

DC-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about dental caries, their treatment and/or the oral care necessary after treatment.

STANDARDS:

1. Provide patient/family with written patient information literature on dental caries, treatment and/or the oral care necessary after treatment.
2. Discuss the content of the patient information literature with the patient/family.

DC-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

DC-N NUTRITION

OUTCOME: The patient/family will understand the importance of a balanced diet, low in carbohydrates, especially simple sugars, and with adequate calcium and fluoride.

STANDARDS:

1. Discuss the relationship between a diet high in carbohydrates, especially simple sugars, to the development of dental caries. Give examples of foods high in simple sugars, i.e., crackers, potato chips, candy, pre-sweetened cereals.
2. Discuss the importance of calcium and fluoride intake as it relates to tooth development/mineralization.
3. Refer to a registered dietician as appropriate.

DC-P PREVENTION

OUTCOME: The patient/family will understand ways to prevent dental caries.

STANDARDS:

1. Explain that early entry into dental care (infancy and prenatal) is important in the prevention of dental caries.
2. Explain that an important factor in the prevention of cavities is the removal of plaque by brushing the teeth and flossing between them daily. Discuss and/or demonstrate the current recommendations and appropriate method for brushing and flossing.
3. Explain that the frequency of carbohydrate consumption increases the rate of acid attacks, thereby increasing the risk of dental decay. **Refer to DC-N.**
4. Explain that pathogenic oral bacteria may be transmitted from one person to another; therefore, it is especially important that families with small children (ages 6 months to 8 years) control active tooth decay in all family members.
5. Explain that the use of fluoride strengthens teeth and may rebuild the early damage caused by bacteria/acid attacks. The most common source of fluoride is drinking water. It is also available in toothpastes and rinses, varnishes or fluoride drops/tablets. Consult with a dentist/physician to determine if the drinking water contains adequate fluoride and if supplementation is needed. Explain that the use of topical fluoride is important in the prevention of decay in persons exposed to radiation therapy, as applicable.
6. As appropriate, discuss sealants as an intervention to prevent dental caries.
7. Explain that the recession of gingival tissue (gums) exposes the softer dentin portion of the tooth (root). This portion of the tooth does not have an enamel covering, therefore, it is more susceptible to decay. Gingival recession may have a variety of causes:
    a. Natural aging process
    b. Loss of attached tissue associated with periodontal disease **Refer to PD.**
    c. Improper brushing methods
    d. Genetic predisposition (frenulum/frenum attachment)

DC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM**.
2. Explain that short-term use of Tylenol, NSAIDS, desensitizers, and/or narcotics may be helpful in pain management as appropriate.
3. Explain that antibiotics may be helpful in pain relief in the case of abscess.
4. Explain non-pharmacologic measures that may be helpful with pain control, i.e., avoid hot and cold foods.
5. Explain that dental anxiety may be controlled or relieved by the use of anxiolytics or antihistamines as appropriate.
6. Explain that local anesthetics and/or nitrous oxide may be used to control pain during dental procedures.

DC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the risk(s)/benefit(s) of the test(s) and the risk(s) of refusal of the test(s).

STANDARDS:

1. Discuss the test(s) to be performed, i.e., x-ray, pulp vitality.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks of non-performance of the testing.

DC-TX TREATMENT

OUTCOME: The patient will understand the necessary treatment (filling, root canal, extraction) and the proper oral care after treatment.

STANDARDS:

1. Explain the basic procedure to be used (filling, root canal, extraction) and the indication, common complications and alternatives as well as the risks of non-treatment.
2. Review the specific elements of oral care after treatment. **Refer to DC-P.**
3. Discuss the indications for returning to the provider, i.e., bleeding, persistent or increasing pain and fever.

DM—Diabetes Mellitus

DM-C COMPLICATIONS

OUTCOME: The patient/family will understand that serious complications may occur as a result of long-term uncontrolled blood sugar.

STANDARDS:

1. Emphasize that the end-organ damage (i.e., kidney failure, blindness, heart attack, impotence, limb amputations) results from long-term high blood sugar.
2. Emphasize that optimal blood sugar control can reduce the risk of complications and end-organ damage.
3. Explain that routine examinations are essential and monitoring for complications is required.
4. Discuss common complications of uncontrolled high blood sugar (i.e., blindness, impotence, increased yeast infections, increased urinary tract infections, kidney failure, loss of limbs, heart attack, stroke, early death).
5. Explain that patients with Type 2 DM are at high risk for infectious diseases. Review the current recommendations for immunizations and refer for immunization as appropriate. **Refer to IM.**
6. Explain that patients with Type 2 DM are at high risk for visual loss. Review the current recommendations for eye examinations and refer to appropriate heath-care providers. **Refer to ODM.**
7. Explain that uncontrolled blood sugar can result in small-vessel damage in the heart which leads to heart attacks and cannon usually be treated. Explain that Type 2 DM also worsens atherosclerotic disease, which can also lead to heart attacks and strokes. **Refer to CVA, CAD, and PVD.**

DM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

DM-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the basic pathophysiology and symptoms of Type 2 DM.

STANDARDS:

1. Briefly describe the pathophysiology of Type 2 DM, including the concept of insulin resistance.
2. Emphasize that the end-organ damage (i.e., kidney failure, blindness, heart attack, impotence, limb amputations) results from high blood sugar and that the goal of management is to keep blood sugar as near to normal as possible.
3. Describe risk factors for development and progression of Type 2 DM, i.e., family history, obesity, high intake of simple carbohydrates, sedentary lifestyle.
4. Describe feelings/symptoms which the patient may experience when blood sugar is high, i.e., increased thirst, increased urination, lethargy, headache, blurry vision, impaired concentration.
5. Emphasize that Type 2 DM is a chronic, controllable condition which requires permanent lifestyle alterations and continuous attention and medical care. **Refer to DM-LA.**

DM-EQ EQUIPMENT

OUTCOME: The patient/family will understand the home management and self-care activities necessary to control blood sugar and make a plan to integrate these activities into daily life.

STANDARDS:

1. Discuss the specific components of this patient's home glucose monitoring and/or home blood pressure monitoring and/or home ketone monitoring and/or home insulin pumps.
2. Demonstrate and receive return demonstration of home glucose monitoring and/or the use of other home equipment.
3. Explain that home glucose monitoring (when prescribed) is a tool to assist the patient in home management of blood sugar.
4. Discuss the importance of logging home glucose readings and insulin administration.
5. Emphasize the importance of home blood pressure monitoring as appropriate.
6. Emphasize the importance of bringing home monitoring records (i.e., blood pressure, glucose) to all medical appointments.

DM-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in achieving and maintaining good blood sugar control and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that increased daily activity will reduce the body's resistance to insulin.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

DM-FTC FOOT CARE AND EXAMINATIONS

OUTCOME: The patient/family will understand the risks of skin breakdown, ulcers, and lower extremity amputation associated with Type 2 DM and develop a plan for blood sugar control and regular foot care to prevent these complications.

STANDARDS:

1. Identify risks that can result in amputation. Stress that wounds do not heal properly if blood sugar is elevated.
2. Discuss the current recommendations for periodic foot screening.
3. Demonstrate the proper technique for a daily home foot check by patient or support person.
4. Discuss "dos and don'ts" of diabetic foot care (i.e., don't go barefoot, wear appropriate footwear, don't trim your own nails and/or ingrown toe nails, don't soak your feet).
5. Discuss the relationship between peripheral vascular disease, neuropathy, and high blood sugar. Explain that the progression to amputation is typical without early and appropriate intervention. **Refer to PVD.**
6. Emphasize the importance of footwear which is properly fitted for patients with diabetes. Refer for professional evaluation and fitting as appropriate.
7. Remind the patient to remove shoes for each clinic visit.
8. Emphasize the importance of a regularly scheduled detailed foot exam by a trained health care provider.

DM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the prevention of complications and progression and will develop a plan to make and keep follow-up appointments.

STANDARDS:

1. Emphasize the importance of early intervention to prevent complications.
2. Explain that regular medical appointments are necessary to monitor and to adjust treatment plans to attain blood sugar, blood pressure, and lipid control.
3. Explain that the home glucose and home blood pressure monitoring logs are tools for evaluating the treatment plan and should be brought to every appointment.
4. Explain that diabetes management involves many health care providers. Explain that since Type 2 DM is a chronic condition which affects the entire body, total care is essential. Emphasize the importance of keeping appointments with all health care providers, i.e., dental, eye care, foot care, laboratory.
5. Discuss the procedure for making appointments.

DM-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management and self-care activities necessary to control blood sugar and make a plan to integrate these activities into daily life.

STANDARDS:

1. Discuss the specific components of this patient's home management (i.e., nutrition, exercise, home glucose monitoring, self-administration of insulin, taking medications).
2. Demonstrate and receive return demonstration of home glucose monitoring and/or insulin administration as appropriate.
3. Describe proper storage, care and disposal of medicine and supplies.
4. Explain that home glucose monitoring (when prescribed) is a tool to assist the patient in home management of blood sugar.
5. Discuss the importance of logging home glucose readings and insulin administration and emphasize the importance of bringing the record to all medical appointments.
6. Emphasize the importance of daily foot checks and appropriate foot care. **Refer to DM-FTC.**
7. Emphasize the importance of good personal and oral hygiene. **Refer to WL-HY**.
8. Emphasize the importance of nutritional management. Refer to registered dietician or other local resources as appropriate.

DM-KID KIDNEY DISEASE

OUTCOME: The patient/family will understand the risks of kidney damage and end-stage renal disease resulting in dialysis associated with Type 2 DM and develop a plan for blood sugar control and regular medical examinations to prevent these complications.

STANDARDS:

1. Emphasize that high blood sugar results in damage to the kidneys. This may result in renal failure requiring long term dialysis or kidney transplant. Once kidney damage occurs it cannot be reversed.
2. Emphasize the need for regular urine analysis and blood chemistry screening.
3. Emphasize that high blood pressure worsens diabetic kidney disease. Reinforce the importance of regular blood pressure screening and taking antihypertensive medications as prescribed. **Refer to HTN.**

DM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about Type 2 DM.

STANDARDS:

1. Provide the patient/family with written patient information on Type 2 DM.
2. Discuss the content of the patient information with the patient/family.

DM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand that the most important component in control of high blood sugar is the patient's lifestyle adaptations and will develop a plan to achieve optimal blood sugar control.

STANDARDS:

1. Emphasize that diet and exercise are the critical components of blood sugar control and medical therapies can at best supplement diet and exercise.
2. Emphasize that the end-organ damage (i.e., kidney failure, blindness, heart attack, impotence, limb amputations) results directly and indirectly from high blood sugar and that the goal of management is to keep blood sugar as near to normal as possible.
3. Explain that the longer the blood sugar is elevated, the greater the damage will be.
4. State the reasons for blood glucose monitoring – to keep track of the level of blood sugar and permit changes to the treatment plan necessary to keep sugar under control.

DM-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen.

STANDARDS:

1. Explain that diet and exercise are the key components of control of Type 2 DM and that medication(s) may be prescribed as a supplement to nutrition planning and increased physical activity.
2. Describe the proper use, benefits, and common or important side effects of the patient's medication(s). State the name, dose, and time to take pills and/or insulin.
3. For patients on insulin, demonstrate steps in insulin administration. Describe proper storage, care and disposal of medicine and supplies.
4. Reinforce the need to take insulin and other medications when sick and during other times of stress.
5. Emphasize the importance of full participation in the medication regimen. Explain that many medications for Type 2 DM do not exert an immediate effect and must be used regularly to be effective.
6. Briefly explain the mechanism of action of the patient's medications as appropriate.
7. Discuss any significant drug/drug or food/drug interactions, including interaction with alcohol.
8. Discuss the signs, symptoms and appropriate actions for hypoglycemia.

DM-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

DM-N NUTRITION

OUTCOME: The patient/family will understand the importance of nutritional management in the control of blood sugar and develop a plan to meet nutritional goals.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and responsible eating.
2. Review the food guide pyramid and its role in meal planning. Refer to registered dietician or other local resources as appropriate.
3. Emphasize the importance of reading food labels. Instruct the patient/family as necessary.
4. Discuss the merits of various food preparation methods, i.e., broiling or baking is preferred over frying, avoid gravies and sauces, rinsing or blotting excess grease.
5. Emphasize the importance of appropriate serving sizes.
6. Emphasize that extra caution or planning is required when eating out, using USDA commodities, or going to special events since these foods are usually high in fat and sugar and serving sizes are often inappropriately large.
7. Emphasize that carbohydrates and low-fat proteins are preferred and that sugars and fats should be limited.

DM-P PREVENTION

OUTCOME: The patient/family will understand major risk factors for development of Type 2 DM and will develop a plan for risk reduction.

STANDARDS:

1. Discuss the role of obesity in the development of Type 2 DM.
2. Emphasize that to maintain health and prevent diabetes, extra commitment is necessary for people with a family and/or gestational history of Type 2 DM.
3. Explain that following the food guide pyramid and maintaining adequate activity levels will reduce the risk of getting Type 2 DM.
4. Explain that many people have Type 2 DM for as much as 5-7 years before diagnosis, and that end-organ damage is occurring during that time. Emphasize the importance of regular screening. Discuss current recommendations for screening.
5. Explain that the child of a mother who had high blood sugar during pregnancy is at greatly increased risk for development of Type 2 DM. Emphasize that family planning, pre-conception screening, and early prenatal care can significantly reduce this risk.

DM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the importance of appropriate management of pain.

STANDARDS:

1. Explain that lower extremity pain may be significant for complications associated with neuropathy which needs to be discussed with the medical provider.
2. Explain that the use of over the counter medications for chronic pain management needs to be assessed by the medical provider to minimize risk to kidney function.
3. Explain that all chest pain must be evaluated by the medical provider to rule out the possibility of myocardial infarction.
4. **Refer to PM or CPM.**

DM-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening test including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening test (i.e., guaiac, blood pressure, hearing, vision, development, mental health).
2. Explain the process and what to expect after the test.
3. Emphasize the importance of follow-up care.
4. Explain the recommended frequency of various screenings.

DM-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in diabetes mellitus.

STANDARDS:

1. Explain that uncontrolled stress can contribute to insulin resistance and lead to increased morbidity and mortality.
2. Explain that uncontrolled stress can interfere with the treatment of diabetes mellitus.
3. Explain that effective stress management may reduce the adverse consequences of diabetes, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from diabetes mellitus.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

DM-WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care. As appropriate, they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the reasons to care appropriately for the wound; decreased infection rate, improved healing, etc.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that should prompt immediate follow-up: increasing redness, purulent discharge, fever, increased swelling/pain, etc.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.
5. Emphasize the importance of follow-up.

DIA—Dialysis

DIA-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient will have a basic understanding of where the kidneys are and their overall function.

STANDARDS:

1. Explain that the normal human body has two kidneys located on either side of the spine just slightly below the ribcage. Each kidney weighs about a quarter of a pound and is the size of a fist. The shape is similar to that of a kidney bean.
2. Discuss that the kidneys help the body maintain fluid levels and assist in regulating blood pressure. In addition, a variety of other chemicals are produced and released by the kidneys so that a balance is always maintained.
3. Review the four major functions of the kidneys, elimination of waste products through an internal blood filtering system, regulation of blood formation and red blood cell production, regulation of blood pressure, and control of the body's chemical and fluid balance.

DIA-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with dialysis and with the decision not to have dialysis.

STANDARDS:

1. Explain that infections are common in dialysis patients and that the patient/family should report all elevations in body temperature to the dialysis staff. Infection, particularly at the site may require immediate hospitalization for IV antibiotic therapy.
2. Explain that deviations from prescribed dietary and fluid restrictions may result in acute metabolic problems, which must be addressed by the dialysis unit.
3. Explain that even with proper dialysis, patients may experience fluid imbalances and that all shortness of breath, unusual swelling, dizziness, etc. should prompt immediate medical evaluation.

DIA-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the causes associated with his/her end stage renal disease.

STANDARDS:

1. Explain that End Stage Renal Disease usually results from long term or prolonged medical conditions such as hypertension or diabetes.
2. Chronic kidney failure may also be the result of heredity such as polycystic disease.
3. At present there is no known cure for chronic kidney disease, however dialysis or transplantation are treatment options.

DIA-EQ EQUIPMENT

OUTCOME: The patient/family/caregiver will understand the purpose, use, and care associated with the patient's prescribed dialysis regimen.

STANDARDS:

1. Discuss the indications for and benefits of prescribed medical equipment.
2. Discuss and/or demonstrate proper use and care of medical equipment; participate in return demonstration by patient/family/caregiver as appropriate.
3. Discuss signs of equipment malfunction and proper action in case of malfunction.
4. Emphasize the safe use of equipment, including infection control measures. Explain that equipment tubing is designed for a single use.
5. Discuss proper disposal of associated medical supplies.

DIA-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the importance of fully participating in the treatment regimen and appropriate follow-up and coordination with all health care providers.

STANDARDS:

1. Discuss the individual's responsibility in the management of end stage renal disease including the responsibility to keep all health care providers informed of changes to the treatment plan.
2. Review the treatment plan with the patient/family/caregiver, emphasizing the importance of follow-up care.
3. Discuss the procedure for obtaining follow-up appointments and the procedure for obtaining emergent care appointments.

DIA-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family/caregiver will receive written information regarding the specific type of dialysis the patient is currently receiving, i.e., hemodialysis or peritoneal dialysis.

STANDARDS:

1. Provide the patient/family/caregiver with written patient information literature on specific mode of dialysis.
2. Discuss the content of patient information literature with the patient/family/caregiver.

DIA-M MEDICATION

OUTCOME: The patient/family/caregiver will understand the medications used in the management of the patient's end stage renal disease.

STANDARDS:

1. Explain the medications to be used by this patient including the dosage, timing, proper use and storage of the medication, important and common side effects of the medication including drug/drug and drug/food interactions.
2. Discuss with patient/family/caregiver the need to review all over the counter medications and herbal products prior to use with the dialysis unit pharmacy staff.
3. Discuss medications which may be used during dialysis and the common or important complications which may result.
4. Explain that the patient's medications may change after starting dialysis. Emphasize the importance of bringing all medications to medical appointments.

DIA-MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

DIA-N NUTRITION

OUTCOME: The patient/family will understand the specific prescribed dietary regimen as it relates to their ongoing dialysis.

STANDARDS:

1. Each diet is individualized, however typical dietary restrictions may include calories, fluids, protein, sodium, potassium, calcium and phosphorus.
2. Refer to a Registered Dietician as appropriate.

DIA-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s), as well as the risks, benefits, alternatives to the proposed procedure(s) and associated factors affecting the patient.

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
3. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

DIA-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as appropriate, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

SUP—Dietary Supplements

SUP-C COMPLICATIONS

OUTCOME: The patient and family will understand the implications for misuse of vitamin and mineral supplements, functional foods, nutritional oral supplements, and herbal use.

STANDARDS:

1. Explain that excessive intake of vitamins and/or minerals through supplementation or functional foods can cause adverse effects up to and including death.
    a. Explain that functional foods are foods that provide health benefits beyond basic nutrition and are adjunctive to a balanced diet.
    b. Explain that some vitamin and/or mineral supplements may interfere with medications and the need to consult a physician, pharmacist, or registered dietitian before starting any new supplement.
    c. Explain that mega doses of vitamins, minerals, or other supplements may have toxic effects.
    d. Discuss common and important signs/symptoms of toxicity as it relates to the patient's supplement regimen
2. Explain that nutritional oral supplement is a liquid food formula that can be used to add or maintain the caloric level of an individual when unable to eat a usual diet during illness, infection, loss of appetite, or when snacks or meals are delayed or missed.
    a. Explain that nutritional oral supplements contain minimal to large amounts of vitamins and mineral.
    b. Explain that prolong use of some nutritional oral supplements when eating an adequate diet my result in weight gain.
    c. Discuss that diarrhea may be a side effect for some individuals.
    d. Consult a physician or registered dietitian for a specific formula to fit an individual's nutritional needs.
3. Explain that use of some herbal remedies may seriously complicate some medical conditions and/or interfere with some prescribed or over the counter medications.
    a. Explain that herbal supplements and remedies in this country are not regulated by Food and Drug Administration and may not be pure and safe to use.
    b. Explain that despite the evidence of safety and efficacy of most traditional herbal remedies; a patient should notify their physician, pharmacist or registered dietitian before use.

SUP-FU FOLLOW-UP

OUTCOME: The patient and family will understand the importance of a follow-up plan and keeping appointments.

STANDARDS:

1. Emphasize the patient's responsibilities in developing and following a supplementation plan and keeping follow-up appointments.
2. Discuss the procedure for making appointments.
3. Discuss any necessary preparation for lab test(s).

SUP-I INFORMATION

OUTCOME: The patient and family will understand the indication for use of supplements, fortified foods, nutritional oral supplements, and herbal remedies.

STANDARDS:

1. Explain the importance of vitamins, minerals, and other supplements in the normal functioning body.
2. Explain that certain disease states, conditional, or medication regimens may require the use of vitamin and/or mineral supplements.
3. Explain that there are 13 organic vitamins, four are fat-soluble and nine are water-soluble.
4. Explain that there are 22 inorganic essential minerals needed in the diet.
    a. Macro minerals include calcium, phosphorus, magnesium, potassium, sodium, chloride, and sulfur.
    b. Trace minerals include but are not limited to the following: iron, copper, selenium, fluoride, iodine, chromium, zinc, manganese, molybdenum, and colbalt.
    c. Food fortification and functional foods play a very important role in determining the type and supplementation that a patient will receive.
5. Explain that many plants contain biologically active chemicals known as phytochemicals that may have some disease-prevention properties.
6. Discuss that all these supplements including herbal remedies are very expensive and most insurance policies will not cover cost.
7. Explain that all current vitamins, supplements, and/or herbal use should be documented on the patient's medication list.

SUP-SCH SCHEDULE

OUTCOME: The patient and family will understand the importance of following the prescribed timing of supplements in regard to other food and medications.

STANDARDS:

1. Explain that the use of all vitamin/mineral or other types of supplements should be used only under the advice of a registered dietitian and a physician.
2. Explain that some supplements may require specific timing when taking other medications and/or supplements, i.e. calcium is better absorbed with a meal but should not be taken at the same time as iron supplements.
3. Review schedule with patient and family.

DCH—Discharge from Hospital

DCH-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) proper use and care of home medical equipment provided at hospital discharge.

STANDARDS:

1. Discuss indications for and benefits of prescribed home medical equipment.
2. Discuss types and features of home medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of home medical equipment, participate in return demonstration by patient/family.
4. Discuss signs of equipment malfunction and proper action in case of malfunction.
5. Emphasize safe use of equipment, i.e., no smoking around O2, use of gloves, electrical cord safety, disposal of sharps).
6. Discuss proper disposal of associated medical supplies.

DCH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep scheduled follow-up appointments after discharge.

STANDARDS:

1. Discuss the importance of follow-up care following hospitalization.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize the importance of keeping appointments.

DCH-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of their disease processes following hospital discharge and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer complications, fewer falls/injuries.
3. Explain the use and care of any necessary home medical equipment.

DCH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information regarding their discharge plans including medical therapies, follow up appointments, and contact information.

STANDARDS:

1. Provide patient/family with written patient information regarding their discharge plans including:
   a. Medical therapies prescribed
   b. Follow up appointments
   c. Follow up lab work
   d. Assessments required
   e. Cautions regarding the discharge plans
   f. Contact information
2. Discuss the discharge plan with the patient/family.

DCH-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of the disease state or condition or to improve mental or physical health following hospital discharge.

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over - nutrition, exercise, safety, and injury prevention, avoidance of high risk behaviors, and participation in the treatment plan.
2. Emphasize that an important component in the prevention or treatment of disease is the patient's adaptation to a healthier, lower risk lifestyle.
3. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

DCH-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Discuss the importance of following the medical regimen.
3. Discuss the importance of informing your providers and pharmacists of any allergies or adverse medication reactions that you may have experienced.
4. Discuss the importance of being able to identify any discharge medications.
5. Discuss the importance of being able to take the appropriate amount of medication. Ensure dosage forms can be obtained (i.e., breaking tablets in half or using a pill cutter) and that appropriate measuring devices (oral syringes, droppers) are provided and instruction on their use given.

DCH- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

DCH-N NUTRITION

OUTCOME: The patient will understand the need for balanced nutrition and plan for the implementation of dietary modification following hospital discharge if needed.

STANDARDS:

1. Review nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to the specific disease states.

DCH-POC PLAN OF CARE

OUTCOME: The patient/family will have a basic understanding of the discharge plan for care, including the plans for pain management.

STANDARDS:

1. Explain the basic plan of care for the patient, including the following:
   a. Plan for continued home treatment
   b. Anticipated assessments
   c. Tests to be performed, including laboratory tests, x-rays, and others
   d. Therapy to be provided, i.e., medication, physical therapy, dressing changes
   e. Advance directives
   f. Plan for pain management
   g. Nutrition and dietary plan including restrictions if any
   h. Follow-up plans

DCH-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure, including indications, complications, and alternatives, as well as possible results of non-treatment.

STANDARDS:

1. Discuss the indications, risks, and benefits and alternatives for the proposed procedure(s) as well as the risk of not undergoing the procedure.
2. Explain the process and what to expect after the procedure.
3. Discuss pain management as appropriate.
4. Emphasize post-procedure management and follow-up.
5. Discuss procedure findings and implications as appropriate.

DCH-REF REFERRAL

OUTCOME: The patient/family will understand the referral process and financial responsibilities.

STANDARDS:

1. Choose from the following standards as appropriate.
    a. Emphasize that referrals to outside providers by Indian Health Service primary providers typically will be processed by Contract Health Services.
    b. Explain the procedure for the referral to the private sector is usually based on a priority system and/or waiting list.
    c. Explain that coverage by insurance companies and Medicare/Medicaid packages will be utilized prior to utilizing contract health service funds in most cases. The Indian Health Service is a payer of last resort.
    d. Discuss the rules/regulations of Contract Health Services.
    e. Refer as appropriate to community resources for Medicaid/Medicare enrollment, i.e., Benefits Coordinator.
    f. Discuss the importance of follow-up care and the requirement to notify contract health services of any future appointments and procedures by the private sector. **Referrals are for one visit only** (unless otherwise specified.) Future and/or additional referrals must be approved prior to the appointment.

DCH-RI PATIENT RIGHTS AND RESPONSIBILITIES

OUTCOME: The patient/family will have a basic understanding of their rights and responsibilities as well as the process for conflict resolution.

STANDARDS:

1. Discuss the patient's responsibility to follow the agreed upon plan of care and to keep follow-up appointments.
2. Briefly explain the process for resolving conflicts if the patient/family believe that their rights have been violated.
3. Discuss availability of cultural/spiritual/psycho social services that may be available as appropriate.

DCH-S SAFETY

OUTCOME: The patient/family will understand the necessary precautions to prevent injury following hospital discharge.

STANDARDS:

1. Discuss the mutually agreed upon plan of care for safety based on the patient-specific risk assessment.
2. Emphasize safe use of equipment. **Refer to DCH-EQ.**

DCH-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed at the time of or following hospital discharge including indications and its impact on further care.

STANDARDS:

1. Explain the test(s) ordered.
2. Explain the necessity, benefits, and risks of the test to be performed.
3. Explain the testing process to help the patient understand what he/she might experience during the test.
4. Explain the meaning of the test results, as appropriate.

DCH-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available based on the specific disease process, test results, and individual preferences.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
2. Discuss the treatment plan including lifestyle adaptations, cultural practices, pharmacologic, and psycho social aspects of the treatment plan.
3. Discuss the importance of participating in the treatment plan, including scheduled follow-up.
4. Refer to community resources as appropriate.

DIV—Diverticulitis / Diverticulosis

DIV-C COMPLICATIONS

OUTCOME: The patient/family will understand the signs of complications and will plan to return for medical care if they occur.

STANDARDS:

1. Explain that some possible complications of diverticulosis and diverticulitis may include hemorrhage, abscess development and perforation with peritonitis, bowel obstruction, intussusception, and volvulus.
2. Advise the patient to seek immediate medical care for any signs of complications, such as lower abdominal cramping, abdominal distention fever, malaise, hemorrhage.

DIV-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of diverticulitis/diverticulosis.

STANDARDS:

1. Explain that a diverticulum is a pouch or saccular dilatation from the main bowel cavity. Diverticulosis is the condition in which an individual has multiple diverticulae. Diverticulitis is an inflammation of one or more diverticulae.
2. Explain that- some of the- predisposing factors may include congenital predisposition, weakening and degeneration of the muscular wall of the intestine, chronic over distention of the large bowel, and a diet low in roughage.
3. Explain that diverticulosis develops in nearly 50% of persons over age 60, but only a small percentage develops diverticulitis.
4. Explain that diverticulosis-ma-y be accompanied by minor bowel irregularity, constipation and diarrhea.
5. Explain that symptoms of diverticulitis may range from mild abdominal soreness and cramps with "gas" and low grade fever, to more severe cramping and pain accompanied by fever, chills, nausea, abdominal rigidity and massive hemorrhage.
6. Inform the patient that diverticulitis may be acute or chronic.

DIV-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

DIV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about diverticulitis and or diverticulosis.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding diverticulitis and/or diverticulosis.
2. Discuss the content of the patient information literature with the patient/family.

DIV-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen and make a plan to take the medication as prescribed.

STANDARDS:

1. Describe the proper use, benefits, and common or important side effects of the patient's medications. State the name, dose, and time for administration as applicable.
2. Discuss any significant drug/drug or drug/food interactions, including interaction with alcohol.
3. Discuss with the patient/family the need to complete the full course of antibiotics, as prescribed (when indicated.)
4. Caution the patient/family against utilizing over-the-counter medications for constipation without consulting his/her provider.

DIV- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

DIV-N NUTRITION

OUTCOME: The patient/family will understand how dietary modification may assist in the control of bowel function and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Emphasize the hazards of constipation.
3. Explain that during periods of acute inflammation, it may be necessary to begin with a very restricted diet and slowly progress to a bland diet.
4. Explain that bulk can be added to stools by eating fruits and vegetables with a high fiber content (seedless grapes, fresh peaches, carrots, lettuce).
5. Encourage a diet that is high in fiber and low in sugar to maintain intestinal tract function. Advise to avoid indigestible roughage, such as celery and corn.
6. Provide list of appropriate foods that are high in fiber and low in sugar.
7. Advise the patient/family to avoid extremely hot or cold foods and fluids, because they may cause flatulence. Also, alcohol, which irritates the bowel, should be avoided. Stress the importance of thoroughly chewing all foods.
8. Assist the patient/family in developing appropriate meal plans.
9. Stress the importance of water in maintaining fluid balance and preventing constipation.
10. Refer to dietitian as appropriate.

DIV-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of diverticulitis and/or diverticulosis.

STANDARDS:

1. Discuss the effects of a fatty, low fiber diet on the colon.
2. Provide and review a list of low fat, high fiber foods.
3. Assist the patient/family in meal planning that includes low fat, high fiber foods and avoids high fat, low fiber foods.
4. Explain that the etiology of Crohn's disease is unknown and there is no known prevention, but an appropriate diet may prevent or slow progression of the disease.

DIV-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that diverticulitis with pain usually responds to a liquid or bland diet and stool softeners to relieve symptoms, minimize irritation, and decrease the spread of the inflammation.
2. Discuss the plan for pain management during the acute phase, which may include opiate or non-opiate analgesics and anticholinergic to decrease colon spasms.
3. Advise the patient not to use over the counter pain medications without checking with his/her provider.
4. Discuss non-pharmacologic methods of pain control as appropriate.

DIV-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Proctosigmoidoscopy and Colonoscopy
   a. Explain that proctosigmoidoscopy and colonoscopy may be utilized to directly visualize the inside of the colon and enable biopsies to be obtained. The information from the colonoscopy may be necessary to diagnose the specific type of bowel disease.
   b. Explain that the procedure involves introducing a flexible tube through the anus and rectum.
   c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.
2. Barium Enema
   a. Explain that the barium enema is an x-ray to assess the extent of the disease, identify lesions, detect pseudo polyps, carcinoma, and strictures.
   b. Explain that barium liquid will be introduced by enema and radiographs taken.
   c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.

DIV-TX TREATMENT

OUTCOME: The patient/family will understand the prescribed treatment for diverticulitis/diverticulosis and have a plan to fully participate in the treatment regimen.

STANDARDS:

1. Discuss the specific treatment plan, which may include the following:
   a. During acute episodes, nothing by mouth and IV fluid and nutritional support may be necessary in order to rest the bowel
   b. Liquid or bland diet during the less acute phase, then a high fiber diet to counteract the tendency toward constipation
   c. Stool softeners
   d. Antimicrobial therapy to combat infection
   e. Antispasmodics to control smooth muscle spasms
   f. Surgical resection of the area of involved colon and sometimes temporary colostomy
2. Advise the patient to avoid activities that raise intra-abdominal pressure, i.e., straining during defecation, lifting, coughing.
3. Discourage smoking, as it irritates the intestinal mucosa.

LIP—Dyslipidemias

LIP-C COMPLICATIONS

OUTCOME: The patient will understand the complications of uncontrolled dyslipidemia.

STANDARDS:

1. Review the disease process of atherosclerosis/thrombosis, and how high cholesterol is involved in this process and its involvement in cerebrovascular disease (stroke), cardiovascular disease (heart attack), and peripheral vascular disease.
2. Explain that heart attacks may result due to blocked arteries in the heart.
3. Explain that strokes may result due to blocked arteries in the neck or brain.
4. Explain that leg pain and loss of use of legs may result due to blocked arteries in the legs.

LIP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

LIP-DP DISEASE PROCESS

OUTCOME: The patient will understand what causes their dyslipidemia.

STANDARDS:

1. Review the causative factors of dyslipidemia (i.e., genetic, DM, thyroid disease, liver disease, kidney disease, drugs) as appropriate to the patient.
2. Review lifestyle factors which may worsen dyslipidemia (i.e., obesity, high saturated fat/carbohydrate intake, lack of regular exercise, tobacco use, alcohol intake).
3. Review factors other than dyslipidemias which predispose toward development of atherosclerotic disease, i.e., DM, HTN, low HDL, tobacco use, age, or family history of premature heart disease. Emphasize that dyslipidemias in combination with other risk factors greatly increase the risk of other vascular diseases including heart attacks and strokes.

LIP-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
2. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
3. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
4. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
5. Discuss medical clearance issues for physical activity.

LIP-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of follow-up and will develop a plan to manage their dyslipidemia and to make and keep follow-up appointments.

STANDARDS:

1. Emphasize that the treatment plan and full participation with it are the responsibility of the patient.
2. Encourage the patient to get a fasting lipid profile on a regular schedule, keep appointments, and fully participate with the therapeutic plan.

LIP-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about dyslipidemia.

STANDARDS:

1. Provide patient/family with written patient information literature on the dyslipidemia.
2. Discuss the content of patient information literature with the patient/family.

LIP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle adaptations necessary to maintain control of dyslipidemia and develop a realistic plan to accomplish this.

STANDARDS:

1. Discuss the importance of regular exercise, weight control, and a reduced fat diet in the control of dyslipidemia.
2. Explain that regular aerobic exercise lowers lipid levels and recommend that the patient should start slow and work up to an appropriate exercise level that is recommended by the health care provider.
3. Discuss the importance of cessation of tobacco use in the control of dyslipidemia.
4. Assist the patient to formulate a therapeutic plan which includes stress reduction, diet, exercise, and medications, as indicated.
5. Review the nationally accepted, current lipid reduction goals and assist the patient to establish a personal goal for lipid control.

LIP-M MEDICATIONS

OUTCOME: The patient will understand the importance of their prescribed medications.

STANDARDS:

1. Briefly review the different classes of lipid lowering drugs.
2. Review the proper use, benefits, and common side effects of these medications.
3. Review the clinical effects expected with these medications.
4. Review medications which adversely affect lipids as appropriate.

LIP- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

LIP-N NUTRITION

OUTCOME: The patient will understand the interaction between diet and lipid levels and formulate a healthy nutrition plan.

STANDARDS:

1. Explain the basics of the Step I AHA diet for all patients with dyslipidemia. Refer to dietitian or other local resources as available.
2. Explain the importance of carbohydrates (including alcohol) and their relationship to elevated triglycerides.
3. Discuss the importance of decreasing total dietary fat intake and substituting monounsaturated fats for other dietary fats.

LIP-P PREVENTION

OUTCOME: The patient/family will understand ways to prevent dyslipidemia.

STANDARDS:

1. Explain that consuming a diet low in fat and cholesterol, controlling weight, and exercising may help prevent dyslipidemia.

LIP-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in lipid disorders.

STANDARDS:

1. Explain that uncontrolled stress can raise lipids and increase the severity of coronary artery disease.
2. Explain that uncontrolled stress can interfere with the treatment of lipid disorders.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the risk of morbidity and mortality from arterial disease.
4. Explain that effective stress management may help reduce the severity of arterial disease, as well as help improve the health and well-being of the patient.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

LIP-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

E

ECC—Early Childhood Caries

ECC-C COMPLICATIONS

OUTCOME: The parent and/or family will understand the effects and consequences of ECC on their child.

STANDARDS:

1. Review the consequences of severe tooth decay, i.e., infection, tooth loss, speech problems, aesthetics.
2. Review treatment modalities (tooth restoration, behavior management).
3. Review the health risks of general anesthesia.
4. Review the costs of extensive treatment.

ECC-DP DISEASE PROCESS

OUTCOME: The parent and/or family will understand the causes, identification, and prevention of Early Childhood Caries (ECC).

STANDARDS:

1. Review the current factual information regarding the causes of ECC.
2. Discuss how dental disease germs can be passed from parent to infant.
3. Discuss the role of sugar.
4. Review how to identify early signs of ECC.

ECC-FU FOLLOW-UP

OUTCOME: The parent and/or family will understand the importance of infant and early childhood oral health care including dental well checks.

STANDARDS:

1. Discuss dental well child visits.
2. Review recommendations for early childhood dental care.
3. Discuss the importance of follow up in patients who have developed dental disease.

ECC-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent and/or family will understand that primary dentition begins to develop during fetal life and that primary teeth serve several purposes.

STANDARDS:

1. Review primary tooth development.
2. Discuss the role of primary teeth in the growth and development of the mandible, maxilla, and permanent teeth.

ECC-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the ECC.

STANDARDS:

1. Provide patient/family with written patient information literature on ECC.
2. Discuss the content of patient information literature with the patient/family.

ECC-LA LIFESTYLE ADAPTATIONS

OUTCOME: The parent and/or family will understand how to avoid the disease, adopt good feeding practices, avoid falling prey to old habits and develop positive oral hygiene habits.

STANDARDS:

1. Discuss attitudes toward feeding habits.
2. Review breastfeeding and bottle feeding practices.
3. Provide information on alternatives to misuse of baby bottles, i.e., no bottles in the bed, no propping of bottles, weaning at 12 months of age.

ECC- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ECC-N NUTRITION

OUTCOME: The patient/family will understand the need for balanced nutrition and plan for the implementation of dietary modification if needed.

STANDARDS:

1. Review normal nutritional needs for optimal general and dental health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to Early Childhood Caries.
4. Emphasize the importance of fully participating in the prescribed nutritional plan.

ECC-P PREVENTION

OUTCOME: The parent and/or family will understand how to prevent ECC.

STANDARDS:

1. Review adult oral hygiene with the parent.
2. Review infant/child oral hygiene, i.e., the use of a soft washcloth to clean the gums of infants.
3. Discuss methods of prevention, including fluoride supplementation and limitation of sugar in diet.
4. Explain to parents the methods of early identification of dental disease in infants and small children. Explain the importance of early treatment.
5. Review proper use of and alternatives to misuse of the bottle or nipple, i.e., no bottles in bed, no propping of bottles, and weaning at 12 months of age.
6. Emphasize that nothing should be given from a bottle except formula, breastmilk, water, or electrolyte solution, i.e., no juice or soda pop.

ECC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM**.
2. Explain that short-term use of NSAIDS may be helpful in pain management as appropriate.
3. Explain non-pharmacologic measures that may be helpful with pain control, i.e., avoid hot and cold foods.

ECC-PRO PROCEDURES

OUTCOME: The patient/family will understand procedure(s) to be performed to treat ECC and the risk of not treating ECC.

STANDARDS:

1. Explain the procedures proposed as well as alternatives and/or the risk of doing nothing.
2. Discuss common and important complications of treatment or non-treatment.

ECC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the risk(s)/benefit(s) of the test(s) and the risk(s) of refusal of the test(s).

STANDARDS:

1. Discuss the test(s) to be performed, i.e., x-ray.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks of non-performance of the testing.

ECC-TX TREATMENT

OUTCOME: The patient will understand the necessary treatment (i.e., filling, capping) and the proper oral care after treatment.

STANDARDS:

1. Explain the basic procedure to be used (i.e., filling, capping) and the indication, common complications and alternatives as well as the risks of non-treatment.
2. Review the specific elements of oral care after treatment. **Refer to DC and ECC-P.**
3. Discuss the indications for returning to the provider, i.e., bleeding, persistent or increasing pain, and fever.

ECZ—Eczema/Atopic Dermatitis

ECZ-C COMPLICATIONS

OUTCOME: The patient/family will be able to recognize common and important complications, the symptoms should be reported immediately, and appropriate intervention(s) taken to prevent complications.

STANDARDS:

1. Discuss the possible symptoms that can lead to complications, i.e., painful dry, red skin rash that itches or is cracked, blisters, peeling, tender, or oozing skin.
2. Review the effects of skin rashes that get out of control, i.e., pain, swelling, redness, drainage, or a fever. **Refer to SWI**.
3. Emphasize that permanent scarring or hair loss may develop if not treated early.
4. Relate that there is no cure for eczema, however, flare-ups can be treated and controlled.

ECZ-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of atopic dermatitis and eczema.

STANDARDS:

1. Briefly review the anatomy/physiology and how it relates to the protective functions of the skin.
2. Discuss that atopic dermatitis and eczema is a name given to a group of skin problems that share a pattern of changes in the surface of the skin.
3. Discuss that atopic dermatitis or eczema can begin in infancy, can last for years and can often be successfully controlled.
4. Discuss the many risk factors for eczema/atopic dermatitis including family history of asthma, food allergies, stress, and things your skin touches such as plants and animals.
5. Discuss that seasonal flare-ups are common.
6. Explain how dryness and itching can cause breaks in the skin and allow bacteria to enter the body.
7. Emphasize the importance of keeping nails cut short to help prevent breaking the skin from scratching. Bacteria are common under fingernails and can cause skin infection from scratching.
8. Discuss the importance of daily hygiene and skin inspection.
9. Explain that use of mild, non-drying, unscented soaps, avoiding very hot water and the use of moisturizing lotion or cream after bathing are all helpful. Perfumes in soaps and lotions may make eczema or atopic dermatitis worse.
10. List symptoms that need to be reported immediately: skin infection, pain, swelling, redness, a thick or colored drainage, or a fever.

ECZ-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the family's understanding of how to obtain follow-up appointments. Correct any misinformation.
3. Emphasize the importance of keeping follow-up appointments.

ECZ-L PATIENT INFORMATION LITERATURE

OUTCOME: The family/patient will receive written information about eczema/atopic dermatitis.

STANDARDS:

1. Provide family/patient with written patient information literature about eczema/atopic dermatitis.
2. Discuss content of the patient information literature with the patient/family.

ECZ-M MEDICATIONS

OUTCOME: The patient/family will understand the importance of full participation with the prescribed medication regimen.

STANDARDS:

1. Discuss the reason for specific medication, treatment, and environmental changes needed to treat this patient's condition.
2. Review directions for use of medication and duration of therapy.
3. Discuss expected benefits of therapy and the important and common side effects.
4. Discuss warning signs to report to the doctor.
5. Discuss the importance of fully participating with medication regimen.
6. Advise that both topical and oral medications can trigger a skin reaction like hives or sunburn. Warn to be alert for any reactions to new medications. Advise patient/family to call a provider to get a substitute medication if a reaction occurs.
7. Emphasize the importance of follow-up.

ECZ- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ECZ-N NUTRITION

OUTCOME: The patient/family will understand nutritional factors that may affect atopic dermatitis or eczema.

STANDARDS:

1. Discuss that some foods may affect atopic dermatitis or eczema. Common triggers are milk products, egg products or wheat products.
2. Refer to a registered dietician as appropriate.

ECZ-P PREVENTION

OUTCOME: The patient/family will understand the appropriate measures to prevent eczema and atopic dermatitis flare-ups.

STANDARDS:

1. Discuss that breast-fed infants are less likely to develop atopic dermatitis or eczema.
2. Discuss avoiding exposure to extreme temperatures, dry air, pet danders, harsh soaps, and bubble baths.
3. Consider the use of cotton blankets and clothing, rather than more irritating fabrics such as wool, or stiff synthetics like polyester.
4. Explain the importance of good hygiene and protection of skin by patting dry after shower or bath to leave some moisture on the skin. Instruct to apply a moisturizing cream, lotion or ointment immediately after bathing to retain moisture in the skin.
5. Explain that skin care products which contain alcohol, perfumes, dyes or allergens may actually worsen the condition.
6. Discuss the importance of avoiding skin contact with irritating chemicals, plants, jewelry, and other substances that trigger skin allergies and dermatitis.
7. Explain that a room humidifier will add moisture to indoor air during the winter heating season.

ECZ-WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care and infection control measures. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the rationale for appropriate care to the wound, i.e., decreased infection rate, improved healing.
2. Demonstrate and explain the correct procedure for caring for this patient's wound. Ask for a return demonstration if needed.
3. Describe signs and symptoms that would require immediate follow-up, i.e., increasing redness, purulent discharge, fever, increased swelling, or pain.
4. Detail the supplies necessary for care of this wound and how/where they may be obtained and the proper methods for disposal of contaminated supplies.
5. Emphasize the importance of follow-up.

ELD—Elder Care

ELD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

ELD-DP DISEASE PROCESS/AGING

OUTCOME: The patient/family will understand the normal aging process and will develop an action plan to maintain optimal health while aging.

STANDARDS:

1. Explain the normal anatomy and physiology of the aging process:
   a. it is normal to slow down as one ages
   b. some lapses in short-term memory are common
   c. some decrease in sex drive and ability to perform are common
   d. changes in sleeping patterns are common
   e. presbyopia (far sightedness) is nearly universal as humans age.
2. Explain that older individuals often have several chronic diseases that may need special attention in light of their advanced age.
3. Depression is common and may be difficult to diagnose. Family and caregivers should be instructed to watch for signs of depression, i.e., loss of appetite, social withdrawal.

ELD-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.

ELD-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
2. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
3. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
4. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
5. Discuss medical clearance issues for physical activity.

ELD-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand their responsibility in health maintenance and the importance of keeping follow-up appointments.

STANDARDS:

1. Explain the procedure for obtaining follow-up appointments. Emphasize the importance of having appointments with the same health care provider when possible.
2. Emphasize the importance of keeping appointments.
3. Discuss the importance of bringing all medications to each visit.
4. Stress the importance of full participation with the health maintenance plan between visits.
5. Emphasize the importance of regular health screening for older adults, i.e., colonoscopy, mammograms, pap smears, PSAs.
6. Refer to community resources as appropriate, i.e., meals on wheels, elder transportation vans, Medicare.

ELD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family caregiver will receive written information about aging or elder health care issues.

STANDARDS:

1. Provide the patient/family/caregiver with written patient information about aging or elder health care issues.
2. Discuss the content of the patient information literature with the patient/family/caregiver.

ELD-LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient/family/caregiver will understand the lifestyle adjustments needed to maintain optimal health and will develop a plan o modify behavior where needed.

STANDARDS:

1. Discuss the patient/family/caregiver level of understanding and acceptance of the aging process.
2. Refer to Social Services, Mental Health, Physical Therapy, Rehabilitative Services and/or other resources as appropriate.
3. Review the lifestyle areas that may require adaptations, i.e., diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships, transportation issues, isolations issues.
4. Explain that as people age they may require more assistance from other sources than previously. Assist in identifying a support system.

ELD-M MEDICATIONS

OUTCOMES: The patient/family/caregiver will develop a plan for the patient taking prescribed medications correctly.

STANDARDS:

1. Review the patient's medication regimen.
2. Suggest techniques to ensure that medications are taken correctly, i.e., weekly medicine dispensing boxes, written lists.
3. Emphasize the importance of taking all medications to each visit.
4. Emphasize the importance of fully participating in the medication regimen.
5. Consider community health nursing referral to assess the elder patient's ability to fully participate with taking their medications correctly, as appropriate.

ELD- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ELD-N NUTRITION

OUTCOME: The patient/family/caregiver will understand dietary requirements for optimal health in this patient.

STANDARDS:

1. Assess nutritional status using 24-hour diet recall or other tool.
2. Discuss this patient's specific nutrition plan.
3. Identify problems such as dental or gum disease, financial limitations, cognitive limitations or other conditions which may limit the patient's ability to achieve good nutrition. Refer as appropriate.

ELD-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family/caregiver will understand the importance of injury prevention and make a plan to implement safety measures.

STANDARDS:

1. Explain the importance of body mechanics in daily living to avoid injury, i.e., proper lifting techniques.
2. Assist the patient/family/caregiver in identifying ways to adapt the home to improve safety and prevention injuries, i.e., remove throw rugs, install bars in tub/shower, secure electrical cords, install ramps.
3. As appropriate, stress the importance of mobility assistance devices, i.e., canes, walkers, wheel chairs, therapeutic shoes.
4. Discuss the current/potential abuse of alcohol or drugs.
5. Emphasize the importance of NEVER smoking in bed. Refer to smoking cessation programs as appropriate.
6. Discuss the potential for elder abuse/neglect (including financial exploitation) and ways to identify abuse/neglect. Refer as appropriate.

ELD-SM STRESS MANAGEMENT

OUTCOMES: The family member will understand the role of stress management when taking care of the elderly.

STANDARDS:

1. Explain that uncontrolled stress can contribute to physical illness, emotional distress, and early mortality of the caregiver.
2. Emphasize the importance of seeking professional help as needed to reduce stress.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality of both the caregiver and the elder.
4. Explain that effective stress management may help to improve the health and well-being of the family member.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate, i.e., respite care, behavioral or mental health professionals.

EOL—End of Life

EOL-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

EOL-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms and prognosis of his/her illness.

STANDARDS:

1. Explain the basic anatomy and physiology of the patient's disease and the effect upon the body system(s) involved.
2. Discuss signs/symptoms of worsening of the patient's condition and when to seek medical care.

EOL-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) proper use and care of medical equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed medical equipment to be used during the hospital stay and after discharge, as appropriate.
2. Discuss and/or demonstrate proper use and care of medical equipment, including safety and infection control principles.
3. Assist in return demonstration by patient/family.

EOL-GP GRIEVING PROCESS

OUTCOME: The patient/family will understand the grieving process, recognize the sense of loss, and embrace the importance of preparing for the end of life emotionally and spiritually.

STANDARDS:

1. Explore the various losses and feelings that affect the patient and his/her loved ones when faced with a terminal illness. Explain that grief and a sense of loss become more intense when a patient is dying.
2. Discuss fears, myths and misconceptions of the dying process with the patient/family.
3. Discuss the importance of keeping open communication and promoting social interaction in preserving the dignity of the patient.
4. Explain that the five major losses experienced by a dying patient are; loss of control, loss of identity, loss of achievement, loss of social worth, and loss of relationships.
5. Explore how separation and mourning are aspects of the bereavement process.
6. Explain that bereavement coincides with the patient's imminent death and continues through the actual death event and the period of time immediately thereafter.
7. Explain that the need to repeatedly verbalize feelings is a normal part of grieving.

EOL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the patient's specific disease process, hospice care, end of life issues, advanced directives, support groups or community resources as appropriate.

STANDARDS:

1. Provide patient/family with written patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

EOL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the physiological, emotional and spiritual lifestyle adjustments necessary to cope with their terminal illness. They will understand that the plan of care will be based on the patient's wishes and the family's needs to enhance comfort and improve the quality of the patient's life.

STANDARDS:

1. Explain that the patient/family's values and beliefs will be respected and that the patient/family will be included in the decision making process.
2. Explain the need to remain active and the need to participate in familial, social, traditional, cultural and religious/spiritual activities and interactions when possible.
3. Explain the requirement for increased rest and sleep.
4. Assist with appropriate grieving strategies based on the provider's assessment of the patient/family's level of acceptance.
5. Refer to Social Services, Mental Health, Physical Therapy, Occupational Therapy, hospice, and/or community resources as appropriate.
6. Review lifestyle areas that may require adaptations (i.e., diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships). Discuss lifestyle changes in relation to his/her disease progression.
7. Inform the patient/family of local resources to accommodate their need for privacy and family gatherings if available.
8. Explain the importance of safety and infection control as applicable.

EOL-LW LIVING WILL

OUTCOME: The patient/family will understand the process of making a living will and its role in maintaining a sense of control in the patient's medical care and decisions.

STANDARDS:

1. Review the option of Advanced Directives/ Living Will with the patient and his/her family. Explain treatment options and answer questions in a manner the patient/family will understand.
2. Refer to appropriate services to assist the patient in making a living will, i.e., Social Services, Clergy, Lawyer.
3. Discuss giving designated persons access to the patient's complete health record and care management, including all necessary legal documents.

EOL-M MEDICATION

OUTCOME: The patient/family will understand the role of medication in control of pain and other discomforts. The patient/family will verbally summarize the medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Discuss the medication treatment plan.
3. Explain that pain, nausea and other discomforts can usually be controlled with medication. Discuss the use of adjunctive medication, if indicated, to control analgesic side effects, i.e., anti-emetics, laxatives, antacids.
4. Emphasize the importance of the patient/family's active participation with the provider in treatment decisions.
5. Explain that acute, severe or breakthrough pain should be immediately reported to the provider.
6. Discuss patient/family concerns about addiction. Explain that addiction is not an issue for terminally ill patients.
7. Discuss the importance of full participation with the medication regimen in order to assure optimal comfort levels. For example, round-the-clock dosing of pain medication is more effective in the treatment of chronic pain than medications that are taken after the pain recurs.
8. Explain that insomnia is often a significant problem for end of life patients. Emphasize the importance of developing a plan with the provider to address this issue as appropriate.
9. Explain that spiritual pain is a reality and cannot be controlled with medications.
10. Explain that excess sedation and euphoria are not goals of palliative pharmacologic therapy.
11. Explain that to some extent, pain may counteract the sedative and respiratory depressant effects of opiates.

EOL- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

EOL-N NUTRITION

OUTCOME: The patient/family will understand the importance of a nutritionally balanced diet in the treatment of their disease and the support of the terminal patient.

STANDARDS:

1. Assess the patient's current nutritional habits. Review how these habits might be improved.
2. Emphasize the necessary component - WATER - in a healthy diet.
3. Explain that constipation is a common side-effect of opiates. Dietary measures such as increased water, increased fiber, increased fruit juices and decreased intake of milk products may be helpful. Other control measures should be discussed with the provider prior to initiation.
4. Encourage ingestion of small, frequent meals and/or snacks.
5. Emphasize the importance of mouth care as appropriate.
6. If a specific nutrition plan is prescribed discuss this with the patient/family.
7. Discuss that failure to thrive may be a sign of impending death and may be seen in spite of adequate nutritional intake.

EOL-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process/aging process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM.**
2. Explain that narcotics and other medications may be helpful to control pain and the symptoms associated with pain.
3. Explain non-pharmacologic measures that may be helpful with pain control.

EOL-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand that grief reactions are common at the end of life and that depression may be seen.

STANDARDS:

1. Discuss symptoms of grief reaction, i.e., vigilance, trouble concentrating, hyperattentiveness, insomnia, distractibility.
2. Explain that the patient/family may need additional support, sympathy, time, attention, compassion and communication.
3. Explain that if anti-depressant drugs are prescribed by the provider, full participation with the treatment regimen is important to maximize effectiveness of the treatment.
4. Refer to community resources as appropriate, i.e., bio-feedback, yoga, Healing Touch, Herbal Medicine, laughter, humor, Traditional Healer, guided imagery, massage, acupuncture, acupressure.
5. Explain that many mechanisms for dealing with grief and depression are available, i.e., support groups, individual therapy, family counseling, spiritual counseling. Refer as appropriate.

EOL-SM STRESS MANAGEMENT

OUTCOMES: The patient/family member will understand the role of stress management in end of life situations.

STANDARDS:

1. Explain that uncontrolled stress can contribute to a faster decline in physical health and cause further emotional distress for the patient, as well as contribute to physical illness, emotional distress, and early mortality of the caregiver.
2. Explain that effective stress management may help to improve the patient's outlook, as well as the health and well-being of both the patient, caregiver and family members.
3. Emphasize the importance of seeking professional help as needed to reduce stress.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality of both the caregiver and the patient.
5. Discuss various stress management strategies which may maintain or improve quality of life. Examples for patient, caregiver and family members may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. practicing meditation
    i. self-hypnosis
    j. using positive imagery
    k. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    l. spiritual or cultural activities
6. Provide referrals as appropriate.

EOL-TX TREATMENT

OUTCOME: The patient/family will understand the difference between palliative and curative treatments; and understand that the focus of the treatment plan will be on the quality of life rather than quantity of life.

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of a treatment plan.
2. Explain what signs/symptoms should prompt an immediate call to the provider.
3. Explain the difference between palliative and curative treatments.
4. Explain that end of life treatments will typically not prolong the patient's life but are meant to improve the quality of life by increasing patient comfort.

F

FP—Family Planning

FP-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient will have a basic understanding of anatomy and physiology and it relationship to reproduction.

STANDARDS:

1. Identify and explain the functions of the reproductive system.
2. Discuss the menstrual cycle.
3. Discuss conception vs. contraception.

FP-DIA DIAPHRAGM

OUTCOME: The patient will understand the safe and effective use of a diaphragm.

STANDARDS:

1. Discuss the method of insertion.
2. Emphasize the use of spermicide.
3. Discuss the amount of time the diaphragm must be left in place.
4. Emphasize that the diaphragm must be used each time intercourse takes place.
5. Emphasize that the diaphragm must be refitted if there is a 10 pound weight loss or gain, and after childbirth.

FP-DPO DEPOT MEDROXYPROGESTERONE INJECTIONS

OUTCOME: The patient will understand risks, benefits, side effects, and effectiveness of depot medroxyprogesterone injections.

STANDARDS:

1. Explain the method of action and effectiveness of depot medroxyprogesterone.
2. Discuss the method of administration and importance of receiving the medication on time (typically every 3 months).
3. Discuss the contraindications, risks, and side effects of the medication.

FP-EC EMERGENCY CONTRACEPTION (POST-COITAL)

OUTCOME: The patient/family will understand risks, benefits side effects, safety and effectiveness of Emergency Contraception.

STANDARDS:

1. Explain the methods of possible actions and effectiveness of Emergency Contraception.
2. Identify indications for use - a potential candidate is a reproductive-age woman who has had unprotected sexual intercourse within 72 hours of presenting herself for medical care, independent of the time of the menstrual cycle. Most common reasons for seeking the treatment are failure of a barrier method or failure to use any method.
3. Discuss the safety: there are no contraindications to EC pill due to the small overall hormone dose and the short duration of use. (Some studies excluded women from participating if they had an absolute contraindication to taking oral contraceptives). EC has no adverse affect on a fetus, if taken inadvertently. EC may be used during breastfeeding without effect on milk quantity or quality.
4. Review side effects, and management:
    a. Levonorgestal-only regimen: Nausea occurs in approximately 23 percent of women and vomiting occurs in about 6 percent, usually limited to the first three days after treatment.
    b. Combined estrogen-progestin (Yuzpe) regimen: Nausea and vomiting occur in about 43 and 16 percent, usually limited to the first three days after treatment.
    c. Both side effects can be minimized by the use of anti-emetic pre-treatment.
    d. A small number of women may experience irregular bleeding or spotting after taking ECs, this is not their menses. Most women will have their menstrual period within one week before or after the expected time.
    e. Breast tenderness can occur after EC treatment.

FP-FC FOAM AND CONDOMS

OUTCOME: The patient will have a basic understanding of the safe and effective use of foam and condoms.

STANDARDS:

1. Discuss proper use and application of foam and condoms.
2. Emphasize the importance of use each time intercourse takes place.
3. Emphasize why condoms must be applied before penetration.
4. Emphasize that male must withdraw before erection subsides.
5. Advise concomitant use of spermicidal foam as recommended by the medical provider.
6. Discuss use of spermicidal suppositories and intravaginal films.
7. Discuss that condoms provide possible protection against STIs.

FP-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

FP-IC IMPLANT CONTRACEPTION

OUTCOME: The patient will understand the safe and effective use of implantable contraceptives.

STANDARDS:

1. Discuss and review all birth control methods with the patient.
2. Explain the insertion procedure and mechanism of action including duration of effectiveness.
3. Discuss contraindications, risks, and side effects, including the possibility of pregnancy.
4. Stress the importance of yearly follow-up.

FP-IUD INTRAUTERINE DEVICE

OUTCOME: The patient will understand the safe and effective use of the IUD.

STANDARDS:

1. Explain why IUDs are more easily retained in multiparous vs. nulliparous women.
2. Explain how IUDs work.
3. Emphasize the importance of monthly string checks.
4. Emphasize the importance of reporting abnormal vaginal discharge, fever, or pain with intercourse.
5. Discuss contraindications to placement of IUDs.
6. Explain that the copper IUD's need periodic replacement.

   NOTE: IUDs may be UNAVAILABLE from time to time due to medicolegal reasons.

FP-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about family planning.

STANDARDS:

1. Provide patient/family with written patient information literature on family planning.
2. Discuss the content of the patient information literature with the patient/family.

FP- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

FP-MT METHODS

OUTCOME: The patient will receive information regarding the available methods of birth control.

STANDARDS:

1. Discuss the reliability of the various methods of birth control.
2. Discuss how each method is used in preventing pregnancy.
3. Discuss contraindications, benefits, and potential costs of each method.

FP-N NUTRITION

OUTCOME: The patient will understand the role of folic acid in the prevention of neural tube defects and the importance of a balanced diet.

STANDARDS:

1. Identify the amount of folic acid required.
2. Explain that to be maximally effective, folic acid should be given before conception.
3. Identify food sources and supplemental forms of folic acid.
4. Discuss the importance of a balanced diet.

FP-OC ORAL CONTRACEPTIVES

OUTCOME: The patient will understand the safe and effective use of oral contraceptives.

STANDARDS:

1. Explain how the "pill" inhibits ovulation.
2. Discuss the methods of taking oral contraceptives.
3. Discuss the contraindications, risks, and side effects.
4. Discuss the signs and symptoms of complications.
5. Specifically counsel on potential drug interactions, especially that antibiotics may make the contraceptive ineffective.

FP-ST STERILIZATION

OUTCOME: In order to make an informed decision about irreversible contraception, the patient will receive information about sterilization.

STANDARDS:

1. Explain tubal ligation vs. vasectomy. Emphasize that these are PERMANENT methods of contraception.
2. Explain laparoscopic (LEC) procedures: Anesthesia, CO2, incision, vaginal bleeding.
3. Explain vasectomy procedures.
4. Discuss the possible side effects and risks: Infection, pain, failure, and bleeding at incision site.
5. Explain that IHS and the state may have specific legal criteria that must be met in order to be eligible for sterilization.
6. Review availability of other methods that can prevent or delay pregnancy as an option to permanent sterilization.
7. Offer behavioral health follow-up as appropriate.

FRST—Frostbite

FRST-C COMPLICATIONS

OUTCOME: The patient and/or family will understand the consequences of frostbite; and the complications associated with frostbite.

STANDARDS:

1. Explain that the severity of frostbite is associated with how deep the freeze is. No tissue is safe. This can involve the skin layers as well as the fat, muscle, blood vessels, lymphatics, nerves and even the bones.
2. Discuss that frostbite is just like receiving a burn; and is categorized based upon the extent of the tissue injury.
    a. First Degree: is a partial freeze of the skin. Clinical Appearance: Redness, swelling, possible peeling of skin about a week later. Symptoms: Periodic burning, stinging, aching, throbbing; excessive sweating in the area.
    b. Second Degree: All layers of the skin have frozen. Clinical Appearance: Redness, significant swelling, blisters, black scabs, Symptoms: Numbness, heaviness of the affected area.
    c. Third Degree: Skin and subcutaneous tissues are completely frozen. Clinical Appearance: Purplish blisters (blood-filled), dusky blue skin discoloration, death of the skin. Symptoms: Loss of sensation, area feels like “wood”. Later on, the area has significant burning and throbbing.
    d. Fourth Degree: Complete involvement of skin, fat, muscle, bone. Clinical Appearance: Minimal swelling. The area is initially quite red, then becomes black. Symptoms: Occasional joint pain.
3. Emphasize the importance to avoid thawing and then refreezing the injury. This is very dangerous and can cause serious sequella.

FRST-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

FRST-DP DISEASE PROCESS

OUTCOME: The patient and/or family will understand how frostbite occurs the signs and symptoms of frostbite, and risk factors associated with frostbite.

STANDARDS:

1. Explain that frostbite, simply defined, is the freezing of the skin and/or the bodily tissues under the skin.
2. Discuss signs and symptoms of frostbite with the patient/family:
    a. Mild frostbite (frostnip) affects the outer skin layers and appears as a blanching or whitening of the skin.
    b. Severe frostbite: the skin will appear waxy-looking with a white, grayish-yellow or grayish-blue color.
    c. Affected body parts will have no feeling (numbness) and blisters may be present.
    d. The tissue will feel frozen or "wooden".
    e. Other symptoms include swelling, itching, burning and deep pain as the area is warmed.
3. Discuss the pathophysiology of frostbite: the fluids in the body tissues and cellular spaces freeze and crystallize. This can cause damage to the blood vessels and result in blood clotting and lack of oxygen to the affected area.
4. Review with patient/family predisposing conditions to frostbite:
    a. exposure of the body to cold
    b. length of time a person is exposed to the cold
    c. temperature outside
    d. wind-chill factor
    e. humidity in the air
    f. wetness of clothing and shoes
    g. ingestion of alcohol and other drug
    h. high altitudes
5. Explain that frostbite can occur in a matter of minutes.
6. Discuss with patient/family that the most common parts of the body affected by frostbite include the hands, feet, ears, nose and face.
7. Review with patient/family the medical conditions that make some at greater risk for frostbite:
    a. the elderly and young
    b. persons with circulation problems
    c. history of previous cold injuries
    d. ingestion of particular drugs, i.e., alcohol, nicotine and beta-blockers
    e. persons from southern/tropical climates exposed to cold weather conditions.

FRST-FU FOLLOW-UP

OUTCOME: The patient and/or family will understand the seriousness of frostbite and the importance of follow up care.

STANDARDS:

1. Discuss the importance of follow up appointments after frostbite to determine if there is any permanent or ongoing damage.
2. Discuss the importance of keeping follow up appointments.
3. Discuss the procedures for obtaining follow up appointments.

FRST-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient and/or family will receive written information about frostbite, and important preventive measures.

STANDARDS:

1. Provide patient/family with written information on frostbite and prevention of frostbite.
2. Discuss the content of frostbite written information with the patient/family.

FRST-M MEDICATIONS

OUTCOME: The patient/family will understand the use of medications to manage frostbite.

STANDARDS:

1. Explain to patient/family that the blistered areas may require topical medications applied during dressing changes as prescribed by provider.
2. Discuss appropriate medications available for acute and chronic pain.
3. Advise patient/family that a tetanus vaccination is necessary if not received in last 5-10 years.
4. Discuss the common and important side effects and drug interactions of medications prescribed.

FRST- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

FRST-N NUTRITION

OUTCOME: The patient/family will understand the nutritional problems associated with frostbite.

STANDARDS:

1. Discuss that based on severity of the injury the need for replenishment of calories, fluids, protein, nitrogen and other nutrients may be essential.
2. Refer to a registered dietician as appropriate.

FRST-P PREVENTION

OUTCOME: The patient/family will understand ways to prevent frostbite.

STANDARDS:

1. Discuss with the patient/family that the majority of frostbite cases are preventable, and that it is easier to prevent frostbite than to treat it.
2. Emphasize the importance of keeping clothing/socks dry. Wet clothing predisposes to frostbite.
3. Explain that it is important to minimize wind exposure. Wind proof clothing can be helpful. High winds increase heat loss from the body.
4. Discuss that it is important to wear loose, layered clothing (i.e., hat, gloves, loosely fitting layered clothing). Constrictive clothing increases the likelihood of frostbite as does immobilization and dependency of the extremities. Proper clothing for winter weather insulates from the cold, lets perspiration evaporate and provides protection against wind, rain and snow. Wear several layers of light, loose clothing that will trap air, yet provide adequate ventilation. This is better protection than one bulky or heavy covering.
5. Discuss the importance to stocking the vehicle appropriately for winter travel (i.e., blankets, gloves, hats).
6. Discuss that when in frostbite-causing conditions, dressing appropriately, staying near adequate shelter and remaining physically active can significantly reduce the risk of suffering from frostbite.
7. Discuss the importance of avoiding alcohol, and other drugs while participating in outdoor activities.
8. Review the sensations associated with overexposure to cold, i.e., sensations of intermittent stinging, burning , throbbing and aching are all early signs of frostbite. Get indoors.
9. Discuss with patient/family the medical conditions that make some at greater risk for frostbite:
    a. the elderly and young
    b. persons with circulation problems
    c. history of previous cold injuries
    d. ingestion of particular drugs, i.e., alcohol, nicotine and beta-blockers
    e. persons from southern/tropical climates exposed to cold weather conditions.

FRST-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand how to manage the pain associated with the acute and chronic tissue damage caused from frostbite.

STANDARDS:

1. Discuss that there has been some evidence that aloe vera in a 70% concentration when applied topically may be helpful in pain management.
2. Discuss appropriate pain management plan with patient/family.

FRST-TX TREATMENT

OUTCOME: The patient and/or family will understand the management and treatment of frostbite.

STANDARDS:

1. Discuss the goal of treatment with the patient; prevention of further exposure to affected area(s), and management and prevention of complications.
2. Emphasize the need to have frostbite injuries rewarmed under medical supervision.
3. Explain that the patient needs to get to a warm place where he/she can stay warm after thawing. Refreezing can cause more severe tissue damage.
4. Review proper thawing process:
    a. Use warm-to-the touch water 100˚ F (38˚ C.) For 30-45 minutes until a good color (flush) has returned to the entire area. Emphasize that this process may be painful, especially the final few minutes.
    b. Leave the blisters intact. Cover with a sterile or clean covering if protection is needed to prevent rupturing of blisters.
    c. Keep the affected part(s) as clean as possible to reduce the risk of infection.
    d. Keep the affected area elevated above the level of the heart.
5. Emphasize the importance of having a current tetanus booster (within5-10 years).
6. Review treatment modalities that are not deemed appropriate methods to treat frostbite:
    a. Don’t use dry heat (sunlamp, radiator, heating pad) to thaw the injured area.
    b. Don’t thaw the injury in melted ice.
    c. Don’t rub the area with snow.
    d. Don’t use alcohol, nicotine or other drugs that may affect blood flow.

FRST-WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care.

STANDARDS:

1. Explain the reasons to care appropriately for the wound, i.e., decreased infection rate, improved healing.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that should prompt immediate follow-up, i.e., increasing redness, purulent discharge, fever, increased swelling/pain.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.
5. Emphasize the importance of follow-up.
6. Demonstrate the necessary wound care techniques.

G

GB—Gallbladder

GB-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient will have a basic understanding of where the gallbladder is in the body and its function in digestion.

STANDARDS:

1. Discuss that the gallbladder is a small bag found under the liver.
2. Explain that the function of a normal gallbladder is to store bile, concentrate it by removing water and empty this concentrated bile into the intestine when fatty foods are eaten.
3. Explain that the gallbladder empties through the cystic duct into the common bile duct which then empties into the small intestine. Explain that the common bile duct also drains the liver and the pancreas.
4. Explain that the bile helps to digest the fat in the foods.

GB-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of untreated or progressed gallbladder disease. (Please choose from the following standards as they apply to this patient's specific disease process.)

STANDARDS:

1. Explain that if the amount of bile and other chemicals inside the gallbladder get out of balance gallstones can form. Most gallstones are cholesterol gallstones and form when too much cholesterol is secreted into the gallbladder from the liver.
2. Explain that gallstones usually don't cause a problem if they stay in the gallbladder. Approximately 80% of people with gallstones have no symptoms at all.
3. Explain that sometimes gallstones move into the ducts that drain the gallbladder and that this may lead to pain, infections, diseases of the liver, disease of the pancreas and may lead to gangrene or perforation of the gallbladder.
4. Empyema of the gallbladder (pus in the gallbladder) is a serious complication of acute cholecystitis and can result in death in about 25% of cases. Empyema is relatively rare, however, it does occur in about 2% of cases of acute cholecystitis.
5. Explain that patients with choledocholithiasis (stones in the common bile ducts) may get cholangitis (infection of the bile ducts). This is very serious and may be treated with antibiotics and may require surgery. Choledocholithiasis may also result in pancreatitis. **Refer to PC.**
6. Explain that risk of serious complications can be reduced by seeking prompt medical attention.

GB-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the causes and symptoms of his/her gallbladder disease. (Please choose from the following standards as they apply to this particular patient.)

STANDARDS:

1. Explain that gallstones (cholelithiasis) can cause problems when a gallstone gets lodged in either the cystic duct or the common bile duct. This can result in right upper quadrant abdominal pain, nausea, vomiting, heartburn and back pain.
2. Explain that gallstones in the common bile duct can also result in jaundice or pancreatitis. This condition is called choledocholithiasis.
3. Explain that biliary colic is a mild form of gallbladder disease and results in right upper quadrant abdominal pain several hours after eating a fatty meal. The pain is not relieved by changes in position, over-the-counter medications or passing gas. It will usually spontaneously resolve in 1-5 hours.
4. Explain that acute cholecystitis is similar to biliary colic but is more severe. It results from inflammation of the gallbladder. Infection is often present. The pain with cholecystitis is more severe and often patients complain of pain with breathing. This is a severe condition which can progress to perforation of the gallbladder or gangrene. Patients with acute cholesystitis should seek immediate medical attention.
5. Explain that chronic cholecystitis results from long term inflammation of the gallbladder with or without stones and results in scarring of the gallbladder. Patients with chronic cholecystitis will often have gas, nausea or abdominal discomfort after meals.
6. Explain that some drugs may induce gall bladder disease.
7. Explain that gallbladder disease is more common in the following groups of people:
    a. Women
    b. People over 40
    c. Women who have been pregnant (especially women with multiple pregnancies)
    d. People who are overweight
    e. People who eat large amounts of dairy products, animal fats and fried foods, i.e., high fat diet
    f. People who lose weight very rapidly
    g. People with a family history of gallbladder disease
    h. Native Americans (especially Pima Indians), Hispanics and people of Northern European descent
    i. People with sickle-cell anemia, cirrhosis, hypertriglyceridemia (especially with low HDL cholesterol),or diabetes.

GB-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of fully participating in the treatment regimen and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of gallbladder disease.
2. Review the treatment plan with the patient, emphasizing the importance for follow-up care.
3. Discuss the procedure for obtaining follow-up appointments.

GB-L LITERATURE

OUTCOME: The patient/family will receive written information about gallbladder disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on gallbladder disease.
2. Discuss the content of patient information literature with the patient/family.

GB-M MEDICATIONS

OUTCOME: The patient/family will understand the medications to be used in the management of gallbladder disease.

STANDARDS:

1. Explain as indicated that some medications may be used to dissolve small gallstones.
2. Explain the regimen to be implemented in pain control as indicated.
3. Explain the medications to be used in this patient including the dosage, timing, proper use and storage of the medication, important and common side-effects of the medication including drug-drug and drug-food interactions.

GB- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

GB-N NUTRITION

OUTCOME: The patient/family will understand ways diet relates to gallbladder disease.

STANDARDS:

1. Explain that a diet that is high in fat and simple sugars can contribute to the formation of gallstones.
2. Explain that rapid weight loss should be avoided as it may contribute to formation of gallstones. Encourage overweight persons to undertake a rational approach to weight loss that includes exercise and moderate dietary limitation under the consultation of a physician.

GB-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of gallbladder disease.

STANDARDS:

1. Explain that maintaining a normal body weight and avoiding fasts are keys to reducing the risk of gallstones.
2. Explain that a low fat diet will help prevent gallbladder disease.
3. Explain that regular vigorous exercise reduces the risk of gallbladder disease. Exercises that seem most helpful are brisk walking, jogging, and racquet sports.

GB-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management in gallbladder disease is specific to the disease process of this particular patient and may be multifaceted.
2. Explain that often antispasmodics may be helpful.
3. Explain that short term use of narcotics may be helpful in pain management.
4. Explain that other medications may be helpful to control the symptoms of nausea and vomiting.
5. Explain that administration of fluids may help with pain relief and resolution of symptoms.
6. **Refer to PM.**

GB-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s) as well as risks, benefits and alternatives to the proposed procedure(s). **Refer to SPE.**

STANDARDS:

1. Explain the specific procedure to be performed including the risks and benefits both of doing the procedure and adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure including expectant management, as appropriate.

GB-TE TESTS

OUTCOME: The patient/family will understand the proposed test(s) as well as risks, benefits and alternatives to the proposed test(s).

STANDARDS:

1. Explain the test to be performed including the potential benefit to the patient and any adverse effects of the test or adverse effects which might result from refusal of the test.
2. Explain the testing process to help the patient understand what he/she might experience during the test.
3. Explain any preparation the patient may need to do for the proposed test, i.e., NPO status.

GE—Gastroenteritis

GE-C COMPLICATIONS

OUTCOME: The patient/family will understand the possible complications of gastroenteritis and which patients are at high risk for complications.

STANDARDS:

1. Discuss the common or serious complications of gastroenteritis, such as:
   a. dehydration
   b. electrolyte imbalance
   c. need for hospitalization.
2. Explain that people with concurrent or chronic illness, the elderly, the very young, or people who have prolonged episodes of gastroenteritis are at higher risk for complications.

GE-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

GE-DP DISEASE PROCESS

OUTCOME: The patient will understand the causes and symptoms of gastroenteritis.

STANDARDS:

1. Explain that gastroenteritis is usually caused by a viral infection and will go away on its own.
2. Review the signs and symptoms of gastroenteritis such as:
   a. colicky abdominal pain
   b. fever which may be low grade or higher
   c. diarrhea
   d. nausea and/or vomiting.
3. Discuss the potential for dehydration and signs of dehydration:
   a. dry sticky mouth
   b. no tears when crying
   c. no urine output for 8 hours or more
   d. sunken fontanelle (in an infant)
   e. sunken appearing eyes
   f. others as appropriate.
4. Explain the need to seek immediate medical care if dehydration is suspected.

GE-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of fully participating in treatment regimen and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of gastroenteritis.
2. Review the treatment plan with the patient, emphasizing the importance of checking for signs of dehydration.
3. Discuss the procedure for obtaining follow-up appointments as appropriate.

GE-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of gastroenteritis and make a plan for implementation.

STANDARDS:

1. Discuss the home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer future infections, fewer emergency room visits, fewer hospitalizations and fewer complications, as well as a healthier life.
3. Explain the relationship between hygiene and infection control principles. Emphasize importance of hand washing.

GE-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about gastroenteritis.

STANDARDS:

1. Provide the patient/family with written information about gastroenteritis.
2. Discuss the content of patient information literature with the patient/family.

GE-M MEDICATIONS

OUTCOME: The patient /family will understand the limited role medications play in the management of gastroenteritis.

STANDARDS:

1. Explain that in most cases of gastroenteritis no medication is needed.
2. If medication is prescribed for nausea relief or diarrhea control, provide a brief description of how the medication works, what the common or problematic side-effects.
3. Explain that many medications prescribed for nausea or diarrhea may cause drowsiness and the patient should avoid activities such as driving or operating heavy machinery while using these medications.
4. Explain the importance of proper hydration even in the face of drowsiness.

GE- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

GE-N NUTRITION

OUTCOME: The patient will understand ways to treat gastroenteritis by nutritional therapy.

STANDARDS:

1. Explain that in gastroenteritis the gastrointestinal tract is not working properly.
2. Explain that gastrointestinal rest is essential to quick recovery from gastroenteritis.
3. Explain that water and many other clear liquids are rapidly absorbed across the stomach wall and do not require that the gastrointestinal tract be working properly. (Oral electrolyte solutions are excellent clear fluids for all who will take them.)
4. Discourage the use of juices as many of them will make the diarrhea worse.
5. Discourage the use of caffeinated beverages as they are dehydrating.
6. Explain that clear liquids taken in small amounts and frequently will often result in resolution of the vomiting, i.e., 1 teaspoonful to 1 tablespoonful every 5-10 minutes.
7. Explain that it is usually appropriate to go to a high starch/low fat diet gradually.

GE-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

GE-TE TESTS

OUTCOME: The patient /family will understand the conditions under which testing is necessary and the specific test(s) to be preformed, technique for collecting samples and the expected benefit of testing and any associated risks. The patient/family will also understand alternatives to testing and the potential or risks associated with the alternatives, i.e., risk of non-treatment.

STANDARDS:

1. Explain that tests may be necessary for prolonged gastroenteritis or gastroenteritis accompanied by diarrhea with blood or mucus. Discuss the procedure for collecting the sample, the benefit expected and any associated risks.
2. Explain the alternatives to the proposed test(s) and the risk/benefits ratio of the testing and alternatives including the risk of non-treatment.

GE-TX TREATMENT

OUTCOME: The patient/family will understand the treatment plan for gastroenteritis.

STANDARDS:

1. Explain that the major treatment for viral gastroenteritis is dietary modification.
2. Explain that if the gastroenteritis is caused by a bacterium, antibiotics may be prescribed.
3. Explain that if the patient fails attempts at oral rehydration, I.V. rehydration is frequently necessary.

GER—Gastroesophageal Reflux Disease

GER-DP DISEASE PROCESS

OUTCOME: The patient will understand the anatomy and pathophysiology of gastroesophageal reflux disease.

STANDARDS:

1. Explain the anatomy and physiology of the esophagus and stomach.
2. Explain the process of acid reflux into the esophagus.
3. Explain how and why stomach acid reflux into the esophagus causes pain and disease.
4. Explain long-term complications of untreated GERD including carcinoma of the esophagus.

GER-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

GER-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about gastroesophageal reflux disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on gastroesophageal reflux disease.
2. Discuss the content of the patient information literature with the patient/family.

GER-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient and/or family will understand how to control GERD through lifestyle adaptation.

STANDARDS:

1. Emphasize the importance of tobacco cessation and decreased alcohol consumption.
2. Identify obesity as a major exacerbating factor in GERD. Discuss the importance of regular exercise and its role in obtaining and maintaining desirable weight.
3. Identify foods that may aggravate GERD.
4. Review the effect of timing of meals, i.e., no large meals before bedtime, more frequent light meals instead of few large meals.
5. Discuss physical control measures such as elevating the head of the bed.

GER-M MEDICATIONS

OUTCOMES: The patient/family will understand the medication, dosage and side effects that may occur. Patient/family will understand how the medication works to prevent the symptoms of GERD.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication..
2. Explain how the medication works to prevent the symptoms of GERD.
3. Explain that non-pharmacologic therapies in combination with medications will help reduce the symptoms of GERD.
4. Emphasize the importance of possible drug interactions with foods and over the counter medications.

GER- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

GER-N NUTRITION

OUTCOME: The patient will understand the need for balanced nutrition and plan for the implementation of dietary modification as needed.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to Gastroesophageal Reflux Disease.
4. Emphasize the importance of fully participating in the prescribed nutritional plan.

GER-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

GER-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in gastroesophageal reflux disease.

STANDARDS:

1. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the risk of morbidity from gastroesophageal reflux disease.
2. Explain that effective stress management may help reduce the severity of gastroesophageal reflux disease, as well as help improve the health and well-being of the patient.
3. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
4. Provide referrals as appropriate.

GER-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Upper gastrointestinal barium studies.
2. Explain that the upper GI barium study is an x-ray to assess the degree and extent of the disease.
3. Explain that barium liquid will be swallowed and radiographs taken.
4. Discuss NPO status as indicated.
5. Discuss the test(s) for H. Pylori and how testing may assist in diagnosis and treatment.
6. Discuss as appropriate the procedure for EGD and the risks and benefits of performing this test. **Refer to SPE.**

GER-TX TREATMENT

OUTCOME: The patient and/or family will understand the medical and surgical treatments available for GERD.

STANDARDS:

1. Discuss the use, benefits, and common side effects of the patient's prescribed medications.
2. Discuss possible surgical interventions for GERD as appropriate.

GENE—Genetic Disorders

GENE-BH BEHAVIORAL AND SOCIAL HEALTH

OUTCOME: The patient/family will understanding the behavioral and social aspects of this genetic disorder.

STANDARDS:

1. Discuss that caring for special needs individuals may result in a variety of emotions and may require medical intervention or counseling.
2. Refer to community resources as appropriate.
3. Refer to a social worker for assistance with special programs.

GENE-C COMPLICATIONS

OUTCOME: The patient/family will understand complications which are more common with this genetic disorder than in the general population.

STANDARDS:

1. Discuss complications more common in persons with this genetic disorder (i.e., hypothyroidism, alantoaxial instability with Down syndrome.)

GENE-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction, as appropriate.
6. Discuss proper disposal of associated medical supplies.

GENE-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointment.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that follow-up appointments should be kept.

GENE-I INFORMATION

OUTCOME: The parents/family will understand the genetic disorder that has been diagnosed or is being considered.

STANDARDS:

1. Discuss the symptoms of the genetic disorder
2. Discuss the inheritance pattern of the genetic disorder, if known.
3. Explain implications for future pregnancies, as appropriate.
4. Refer to pre-pregnancy and/or genetic counseling, as available or appropriate.

GENE-L PATIENT INFORMATION LITERATURE

OUTCOME: The parents/family will receive written information about the genetic disorder.

STANDARDS:

1. Provide the parents/family with written information about the genetic disorder.
2. Discuss the content of the patient information literature with the parent(s)/family.

GENE- LA LIFESTYLE ADAPTATION

OUTCOME: The patient/family will understand lifestyle adaptations necessary to care for a person with a genetic disorder.

STANDARDS:

1. Discuss lifestyle adaptations specific to this genetic disorder.
2. Discuss the availability of special programs and explain that parent must be advocates for their child with special needs (i.e., Birth to 3, Head Start, special school programs)
3. Refer to community services, resources, or support groups, as available.

GENE- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

GENE-N NUTRITION

OUTCOME: The patient/family will understand the special nutritional needs of persons with this genetic disorder.

STANDARDS:

1. Discuss nutritional needs of persons with this genetic disorder (i.e., some genetic disorders cause failure to thrive while others may cause obesity).
2. Refer to a registered dietitian.

GENE-P PREVENTION

OUTCOME: The parents/family will understand any preventive measures for future occurrences of a genetic disorder, as appropriate.

STANDARDS

1. Discuss factors that influence the occurrence of genetic disorders (i.e., older maternal age predisposes to Down syndrome).
2. Discuss genetic counseling options especially with families with previous occurrences of genetic disorders.

GENE-PA PARENTING

OUTCOME: The parent will understand the special parenting challenges of this genetic disorder.

STANDARDS:

1. Discuss that many genetic disorders render the patient incapable of independent life and that the parents will need to plan for long term care of the patient.
    a. Discuss that many of these patients will require parenting well beyond 18 years of life.
    b. Discuss that the parents should plan early for an alternative care plan in the event of death of the parents (i.e., designating a guardian, setting up trust funds)
    c. Discuss the need for consistent parenting especially in children with special needs.
    d. Discuss the need for respite care (alternative caregivers) to allow for time for the parent to have time for him/herself.

GENE-PT PHYSICAL THERAPY

OUTCOME: The patient/family will understand the role that physical/occupational/speech therapies play in the functional ability of persons with genetic disorders.

STANDARDS:

1. Discuss physical/occupational/speech therapies as appropriate to this patient.
2. Refer as appropriate.

GENE-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand safety issues specific to this genetic disorder.

STANDARDS:

1. Discuss that some genetic disorders result in lower IQs and that this often makes the patient more vulnerable to many personal safety hazards including sexual abuse/assault.
2. Discuss safety and injury prevention issues as related to this genetic disorder.

GENE-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in the treatment of genetic disorders.

STANDARDS:

1. Discuss that uncontrolled stress may increase alcohol and other drug use and interfere with treatment.
2. Emphasize the importance of seeking professional help as needed to reduce stress.
3. Discuss the various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Talking with people you trust about your worries or problems
    d. Setting realistic and meaningful goals
    e. Getting enough sleep
    f. Making healthy food choices
    g. Regular physical activity
    h. Taking vacations
    i. Practicing meditation
    j. Self-hypnosis
    k. Using positive imagery
    l. Practicing relaxation methods such as deep breathing or progressive muscular relaxation
    m. Spiritual or cultural activities.
4. Provide referrals as appropriate

GENE- TE TESTS

OUTCOME: The patient/ family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered. Test may be performed to rule out other disease processes.
2. Explain the necessity, benefits and risks of the test to be performed, as appropriate, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test, including appropriate collection.
5. Explain the meaning of the test results, as appropriate.

GIB—GI Bleed

GIB-C COMPLICATIONS

OUTCOME: The patient/family will understand the seriousness of gastrointestinal bleeding and will verbalize intent to obtain treatment if symptoms occur.

STANDARDS:

1. Explain that severe blood volume depletion and anemia can result from untreated gastrointestinal bleeding.
2. Explain that complications may be prevented with prompt treatment.
3. Discuss the symptoms of gastrointestinal bleeding, e.g. vomiting blood or coffee-ground emesis or black, tarry or bloody stools.

GIB-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

GIB-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the etiology and pathophysiology of their gastrointestinal disease.

STANDARDS:

1. Explain that gastrointestinal bleeding may have a variety of causes e.g. esophagitis, gastritis, peptic ulcers, esophageal varices, Crohn's disease, polyps, ulcerative colitis, diverticulosis or cancer.
2. Explain that the bleeding may present itself in a variety of ways, depending on the source and severity of the bleeding.
3. Explain that massive bleeding may result in weakness, dizziness, faintness, shortness of breath, crampy abdominal pain, diarrhea, or death.

GIB-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment, as appropriate.
3. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
4. For inpatients, explain that the various alarms are to alert the medical personnel of the patient’s status and/or the function of the equipment.
5. Emphasize the importance of not tampering with any medical device.

GIB –FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up, care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

GIB –L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the disease process involved with the gastrointestinal bleeding.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding the disease process involved with the gastrointestinal bleeding.
2. Discuss the content of the patient information literature with the patient/family.

GIB -M MEDICATIONS

OUTCOME: The patient will verbally summarize the prescribed medication regimen and the importance of full participation .

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Discuss the use of antacids and medications to decrease acid production. Stress that absence of symptoms does not mean that the medication is no longer needed.
3. Stress the importance of avoiding substances containing aspirin, alcohol, nonsteroidal anti-inflammatory drugs, ibuprofen, and steroids, which might aggravate or precipitate further bleeding.
4. Discuss the importance of full participation with the medication regimen in order to promote healing and assure optimal comfort.

GIB- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

GIB –N NUTRITION

OUTCOME: The patient/family will understand the prescribed diet.

STANDARDS:

1. Explain that rest of the gastrointestinal tract may be required in the immediate GI bleed period.
2. Explain that IV nutrition support may be necessary if prolonged abstinence from food is required.
3. Explain that certain foods are likely to exacerbate the GI condition and should be avoided, i.e., alcohol, caffeine, fatty foods
4. Explain that gradual introduction of oral nutrients will be accomplished while decreasing IV nutrition support. Bowel irregularity is common during this period of time.
5. Explain that bland starchy foods are easier to digest and may be more easily tolerated.
6. Discuss that consumption of yogurt (with live or active cultures) is often helpful to resume normal bowel flora.

GIB –P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of gastrointestinal bleeding episodes.

STANDARDS:

1. Stress the importance of avoiding substances containing aspirin, alcohol nonsteroidal anti-inflammatory drugs, ibuprofen, and steroids, which might aggravate or precipitate bleeding.
2. Emphasize the importance of bowel regular bowel movements in the prevention of GI bleeds.

GIB-TE TESTS

OUTCOME: The patient/family will understand the diagnostic tests to be performed, the risk(s) and benefits of the proposed test as well as the risk(s) of non-performance of the test(s).

STANDARDS:

1. Explain that examining-a stool sample for occult blood is a simple and reliable method for determining subtle bleeding in the GI tract.
2. Explain that the cause of the bleeding may be found by directly visualizing the inside of the GI tract via an endoscope, a tube that is passed either by the mouth or the rectum.
3. Explain that sometimes defects of the GI tract that cause bleeding may be detected by x-ray by performing either a barium swallow or upper GI series or a barium enema.
4. Explain that the preparation for many of these procedures require that nothing be taken by mouth for several hours before the procedure, and enemas are usually required for the lower GI tests.
5. Explain that local anesthetics and sedation are usually given prior to the endoscopic procedures.

GIB-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate management of the gastrointestinal bleeding.

STANDARDS:

1. Explain that IV fluids and/or blood transfusions may be necessary to replace lost blood volume. **Refer to BL.**
2. Explain that for upper GI bleeding, gastric lavage may be necessary to remove the blood from the GI tract and prevent further complications.

3. Explain that electrocoagulation or photocoagulation (laser) may be necessary to stop the bleeding.
4. Explain that surgery may be necessary to resect the bleeding area or tumor if other measures are not effective.

GBS—Guillain-Barre Syndrome

GBS-C COMPLICATIONS

OUTCOME: The patient/family will understand the effects and consequences possible as a result of Guillain-Barre Syndrome and understand that fully participating in the plan of care may help prevent these complications.

STANDARDS:

1. Explain that because of decreased inspiratory and expiratory capacities, coughing may become ineffective and the airway compromised, leading to hypoxia, atelectasis, pneumonia and aspiration.
2. Explain that aspiration may also be the direct result of weakness of the laryngeal and glottic musculature, and that airway obstruction may occur as a result of tongue and retropharyngeal weakness.
3. Emphasize that changes in speech, tongue protrusion and swallowing problems are signs of impending respiratory dysfunction and should trigger an immediate visit to the healthcare provider.
4. Explain that another serious complication that can be treated with medications is cardiac rhythm disturbances.
5. Explain that other complications that are less serious, but still require treatment may be abnormal blood pressure, urinary retention, gastrointestinal dysfunction and fluid and electrolyte abnormalities.
6. Explain that common complications of paralysis such as pressure sores and contractures may be minimized or eliminated by careful attention to skin care, positioning and passive exercise.

GBS-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology, symptoms and prognosis of Guillain-Barre Syndrome.

STANDARDS:

1. Explain to the patient that Guillain-Barre' syndrome is an inflammatory disease with widespread involvement of the peripheral and cranial nerves. It usually affects young adults and persons in their 50s. There is a higher incidence in men and Caucasians. The cause of the syndrome is unknown, but many persons with this syndrome experience a mild respiratory or gastrointestinal infection 1 to 3 weeks before the onset of the neuritic signs and symptoms. Viral infections may function as a trigger to set off the autoimmune response to damage the peripheral nerves.
2. Explain that weakness usually begins in the distal muscles of the limbs, develops bilaterally over a period of a few days and ascends to the trunk, arms, and cranial muscles producing total motor paralysis within a few days (10 to 14 days.) This paralysis may involve the muscles of respiration and facial muscles so that the patient cannot breathe, chew, swallow, talk or open the eyes. Sensory symptoms may or may not be present.
3. Explain that muscle atrophy does not occur and the paralysis is usually temporary.
4. Explain that there is *usually* no pain, but tingling, burning, aching or cramping pain may occur.
5. Emphasize that recovery is usually total over time, but that convalescence may be lengthy and that recovery may continue from 3 months to 2 years.
6. Explain that there is a risk of recurrence. Persons who have experienced one episode of Guillain-Barre syndrome are at higher risk of another episode over the general population.

GBS-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment, as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment, as appropriate.
4. Participate in a return demonstration by the patient/family, as needed.
5. Discuss signs of equipment malfunction and proper action in case of malfunction, as appropriate.
6. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
7. Emphasize the importance of not tampering with any medical device.

GBS-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make plans to keep follow-up appointments and return immediately for signs of complications.

STANDARDS:

1. Stress the importance of keeping follow-up appointments and continuing the prescribed therapy even after the condition improves.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize the importance of keeping follow-up appointments.
4. Emphasize that changes in speech, tongue protrusion and swallowing problems are signs of impending respiratory dysfunction and should trigger an *immediate* visit to the healthcare provider or emergency facility.

GBS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about Guillain-Barre Syndrome.

STANDARDS:

1. Provide the patient/family with written patient information regarding Guillain-Barre Syndrome.
2. Discuss the content of the patient information literature with the patient/family.

GBS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will strive to make the lifestyle adaptations necessary to prevent complications of Guillain-Barre Syndrome and improve mental and physical health.

STANDARDS:

1. Teach the patient to check his feet daily for injuries. Minor injuries may go unnoticed because of sensory impairment.
2. Stress that over fatigue which decreases accuracy of motor coordination should be avoided.
3. Explain that career counseling may be needed if recovery of neurologic function is prolonged.
4. Encourage the patient/family to contact the Guillain-Barre Syndrome Support Group, International, P.O. Box 262, Wynnewood, PA 19096 for more information, newsletters and a list of chapters.

GBS-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and be able to demonstrate and explain the use of the prescribed regimen.

STANDARDS:

1. Explain that the use of IV immunoglobulin has been found to reduce the clinical symptoms of Guillain-Barre Syndrome.
2. Explain that analgesics and muscle relaxants may be used for joint and muscle pain and muscle spasms.
3. Discuss the proper use, benefits, common side effects, and common interactions of the prescribed medications. Review the signs of possible toxicity and appropriate follow-up as indicated.
4. Emphasize the importance of fully participating in the medication regimen.
5. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
6. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

GBS- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

GBS-N NUTRITION

OUTCOME: The patient/family will understand the importance of maintaining or improving optimal nutritional status**.**

STANDARDS:

1. Explain that preventing or correcting weight loss that results in malnutrition is necessary to maintain optimal body function.
2. Explain that food textures may be modified as needed secondary to chewing or swallowing limitations (dysphagia).
3. Explain that it may be necessary to use oral supplements to meet energy needs. The use of vitamin/mineral supplements may be necessary.
4. As indicated, explain that nutrition may need to be maintained utilizing a feeding tube or parenteral nutrition during the most acute phases of illness.

GBS-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed including the indications and impact on further care.

STANDARDS:

1. Explain that a spinal tap may be indicated to test for protein, which is usually elevated with Guillain-Barre Syndrome.
2. Explain that nerve conduction studies may be performed. Slowing of conduction velocity in peripheral nerves is present with Guillain-Barre Syndrome and may be used to monitor the course of the disease.
3. Explain that periodic pulmonary function studies may be done to screen for respiratory compromise so special care can be implemented in a timely manner.
4. Explain the benefits and risks of the test to be performed and how it relates to the course of treatment.

GBS-TX TREATMENTS

OUTCOME: The patient/family will understand the possible treatments that may be available for Guillain-Barre Syndrome.

STANDARDS:

1. Explain that plasmapheresis produces temporary reduction in the circulating antibodies and sometimes an improvement in symptoms. Usually five exchanges are done within the first two weeks of symptoms for optimal results.
2. Explain that the treatment plan for Guillain-Barre Syndrome includes close monitoring of respiratory status and may include intubation and mechanical ventilation if the airway or respiratory status are compromised.
3. Explain that during the most acute phase, if indicated, cardiac monitoring will occur and dysrhythmias will be treated.
4. Explain that other treatment is supportive to prevent complications of immobility.
5. Emphasize that extensive rehabilitation is usually necessary for a full recovery.

H

HA—Headaches

HA-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand the basic the AP of their particular type of headache.

STANDARDS:

1. Explain that headaches are multifactorial and the pathophysiology is dependant on the disease process.
2. Discuss the pathophysiogoly and related anatomy of this patient disease process.

HA-C COMPLICATIONS

OUTCOME: The patient/family will understand the effects and consequences possible as a result of headaches, failure to manage headaches, or as a result of treatment.

STANDARDS

1. Discuss the possible complications, including:
    a. Depression or other mood disorders
    b. Suicidal behaviors
    c. Domestic violence
    d. Substance abuse
    e. Substance use
    f. Employment problems.
    g. Relationship problems
    h. Cognitive difficulties
    i. Appetite change
    j. Sensitivity to light and noise
    k. Alteration in sleep patterns

HA-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the headache pain symptoms, type (migraine, tension, sinus, or cluster) and the causes if known.

STANDARDS:

1. Explain that the patient is the primary source of information about the pain's location, quality, intensity, onset, precipitating, or aggravating factors, frequency of headache pain and the measures that bring relief.
2. Discus the current knowledge of this patient's type of headache.
3. Emphasize the importance of communicating information about the headache to the provider.
4. Discuss that the patient's presentation of symptoms is a unique combination of the type of pain, individual experiences and sociocultural adaptive responses.
5. Explain that headache pain may act as a warning sign of some problems in the body, including:
   a. Sinus problems
   b. Dehydration
   c. Decayed teeth
   d. Problems with eyes, ears, nose or throat
   e. Infections and fever
   f. Injury to the head
   g. Physical or emotional fatigue
   h. Exposure to toxic chemicals
   i. High blood pressure
   j. Sleep apnea
   k. Mood disorders
   l. Caffeine withdrawal (i.e., coffee, chocolate, tea, soft drinks)
   m. Hangovers
   n. Tumor (extremely rare)
6. Emphasize that influencing factors from internal and external changes are present. Some of these factors include:

Internal Factors:	**External Factors:**
Hormonal changes	Weather changes
Stress	Alcohol
Change in sleep habit	Bright /flickering light

HA-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.
4. Discuss important warning signs that would indicate earlier follow up is needed, including:
    a. If the headache keeps you from your usual activities
    b. If the headache lasts more than one day
    c. If you have fever, stiff neck, nausea, or vomiting
    d. If you feel drowsy or want to go to sleep
    e. If you have had a recent head injury
    f. If you develop eye pain, blurred vision, or trouble seeing
    g. If you suspect the headache was caused by medicines
    h. If you have persistent headaches seen by doctor
    i. If the headache was the result of a head injury
    j. If you have difficulty speaking
    k. If you develop numbness or weakness of the arms or legs
    l. If the headaches increase in intensity or frequency over time
    m. If you experience instantaneous onset of severe headache
    n. If the headaches require the daily use of pain-reliever medications
    o. If the headache is experienced by very young children (preschool age)
    p. If there is new onset headaches in middle-aged people.

HA-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient /family will receive written information about headache pain.

STANDARDS:

1. Provide the patient/family with written patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

HA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle changes necessary to optimize performance of everyday activities and promote well-being.

STANDARDS:

1. Explain that treatment of headache pain is very individualized and may involve lifestyle adaptation, i.e., medication, rest and relaxation, exercise, stress-reduction, and/or internal or external changes.
2. Explain that exercise and social involvement (i.e., familial, traditional, cultural) may decrease the sense of pain and the depression and anger associated with pain.
3. Review lifestyle areas that may require adaptations, i.e., diet, substance use, rest and sleep patterns, physical activity, sexual activity, role changes, communication skills and interpersonal relationships.
4. Discuss lifestyle changes in relation to headache style.
5. Discuss techniques that may reduce stress and depression, such as meditation, maintaining regular sleep patterns, exercise program, hobbies and crafts, acupuncture, spiritual and cultural activities, or biofeedback training.
6. Refer to community resources as appropriate.

HA-M MEDICATION

OUTCOME: The patient/family will understand their medication regimen and the importance of fully participating with the therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Discuss that there are many medications for the treatment or prevention of headaches and that narcotics are usually not indicated.
3. Explain that excess sedation and euphoria are not goals of palliative pharmacotherapy.
4. Emphasize that headache pain is not always completely understood and it is often necessary to take prophylactic medicines to assure optimal comfort levels. It is important to take preventive medication exactly as prescribed to prevent or reduce pain.
5. Discuss patient/family concerns about addiction. Explain the difference between psychological addiction and physical dependence upon prescribed medications. Reinforce that addiction is psychological dependence on a drug and is not equivalent to tolerance or physical dependence.
6. Emphasize the importance of consulting with provider before taking any OTC or herbal/traditional remedies.
7. Discuss the use of adjunct medications, if indicated, to control analgesic side effects, i.e., anti-emetics, laxatives, antacids.

HA- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HA-N NUTRITION

OUTCOME: The patient/family will understand the important contribution of healthy food choices and an adequate fluid intake in the treatment of headaches. They will be able to identify some dietary factors that may affect their headaches.

STANDARDS:

1. Assess eating habits.
2. Stress that eating regularly and not skipping meals is important.
3. Emphasize the necessary component – water – in a healthy diet.
4. Explain that constipation is a common side effect of some pain medications. Dietary measures such as increased water, increased fiber, increased fruit and decreased intake of milk products may be helpful.
5. Refer to dietitian or other local resources as indicated.

HA-P PREVENTION

OUTCOME: The patient/family will understand that headaches have varying etiologies and the mechanisms are not known for many headaches. The patient/family will identify the precipitating factors, if known, and develop a plan to maximize prevention strategies.

STANDARDS:

1. Discuss strategies for identifying headache triggers (i.e., journal, activity and food log).
2. Stress the importance of avoiding any known triggers.
3. Discuss that prophylactic medications must be taken as directed to be effective.
4. Emphasize that headaches seem to be more common during stressful times. **Refer to HA-SM.**

HA-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand that grief reactions and mood disorders are common with chronic headaches.

STANDARDS:

1. Discuss symptoms of mood disorders that may need additional professional support, sympathy, time, attention, compassion, and communication for patient/family.
2. Explain that if anti-depressant drugs are prescribed by the provider, full participation with the treatment plan is important to maximize the effectiveness of the treatment.
3. Explain that many mechanisms for dealing with grief and depression are available, i.e., support groups, individual therapy, family counseling, spiritual guidance.
4. Refer to community resources as appropriate.

HA-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in headache management.

STANDARDS:

1. Explain that uncontrolled stress may exacerbate the symptoms of headache. This can set up a cycle of pain-stress which becomes self-sustaining and may escalate.
2. Discuss that in chronic headaches, uncontrolled stress may lead to depression or other mood disorders.
3. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as inappropriate eating, all which can increase the severity of pain.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

HA-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Explain the test ordered.
2. Discuss the necessity, benefits and risks of the test to be performed, as appropriate, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Discuss the meaning of the test results, as appropriate.

HA-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available based on the specific history, test results, and individual preferences.

STANDARDS:

1. Discuss with the patient/family the possible appropriate noninvasive pain relief measures, i.e., massage, heat, cold, rest, over-the-counter medications, books or tapes for relaxation.
2. Discuss with the patient/family the possible alternative pain relief measures, when appropriate, i.e., meditation, imagery, acupuncture, healing touch traditional healer, biofeedback, hypnosis.
3. Discuss with the patient/family the possible appropriate pharmacotherapy. **Refer to HA-M.**
4. Discuss with the patient/family other possible approaches, i.e., lifestyle changes, physical therapy, nutritional changes, stress management, or psychotherapy.
5. Emphasize the importance of the patient/family's active involvement in the development of a treatment plan.

HEAT—Heatstroke

HEAT-C COMPLICATIONS

OUTCOME: The patient and/or family will understand the consequences of heat stroke and the complications associated with heatstroke.

STANDARDS:

1. Explain that the body tissues and cells breakdown (denaturization of enzymes, destabilization of cells and breakdown of metabolic pathways) when the body's temperature increases above 105.8˚ F (41˚ C).
2. Discuss the complications of multisystem failure and the risks of morbidity and mortality that can occur as a result of heatstroke.
3. Discuss the possibility of circulatory collapse, which may precede permanent brain damage or death.

HEAT-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

HEAT-DP DISEASE PROCESS

OUTCOME: The patient and/or family will understand how heat stroke occurs and the signs and symptoms of heatstroke.

STANDARDS:

1. Discuss the two different categories of heatstroke: exertional and non-exertional.
2. Discuss signs and symptoms of heatstroke with the patient:
   a. headache
   b. vertigo
   c. fatigue
   d. decreased sweating
   e. skin warm to touch
   f. flushing
   g. increased heart rate
   h. increased respiratory rate.
3. Discuss the pathophysiology of heat stoke: inadequacy or failure of the heat loss mechanism.
4. Discuss warning signs of heat stroke: headache, weakness, and sudden loss of consciousness.
5. Discuss with the patient that heatstroke is an emergency.
6. Explain that some disease states or conditions may predispose to heat stroke, i.e., diabetes, anhydrosis or previous episodes of heat stroke.
7. Explain that environmental conditions such as high humidity, extremely high temperatures can predispose to heat stroke.
8. Discuss that tight clothing or spandex or rubber clothing can predispose to heat stroke.

HEAT-EX EXERCISE

OUTCOME: The patient and/or family will understand how heatstroke can be influenced by exercise.

STANDARDS:

1. Discuss with patient/family how exercising in a warm environment, excessive exercising and prolonged exercise and exertion can lead to heatstroke.
2. Discuss the importance of frequent hydration and rest when exercising in a warm environment.

HEAT-FU FOLLOW-UP

OUTCOME: The patient and/or family will understand the seriousness of heatstroke and the importance of follow up care.

STANDARDS:

1. Discuss the importance of follow up appointments after a heat stroke to determine if there is any permanent or ongoing damage.
2. Discuss the importance of keeping follow up appointments.
3. Discuss the procedures for obtaining follow up appointments.

HEAT-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient and/or family will receive written information about heatstroke, and important preventive measures.

STANDARDS:

1. Provide patient/family with written information on heatstroke and prevention of heatstroke.
2. Discuss the content of heatstroke written information with the patient/family.

HEAT-M MEDICATIONS

OUTCOME: The patient/family will understand the use of medications in the emergency room to manage heatstroke.

STANDARDS:

1. Discuss with the patient that pharmacological therapy may not be required.
2. Discuss with the patient that signs/symptoms such as dysrhythmia and shivering may occur as a complication of heatstroke and may require medication therapy.
3. Discuss with the patient that once they leave the hospital they may require medications that will treat the complications that have occurred from the heatstroke.
4. Discuss with the patient the importance of following the instructions in regards to their medications.
5. Discuss the common and important side effects and drug interactions of the medications prescribed.

HEAT- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HEAT-N NUTRITION

OUTCOME: The patient/family will understand the importance of adequate hydration and that water is the beverage of choice.

STANDARDS:

1. Explain that water is the beverage that best hydrates the body.
2. Discuss that caffeinated beverages and alcohol are especially dangerous and may predispose to dehydration and heat stroke.

HEAT-P PREVENTION

OUTCOME: The patient/family will understand ways to prevent heatstroke.

STANDARDS:

1. Discuss that it is easier to prevent heat stroke than to treat it.
2. Discuss with the patient/family that the majority of heat stroke cases are preventable by avoiding extremely hot/humid environments, inadequately ventilated spaces, inadequate fluid intake and heavy clothing in warm conditions.
3. Discuss with the patient/family ways to prevent heatstroke when heat exposure cannot be avoided; reducing or eliminating strenuous activities, staying adequately hydrated, frequently taking showers, wearing light weight clothing and avoiding direct sunlight.
4. Discuss that up to a liter an hour may be required to prevent dehydration and predispose to heat stroke.
5. Discuss with the patient the most likely time of year to develop heatstroke: summer.
6. Discuss with patient the risk factors such as increased age, debility, low fluid intake, excessive exercise, alcohol and drug use, chronic disease, living conditions with no air-conditioning, travel to warmer climates, and prolonged outdoor activities.

HEAT-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

HEAT-TX TREATMENT

OUTCOME: The patient and/or family will understand the management and treatment of heatstrokes.

STANDARDS:

1. Discuss the importance of seeking emergency care if heatstroke is suspected.
2. Discuss the importance of slowly decreasing the temperature of the person.
3. Discuss the management of heatstroke in the emergency department; protection of airway, intravenous administration of fluids, monitoring of temperature, decreasing of temperature, and monitoring of cardiorespiratory status.
4. Discuss the goal of treatment with the patient; prevention of further heat loss, decrease in the core body temperature, and management and prevention of complications.
5. Discuss with the patient/family the importance of seeking emergency help as soon as possible in the incidence of a heatstroke.
6. Discuss the probability that the person experiencing a heatstroke may be admitted to an intensive care unit for extensive monitoring.

HEP—Hepatitis A,B,C

HEP-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family/caregiver will understand the basic function of the liver and its relationship to hepatitis.

STANDARDS:

1. Briefly identify and explain the function of the liver.
2. Discuss the liver's role in detoxifying and cleansing the body.
3. Explain the word "hepatitis" means inflammation of the liver.
4. Explain that common viral infections that affect the liver include Hepatitis A, Hepatitis B, and Hepatitis C.

HEP-C COMPLICATIONS

OUTCOME: The patient , family & caregiver will understand the long term consequences of viral infections with HAV, HBV, and HCV. The patient will learn how to protect the liver from further harm.

STANDARDS:

1. Explain that most persons who get HCV carry the virus the rest of their lives and most of these have some liver damage. Some may develop cirrhosis (scarring) of the liver or liver failure.
2. Discuss ways to care for the liver:
   a. Avoid alcoholic beverages
   b. Inform your provider of all the medications, even over the counter and herbals medication
   c. Have regular doctor visits
   d. Get vaccinated against Hepatitis A and B.
3. Explain that the most common symptom with long term hepatitis C is extreme tiredness.

HEP-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

HEP-DPA DISEASE PROCESS HEPATITIS A

OUTCOME: The patient/family or caregiver will understand that hep A is an inflammation of the liver caused by hepatitis A virus (HAV).

STANDARDS:

1. Explain that the symptoms of HAV infection will usually last for about 3 weeks.
2. Discuss that the patient's symptoms may include fever, nausea, vomiting, jaundice, diarrhea, fatigue, abdominal pain, dark urine and appetite loss.
3. Emphasize that other symptoms such as respiratory symptoms, rash and joint pain may also develop.
4. Explain to the patient/family that in the early stages of infection the virus is easily transmitted to others by contact with body fluids and excrements (usually fecal/oral route).
5. Explain that in children the disease is usually mild and may even be asymptomatic.

HEP-DPB DISEASE PROCESS- HEPATITIS B

OUTCOME: The patient, family or caregiver will understand that hepatitis B is an inflammation of the liver caused by infection with Hepatitis B virus (HBV).

STANDARDS:

1. Review the transmission modes, known risk groups and child exposure.
2. Discuss the symptoms of acute HBV: nausea, vomiting, jaundice, rash, abdominal pain, malaise, fever may be absent or mild.
3. Discuss that following acute infection with HBV one may become a carrier, resolve the disease, or develop chronic Hepatitis B.
4. Discuss the symptoms of chronic HBV: including malaise, anorexia, weight loss, fatigue, cirrhosis and predisposition to liver cancer.
5. Explain that HBV is a blood born pathogen and is spread by contact with contaminated blood or other body fluids. The most common ways to get it are through unprotected sex, sharing needles, sharing personal items, or by perinatal transmission.

HEP-DPC DISEASE PROCESS HEPATITIS C

OUTCOME: The patient, family or caregiver will understand that hepatitis C is a liver disease caused by infection with Hepatitis C virus (HCV) which is found in the blood of persons with the disease. Formerly called non-A, non-B is the most common chronic blood borne viral infection.

STANDARDS:

1. Explain that Hepatitis C is an infection transmitted primarily by blood. 85% of persons infected with HCV cannot clear the infection and the virus continues to multiply in the body. As a result, chronic infection occurs and may be contagious.
2. Discuss the primary risk factors associated with HCV, i.e., sharing needles when injecting drugs and exposure to blood in the health care setting. Sexual transmission may occur but is low. Blood transfusion associated cases are now rare.
3. Discuss the signs and symptoms of HCV: jaundice, fatigue, abdominal pain, loss of appetite, and bouts of nausea and vomiting. (1 in 10 people will have symptoms when initially infected).
4. Differentiate between acute and chronic infection. Note that it could be years before person with chronic infection may experience symptoms serious enough to prompt seeking medical care. Consequences may appear 10-20 years after infection.
5. Discuss that chronic HCV may result in cirrhosis and/or liver cancer.

HEP-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the need for keeping appointments for medical follow-up and immunization as appropriate.

STANDARDS:

1. Explain that persons with hepatitis C may need to consider immunization against Hepatitis A and B to prevent further liver damage.
2. Discuss the importance of follow-up care.
3. Encourage the patient to keep follow-up appointments.
4. Refer to community resources as appropriate.

HEP-L LITERATURE

OUTCOME: The patient/family or caregiver will receive written information about hepatitis, vaccine information or preventive measures.

STANDARDS:

1. Provide patient/family with written information on hepatitis, vaccine information and/or preventive/protective measures.
2. Discuss protective and risk reduction measures and provide written information.

HEP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary for healing and performance of daily living activities.

STANDARDS:

1. Review lifestyle areas that may require adaptations such as:
    a. sexual activity
    b. traveling
    c. avoiding alcohol use and illegal drug use
    d. avoid intake of foods that may be at high risk for transmission of Hepatitis A.

HEP-M MEDICATION

OUTCOME: Patient/Family with understand medications to manage hepatitis.

STANDARDS:

1. Review the proper use, benefits and common side effects of the prescribed medication.
2. Emphasize the importance of adhering to medication regimen.
3. Emphasize the importance of possible drug interactions with foods, drugs, herbals, oral nutritional supplements, over the counter medications, as appropriate.

HEP- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HEP-N NUTRITION

OUTCOME: The patient/family will understand the importance of a nutritionally balanced diet in the treatment of the disease. They will be able to identify foods and a meal plan that will promote the healing process if applicable.

STANDARDS:

1. Discuss current nutritional habits and needs. Address anorexia and weight loss as appropriate.
2. Emphasize the necessary component, water, in a healthy diet.
3. Review the patient's prescribed diet if applicable.
4. Refer to registered dietician or other local resources as indicated.

HEP-P PREVENTION

OUTCOME: The patient/family/caregiver will understand the modes of transmission, ways to prevent acquiring the virus.

STANDARDS:

1. The best way to prevent exposure to virus is by careful hand washing. Review standard precautions for use by child care workers, health care workers, corrections officers and food service workers.
2. Discuss immunization against Hepatitis A and B as methods of prevention.
3. Explain that there is no vaccine for prevention of hepatitis C.
4. Discuss the use of immunoglobulin against Hep A and B for post exposure prophylaxis.
5. Explain that hepatitis A is generally spread by fecal - oral route. Careful hand washing is paramount.
6. Explain that hepatitis B and C are spread by blood contact. Standard precautions are paramount. Do not share personal items such as toothbrushes, razors, or needles.
7. Hepatitis B can be spread by sexual transmission. Adequate protective barriers are important.
8. Persons with hepatitis should not donate plasma, blood, sperm or organs as this may spread the virus to others.

HEP-TE TESTS

OUTCOME: The patient/family or caregiver will understand the importance of testing.

STANDARDS:

1. Discuss the need for testing if you think you have been exposed to hepatitis A, B, or C.
2. Explain that if you test positive, further testing may be necessary.

HEP-TX TREATMENT

OUTCOME: The patient/family or caregiver will understand treatment for Hepatitis A, B or C.

STANDARDS:

1. Explain that some antiviral medications may be helpful in the treatment of hepatitis.
2. Discuss current treatment options.
3. Discuss the importance of protecting the liver from further harm by not drinking alcohol, getting vaccinated against hepatitis A and B.
4. Advise against starting any new prescription or over the counter medication, herbal products, and oral nutritional supplements without first discussing hepatitis status with the provider.
5. Emphasize the importance of rest and proper nutrition in recovery from hepatitis.

HIV—Human Immunodeficiency Virus

HIV-C COMPLICATIONS

OUTCOME: The patient and/or family will understand the effects and consequences possible as a result of HIV/AIDS, failure to manage this disease state/condition, or as a result of treatment.

STANDARDS:

1. Discuss the common or significant complications associated with HIV/AIDS:
   a. Bacterial infections;
   b. Viral infections;
   c. Fungal infections;
   d. Parasitic infections;
   e. Cancers.
2. Discuss common or significant complications which may be prevented by full participation with the treatment regimen.
3. Discuss common or significant complications that may result from treatment(s).

HIV-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

HIV-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the risk factors, methods of transmission and prevention of HIV (Human Immunodeficiency Virus) and the progression from HIV positive status to AIDS (acquired immunodeficiency syndrome).

STANDARDS:

1. Explain the methods of HIV transmissions, i.e., semen, blood and blood product transfusions, needle sharing, accidental needle sticks, vaginal fluids, mother to infant, and in rare cases, organ or tissue transplants and unsterilized dental or surgical equipment.
2. Explain that HIV is a virus and there is no current vaccine to prevent its occurrence.
3. Explain that the human immunodeficiency virus attacks the immune system resulting in increased susceptibility to infections and cancers.
4. Explain the difference between HIV infection and AIDS. Explain that it is currently believed that all HIV infections will progress to AIDS. Early treatment and strict participation may slow the progression from HIV infection to AIDS.
5. Some symptoms of AIDS may be unusual or more frequent infections that are especially difficult to treat.
6. Explain the current knowledge about the progression of HIV and AIDS.

HIV-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

HIV-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the importance of follow-up and testing as appropriate and will formulate a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care with referral resources and assistance from HIV case managers.
2. Discuss the procedure for accessing health care resources for HIV positive patients.
3. Discuss importance of follow-up appointments and follow-up testing as appropriate for this patient if initial or repeat HIV tests are negative.
4. Refer as appropriate to community resources.

HIV-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand how to manage HIV/AIDS at home.

STANDARDS:

1. Discuss the risks and benefits of the use of over the counter medications for symptom relief.
2. Discuss the use of alternative therapies or complementary medicinals that may be useful in symptom relief.
3. Help the patient/family identify appropriate resources for managing HIV/AIDS at home.

HIV-HY HYGIENE

OUTCOME: The patient will recognize good personal hygiene as an important component of preventing complications.

STANDARDS:

1. Discuss hygiene as part of a positive self image.
2. Review bathing and daily dental hygiene habits, i.e., don't share razors and toothbrushes.
3. Discuss the importance of hand washing in infection control.
4. If using IV drugs, discuss the importance and implications of not sharing needles; discuss the proper disposal of used needles.
5. Discuss the importance and implications of preventing unprotected sexual activity:
    a. Use a new latex or polyurethane condom every time you have vaginal or anal sex. Condoms other than latex or polyurethane are not effective in the prevention of HIV.;
    b. During oral sex use a condom, dental dam or plastic wrap;
    c. If you use sexual devices, don't share them;
    d. Don't share razor blades or tooth brushes
6. Discuss any hygiene habits that are specifically pertinent to this disease state or condition.

HIV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family/caregiver will receive written information about HIV and other sexually transmitted infections (STIs).

STANDARDS:

1. Provide the patient/family with written patient information literature on HIV and/or other sexually transmitted infections.
2. Discuss the content of patient information literature with the patient/family.
3. Caution the patient that information found on the Internet is not necessarily screened for accuracy and may not be correct. Emphasize the importance of using reliable sources of information.

HIV-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of the disease state or condition or to improve mental or physical health.

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over - diet, exercise, safety and injury prevention, avoidance of high risk behaviors, and full participation with treatment plan:
   a. Follow safer sex practices
   b. Tell your sexual partner(s) that you have HIV
   c. If your partner is pregnant, tell her you have HIV
   d. Tell others who need to know, i.e., family, friends, health providers
   e. Don't share needles or syringes
   f. Don't donate blood or organs
   g. If you are pregnant, get medical care right away
2. Emphasize that an important component in the prevention or treatment of disease is the patient's adaptation to a healthier, lower risk lifestyle.
3. Emphasize the importance of not smoking, using illegal drugs, or alcohol as these further weaken your body.
4. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

HIV-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of fully participating with the prescribed medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription, complementary medicine or traditional remedies, to the provider.

HIV- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HIV-N NUTRITION

OUTCOME: The patient will understand the need for balanced nutrition and plan for the implementation of dietary modification if needed.

STANDARDS:

1. Discuss the fact that wasting syndrome is a serious, yet common, complication that can be prevented or minimized by maximizing nutrition.
2. Review nutritional needs for optimal health when living with HIV/AIDS. The patient/family will understand that fighting an infection (HIV) requires maximizing dietary intake.
3. Discuss current nutritional habits. Assist the patient in identifying health promoting nutritional habits.
4. Discuss nutritional modifications as related to the specific disease state/condition, especially in regards to fluid, protein and calories.
5. Emphasize the importance of fully participating in the prescribed nutritional plan.
6. Emphasize the importance of food safety.
7. Discuss nutrition supplements, i.e., vitamin and mineral supplements, antioxidants, complementary supplements.

HIV-P PREVENTION

OUTCOME: The patient will develop a healthy behavior plan, which will prevent/reduce exposure to HIV infections.

STANDARDS:

1. List circumstances/behaviors that increase the risk of HIV infection:
   a. IV drug use and sharing needles.
   b. Multiple sexual partners.
   c. Unprotected sex, i.e., sex without latex or polyurethane condoms or other protective agents, dental dams, plastic wrap.
   d. Anal intercourse
   e. Breastfeeding by an HIV infected mother
   f. Being born to an HIV infected mother
   g. Presence or history of another sexually transmitted infections
   h. Victims of rape
   i. Involvement in a abusive relationship.
2. Describe behavior changes which prevent/reduce transmission of HIV virus.
3. Discuss/demonstrate proper application of condom with model if available. Discuss proper lubricant type. (No oil based lubricants.)
4. Describe how alcohol/substance use can impair judgment and reduce ability to use protective measures.
5. Explain ways to reduce exposure to infected persons.
6. Explain that the best way to prevent exposure to HIV is to abstain from risky sexual behavior and from recreational drug use.

HIV-PN PRENATAL

OUTCOME: The patient/family will understand risk factors for HIV (mother and child) and offer referral for testing.

STANDARDS:

1. Discuss risk factors for HIV (mother and child).
2. Offer referral for HIV testing.
3. Explain that early detection, early treatment and full participation with the medication regimen as well as maintaining a healthy lifestyle will often result in a better quality of life and slower progression of the disease and may have beneficial effects upon the delivery and longevity of the child.

HIV-S SAFETY

OUTCOME - The patient/family/caregiver will understand principles of planning and living within a safe environment.

STANDARDS:

1. Explain that opportunistic infections are a major cause of death.
2. Discuss the need to prevent opportunistic infections through creating and living within a safe environment.
3. Assist the patient/family/caregiver in identifying ways to adapt the home to improve safety and prevent injury, illness and disease transmission appropriate to the patient's age, disease state and condition.
4. Identify which community resources promote a safe living environment.

HIV-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in HIV/AIDS.

STANDARDS:

1. Explain that uncontrolled stress can contribute to a suppressed immune response and increased complications from HIV/AIDS.
2. Explain that effective stress management may help to reduce the adverse consequences of HIV/AIDS, as well as improve the patient's health and well-being.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance abuse, all which can increase the risk of morbidity and mortality from HIV/AIDS.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
5. Discuss suggestions for dealing with the emotional toll of living with HIV/AIDS:
    a. Learn all you can about HIV/AIDS;
    b. Be proactive, take an active role in your treatment;
    c. Maintain a strong support system;
    d. Take time to make important decisions concerning your future;
    e. Come to terms with your illness.
6. Provide referrals as appropriate.

HIV-TE TESTS

OUTCOME: The patient/family will understand the reason for testing, the expected outcome and whether the test will be confidential or anonymous.

STANDARDS:

1. Explain that early detection, early treatment and full participation with the medication regimen as well as maintaining a healthy lifestyle will often result in a better quality of life and slower progression of the disease.
2. Explain that identification of all partners is necessary to facilitate the treatment of those persons and limit further spread of the infection.
3. Explain that if you receive a diagnosis of HIV/AIDS, your doctor will use a test to help predict the probable progression of your disease. This test measures the amount of virus in your blood and aids in determining your course of treatment.
4. Emphasize the importance of using only approved test kits for HIV (as of November 2004 is the Home Access HIV test marketed by Home Access Health).

HIV-TX TREATMENT

OUTCOME: The patient/family will understand the importance of a comprehensive treatment plan.

STANDARDS:

1. Explain that according to current guidelines, treatment should focus on achieving the maximum suppression of symptoms for as long as possible. This aggressive approach is known as high active antiretroviral therapy (HAART). The aim of HAART is to reduce the amount of virus in your blood to very low levels, although this doesn't mean the virus is gone.
2. Emphasize and discuss the importance of a comprehensive treatment plan, which includes health and risk assessment, common lab tests, disease staging, prophylaxis therapy, immunizations, social and insurance needs, plus follow up.
3. Discuss the process for developing a comprehensive treatment plan.
4. Help the patient/family identify the appropriate resources for developing a comprehensive treatment plan.
5. Explain that identification of all partners is necessary to facilitate the treatment of those persons and limit further spread of the infection.

HTN—Hypertension

HTN-C COMPLICATIONS

OUTCOME: The patient will understand the complications of uncontrolled hypertension.

STANDARDS:

1. Explain that arteriosclerosis and atherosclerosis impede blood flow through the circulatory system.
2. Explain that heart attacks may result from the heart having to work harder to pump blood through congested and hardened arteries.
3. Explain that blindness may result from injured blood vessels in the eye.
4. Explain that strokes may result from ruptures of injured blood vessels in the brain.
5. Explain that circulatory complications eventually impair the ability of the kidneys to filter out toxins.

HTN-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

HTN-DP DISEASE PROCESS

OUTCOME: The patient will understand hypertension and summarize its causes.

STANDARDS:

1. Explain the difference between systolic and diastolic pressure. Define the normal ranges.
2. Review causative factors:
   a. Lifestyle Factors: Obesity, high sodium intake, high fat and cholesterol intake, lack of regular exercise
   b. Special Conditions: Pregnancy, oral contraceptives
   c. Disease States: Diabetes, hyperthyroidism
   d. Personal Factors: Family history, sex, race.
3. Discuss that most hypertension is asymptomatic, but some patients may experience headache, dizziness, faintness, nosebleed, or ringing in the ears and any of these symptoms should prompt immediate re-evaluation by a physician.

HTN-EQ EQUIPMENT

OUTCOME: The patient/family will receive information on the use of home blood pressure monitors.

STANDARDS:

1. Provide the patient/family with information on the use of the specific home blood pressure monitor.
2. Discuss the use of blood pressure monitoring equipment in public places, i.e., stores.
3. Discuss when to contact a health care provider for a blood pressure value which is outside the patient's personal guidelines.

HTN-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain how regular exercise helps to reduce high blood pressure and maintain normal blood pressure.
2. Discuss activity allowances and expectations (heavy lifting may predispose to complications).
3. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
4. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
5. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
6. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
7. Discuss medical clearance issues for physical activity.

HTN-FU FOLLOW-UP

OUTCOME: The patient participates in the treatment plan and understands the importance of full participation .

STANDARDS:

1. Discuss the individual's responsibility in the management of hypertension.
2. Encourage regular blood pressure and weight checks.
3. Review treatment plan with the patient, emphasizing the need to keep appointments, take medication as directed, make indicated lifestyle changes, and control co-morbid conditions.

HTN-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about hypertension.

STANDARDS:

1. Provide the patient/family with written patient information literature on hypertension.
2. Discuss the content of the patient information literature with the patient/family.

HTN-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle adjustments necessary to maintain control of blood pressure and develop a plan to modify his/her risk factors.

STANDARDS:

1. Emphasize the importance of weight control.
2. Discuss the importance of a program of regular exercise.
3. Discuss the relationship of stress to hypertension. Suggest ways of reducing stress—napping, meditation, exercise and "just relaxing."
4. Explain that use of tobacco, either smoking or use of smokeless tobacco, can worsen hypertension and increase the risk of complications.

HTN-M MEDICATIONS

OUTCOME: If on medication, the patient will verbally summarize their medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Explain the importance of avoiding over-the-counter medications without checking with a physician.

HTN- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HTN-N NUTRITION

OUTCOME: The patient will verbally summarize methods for control of blood pressure through weight control and diet modification.

STANDARDS:

1. Explain the role of salt intake in hypertension and ways to decrease salt intake:
   a. Remove the salt shaker from the table
   b. Taste food before salting
   c. Discuss other seasonings
   d. Read food labels to determine sodium content.
2. Discuss caffeine and its role in hypertension.
3. Discuss the importance of weight loss in controlling hypertension**. Refer to WL-N.**
4. Encourage adequate intake of fruits, vegetables, water and fiber.

HTN-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in hypertension.

STANDARDS:

1. Explain that uncontrolled stress can worsen hypertension and increase risk factors of cardiovascular disease.
2. Explain that uncontrolled stress can interfere with the treatment of hypertension.
3. Explain that effective stress management may reduce the adverse consequences of hypertension, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from hypertension.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

HTN-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

HTH—Hyperthyroidism

HTH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the anatomy and physiology of the pituitary-thyroid axis.

STANDARDS:

1. Explain the normal location, function, and feedback mechanism of the pituitary-thyroid axis (heart rate, muscle strength, bowel function, fat metabolism, energy level, hair growth, and mood).
2. Discuss the changes to the thyroid gland and the body's metabolic state as a result of hypothyroidism.
3. Discuss the impact of these changes on the patient's health and well-being.

HTH-C COMPLICATIONS

OUTCOME: The patient/family will understand the effects and consequences possible as a result of hyperthyroidism, failure to manage hyperthyroidism, or as a result of treatment.

STANDARDS:

1. Discuss the significant complications associated with hyperthyroidism (atrial fibrillation, heart failure, angina, myocardial infarction, osteoporosis, depression, personality changes, proptosis).
2. Explain that taking medications as prescribed may prevent most or all significant complications.
3. Discuss common or significant complications which may result from treatment, i.e., subsequent hypothyroidism and the need to take lifelong medication.

HTH-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology of hyperthyroidism.

STANDARDS:

1. Explain that hyperthyroidism occurs when the amount of thyroid hormone in the blood is too high. It affects over 2½ million Americans. More women have this problem than men.
2. Explain that hyperthyroidism leads to an overall increase in a person's metabolism, which can cause a number of problems.
3. Review the patient-specific cause and expected course of hyperthyroidism, i.e., "increased production" due to hypersecretory state (i.e., Grave's disease, toxic nodule, toxic multinodular goiter, or overproduction of TSH from pituitary), "leakage" of stored hormone due to thyroid damage (as in thyroiditis), or too much supplement.
4. Review the symptoms of hyperthyroidism:
    a. feelings of excessive warmth and sweating
    b. palpitations
    c. tremors
    d. weight loss despite having an increased appetite
    e. more frequent bowel movements
    f. weakness
    g. limited endurance
    h. difficulty concentrating
    i. memory impairment
    j. nervousness
    k. tiredness
    l. difficulty sleeping
    m. depression
    n. personality changes
    o. enlarged thyroid—usually nontender.

HTH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up and will make a plan to obtain and keep appropriate follow-up appointments.

STANDARDS:

1. Discuss the individual's responsibility in the management of hyperthyroidism.
2. Review treatment plan with the patient, emphasizing the need for keeping appointments, fully participating with medication therapy, returning for appropriate follow-up, lab tests, and appointments.
3. Review the symptoms, which should be reported and evaluated (both symptoms of hyperthyroidism and hypothyroidism).
4. Assist the patient in obtaining a follow-up appointment as necessary.

HTH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about hyperthyroidism.

STANDARDS:

1. Provide the patient/family with written patient information literature on hyperthyroidism.
2. Discuss the content of the patient information literature with the patient/family.

HTH-M MEDICATIONS

OUTCOME: The patient/family will understand the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication.
2. Emphasize the importance of maintaining strict participation in the medication regimen and monitoring schedule.
3. Explain the signs and symptoms of too much or too little medication.
4. Explain the implications that medications have on current or potential pregnancy.
5. Discuss that some medications may have an adverse effect on the disease state, i.e., amiodarone, iodine.

HTH- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HTH-N NUTRITION

OUTCOME: The patient/family will understand the nutritional needs of the patient with hyperthyroidism.

STANDARDS:

1. Review current nutritional status of patient and the use of dietary supplements.
2. Explain the importance of preventing or treating the complications associated with the patient's high metabolic rate, including bone demineralization.
3. Discuss that supplementation of the diet may be necessary for the following: vitamins A and C, B complex (esp. Thiamin, riboflavin, B6 and B12).
4. Discuss fluid requirements with the patient/family. This should be 3-4 liters per day unless contraindicated by cardiac or renal problems.
5. Discuss the need to avoid alcohol as it may cause hypoglycemia and diuresis.
6. Refer to a registered dietician as appropriate.

HTH-SCR SCREENING

OUTCOME: The patient/family will understand the screening device.

STANDARDS

1. Explain the screening device to be used.
2. Explain why the screening is being performed.
3. Discuss how the results of the screening will be used.
4. Emphasize the importance of follow-up care.

HTH-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed, the risk(s)/benefit(s) of the test(s) and the risk of refusal of the test(s).

STANDARDS:

1. Explain the test ordered (i.e., TSH, T3, T4, nuclear scan, ultrasound).
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks of non-performance of the testing.

HTH-TX TREATMENTS

OUTCOME: The patient/family will understand the possible treatments that may be performed based on the test results.

STANDARDS:

1. List the patient-specific possible therapies that might be utilized to treat hyperthyroidism (beta-blocker, anti-thyroid drugs, radioactive iodine, surgery).
2. Briefly explain each of the possible applicable treatments.
3. Explain that the patient and medical team will make the treatment decision after reviewing the results of diagnostic tests.
4. Explain the implications that treatment would have on current or potential pregnancy.

HPTH—Hypothermia

HPTH-C COMPLICATIONS

OUTCOME: The patient/Family will understand common or serious complications of hypothermia.

STANDARDS:

1. Explain that complications depend on how low and how long the body temperature falls.
2. Explain that the lower the core body temperature, the greater the chance of complications and permanent damage.
3. Discuss common and important complications of hypothermia, i.e., arrhythmias, dehydration, hyperkalemia, hyperglycemia, hypoglycemia, altered arterial blood gasses, infection, gangrene, amputation, coma, and frostbite. **Refer to FRST**.
4. Emphasize to seek early medical intervention.

HPTH-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

HPTH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of hypothermia.

STANDARDS:

1. Explain that body temperature regulation is achieved through precise balancing of heat production, heat conservation, and heat loss.
2. Explain the normal body temperature range is considered to be 36.2° to 37.7°C (96.2° to 99.4° F) but that all parts of the body do not have the same temperature.
3. Explain that a drop in the body's core temperature to 95° F or below is the definition of hypothermia.
4. Discuss that hypothermia usually comes on gradually and people aren't aware they need medical attention.
5. Discuss that common behaviors/signs may be a result of changes in motor coordination and levels of consciousness caused by hypothermia. Some common signs are:
    a. shivering, which is your body's attempt to generate heat through muscle activity
    b. "umbles" — stumbles, mumbles, fumbles and grumbles.
    c. Slurred speech
    d. Abnormally slow rate of breathing
    e. Cold, pale skin
    f. Fatigue, lethargy, or apathy
6. Explain the extremities are generally cooler than the trunk and the body core is generally warmer than the skin surface.
7. Briefly describe hypothermia causes vasoconstriction, alterations in microcirculation, coagulation, and ischemic tissue damage.
8. Explain that environmental conditions, inadequate clothing, and some disease states or conditions may predispose to hypothermia.

HPTH -EQ EQUIPMENT

OUTCOME: The patient/family will understand the indication for the use of equipment.

STANDARDS:

1. Discuss the indications for and benefits of prescribed equipment.
2. Discuss types and features of medical equipment as appropriate.
3. Discuss signs of equipment malfunction and the proper action to take in case of malfunction.

HPTH -FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the prevention of complications.

STANDARDS:

1. Discuss the importance of keeping follow-up appointments.
2. Discuss the procedure for obtaining follow-up appointments.

HPTH -L PATIENT INFORMATION LITERATURE

OUTCOME: The parent(s) and family will receive written information about hypothermia and important preventative measures.

STANDARDS:

1. Provide the patient and/or family with written information about hypothermia.
2. Discuss the content of the patient information literature with the patient and/or family.

HPTH -M MEDICATIONS

OUTCOME: The patient/family will understand the use of medications to manage hypothermia

STANDARDS:

1. Discuss with the patient that complications of hypothermia may require medication therapy.
2. Discuss the importance of taking medication as prescribed.
3. Discuss the common and important side effects and drug interactions of the medications prescribed.

HPTH- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

HPTH -N NUTRITION

OUTCOME: The patient/family will understand the importance of adequate nutrition to promote healing.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between making healthy food choices and the healing process.
3. Refer to registered dietician.

HPTH -P PREVENTION

OUTCOME: The patient/family will understand ways to decrease the risk of hypothermia.

STANDARDS

1. Explain that it is easier to prevent hypothermia than to treat it.
2. Discuss risk factors to decrease the risk of hypothermia:
    a. poor or inadequate insulation from the cold or wind
    b. impaired circulation from tight clothing or shoes
    c. fatigue
    d. altitude
    e. wind
    f. immersion
    g. injuries
    h. circulatory disease
    i. poor nutrition
    j. dehydration
    k. alcohol or drug use
    l. tobacco products
    m. extremes of age
3. Discuss ways to decrease risk of hypothermia such as:
    a. Using appropriate layered clothing
    b. avoiding overexertion while outdoors in cold weather
    c. stay dry as much as possible
    d. keep an emergency supply kit in the car which may include blankets, food, matches, candles

HPTH -PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control symptoms of pain.
4. Discuss non-pharmacologic measures that may be helpful with pain control.

HPTH-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in recovery from hypothermia.

STANDARDS:

1. Discuss that uncontrolled stress may increase alcohol and other drug use and interfere with treatment.
2. Emphasize the importance of seeking professional help as needed to reduce stress.
3. Discuss the various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. Becoming aware of your own reactions to stress
    b. Recognizing and accepting your limits
    c. Talking with people you trust about your worries or problems
    d. Setting realistic and meaningful goals
    e. Getting enough sleep
    f. Making healthy food choices
    g. Regular physical activity
    h. Taking vacations
    i. Practicing meditation
    j. Self-hypnosis
    k. Using positive imagery
    l. Practicing relaxation methods such as deep breathing or progressive muscular relaxation
    m. Spiritual or cultural activities.
4. Provide referrals as appropriate

HPTH -TE TESTS

OUTCOME: The patient/family will understand the test to be performed and the reasons for the tests.

STANDARDS:

1. Explain the tests ordered (X-Ray, EKG, urine, blood, ABG's).
2. Explain any necessary preparation prior to tests(s).
3. Explain the indications, risks and benefits of the test(s).
4. Explain the meaning of test results in relation to what "normal" results are.
5. Explain the test as it relates to planning the course of treatment.

HPTH -TX TREATMENT

OUTCOME: The patient/family will understand the management and treatment of hypothermia.

STANDARDS:

1. Discuss the importance of seeking emergency medical care if hypothermia is suspected.
2. Explain if medical attention is not readily available then move the person out of the cold, remove wet clothing, insulate the person's body from the cold ground, monitor breathing, share body heat, and if conscious provide warm nonalcoholic beverages.
3. Discuss what **not** to do if hypothermia is suspected:
   a. Don't apply direct heat
   b. Don't massage or rub the person
   c. Don't provide alcoholic beverages
4. Discuss the importance of slowly increasing the temperature of the person and getting the person into dry clothes when applicable.
5. Discuss the management of hypothermia (i.e., monitoring of vital signs, warming blankets, warm IV fluids, extracorporeal circulation)

LTH—Hypothyroidism

LTH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the anatomy and physiology of the pituitary-thyroid axis.

STANDARDS:

1. Explain the normal location, function, and feedback mechanism of the pituitary-thyroid axis (heart rate, muscle strength, bowel function, fat metabolism, energy level, hair growth, and mood).
2. Discuss the changes to the thyroid gland and the body's metabolic state as a result of hypothyroidism.
3. Discuss the impact of these changes on the patient's health and well-being.

LTH-C COMPLICATIONS

OUTCOME: The patient/family will understand the effects and consequences possible as a result of hypothyroidism, failure to manage hypothyroidism, or as a result of treatment.

STANDARDS:

1. Discuss the significant complications associated with hypothyroidism (depression, excessive weight gain, high blood pressure, high cholesterol levels).
2. Discuss that full participation with the treatment regimen may prevent most or all significant complications.
3. Discuss common or significant complications which may result from treatment, i.e., jitteriness, heart racing, headaches. Consistently taking medications at the appropriate dose will minimize these complications.

LTH-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology of hypothyroidism.

STANDARDS:

1. Explain that hypothyroidism occurs when the amount of thyroid hormone in the blood is too low. It affects almost 5% of the population. It is more common in women and in elderly persons.
2. Explain that hypothyroidism leads to an overall decrease in a person's metabolism, which can cause a number of problems.
3. Review the patient-specific cause and expected course of hypothyroidism. In most cases hypothyroidism is a permanent condition that requires life-long treatment with natural thyroid supplement.
4. Review the symptoms of hypothyroidism, which include feelings of:
    a. fatigue
    b. lack of motivation
    c. sleepiness
    d. weight gain
    e. feelings of being constantly cold
    f. constipation
    g. dry skin
    h. hair loss
    i. muscle cramps and muscle weakness
    j. high blood pressure and high cholesterol levels
    k. depression
    l. slowed speech
    m. poor memory
    n. feelings of "being in a fog."

LTH-EX EXERCISE

OUTCOME: The patient/family will understand the relationship between physical activity and hypothyroidism and develop a plan to achieve an appropriate level of activity.

STANDARDS:

1. Explain the normal benefits of a regular exercise program to health and well-being.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.
7. Discuss that in hypothyroidism, severe muscle weakness may occur and exercise tolerance is impaired. Explain that exercise is important not only for weight control, but also to reestablish muscle tone and fitness. In general, intense aerobic exercise should only be attempted after thyroid hormone levels have returned to normal. However, the patient can begin walking and modest weight-bearing exercise as treatment is initiated.

LTH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of making and keeping follow-up appointments and will make a plan to obtain and keep appropriate follow-up appointments.

STANDARDS:

1. Discuss the individual's responsibility in the management of hypothyroidism.
2. Review the treatment plan with the patient, emphasizing the need for keeping appointments, fully participating with medication therapy, returning for appropriate follow-up, lab tests, and appointments.
3. Review the symptoms, which should be reported and evaluated (both symptoms of hyperthyroidism and hypothyroidism).
4. Assist the patient in making follow-up appointments as appropriate.

LTH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about hypothyroidism.

STANDARDS:

1. Provide the patient/family with written patient information literature on hypothyroidism.
2. Discuss the content of the patient information literature with the patient/family.

LTH-LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient/family will understand the lifestyle adaptations necessary to maintain optimal health.

STANDARDS:

1. Emphasize that weight gain, high blood pressure, and high cholesterol levels are associated with hypothyroidism.
2. Explain that although most hypothyroid individuals will lose weight after they begin taking a thyroid supplement, significant weight loss will usually require attention to healthy eating habits and exercise. Individuals should avoid setting unrealistic goals.

LTH-M MEDICATIONS

OUTCOME: The patient/family will understand the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication.
2. Emphasize the importance of maintaining full participation in the medication regimen and monitoring schedule.
3. Explain the signs and symptoms of too much or too little medication.
4. Explain the implications that medications have on current or potential pregnancy.
5. Discuss drug/drug and drug/food interactions as appropriate.
6. Discuss that some medications may have an adverse effect on the disease state, i.e., amiodarone, iodine.

LTH- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

LTH-N NUTRITION

OUTCOME: The patient/family will understand the need for balanced nutrition and plan for the implementation of dietary modification.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss the need for the correct combination of nutrients and vitamins, as well as the need for a low-fat diet without excessive calories.
4. Explain that the following foods must be limited: cabbage, brussel sprouts, kale, cauliflower, asparagus, broccoli, soy beans, lettuce, peas, spinach, turnip greens and watercress as these foods may increase the risk of developing a goiter.
5. Explain that the long term use of soy protein products may be contraindicated.
6. Encourage the use of iodized salt if indicated.
7. Refer to registered dietician.

LTH-SCR SCREENING

OUTCOME: The patient/family will understand the screening device.

STANDARDS

1. Explain the screening device to be used.
2. Explain why the screening is being performed.
3. Discuss how the results of the screening will be used.
4. Emphasize the importance of follow-up care.

LTH-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Explain the test ordered, i.e., TSH, T3, T4, nuclear scan, ultrasound, blood counts.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks/benefits of non-testing.

I

FLU—Influenza

FLU-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications of the flu.

STANDARDS:

1. Discuss that one of the most common complications of the flu is pneumonia and may lead to hospitalization.
2. Explain that the flu causes many deaths in the United States every year.
3. Discuss groups who are at higher risk for complications from the flu such as the elderly and infants. Also discuss that persons with chronic diseases such as pulmonary disease, cardiac disease, renal disease, cancer and diabetes are at higher risk for complications from the flu.
4. Discuss the importance of not giving aspirin or products containing aspirin to children (under 16 years of age) with the flu as it may induce a potentially fatal complication of the flu called Reye Syndrome.

FLU-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the basic pathophysiology of influenza infection.

STANDARDS:

1. Discuss that the flu is caused by an influenza virus and that antibiotics are not helpful in treating the flu.
2. Explain that the flu virus changes every year so that having had the flu in a previous year will not necessarily make one immune to flu this year.
3. Discuss that the most common symptoms of the flu are muscle aches, head ache, fever, malaise, non-productive cough, and fatigue.
4. Explain that the flu is spread from person to person by inhalation of small particle aerosols, by direct contact or by contact with objects that have recently been contaminated by secretions from someone who has the flu.

FLU-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss signs and symptoms that would indicate worsening of the disease and prompt a follow-up visit.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize the importance of keeping follow-up appointments.

FLU-IM IMMUNIZATION

OUTCOME: The patient/family will understand the role that immunization plays in preventing influenza. (Discuss the following as appropriate to this patient and situation.)

STANDARDS:

1. Discuss that the vaccine for the flu is formulated for the viruses that are predicted to be most prevalent this year.
2. Discuss that the currently available injected flu vaccines are killed virus vaccines and cannot cause the flu. (Please refer to current information on this year's flu vaccine.)
3. Discuss that there is a live attenuated intranasal vaccine available. This vaccine may protect individuals not only from the flu strains in the vaccine but also other flu strains. It may also decrease the incidence of colds and ear infections.
4. Discuss that persons who have a history of Guillain-Barre Syndrome, egg hypersensitivity or hypersensitivity to any flu vaccine component should probably not get the flu vaccine unless ordered by a physician.
5. Discuss that current injectable flu vaccines are not licensed for use in individuals under the age of 6 months and that the intranasal flu vaccine is licensed for use in individuals between the ages of 5-49 years.
6. Discuss that persons at high risk for complications from influenza are recommended to receive the flu vaccine every year.
7. Discuss the common and important complications of flu vaccine.

FLU-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about influenza.

STANDARDS:

1. Provide the patient/family with written patient information literature on influenza.
2. Discuss the content of the patient information literature with the patient/family.

FLU-M MEDICATIONS

OUTCOME: The patient/family will understand the role of medications used to reduce flu symptoms and/or duration. (discuss the following as appropriate).

STANDARDS:

1. Discuss treatment of symptoms with OTC medications including decongestants, cough suppressants, antipyretics, analgesics, antihistamines.
2. If appropriate, discuss that aspirin should not be used in patients that are under 16 years of age due to risk of Reye's syndrome.
3. Discuss the use of antiviral treatment for influenza and that therapy must be started within 48 hours.
4. Review the proper use, benefits and common side effects of prescribed medications.
5. Explain the importance of completing the full course of antiviral therapy, as prescribed, to prevent antibiotic resistance and to facilitate complete recovery.
6. Explain the importance of adhering to the medication schedule.
7. Discuss that zinc, Echinacea and vitamin C over the counter products for viral infections have not proven to be effective.
8. Explain that antibiotics are not used for viral illnesses because they are not effective on viruses:
    a. Antibiotics used for viral infections can cause antibiotic resistance
    b. Antibiotics can also cause side effects, allergic reactions, and increased cost with no benefit to treating the viral illness.

FLU- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
    a. Assessment of the nutrition related condition.
    b. Identification of the patient's nutritional problem.
    c. Specific nutrition intervention therapy plan.
    d. Evaluation of the patient's nutritional care outcomes.
    e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

FLU-N NUTRITION

OUTCOME: The patient/family will understand how nutrition may impact the management of influenza.

STANDARDS:

1. Explain that influenza causes increased fluid losses and that extra fluid intake is usually required.
2. Explain that chicken soup may actually be helpful because it provides extra fluid, potassium and sodium.
3. Explain that small frequent meals or sips of fluid may be better tolerated than larger meals.
4. Discuss that vomiting may be present:
    a. Liquids or food will be better tolerated if the stomach is allowed to "rest" for 30 minutes to one hour before attempts to consume other fluids or foods.
        i. Small frequent intake of fluids will be better tolerated.
        ii. 5 to 15 cc's of clear fluid every 5 to 10 minutes until 8 hours have passed without vomiting is one effective strategy.

FLU-P PREVENTION

OUTCOME: The patient/family will understand communicability and measures to prevent the flu.

STANDARDS:

1. Discuss that influenza is a vaccine preventable disease. **Refer to FLU-IM.**
2. Emphasize the importance of receiving influenza vaccine every year as the virus that causes the flu changes every year.
3. Discuss that careful hand washing can help to prevent the spread of influenza.
4. Discuss that avoiding crowded places can decrease chances of getting influenza.
5. Discuss the importance of covering one's mouth and nose when coughing or sneezing and proper disposal of tissues.
6. Explain that influenza can be spread by fomites (i.e., contaminated objects such as telephone receivers), and that common use of disinfectant cleaners may reduce this spread.

L

PB—Lead Exposure/Lead Toxicity

PB-C COMPLICATIONS

OUTCOME: The patient/family will understand the common and important complications of lead exposure and lead toxicity.

STANDARDS:

1. Discuss the effects of lead on neurobehavioral systems as per current medical understanding. (As of 5-2003 it is thought that even low levels of lead exposure, i.e., less than 10Fg/dl can result in subtle neurobehavioral changes such as hyperactivity, lower IQ levels and poor school performance.)
2. Explain that older children and adults with high bone lead levels may exhibit aggressive behavior and antisocial behaviors.
3. As appropriate, discuss the effects of long term high levels of lead exposure. These may include vomiting, abdominal pain, constipation, ataxia, seizures, papilledema, impaired consciousness and eventually coma. The latter of these symptoms are associated with acute lead encephalopathy.

PB-DP DISEASE PROCESS

OUTCOME: The patient/family will understand how humans are exposed to lead and the effects of lead on humans.

STANDARDS:

1. Discuss that lead is most often introduced to humans via hand-to-mouth activity of young children, either as ingested dirt, dust licked off surfaces (including toys) and ingested paint chips. Less commonly lead may be ingested from water flow through lead pipes or brass fixtures, or from food served or prepared in ceramic bowls which have a lead glaze.
2. Discuss that the nutritional status of the individual impacts the amount of lead that is absorbed, i.e., lead ingested on an empty stomach is more likely to be absorbed than if the stomach is full. Calcium and iron may decrease lead absorption by direct competition for binding sites. Iron and/or calcium deficiency are likely to cause an individual to have enhanced lead absorption.
3. Explain that lead interrupts several chemical systems in the body and can lead to toxic levels of other chemicals in addition to the lead. Lead directly interferes with neurotransmitter release in the brain and may directly affect the developmental structure of the brain in utero and in the first few years of life. This latter effect may be an irreversible effect.

PB-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up and will strive to keep scheduled appointments.

STANDARDS:

1. Discuss the importance of regular follow-up care and routine screening for high risk populations.
2. Refer to PHN or community resources as appropriate.

PB-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about lead exposure and lead toxicity.

STANDARDS:

1. Provide the patient/family with written patient information literature on decreasing lead exposure, lead toxicity, and or lead abatement programs.
2. Discuss the content of the patient information literature with the patient/family.

PB- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PB-N NUTRITION

OUTCOME: The patient/family will understand the importance of proper nutrition in prevention and treatment of lead toxicity.

STANDARDS:

1. Discuss that the nutritional status of the individual impacts the amount of lead that is absorbed, i.e., lead ingested on an empty stomach is more likely to be absorbed than if the stomach is full. Discuss that calcium and iron may decrease lead absorption by direct competition for binding sites.
2. Discuss that iron and/or calcium deficiency are likely to cause an individual to have enhanced lead absorption.
3. Refer to the registered dietician and/or physician if a calcium or iron deficiency is present or suspected.

PB-P PREVENTION

OUTCOME: The patient/family will understand mechanisms to prevent or limit exposure to lead.

STANDARDS:

1. Review nutritional mechanisms to decrease lead absorption. **Refer to PB-N**.
2. Discuss mechanisms to decrease lead exposure:
   a. Wash your hands before you eat.
   b. Take your shoes off at the door to avoid tracking in possibly contaminated dust.
   c. Consult the health department before remodeling homes built before 1978.
   d. Avoid eating dirt or paint chips.
   e. Avoid eating out of pottery which may have been glazed with a lead-based glaze.
   f. Avoid home remedies, especially from foreign lands such as Asia or Mexico. (Azarcon, greta, rueda all may contain lead.)
   g. Avoid eating candies, syrups or vanilla manufactured in Mexico or South America.
   h. Avoid crayons not manufactured in the United States.
   i. Avoid mini-blinds which do not have a label indicating that they are lead-free.
3. Explain the importance of removing lead from clothing, shoes and your body if you work in an industry where lead exposure is likely.

PB-SCR SCREENING

OUTCOME: The patient/family will understand the importance of routine screening for high risk populations and who is at highest risk for lead exposure.

STANDARDS:

1. Discuss that the following persons are at highest risk for lead exposure:
    a. Live in or regularly visit a house or day care built before 1950 (especially if there is chipping or peeling paint.)
    b. Live in or regularly visit a house built before 1978 that has been recently remodeled (in the last 6 months.)
    c. Engage in frequent hand-to-mouth activity
    d. Have iron deficiency or anemia
    e. Live with an adult with a job or hobby that involves exposure to lead
        i. Pottery or stained glass
        ii. Bridge construction
        iii. Battery recycling
        iv. Paint and body work on cars or equipment
        v. Furniture manufacturing
        vi. Bullet or fishing weight casting
    f. Have siblings or playmates that have or have had lead poisoning
    g. Live in an area that is known to be contaminated with lead.
2. Discuss the importance of routine screening for all persons in high risk populations.
    a. Routine screening is typically performed at 6 months of age, one year of age and annually through 6 years of age (when hand-to-mouth activity generally decreases):
        i. In older children with mental retardation who may have prolonged hand-to-mouth activity
        ii. In pregnancy
        iii. When deemed appropriate by a healthcare provider
        iv. If requested by a patient or caregiver.

PB-TE TESTS

OUTCOME: The patient/family will understand the type of lead testing to be done and the implication this has for future testing or treatment.

STANDARDS:

1. Explain that lead testing can be done utilizing a variety of specimens.
2. Explain the test to be performed as well as alternative testing mechanisms as appropriate:
    a. Capillary blood testing - usually a screening method and will need to be confirmed with venous blood analysis if the level is greater than 10Fg/dl
    b. Venous blood testing - used as a confirmatory test upon which future testing or treatment will be based
    c. Urinary lead levels - usually used during chelation therapy to determine the response to therapy
    d. Hair lead levels - unreliable secondary to likelihood of contamination or lack of standardized interpretation tools.
    e. Discuss as appropriate the CDC's recommendation for follow-up testing and/or treatment based on venous blood lead levels.
    f. 10-19Fg/dl repeat venous level in 3 months, try to identify sources of lead exposure.
    g. 20-44Fg/dl repeat venous level in 1 week to one month, try to identify sources of lead exposure and remove child from the environment or source from child's environment.
    h. 45-59Fg/dl repeat venous lead level in 48 hours, try to identify sources of lead exposure and remove child from the environment or source from child's environment. Consult toxicologist for possible chelation therapy.
    i. 60-69Fg/dl repeat venous lead level in 24 hours, try to identify sources of lead exposure and remove child from the environment or source from child's environment. Consult toxicologist for possible chelation therapy.
    j. 70Fg/dl repeat venous lead level immediately, try to identify sources of lead exposure and remove child from the environment or source from child's environment. Consult toxicologist for possible chelation therapy.

PB-TX TREATMENTS

OUTCOME: The patient/family will understand the possible treatments that may be performed based on the test results.

STANDARDS:

1. **Refer to PB-TE**.
2. Discuss the role of proper nutrition in treatment of lead exposure and lead toxicity. **Refer to PB-N.**
3. Discuss as appropriate that children with blood lead level $45Fg/dl are often candidates for chelation therapy.
4. Explain that chelation therapy for persons with lead encephalopathy can be life-saving.
5. Discuss as appropriate that chelation for persons without lead encephalopathy may prevent symptom progression and further toxicity.
6. Discuss the agent to be used for chelation in persons who are to undergo chelation. Discuss the risks and benefits of treatment.
7. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of diagnostic tests.

LIV—Liver Disease

LIV – AP ANATOMY AND PHYSIOLOGY

OUTCOME: The Patient/Family will have a basic understanding of where the liver is located in the body and its function.

STANDARDS:

1. Explain that the liver is the largest organ in the abdominal cavity. It is a vital organ responsible for storing, converting, and synthesizing essential nutrients in conjunction to detoxifying drugs and producing clotting factors.
2. Explain that life style practices such as alcohol/substance abuse or exposure to certain toxic materials or viral infections can damage the liver.
3. Explain that the liver has some capacity to regenerate or repair. This ability is inhibited or eliminated by continuous exposure to toxic substances such as alcohol, drugs, infections and other unknown factors.
4. Explain that alcohol and many other foreign substances must be detoxified by the liver in order for the substance to be eliminated from the body.

LIV – C COMPLICATIONS:

OUTCOME: Patient/family will understand the complications of untreated or progressive liver disease (discuss standards that apply to patient's disease process).

STANDARDS:

1. Explain that Ascites, defined as a pathological fluid in the peritoneal cavity, is often seen in patients with hepatic cirrhosis. Review current findings regarding prognosis for patients with Ascites may be poor if not properly managed.
2. Explain that jaundice is a build up of bile acids and bilirubin. It is a yellowish discoloration of the skin, mucus membranes, and some body fluids maybe a sign of a cirrhotic liver.
3. Explain that end stage liver disease may have as a complication intense uncontrollable pruritis.
4. Explain that a common complication of liver disease is esophageal varices. Rupture of one of these varices is a life-threatening complication of liver disease.
5. Discuss that liver disease has a profound impact on clotting factors and may result in uncontrollable bleeding or abnormal clotting which can result in end organ damage of any part of the body.
6. Explain that another common end stage complication of liver disease is encephalopathy which may lead to a comatose state and death.
7. Explain that obesity can contribute to a fatty liver.

LIV-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

LIV – DP DISEASE PROCESS

OUTCOME: The patient/family will understand their specific liver disease. (Discuss the standards that pertain to this patient's liver disease.)

STANDARDS:

1. Explain that cirrhosis is caused by chronic degeneration of the parenchymal liver cells and thickening of the surrounding tissue.
2. Explain that alcohol and some drugs alter both the activation and degradation of key nutrients thereby compromising the overall function of the body.
3. Explain that cryptogenic cirrhosis is caused by unknown etiology.
4. Explain that certain viral infections such as hepatitis may result in destruction of liver cells, cirrhosis or hepatic cancer.
5. Explain that medications and over-the-counter medications and supplements can cause liver damage or liver failure. Larger than recommended dosages of acetaminophen (Tylenol®) can result in irreversible liver damage and death. This effect may be amplified by concurrent use of alcohol.

LIV – FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of fully participating in the treatment regimen and make a plan for appropriate ongoing follow-up.

STANDARDS:

1. Discuss the patient's responsibility in the management of their disease process.
2. Discuss the importance of limiting substances that are toxic to the liver.
3. Emphasize the importance of following the treatment plan even if the patient is asymptotic.
4. Discuss the procedure for obtaining follow-up appointments.
5. Emphasize the importance of keeping follow up appointments.

LIV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about liver disease.

STANDARDS:

1. Provide and discuss written information about liver disease with the patient/family.

LIV-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will collaborate to make the lifestyle adaptations necessary to minimize complications and improve overall health.

STANDARDS:

1. Review lifestyle/changes that the patient can control such as diet, exercise, medication regimen, safety and injury prevention, avoidance of high risk behaviors and full participation with the treatment plan.
2. Emphasis the importance of the patient's adaptation to a healthier and lower risk lifestyle in order to minimize the complications of liver disease.
3. Review the community resources available to assist the patient in making lifestyle changes and make referrals as needed.

LIV-M MEDICATIONS

OUTCOME: The patient/family will understand the medications prescribed in the management of their disease process.

STANDARDS:

1. Emphasize the importance fully participating in the prescribed medication regimen.
2. Discuss proper use, benefits, common side effects, storage, and common interactions of prescribed medication. Review signs of possible toxicity and appropriate follow-up as indicated.
3. Explain to the patient/family that the patient's physician, pharmacist, provider should be contacted before starting, discontinuing or changing any prescription medications, over-the -counter drugs or dietary/herbal supplements.

LIV- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient’s nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient’s nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

LIV-N NUTRITION

OUTCOME: The patient/family will understand the diet regimen pertaining to liver disease.

STANDARDS:

1. Explain that the appropriate dietary regimen is one of the essential components in the management of liver disease.
2. Explain that the patient should meet regularly with a Registered Dietitian for ongoing medical nutrition therapy.
3. Explain that fluid restrictions may be necessary to reduce fluid retention due to portal hypertension.

LIV-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

LIV-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available based on the specific disease process, test results, and individual preferences.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options. Discuss the risks and benefits of treatment as well as the possible consequences of refusing treatment.
2. Discuss the treatment plan including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of adhering to the treatment plan, emphasizing the importance of full participation even if the patient is asymptomatic.
4. Emphasize the importance of keeping scheduled follow-up appointments.
5. Refer to community resources as appropriate.

M

MPS—Menopause

MPS-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the anatomy and physiology of the female reproductive system and the changes associated with menopause.

STANDARDS:

1. Explain the normal anatomy and physiology of the female reproductive system.
2. Explain that hormones produced by the ovaries have wide ranging effects that involve not only the uterus and ovaries but also the brain, skin, blood vessels, heart, bones, breasts, and the urinary system.
3. Explain that menopause is a normal part of life and involves changes in levels of many hormones as well as physical and emotional changes.

MPS-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the potential changes associated with menopause.

STANDARDS:

1. Discuss the changes that may occur with menopause and the impact of these changes on the patient's health. Explain how complications/symptoms of menopause are related to decreased estrogen and other hormones.
    a. Loss of bone density leading to osteoporosis may include oral cavity changes
    b. Increased cardiovascular risks
    c. Loss of fertility
    d. Vasomotor symptoms, hot flashes
    e. Mood changes (Irritability, anxiety, mood swings, depression, agitation, changes in libido) and sleep disturbances
    f. Urogenital symptoms: atrophy, thinning, dryness, vulvar itching/irritation, loss of vaginal elasticity, pain/discomfort with sexual activity, frequent urination, urinary urgency, stress incontinence, pelvic relaxation
    g. Mild concentration and memory impairment
    h. Ocular changes (dryness, burning, pressure, sensitivity to light, blurred vision, increased lacrimation)

i. Weight gain, palpitations, skin changes, joint pain, and headache

j. Hair changes

MPS-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

MPS-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the changes that may occur with menopause.

STANDARDS:

1. Discuss menopause as the end of menstruation and fertility usually defined by no menstruation for 12 months. Explain that menopause may be caused by medical interventions, such as surgery, chemotherapy, or pelvic radiation but more commonly menopause occurs as a result of a normal developmental process.
2. Explain that in the United States menopause typically occurs between 45-55 years of age but may occur earlier or later. The whole process may take several months or years.
3. Discuss common manifestations of menopause:
   a. Vasomotor: hotflashes may include irritability, anxiety, sleeplessness, and agitation
   b. Urogenital: atrophy, thinning, dryness, and loss of elasticity.
4. Discuss the different classifications of menopause:
   a. Age 45-55 with hot flashes and irregular menses assume perimenopausal
   b. Age 45-55 with hot flashes and no menses for 6 months assume menopausal
   c. Age < 45 with hot flashes but regular menses or irregular menses but no hot flashes could be early menopause further investigation may be indicated
   d. Age 40-50 Menopausal symptoms still on oral contraceptives possibly menopause further investigation may be indicated.
5. Discuss how menopause relates to altered hormone production. As appropriate discuss the current understanding of medications/herbals/etc. in the treatment of menopausal changes.

MPS-EX EXERCISE

OUTCOME: The patient/family will understand the relationship between exercise and the changes of menopause and will develop a plan to achieve an appropriate activity level.

STANDARDS:

1. Explain the benefits of regular exercise. Consult a physician or health care provider before beginning an exercise program.
2. Explain the particular relevance of exercise to menopausal changes such as weight gain, depression, and decreased bone density.
3. Review activity recommendations including:
    a. Weight bearing exercise (e.g. walking, dancing, bowling, tennis, basketball, volleyball, soccer, using hand weights)
    b. Exercise involving many muscle groups
    c. Repetitive use of muscle groups to maintain or preserve bone mass
    d. Importance of sustained exercise for 30 minutes at least five times per week.
4. Assist patient/family in developing an appropriate physical activity plan.
5. Refer to community resources as appropriate.

MPS-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss procedure for obtaining follow-up appointments.
3. Emphasize importance of keeping appointments.

MPS-L LITERATURE

OUTCOME: The patient/family will receive written information about menopause.

STANDARDS:

1. Provide the patient/family with written patient information literature on menopause.
2. Discuss the content of the patient information literature with the patient/family.

MPS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand that certain behaviors reduce the risk of complications that may be associated with menopausal changes.

STANDARDS:

1. Discuss behaviors which promote good health and reduce the risk of potential complications associated with menopausal changes, i.e., osteoporosis and cardiovascular disease including:
   a. Avoidance of tobacco, excessive caffeine, and other drugs of abuse
   b. Regular weight bearing exercise to reduce the risk of osteoporosis and regular aerobic exercise to reduce the risk of cardiovascular disease
   c. Stress reduction
   d. Balanced diet low in fat and rich in calcium and Vitamin D
   e. Maintaining a healthy weight.
3. Advise the patient of potential triggers for hot flashes and avoidance of triggers:
   a. Stress and anxiety
   b. Spicy foods
   c. Caffeine
   d. Hot drinks
   e. Alcoholic beverages
   f. Hot environment.
4. Discuss the current recommendations for breast exams including mammography. Refer the patient to a physician for the most current information.

MPS-M MEDICATIONS

OUTCOME: The patient/family will understand the role of medications in the treatment of menopausal changes and complications including benefits and risks of treatment.

STANDARDS:

1. Review the medication(s) with the patient. Reinforce the importance of knowing the drug, dose and dosing interval of medications.
2. Review common side effects, signs of toxicity, and drug interactions of the medications. Review common and important drug/drug, drug/food reactions.
3. Emphasize participation in the medication plan and explain how effective use of medications may reduce complications.

MPS- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

MPS-N NUTRITION

OUTCOME: The patient/family will understand the importance of healthy food choices and plan for dietary modifications as needed.

STANDARDS:

1. Discuss changes of menopause that may be addressed by dietary modifications including:
   a. Weight gain
   b. Cardiovascular changes
   c. Decreased bone density.
2. Discuss optimal nutrition
   a. Appropriate caloric intake in response to metabolic changes associated with aging
   b. Maintain adequate intake of calcium and vitamin D through diet and supplements as needed.
3. Refer to registered dietician, physician or pharmacist as appropriate discuss other dietary modifications or supplements/herbals.

MPS-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure, including indications, complications, and alternatives, as well as possible results of not having the procedure performed.

STANDARDS:

1. Discuss the indications, risks, and benefits for the proposed procedures such as pap smears, mammograms, and endometrial monitoring (transvaginal ultrasound, endometrial biopsy).
2. Explain the process and what to expect before, during, and after the procedure.
3. Discuss pain management as appropriate.
4. Emphasize the importance of fully participating in post-procedure recommendations and follow-up.
5. Discuss procedure findings and implications as appropriate.

MPS-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand principles of injury prevention associated with osteoporosis.

STANDARDS:

1. Discuss ways to reduce risk of falls. Adapt home safety to prevent injury including removing throw rugs, install bars in the tubs and showers, secure electrical cords. **Refer to OS and FALL.**
2. Identify community resources that promote safety and injury prevention.
3. Provide information regarding key concepts for emergencies.

MPS-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in menopausal symptoms.

STANDARDS:

1. Explain that uncontrolled stress may cause increased symptoms of menopause.
2. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as inappropriate eating, all which can compromise overall health.
3. Emphasize the importance of seeking professional help as needed to reduce stress.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
5. Provide referrals as appropriate.

MPS-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

MSX—Metabolic Syndrome

MSX-C COMPLICATIONS

OUTCOME: The patient will understand the complications associated with metabolic syndrome.

STANDARDS:

1. Explain that metabolic syndrome is a precursor to cardiovascular disease and diabetes.
2. Explain that arteriosclerosis and atherosclerosis impede blood flow through the circulatory system.
3. Explain that heart attacks may result from the heart having to work harder to pump blood through congested and hardened arteries.
4. Explain that good control of blood sugar can reverse or prevent progression of pre-diabetes.
5. Explain that strokes may result due to injured blood vessels in the neck or brain.
6. Explain that blindness may result from injured blood vessels in the eye.
7. Explain that leg pain may result due to injured blood vessels in the legs.

MSX-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

MSX-DP DISEASE PROCESS

OUTCOME: The patient will have a basic understanding of the pathophysiology of the metabolic syndrome.

STANDARDS

1. Explain that metabolic syndrome is a combination of dyslipidemia, hypertension and pre-diabetes (insulin resistance).
2. Review the risk factors and causative factors of dyslipidemia, hypertension and pre-diabetes.
3. .Discuss HDL, non-HDL, LDL and triglycerides. Define normal ranges.
4. Explain the difference between systolic and diastolic pressure. Define normal ranges.
5. Discuss the role of insulin resistance**.** Define normal ranges.

MSX –EQ EQUIPMENT

OUTCOME: The patient will receive information on the use of home blood pressure monitors and pedometers.

STANDARDS:

1. Provide the patient with information on the use of specific home blood pressure monitors and pedometers.
2. Discuss the use of blood pressure monitoring equipment in public places, i.e., such as stores.
3. Discuss correct way to record blood pressure and pedometer activity in a logbook and bring to clinic visits.
4. Discuss when to contact a healthcare provider for a blood pressure value which is outside the patient's personal guidelines.
5. Discuss the proper use and care of medical equipment.
6. Discuss signs of equipment malfunction and proper action in case of malfunction.

MSX-EX EXERCISE

OUTCOMES: The patient will understand the relationship of exercise to normal lipids, blood pressure and blood sugar. The patient will develop a physical activity plan.

STANDARDS:

1. Explain that consistent daily physical activity and improve dyslipidemia, blood pressure, blood sugar.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

MSX-FU FOLLOW-UP

OUTCOMES: The patient will understand the importance of follow-up. The patient will develop a plan to make and keep appointments.

STANDARDS:

1. Emphasize the patient's responsibility in developing and following a treatment plan and keeping follow-up appointments.
2. Discuss the procedure for making appointments.
3. Discuss any necessary preparation for lab test(s).

MSX-L PATIENT INFORMATION LITERATURE

OUTCOMES: The patient will receive written information about metabolic syndrome.

STANDARDS:

1. Provide the patient with written information about metabolic syndrome.
2. Discuss the content of the patient information literature with the patient.

MSX-LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient will understand the lifestyle adaptations necessary to prevent or delay the progression of metabolic syndrome and develop a realistic plan to accomplish this.

STANDARDS:

1. Emphasize that healthy food choices and regular physical activity are the critical components in improving metabolic syndrome and preventing the progression to diabetes and cardiovascular disease.
2. Discuss the importance of tobacco cessation. Make referral to tobacco cessation programs if available.
3. Discuss the relationship of stress to metabolic syndrome and suggest ways to reduce stress. Refer to stress reduction program as appropriate.
4. Assist the patient to develop a self care plan.

MSX-M MEDICATIONS

OUTCOMES: The patient/family will understand their medication(s), regimen and the importance of fully participating in therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of the prescribed medications.
2. Discuss any drug-drug or drug-food interactions with this medication as appropriate.
3. Review clinical effects and onset of action expected with these medications.
4. Review recommended monitoring laboratory tests which may be ordered.
5. Explain importance of avoiding over-the-counter medications without checking with a physician and/or pharmacist.
6. Discuss common and important signs of toxicity and/or adverse reactions and what to do if the patient/family suspects a reaction.

MSX- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

MSX-N NUTRITION

OUTCOMES: The patient will understand the importance of nutritional management in the improvement of metabolic syndrome.

STANDARDS:

1. Refer to registered dietician as appropriate.
2. Emphasize that nutritional management includes meal planning, making healthy food choices, appropriate serving sizes and food preparation.
3. Review the food pyramid and its role in meal planning.
4. Explain how to read nutrition information labels. Emphasize the importance of noting the serving size – the serving size may not be the same as the container size.
5. Discuss the merits of various food preparation methods.
6. Describe appropriate portion size and emphasize its importance.
7. Discuss the importance of decreasing total fat intake and using healthier fats sparingly.
8. Explain that excessive salt intake may play a role in hypertension and discuss ways to decrease salt intake.

MSX-P PREVENTION

OUTCOME: The patient will understand ways to prevent cardiovascular disease and diabetes.

STANDARDS:

1. Explain that consuming a diet low in fat and cholesterol, controlling weight and exercising may help prevent complications from metabolic syndrome or progression to cardiovascular disease and diabetes.
2. Emphasize the importance of regular blood sugar, blood pressure, and lipid screening. Discuss current recommendations for screening and/or monitoring.
3. Explain that the metabolic syndrome tends to run in families and that the patient's family members should be evaluated by a physician or other health care provider.

MSX-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in metabolic syndrome.

STANDARDS:

1. Explain that uncontrolled stress can cause increased release of stress hormones which can contribute to insulin resistance, dyslipidemia, obesity and hypertension. This can lead to increased morbidity and mortality from all disease processes included in metabolic syndrome.
2. Explain that uncontrolled stress can interfere with the treatment of metabolic syndrome.
3. Explain that effective stress management may reduce the adverse consequences of metabolic syndrome, as well as help improve the health and well-being of the patient.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality from metabolic syndrome.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

MSX-TE TESTS

OUTCOMES: The patient will understand the test(s) to be performed including indications and its impact on further care.

STANDARDS:

1. Explain the test(s) ordered, i.e., FBS , A1C, Lipids.
2. Explain any necessary preparation prior to the test(s).
3. Explain the indications, risks and benefits of the test(s), including risks of not having the test(s) performed.
4. Explain the meaning of the test results in relation to what “normal” results are, as appropriate.
5. Explain the test as it relates to planning the course of treatment.

N

ND—Neurological Disorder

ND-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

ND-DP DISEASE PROCESS

OUTCOME: The patient and/or family members will understand the patient's neurological disease process.

STANDARDS:

1. Review the anatomy and physiology of the nervous system as it relates to the patient's disease process and its relationship to the patient's activities of daily living.
2. Discuss the pathophysiology of the patient's neurological disorder and how it may affect function and lifestyle.

ND-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) proper use and care of medical equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed medical equipment to be used during the hospital stay and/or at home after discharge.
2. Discuss and/or demonstrate proper use and care of medical equipment; participate in return demonstration by patient/family.
3. Emphasize safe use of equipment.

ND-EX EXERCISE

OUTCOME: The patient and/or family members will understand the importance of exercise in enhancing physical and psychological well-being.

STANDARDS:

1. Explain the hazards of immobility. Discuss how to prevent decubitus ulcers, contractures, constipation, renal calculi, isolation and a loss of self-esteem.
2. Emphasize that physical activity/therapy is an integral part of the patient's daily routine. Make referrals as indicated.
3. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
4. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
5. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
6. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
7. Discuss medical clearance issues for physical activity.

ND-FU FOLLOW-UP

OUTCOME: The patient and /or family members will recognize the importance of routine follow-up as an integral part of health care and maintenance.

STANDARDS:

1. Discuss the importance of routine follow-up by the primary provider, social services, physical therapy, mental health services, registered dietician and community health services.
2. Assess the need for any additional follow-up and make the necessary referrals.

ND-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about neurologic disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on neurologic disease.
2. Discuss the content of the patient information literature with the patient/family.

ND-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient and/or family members will understand what lifestyle adaptations are necessary to cope with the patient's specific neurological disorder.

STANDARDS:

1. Assess the patient's and family's level of acceptance of the disorder.
2. Refer to Social Services, Mental Health, Physical Therapy, Rehabilitative Services, and/or community resources as appropriate.
3. Review the lifestyle areas that may require adaptations: diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships.
4. Refer to occupational therapy as indicated for assistance with activities of daily living.

ND-M MEDICATIONS

OUTCOME: The patient and/or family members will understand the goals of drug therapy, the side effects of the medications and the importance of fully participating in the medication regimen.

STANDARDS:

1. Review mechanisms of action for patient's medication.
2. Discuss the proper use, benefits and common side effects of the patient's prescribed medications. Review signs of possible medication toxicity as indicated.
3. Emphasize the importance of fully participating in the medication regimen.

ND- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ND-N NUTRITION

OUTCOME: The patient and/or family members will understand what dietary modification may be necessary for a patient with a neurological disorder.

STANDARDS:

1. Review the feeding technique appropriate for the patient.
2. Identify problems associated with feeding a neurologically impaired patient:
   a. Motor impairment: Feeding may take more time, swallowing may be difficult and aspiration is a risk.
   b. Sensory impairment: Loss of taste. Inability to sense temperature may result in burns.
3. Consider referral to Social Services for help in obtaining equipment and home health services.

ND-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the importance of appropriate management of pain.

STANDARDS:

1. Explain that neuropathic pain may be significant and needs to be discussed with the medical provider.
2. Explain that the use of over the counter medications for chronic pain management needs to be assessed by the medical provider to minimize risk to kidney function.
3. Explain that all chest pain must be evaluated by the medical provider to rule out the possibility of myocardial infarction.

ND-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient and/or appropriate family member(s) will understand the importance of injury prevention and implement safety measures.

STANDARDS:

1. Explain to patient and family members the importance of body mechanics and proper lifting techniques to avoid injury.
2. Assist the family in identifying ways to adapt the home to improve safety and prevent injuries, i.e., remove throw rugs, install bars in tub/shower, secure electrical cords.
3. Stress importance and proper use of mobility devices (cane, walker, wheel chair).

ND-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

O

OBS—Obesity

OBS-C COMPLICATIONS

OUTCOME: The patient will be able to name at least 2 complications of obesity.

STANDARDS:

1. Emphasize that obesity is the single most important risk factor in Diabetes Mellitus Type 2.
2. Explain how obesity increases the risk for heart disease, infertility, cholelithiasis, musculoskeletal problems, and surgical complications.

OBS-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

OBS-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the process underlying obesity and will be able to relate this process to changes necessary to attain improved health.

STANDARDS:

1. Relate obesity to health outcomes.
2. Emphasize the relationship among obesity, caloric intake, and exercise.
3. Explain that some people have a genetic predisposition to obesity which will require increased persistence to maintain health.

OBS-EX EXERCISE

OUTCOME: The patient will understand the relationship of physical activity in maintaining a healthy body weight, and will strive to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Stress the fact that exercise is a must in any weight loss program.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

OBS-FU FOLLOW-UP

OUTCOME: The patient will understand that improved health requires a lifelong commitment to lifestyle adaptations which will assist with control of obesity.

STANDARDS:

1. Discuss the individual's responsibility in the management of obesity.
2. Review the patient's plan for lifestyle modification, emphasizing the need for keeping appointments, adhering to dietary modifications and increasing activity levels.
3. Encourage regular weight and blood pressure checks.
4. Reassess exercise and activity levels every 3-6 months.

OBS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about obesity.

STANDARDS:

1. Provide the patient/family with written patient information literature on obesity.
2. Discuss the content of the patient information literature with the patient/family.

OBS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the importance of making lifestyle adaptations to attain a healthier body habitus.

STANDARDS:

1. Review dietary modifications and restrictions. Refer to the standards for **OBS-N**.
2. Emphasize the benefits of regular exercise. **Refer to WL-EX.**
3. Discuss the importance of good hygiene since additional body fat increases perspiration.
4. Discuss the pros and cons of alternate weight loss options, i.e., fad diets, surgery, medications.

OBS-M MEDICATION

OUTCOME: The patient/family will understand that weight loss medications can have side effects or drug interactions and the importance of discussing any over-the-counter or prescription weight loss medications with the health care provider prior to initiating said medication(s).

STANDARDS:

1. Explain the potentially serious adverse effects of the specific interactions of the medication with other drugs (including OTC medications and traditional or herbal medicines).
2. Specifically discuss adverse effects of this medication when combined with specific foods.
3. Emphasize the importance of informing the provider (i.e., physician, pharmacist, nurse) of any drug interaction(s) that have occurred in the past.
4. Discuss the risk/benefit ratio of the medication(s) that are being considered.

OBS- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

OBS-N NUTRITION

OUTCOME: The patient will identify dysfunctional eating patterns and plan adaptations in eating which will promote weight loss and improved health.

STANDARDS:

1. Assess current eating patterns. Identify helpful and harmful components of the patient's diet.
2. Emphasize the importance of regular meal times and of eliminating snack foods, fatty foods, fatty red meats, reducing sodium consumption and adding more fresh fruits, fresh vegetables and fiber to the diet.
3. Emphasize the necessary component — water — in a healthy diet. Reduce the use of colas, coffee, and alcohol.
4. Review which community resources exist to assist with diet modification and weight control. Refer to dietitian as appropriate.
5. Anticipate psychological or social stressors which may lead to over-consumption. Teach the patient to splurge by plan, not by impulse.
6. Teach person(s) responsible for food purchase and preparation techniques for avoiding fats and simple carbohydrates in meal plans.

OBS-P PREVENTION

OUTCOME: The patient/family will understand the importance of attaining and maintaining a healthy body weight throughout the life span.

STANDARDS:

1. Emphasize that obesity often begins at conception. Discuss the roles of maternal obesity, gestational diabetes, and overfeeding of infants.
2. Encourage a physically active lifestyle. **Refer to WL-EX**.
3. **Refer to WL-N and OBS-C.**
4. Identify cultural, familial, and personal perceptions of body image and their relationship to obesity and health.

OBS-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in obesity.

STANDARDS:

1. Explain that uncontrolled stress is linked with an increased incidence of obesity, which increases the patient's risk of cardiovascular disease, diabetes mellitus, stroke, etc.
2. Explain that uncontrolled stress can interfere with the treatment of obesity.
3. Explain that effective stress management may reduce the complications associated with obesity, as well as help improve the patient's self esteem, health, and well-being.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the risk of morbidity and mortality from obesity.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

OBS-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

ORTH—Orthopedics

ORTH-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient and/or family will have a basic understanding of the anatomy and physiology as it relates to the disease state or condition.

STANDARDS:

1. Explain the normal anatomy and physiology of the body part affected.
2. Discuss the changes to the anatomy and physiology as a result of this condition and/or injury as applicable.
3. Discuss the impact of these changes on the patient's health, well-being and/or mobility.

ORTH-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of orthopedic conditions and/or procedures.

STANDARDS:

1. Explain that failure to fully participate in the prescribed therapy may result in a deficit in function of the limb or body part involved.
2. Discuss common and important complications associated with this illness, injury or condition.

ORTH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the current knowledge regarding the patient's orthopedic condition and symptoms.

STANDARDS:

1. Explain that an orthopedic condition involves the bones and/or joints. Describe the specific condition.
2. Discuss the current information regarding causative factors and pathophysiology of this disease state/condition.
3. Discuss the signs/symptoms and usual progression of this disease state/condition.
4. Discuss the signs/symptoms of exacerbation/worsening of this disease state/condition.

ORTH-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate, when appropriate, the proper use and care of orthopedic equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss the types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care/cleaning of the medical equipment prescribed.
4. Participate in a return demonstration by the patient/family as appropriate.
5. Discuss signs of equipment malfunction and proper action to take in case of malfunction, as appropriate. Provide contact information as appropriate.
6. Emphasize the safe use of medical equipment.
7. Discuss the proper disposal of associated medical supplies.

ORTH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular follow-up and will develop a plan to manage the orthopedic condition and keep follow-up appointments.

STANDARDS:

1. Emphasize that fully participating in the treatment plan is the responsibility of the patient.
2. Review the treatment plan with the patient/family, emphasizing the need for keeping appointments, fully participating with the medication and physical therapy plan.
3. Review the symptoms which should be reported and measures to take if they occur.
4. Stress the importance of keeping follow-up appointments and continuing the therapy for its prescribed duration.

ORTH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information regarding the specific type of orthopedic condition/injury and its treatment.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding the specific type of orthopedic condition/injury and its treatment.
2. Discuss the content of the patient information literature with the patient/family.

ORTH-M MEDICATIONS

OUTCOME: The patient will understand the importance of their prescribed medications and fully participating in the medication treatment plan.

STANDARDS:

1. Discuss the proper use, benefits, common side effects, and common interactions of the prescribed medications. Review signs of possible toxicity and appropriate follow up as indicated.
2. Emphasize the importance of fully participating in the medication plan.
3. Discuss the mechanism of action of the medication as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.

ORTH- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

ORTH-N NUTRITION

OUTCOME: The patient/family will understand the role dietary modification plays in treating orthopedic conditions/injuries and develop an appropriate plan for the necessary dietary modifications.

STANDARDS:

1. Explain that diet can be a contributing factor in the disease process.
2. Explain that diet alone cannot usually treat orthopedic conditions.
3. Encourage the patient to include foods rich in calcium, such as dairy products.
4. Refer to registered dietician as appropriate.

ORTH-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management and the importance of fully participating in the plan.

STANDARDS:

1. Explain that pain management is specific to the disease process/injury of this particular diagnosis and management may be multifaceted.
2. Explain the role of narcotics and other medications in pain management as appropriate.
3. Explain the use of heat and/or cold in the relief of pain as appropriate.
4. Explain that the use of non-pharmacologic measures (i.e., such as physical therapy, imagery, TENS units) in the control of pain.
5. Discuss the importance of restricting the use of the affected body part as recommended by the provider as a pain management tool.

ORTH-PT PHYSICAL THERAPY

OUTCOME: The patient/family will understand the importance of regular physical therapy and will develop a plan to keep physical therapy appointments and fully participate in the physical therapy plan.

STANDARDS:

1. Review the current information regarding the physical therapy indicated for this condition/injury.
2. Explain the benefits, risks and alternatives to the physical therapy plan.
3. Assist the patient/family with a physical therapy plan indicated for this condition/injury. Explain that this may include visits with the physical therapist as well as home exercises.
4. Emphasize that it is the responsibility of the patient to follow the plan.

ORTH-P PREVENTION

OUTCOME: The patient/family will understand that healthy lifestyle behaviors can reduce the risk of developing diseases, conditions, injuries and complication.

STANDARDS:

1. List lifestyle habits that increase the risk for the onset, progression, or spread of the specific orthopedic condition or predispose to injury.
2. Identify behaviors that reduce the risk for the onset, progression, or spread of the specific orthopedic condition or predispose to injury.
3. Assist the patient in developing a plan for prevention of orthopedic conditions and/or injuries.

ORTH-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s), as well as the risks, benefits, alternatives to the proposed procedure(s) and associated factors affecting the patient.

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
3. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

ORTH-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand the principles of injury prevention and plan a safe environment.

STANDARDS:

1. Explain that injuries are a major cause of death.
2. Discuss the regular use of seat belts and children's car seats and obeying the speed limit.
3. Explain that the use of alcohol and/or drugs increases the risk of injury or death, especially when used by someone operating a motor vehicle or other equipment.
4. Assist the family in identifying ways to adapt the home to improve safety and prevent injuries, as appropriate.
5. Discuss injury prevention adaptations appropriate to the patient's age, disease state, or condition.
6. Identify which community resources promote safety and injury prevention and refer as appropriate.

ORTH-TE TESTS

OUTCOME: The patient/family will understand the planned tests that may be performed, including indications and impact on further care.

STANDARDS:

1. Explain the specific test ordered.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Explain any necessary preparation for the test ordered.
4. Explain the meaning of the test results, as appropriate.

ORTH-TX TREATMENTS

OUTCOME: The patient/family will understand the treatment options that may be used to treat the specific condition or injury.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
2. Discuss the treatment plan, including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of fully participating in the treatment plan, including scheduled follow-up and physical therapy.

ORTH-WC WOUND CARE

OUTCOME: The patient/family will understand the importance of wound care and demonstrate how to perform appropriate wound care as applicable.

STANDARDS:

1. Explain the risks and benefits of appropriate wound care and how it relates to the specific condition.
2. Explain step by step how wound care is to be performed. Observe return demonstration as appropriate.
3. Discuss the importance of aseptic technique and appropriate wound care in preventing infection.
4. As appropriate, discuss the proper disposal of soiled wound care items.

OS—Osteoporosis

OS-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of untreated or advanced osteoporosis.

STANDARDS:

1. Explain that the most common complication of untreated or advanced osteoporosis is fracture.
2. Explain that spinal compression fractures are common and result in back pain and the typical "buffalo hump" often seen in elderly patients.
3. Explain that fractures of the long bones including fractures of the hip are common and may be debilitating.
4. Explain that pain (especially early morning low back pain) may be a symptom of osteoporosis even in the absence of demonstrable fractures. This can be mistaken for arthritis.
5. Explain that osteoporosis may cause tooth loss secondary to gingival bone loss. Stress the importance of good oral hygiene.

OS-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

OS-DP DISEASE PROCESS

OUTCOME: The patient will understand some of the causes and symptoms of osteoporosis.

STANDARDS:

1. Explain that humans reach their peak bone mass at about 30. After age 30 progressive bone loss typically occurs.
2. Explain that bone loss may be slowed by consistent daily exercise and appropriate calcium intake. **Refer to OS-N.**
3. Explain that medication, calcium supplementation and hormonal replacement therapies may be helpful in selected cases.
4. State that progressive bone loss may result in fractures and/or pain. **Refer to OS-C.**
5. Discuss risk factors for earlier onset or more severe osteoporosis, such as petite frame, sedentary lifestyle, smoking, inadequate calcium intake, caffeine intake.
6. Discuss the current state of understanding about the role of estrogen and other hormones as they relate to osteoporosis.

OS-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction, as appropriate.
6. Discuss proper disposal of associated medical supplies.

OS-EX EXERCISE

OUTCOME: The patient/family will understand the importance of weight bearing exercise in delaying bone loss and will make a plan for reasonable exercise.

STANDARDS:

1. Explain that exercise decreases bone loss by repetitive use of muscle groups. This repetitive use of muscles causes stress on the bones resulting in build-up of bone mass.
2. Explain that exercises involving weight bearing and many muscle groups are more beneficial than non weight bearing exercises. Some examples of weight bearing exercises are walking, dancing, bowling, tennis, basketball, volleyball, soccer, and for elderly patients using hand-held weights.
3. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
4. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
5. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
6. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
7. Discuss medical clearance issues for physical activity.

OS-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of full participation in the treatment regimen and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of osteoporosis.
2. Review the treatment plan with the patient, emphasizing the importance for follow-up care.
3. Discuss the procedure for obtaining follow-up appointments.

OS-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management plan needed to maintain function and optimal health.

STANDARDS:

1. Review the lifestyle areas that may require adaptation, i.e., diet, exercise.
2. Stress the importance of a calcium rich diet, regular weight-bearing exercise, decreased stress, not smoking, reduced alcohol intake and estrogen replacement therapy as appropriate.
3. Explain to the patient/family members the importance of body mechanics and proper lifting techniques to avoid injury.
4. Assist family/patient to identify ways to adapt the home to improve safety and prevent injury, i.e., remove throw rugs, install bars in tubs and showers, secure electrical cords.

OS-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about osteoporosis.

STANDARDS:

1. Provide the patient/family with written patient information literature on osteoporosis.
2. Discuss the content of the patient information literature with the patient/family.

OS-M MEDICATION

OUTCOME: The patient/family will understand the medications to be used in the management of osteoporosis.

STANDARDS:

1. Discuss the current knowledge about the correct amount of calcium intake for a patient of this age. Discuss ways of obtaining calcium, i.e., supplements, dietary intake, calcium based antacids.
   a. As of 5/2000 the following are believed to be the correct calcium needs for various age groups:
      i. 7-9 years old 700 mg
      ii. 10-12 years old 1000-1400 mg
      iii. 13-16 years old 1200-1400 mg
      iv. 19-49 years old 1000 mg
      v. 50+ years old 1000-1500 mg
2. Explain that Vitamin D improves calcium absorption.
3. Discuss ways to get vitamin D, i.e., supplementation, sunlight exposure. (As of 5/2000, the correct amount of Vitamin D thought to be needed is 400 IU per day.).
4. Discuss the use of estrogen to prevent osteoporosis if appropriate. Discuss potential adverse effects of estrogen as well as the potential benefit.
5. Discuss the use of SERMS (Selective Estrogen Receptor Modifiers) in the prevention and sometimes regression of osteoporosis. Discuss common and important side-effects of the medications.
6. Discuss other medications sometimes used in the treatment of osteoporosis, e.g. Calcitonin, and biphosphonates as appropriate.
7. Discuss the medications to be prescribed for the patient, the proper use, storage, dosage, important and common side-effects.
8. Discuss medications which may increase the risk for osteoporosis, i.e., thiazide diuretics, magnesium, steroid medications.

OS- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

OS-N NUTRITION

OUTCOME: The patient/family will understand some ways to treat osteoporosis by nutritional therapy.

STANDARDS:

1. Discuss that appropriate intake of calcium will reduce the risk of developing osteoporosis and therefore reduce the risk of fracture.
2. Discuss foods high in calcium like all dairy products, some greens like turnip greens, kale, broccoli, collard greens and mustard greens, fish with bones like sardines and salmon and calcium fortified foods, juices and beverages.
3. Discuss that greens are not as good a source of calcium as thy do not contain Vitamin D which is essential to good absorption of calcium.
4. Explain that some greens, like spinach, beet greens and rhubarb, contain a substance (oxalate) which inhibits the absorption of calcium and are not a good source of calcium even though they do contain calcium.
5. Explain that dairy products are an excellent source of calcium and that the fat content of milk has nothing to do with the calcium content.
6. Explain that the body requires a balance of phosphorus and calcium. Carbonated beverages contain an excess of phosphorus and may result in an overall loss of calcium from the body.
7. Explain that caffeine, sodium and excessive amount of protein may result in calcium loss for the body.

OS-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of osteoporosis.

STANDARDS:

1. Explain that peak bone mass is achieved by age 30. A higher peak bone mass will result in a higher starting place when bone mass begins to decrease after age 30.
2. Explain how regular exercise increases bone mass thereby reducing the risk of osteoporosis. Regular exercise after age 30 will decrease the rate of bone loss and in some cases may reverse bone loss.
3. Explain that daily intake of calcium will help prevent bone loss and if adequate calcium intake is accomplished in childhood and adolescence there will be a larger peak bone mass.
4. Explain the current knowledge about appropriate intake of calcium for various age levels.
5. Assist the patient/family in development of a plan to prevent osteoporosis.

OS-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management for selected patients.
3. Explain that other medications may be helpful to control the symptoms of pain.
4. Explain non-pharmacologic measures that may help with pain control.

OS-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

OS-TX TREATMENT

OUTCOME: The patient will understand the treatment plan.

STANDARDS:

1. Explain that the major treatment for osteoporosis is physical activity and appropriate intake of calcium and Vitamin D.
2. Explain that some patients will require other medications in addition to the above mentioned treatment. **Refer to OS-M.**

P

PM—Pain Management

PM-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand that the perception of pain is highly complex and individualized.

STANDARDS:

1. Explain that pain normally acts as the body's warning signal of tissue injury. This warning signal notifies the body to withdraw from the stimulus.
2. Discuss the difference between the body's physiological response to pain and the person's perception of the event.
3. Explain that tissue damage causes the release of chemicals which result in the sensation of pain. Most pain medications work by blocking these chemicals.
4. Explain that touch type signals (i.e., rubbing, stroking, touching) may block the brain's reception of pain signals.

PM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient’s condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PM-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pain symptoms, type (i.e., chronic, acute, malignant) and the causes of the patient's pain if known.

STANDARDS:

1. Explain that the patient is the primary source of information about the pain's location, quality, intensity, onset, precipitating or aggravating factors and the measures that bring relief.
2. Emphasize the importance of communicating information about the pain to the provider.
3. Discuss that the patient's presentation of symptoms is a unique combination of the type of pain, individual experiences and sociocultural adaptive responses.
4. Explain that pain tolerance varies greatly from person to person and in the same individual under different circumstances.
5. Explain that it is very rare for patients to become addicted to drugs administered for the relief of acute pain.

PM-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient’s status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

PM-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that moderate exercise may increase energy, improve circulation, enhance sleep, and reduce stress and depression, and relieve some types of pain.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

PM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

PM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the patient's specific disease process, pain management issues, support groups or community resources as appropriate.

STANDARDS:

1. Provide patient/family with written patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

PM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle changes necessary to optimize performance of everyday activities and promote healing.

STANDARDS:

1. Explain that treatment of pain is very individualized, i.e., medication, rest, exercise, and disease-specific treatment modalities.
2. Explain that exercise and social involvement (i.e., familial, traditional, cultural) may decrease the subjective sense of pain and the depression and anger often associated with pain.
3. Review lifestyle areas that may require adaptations (i.e., diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships). Discuss lifestyle changes in relation to disease progression. Review activity limitation as appropriate.
4. Discuss techniques that may reduce stress and depression such as meditation and biofeedback as appropriate.
5. Refer to community resources as appropriate**. Refer to WL**.

PM-M MEDICATION

OUTCOME: The patient/family will verbally summarize the medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Emphasize that excess sedation and euphoria are not goals of palliative pharmacologic therapy.
3. Explain that chronic pain is usually irreversible and often progressive.
4. Discuss patient/family concerns about addiction. Explain the difference between psychological addiction and physical dependence upon prescribed pain medications. Reinforce that addiction is psychological dependence on a drug; and is not equivalent to tolerance or physical dependence.
5. Explain that insomnia and depression are often significant problems for chronic pain patients. Emphasize the importance of developing a plan with the provider to address these issues as appropriate.
6. Explain that spiritual pain is a reality and cannot be relieved with medications.
7. Discuss the importance of full participation with the medication regimen in order to assure optimal comfort levels. For example, round-the-clock dosing of pain medication is more effective in the treatment of chronic pain than medications that are taken after the pain recurs.
8. Discuss the use of adjunctive medication, if indicated, to control analgesic side effects, i.e., anti-emetics, laxatives, antacids.
9. **Refer to M.**

PM- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PM-N NUTRITION

OUTCOME: The patient/family will understand the importance of a nutritionally balanced diet in the treatment of their pain and specific disease process. They will be able to identify foods and meal plans that will promote the healing process if applicable.

STANDARDS:

1. Assess current nutritional habits and needs.
2. Emphasize the necessary component - WATER - in a healthy diet.
3. Explain that constipation is a common side-effect of opiates. Dietary measures such as increased water, increased fiber, increased fruit juices and decreased intake of milk products may be helpful. Other control measures should be discussed with the provider prior to initiation.
4. Review the patient's prescribed diet, if applicable. Refer to dietitian or other local resources as indicated.

PM-P PREVENTION

OUTCOME: The patient and/or family will understand the source of pain in relation to the appropriate disease process. They will make a plan to avoid the precipitating factors, minimize disease progression, promote healing; and/or maximize coping strategies.

STANDARDS:

1. Discuss importance of fully participating in treatment plan for an acute injury to reduce the risk of residual chronic pain.
2. Discuss good body mechanics in order to reduce risk of musculoskeletal injuries.

PM-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand that grief reactions are common with chronic pain and that depression may be seen and that treatments are available for these problems.

STANDARDS:

1. Discuss symptoms of grief reaction, i.e., vigilance, trouble concentrating, hyperattentiveness, insomnia, distractibility.
2. Explain that the patient/family may need additional support, sympathy, time, attention, compassion and communication.
3. Explain that if anti-depressant drugs are prescribed by the provider, full participation with the treatment regimen is important to maximize the effectiveness of the treatment.
4. Refer to community resources as appropriate, i.e., bio-feedback, yoga, healing touch, herbal medicine, laughter, humor, traditional healer, guided imagery, massage, acupuncture, acupressure.
5. Explain that many mechanisms for dealing with grief and depression are available, i.e., support groups, individual therapy, family counseling, spiritual counseling. Refer as appropriate.

PM-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Explain the test ordered, i.e., EMG, CT scan, ultrasound.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Discuss any necessary preparation for the test(s).

PM-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available based on the specific disease process, test results, and individual preferences.

STANDARDS:

1. Discuss with the patient/family the possible appropriate noninvasive pain relief measures, i.e., TENS units, heat, cold, massage.
2. Discuss with the patient/family the possible alternative pain relief measures, when appropriate, i.e., meditation, imagery, acupuncture, healing touch, traditional healer, hypnosis.
3. Discuss with the patient/family the possible appropriate pharmacologic pain relief measures. **Refer to PM-M**.
4. Discuss with the patient/family the possible appropriate procedural or operative pain management techniques, i.e., nerve block, intrathecal narcotics, local anesthesia.
5. Emphasize the importance of the patient/family's active involvement in the development of a treatment plan.

PC—Pancreatitis

PC-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PC-DP DISEASE PROCESS

OUTCOME: The patient will understand the causes and symptoms of pancreatitis.

STANDARDS:

1. Explain that pancreatitis is an inflammation of the pancreas caused by activation of digestion enzymes produced by the pancreas.
2. Review the signs of pancreatitis, i.e., steady, boring pain radiating to the back or shoulder; low-grade fever; bulky, pale, foul-smelling stools; nausea and/or vomiting; abdominal distention, jaundice.
3. Relate some common causes, i.e., alcohol ingestion, biliary tract disease, postoperative, post-trauma, metabolic conditions, infections, drug-associated, connective tissue disorders with vasculitis.

PC-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of fully participating in treatment regimen and make a plan for appropriate follow-up.

STANDARDS:

1. Discuss the individual's responsibility in the management of pancreatitis.
2. Review the treatment plan with the patient, emphasizing the need for keeping appointments and adhering to dietary modifications.
3. Emphasize the importance of regular medical follow-up and keeping clinic appointments.
4. Encourage participation in a self-help group, such as AA, if appropriate.

PC-L LITERATURE

OUTCOME: The patient/family will receive written information about pancreatitis.

STANDARDS:

1. Provide the patient/family with written patient information literature on pancreatitis.
2. Discuss the content of patient information literature with the patient/family.

PC-M MEDICATIONS

OUTCOME: The patient will understand the type of medication being prescribed, dosage and administration of the medication. They will also be aware of the proper storage of the medication and possible side effects of the drugs.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication.
2. Emphasize the importance of maintaining full participation in the medication regimen and monitoring schedule.
3. Instruct patient on proper administration of the drug.

PC- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PC-N NUTRITION

OUTCOME: The patient will understand ways to minimize future episodes of pancreatitis through nutritional modifications.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between alcohol and pancreatitis.
3. Emphasize the importance of total abstinence from alcohol.
4. Encourage the patient to eat frequent, small meals that are bland and low fat.
5. Encourage the patient to avoid coffee.
6. Assist the patient to develop an appropriate diet plan.
7. Instruct that in many cases a regular diet may be very gradually resumed.
8. Refer to registered dietician as appropriate.

PC-P PREVENTION

OUTCOME: The patient will be able to identify factors related to pancreatitis and, if appropriate, have a plan to prevent future episodes.

STANDARDS:

1. Explain that the major cause of pancreatitis in the US is alcohol ingestion.
2. Explain that if alcohol ingestion was a factor, that complete abstinence from alcohol will decrease the chance of future pancreatitis.
3. Explain that, in some cases, dietary changes may prevent attacks or reduce their severity.

PC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management in gallbladder disease is specific to the disease process of this particular patient and may be multifaceted.
2. Explain that often antispasmodics may be helpful.
3. Explain that short term use of narcotics may be helpful in pain management.
4. Explain that other medications may be helpful to control the symptoms of nausea and vomiting.
5. Explain that administration of fluids may help with pain relief and resolution of symptoms.
6. **Refer to PM**.

PC-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

PC-TX TREATMENT

OUTCOME: The patient will understand the treatment plan.

STANDARDS:

1. Explain that pancreatic secretions can be minimized by eliminating oral ingestion of food and fluid. This must be done to "rest" the pancreas.
2. Explain the proper use of pain medications. **Refer to PM.**
3. Explain that, if the pancreatitis episode is prolonged, total parenteral nutrition may be required to maintain nutrition and promote healing.
4. Refer to community resources as appropriate.

PNL—Perinatal Loss

PNL-C COMPLICATIONS

OUTCOME: Patients will know that the most serious complications of perinatal loss are infection, hemorrhage, and possible decrease in fertility.

STANDARDS:

1. Instruct patient on the signs and symptoms of postpartum complications, i.e., hemorrhage, infections, and the possibility of decreased fertility.
2. Explain that a common complication of perinatal loss is depression and that this is usually treatable.
3. Explain that marital difficulties are common after perinatal loss. Encourage open discussion and family counseling or support groups as appropriate.

PNL-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PNL-DP DISEASE PROCESS

OUTCOME: The patient and significant others(s) will understand the type of perinatal loss they had, i.e., miscarriage, ectopic pregnancy, intrauterine death or stillbirth.

STANDARDS:

1. Explain that perinatal loss is common and is most often not a result of actions or lack of actions of the mother.
2. Explain to the patient and significant others what type of perinatal loss the patient had, i.e., miscarriage, stillbirth.
3. Explain to the patient and significant others what the course of the medical treatment will be, i.e., incomplete miscarriage, dilation and curettage, stillbirth induction of labor and vaginal delivery.
4. If appropriate, explain the cause for perinatal loss if one can be identified.
5. If possible explain the implications of this loss on future pregnancies.

PNL-FU FOLLOW UP

OUTCOME: Patient/family will understand the treatment plan and the importance of making and keeping follow-up appointments.

STANDARDS:

1. Instruct patient/family when to return for follow up visits.
2. Instruct patient/family to call or return immediately to the hospital or clinic for any signs of complication.
3. Refer for family planning as appropriate.

PNL-GP GRIEVING PROCESS

OUTCOME: The patient and significant other(s) will understand the grieving process, signs, and symptoms as it pertains to miscarriage, ectopic pregnancy, stillbirth or neonatal death.

STANDARDS:

1. Discuss that culture plays an important role in the grieving process. (Before any teaching/counseling is initiated a discussion with the patient and significant other(s) will be done to ascertain any cultural beliefs and or taboos associated with death and the grieving process. Cultural preferences should be honored.)
2. Explain that grief is a personal process and patients and significant others(s) may have different reactions to the loss. Offer grief information and different options to assist their grieving process.
3. Discuss the grieving process as it relates to perinatal loss.
4. Explain that it is normal to grieve over the loss of the baby, and that everyone may grieve differently, and that different reactions are normal.
5. Explain that anniversary reactions, increased grief during trigger events (i.e., pregnancy of a friend or family member, holidays) are normal.
6. Discuss the various options available to help with the grieving process.
7. As appropriate, encourage viewing of the infant/fetus, picture taking and naming of the infant/fetus.

PNL-L LITERATURE

OUTCOME: The patient/family will receive written patient information literature on perinatal loss and/or related issues.

STANDARDS:

1. Provide the patient/family with written patient information literature on perinatal loss and/or related issues.
2. Discuss the content of the patient information literature with the patient/family.

PNL-M MEDICATIONS

OUTCOME: Patient/family will understand her medication regimen.

STANDARDS:

1. Instruct patient on her discharge medication(s) and the indications and length of therapy for the medication(s).
2. Review the proper use, benefits and common side effects of the medication(s).
3. Emphasize the importance of maintaining full participation in the medication regimen.
4. Discuss common and important drug interactions with foods, drugs and over the counter medications.
5. Encourage continued use of prenatal vitamins as appropriate.

PNL- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PNL-N NUTRITION

OUTCOME: Patient will understand the need for a balanced diet or special diet as indicated by her medical condition.

STANDARDS:

1. Instruct patient on diet prior to discharge.
2. Encourage patient to continue taking prenatal vitamins or multi vitamin with folic acid.
3. Refer as appropriate to registered dietician or other resources as available.

PNL-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the pain management plan.

STANDARDS:

1. Discuss pain relieving and/or pain management techniques.
2. Patient will be instructed on pain medication available to her and encourage to ask for the medication as needed to relieve her pain.
3. Discuss that pain associated with perinatal loss can be physical, emotional and spiritual. Different techniques may be required to address each type of pain.
4. Discuss non-pharmacologic, traditional or spiritual techniques to address emotional and spiritual needs.

PNL-SM STRESS MANAGEMENT

OUTCOMES: The family member will understand the role of stress management in perinatal loss.

STANDARDS:

1. Explain that perinatal loss may lead to uncontrolled stress, which can contribute to physical illness, emotional distress, and early mortality of the family member.
2. Explain that effective stress management may enable the family member to deal with their loss, as well as help improve their health and well-being.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of depression or suicidal behaviors.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
5. Provide referrals as appropriate.

PNL-TX TREATMENT

OUTCOME: The patient/family will understand the treatment necessary as a result of the perinatal loss if any.

STANDARDS:

1. Explain to the patient and significant others the course of the medical treatment, i.e., dilation and curettage, induction of labor and vaginal delivery, laparoscopy or open abdominal surgery.
2. Discuss issues related to sexual activity and family planning, as appropriate.

PD—Periodontal Disease

PD-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the supportive structures of the tooth.

STANDARDS:

1. Discuss the importance of the supportive structures of the tooth which are composed of attached tissue, periodontal ligaments and alveolar bone.

PD-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the complications of periodontal disease.

STANDARDS:

1. Discuss that periodontal disease may cause seeding of the blood with bacteria. Some of the complications of this may be:
   a. Valvular heart disease
   b. Myocardial infarction
   c. Stroke
   d. Low birth-weight infants
   e. Pre-term delivery
2. Discuss that periodontal disease often results in loss of alveolar bone and loosening of teeth. This may eventually result in tooth loss.
3. Discuss that periodontal disease almost always results in bad breath.
4. Discuss that periodontal disease may result in dental caries. **Refer to DC.**

PD-DP DISEASE PROCESS

OUTCOME: The patient/family will be able to understand the periodontal disease process and list some of the causes.

STANDARDS:

1. Explain that bacterial plaque release toxins that irritate and damage the gums. Over time this infectious process may progress to involve the supporting structures of the tooth leading to bone loss and eventual loss of the tooth/teeth.
2. Explain that genetics and lifestyle choices play a role in the development of periodontal disease, i.e., diseases of the immune system, uncontrolled diabetes, and tobacco and/or alcohol use.
3. Explain that early seeding of the mouth with pathologic bacteria may predispose to the development of periodontal disease.

PD-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of regular dental follow-up.

STANDARDS:

1. Explain the course of treatment for the current disease process, including the schedule for treatments and follow-up.
2. Emphasize the importance of following the current recommendations for routine dental examination and periodontal maintenance appointments.
3. Emphasize the importance of a dental visit if any problems occur between scheduled dental visits.
4. Assist the patient in making follow-up appointments and refer to outside providers as appropriate.

PD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about periodontal disease, its treatment and/or the oral care necessary for prevention/maintenance of disease.

STANDARDS:

1. Provide patient/family with written patient information literature on periodontal disease, treatment and/or the oral care necessary for prevention/maintenance of disease.
2. Discuss the content of the patient information literature with the patient/family.

PD-M MEDICATIONS

OUTCOME: The patient/family will understand the importance of medication in the treatment of the periodontal disease and make a plan to fully participate with therapy.

STANDARDS:

1. Discuss the proper use, benefits, common side-effects, and food or drug interactions of the prescribed medication. Include procedure for follow-up if problems occur.
2. Discuss the use of chlorhexidine as appropriate. Discuss the common and important side-effects, common or important drug interactions (i.e., fluoride) and indications for immediate follow-up.
3. Explain the importance of completing the course of therapy and its role in eradicating the infection and/or decreasing the infectiousness of the periodontal disease.
4. Explain, as appropriate, that failure to complete the course of antibiotics may cause the development of resistant organisms.
5. Discuss, as appropriate, the concomitant use of antipyretics or NSAIDS.

PD- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PD-N NUTRITION

OUTCOME: The patient/family will understand the importance of a balanced diet, low in carbohydrates, especially simple sugars, and with adequate calcium and fluoride.

STANDARDS:

1. Discuss the relationship between a diet high in carbohydrates, especially simple sugars, and the development of dental caries. Give examples of foods high in simple sugars, i.e., crackers, potato chips, candy, pre-sweetened cereals.
2. Discuss the importance of calcium and fluoride intake as it relates to tooth development/mineralization.
3. Discuss foods that may be contraindicated secondary to instability of the teeth, i.e., apples, corn on the cob.
4. Refer to a registered dietician as appropriate.

PD-P PREVENTION

OUTCOME: The patient will be able to identify some ways to help prevent periodontal disease.

STANDARDS:

1. Early entry (prenatal and infancy) into dental care is important in the prevention of periodontal disease.
2. Emphasize the importance of treating all family members with periodontal disease, especially if the family includes children ages 6 months to 8 years.
3. Explain that the best preventive measures are daily plaque removal, primarily by brushing and flossing.
4. Emphasize the importance of regular and timely dental examination and professional cleaning in the prevention of periodontal disease.

PD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM**.
2. Explain that short-term use of Tylenol, NSAIDS, and/or narcotics may be helpful in pain management as appropriate.
3. Explain that antibiotics may be helpful in pain relief.
4. Explain non-pharmacologic measures that may be helpful with pain control, i.e., avoid firm foods.
5. Explain that dental anxiety may be controlled or relieved by the use of anxiolytics or antihistamines as appropriate.
6. Explain that local anesthetics and/or nitrous oxide may be used to control pain during dental procedures.

PD-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the risk(s)/benefit(s) of the test(s) and the risk(s) of refusal of the test(s).

STANDARDS:

1. Discuss the test(s) to be performed, i.e., x-ray, bacteriological testing, periodontal probing.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks of non-performance of the testing.

PD-TX TREATMENT

OUTCOME: The patient will understand the necessary treatment (i.e., scaling and root planning, chemotherapeutics, surgical treatment) and the proper oral care after treatment.

STANDARDS:

1. Explain the proposed procedure including indications, risks, benefits, alternatives and the consequences of non-treatment.
2. Review the specific elements of periodontal maintenance after treatment, i.e., daily plaque removal, use of oral rinses, and keeping scheduled appointments.

PVD—Peripheral Vascular Disease

PVD-C COMPLICATIONS

OUTCOME: The patient/family will understand how to prevent the complications of PVD.

STANDARDS:

1. Discuss common and important complications of PVD, i.e., injury, infection, amputation.
2. Emphasize early medical intervention for any injury, increased pain, decreased sensation, or signs/symptoms of infection (pain, redness, warmth).

PVD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PVD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of PVD.

STANDARDS:

1. Explain that PVD is the result of the buildup of plaque in the interior walls of the vessels supplying the extremities.
2. Explain that PVD is a chronic, progressive, and treatable disease.
3. Review the factors related to the development and progression of PVD (tobacco use, HTN, DM, obesity, and hyperlipidemia). Emphasize the patients with PVD are at greatly increased risk for other vascular diseases (CAD, CVA).
4. Review the symptoms of PVD (pain in extremities during exercise, coolness of hands and/or feet, ulcers of the extremities, skin pallor).

PVD-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of adhering to a treatment regimen, be able to identify appropriate actions to take for symptoms indicating life- or limb-threatening ischemia, and will make a plan to obtain and keep appropriate follow-up appointments.

STANDARDS:

1. Discuss the individual's responsibility in the management of peripheral vascular disease.
2. Review treatment plan with the patient, emphasizing the need for keeping appointments, fully participating with medication therapy, adhering to dietary modifications, and maintaining an appropriate activity/rest balance.
3. Review the symptoms which should be reported and evaluated, i.e., symptoms more frequent or occurring during rest, symptoms lasting longer.

PVD-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to maintain optimal health.

STANDARDS:

1. Emphasize that the most important component of home management in the prevention and treatment of peripheral vascular disease is the patient's adaptation to a healthier, lower risk lifestyle.
2. Discuss lifestyle adaptations that may reduce further risk of peripheral vascular disease and improve the quality of life (cease use of tobacco products, control hypertension and elevated cholesterol through medications, diet and exercise, lose weight as indicated, control diabetes, and increase activity as prescribed by the physician).

PVD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about peripheral vascular disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on peripheral vascular disease.
2. Discuss the content of the patient information literature with the patient/family.

PVD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to maintain optimal health.

STANDARDS:

1. Emphasize that the most important component in the prevention and treatment of peripheral vascular disease is the patient's adaptation to a healthier, lower risk lifestyle.
2. Discuss lifestyle adaptations that may reduce further risk of peripheral vascular disease and improve the quality of life (cease use of tobacco products, control hypertension and elevated cholesterol through medications, diet and exercise, lose weight as indicated, control diabetes, and increase activity as prescribed by the physician).

PVD-M MEDICATIONS

OUTCOME: The patient will understand the importance of following a prescribed medication regimen.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medications.
2. Emphasize the importance of maintaining full participation in the medication regimen.

PVD- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PVD-N NUTRITION

OUTCOME: The patient/family will understand how to control peripheral vascular disease through weight control and diet modification and develop on appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between diet and peripheral vascular disease, hypertension, elevated cholesterol, and obesity.
3. Provide lists of foods that are to be encouraged and avoided. Refer to registered dietician or other local resource as available.
4. Assist in developing an appropriate diet plan to achieve optimal weight and control cholesterol.
5. **Refer to LIP**.

PVD-P PREVENTION

OUTCOME: The patient/family will understand ways to prevent PVD.

STANDARDS:

1. Discuss that prevention of peripheral vascular disease is far better than controlling the disease after it has developed.
2. Explain that consuming a diet low in fat and controlling weight and blood pressure will help to prevent PVD.
3. Discuss that persons with uncontrolled diabetes and uncontrolled hypertension are more likely to develop PVD. Stress the importance of controlling these disease processes. **Refer to DM and HTN.**

PVD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Discuss non-pharmacologic measures that may be helpful with pain control.

PVD-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Explain the test ordered (Doppler ultrasound, angiography).
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.

PVD-TX TREATMENTS

OUTCOME: The patient/family will understand the possible treatments that may be performed based on the test results.

STANDARDS:

1. List the possible procedures that might be utilized to treat the peripheral artery blockage, i.e., angioplasty, arterial bypass.
2. Briefly explain each of the possible treatments.
3. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of the diagnostic tests.

PT—Physical Therapy

PT-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate as appropriate proper use of equipment.

STANDARDS:

1. Discuss indications for and benefits of prescribed equipment.
2. Discuss types and features of medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of medical equipment. Participate in return demonstration by patient/family as appropriate.
4. Discuss signs of equipment malfunction and the proper action to take in case of malfunction.
5. Emphasize safe use of equipment. Discuss proper disposal of any associated medical supplies.

PT-EX EXERCISE

OUTCOME: The patient/family will relate exercise program to optimal health and plan to follow the customized exercise program developed with the Physical Therapist.

STANDARDS:

1. Review the benefits of regular exercise.
2. Discuss the three types of exercise: aerobic, flexibility, and endurance, as appropriate.
3. Review the recommendations of an exercise program:
   a. Start out slowly.
   b. Modification of exercises to accommodate specific health problems.
   c. Exercise according to the specific plan developed for the individual.
4. Discuss the exercise(s) in the customized program.
5. As appropriate, demonstrate and assist in practicing the exercise(s) in the program.
6. Emphasize the importance of following the customized exercise plan developed with the Physical Therapist to achieve optimal benefit.
7. Review the exercise programs available in the community.

PT-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of fully participating with the treatment plan and the process for obtaining follow-up appointments.

STANDARDS:

1. Discuss the patient's responsibility in the management of his/her condition.
2. Emphasize the importance of making and keeping appropriate follow-up appointments.
3. Discuss the process for obtaining follow-up appointments.

PT-GT GAIT TRAINING

OUTCOME: The patient will understand the importance of improved gait and plan to practice.

STANDARDS:

1. Discuss the components necessary for optimal gait:
   a. Normal range of motion
   b. Proper cadence or rhythm
   c. Appropriate stride length
   d. Heel-to-toe pattern to step
2. Discuss the importance of normal range of motion as appropriate. Demonstrate and assist in return demonstrations of specific exercises to increase the range of motion of the affected joint(s) or extremity(s).
3. Discuss the value of cadence or rhythm in walking as appropriate. Demonstrate and assist to accomplish an improved cadence.
4. Discuss stride length as appropriate. Demonstrate appropriate stride length and assist in improving stride.
5. Discuss and demonstrate the usual heel-to-toe pattern of a normal step as appropriate. Assist the patient to learn modification techniques.
6. Emphasize the importance of intentionally practicing improved gait.

PT-I INFORMATION

OUTCOME: The patient/family will understand their physical condition as it relates to their disease process and the rehabilitative process.

STANDARDS:

1. Review the current information about the patient's specific diagnosis.
2. Review the effects that this condition has on the patient's physical status. Emphasize the short/long term effects and the degree of control that the patient has over the condition.
3. Discuss the symptoms which may indicate progression of the condition.

PT-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the physical therapy plan.

STANDARDS:

1. Provide the patient/family with written patient information literature on their physical therapy plan.
2. Discuss the content of patient information literature with the patient/family.

PT- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PT-N NUTRITION

OUTCOME: The patient will understand the need for balanced nutrition and plan for the implementation of dietary modification if needed.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to the specific condition.
4. Emphasize the importance of fully participating in the prescribed nutritional plan.

PT-TX TREATMENT

OUTCOME: The patient/family will understand the common and important risks, anticipated benefits and anticipated progress of the patient's rehabilitation process.

STANDARDS:

1. Review the current information regarding the treatment of the condition.
2. Explain the benefits of the proposed treatment.
3. Assist the patient/family in development of a treatment plan which will achieve treatment goals.
4. Refer to other departments or community resources as appropriate.

PT-WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the reasons to care appropriately for the wound, i.e., decreased infection rate, improved healing.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that should prompt immediate follow-up, i.e., increasing redness, purulent discharge, fever, increased swelling/pain.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.
5. Emphasize the importance of follow-up.

PNM—Pneumonia

PNM-C COMPLICATIONS

OUTCOME: The patient will be able to relate the possible complications, the symptoms that should be reported, and the appropriate actions to prevent complications.

STANDARDS:

1. Discuss the possible complications, e.g. pleural effusion, sustained hypotension and shock, other infections such as bacteremia, and atelectasis due to mucus plugs.
2. Explain that complications may be prevented with prompt treatment with appropriate antibiotics and therapy.
3. Advise patient/family to return if cough, fever or shortness of breath worsen or do not improve.

PNM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PNM-DP DISEASE PROCESS

OUTCOME: The patient will understand pneumonia and its symptoms.

STANDARDS:

1. Explain that pneumonia is an inflammatory process, involving-the terminal airways and alveoli of the lung and is caused by infectious agents.
2. Explain that pneumonia may be contracted by aspiration of oropharyngeal contents, by inhalation of respiratory secretions from infected individuals, through the bloodstream, or directly during surgery or trauma.
3. Explain that patients with bacterial pneumonia may have had an underlying disease that impairs the defenses, such as a preceding viral illness.
4. Explain that weakness and fatigue may persist for weeks after the infection. Encourage a gradual return to normal activities.

PMN-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

PNM-EX EXERCISE

OUTCOME: The patient will be able to demonstrate appropriate deep breathing and coughing exercises.

STANDARDS:

1. Instruct patient in deep breathing, exercises.
2. Instruct patient in techniques to cough effectively.

PNM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

PNM-IS INCENTIVE SPIROMETRY

OUTCOME: The patient will understand the reason for use incentive spirometer and demonstrate appropriate use.

STANDARDS:

1. Explain that regular and appropriate use of the incentive spirometer according to instructions reduces the risk of respiratory complications including pneumonia.
2. Explain that the optimal body position for incentive spirometry is semi-Fowler's position which allows for free movement of the diaphragm.
3. Instruct the patient to exhale normally and evenly inhale maximally through the spirometer mouthpiece.
4. Encourage the patient to hold the maximal inspiration for a minimum of three seconds to allow for redistribution of gas and opening of atelectatic areas.
5. Instruct the patient to exhale slowly and breathe normally between maneuvers.
6. Instruct the patient to repeat this maneuver as frequently as prescribed.

PNM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about pneumonia.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding pneumonia.
2. Discuss the content of the patient information literature with the patient/family.

PNM-M MEDICATIONS

OUTCOME: The patient and/or family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Review the proper use, benefits and common side effects of prescribed medications.
2. Explain the importance of completing the full course of antibiotic therapy, as prescribed, to prevent antibiotic resistance and to facilitate complete recovery.
3. Explain the importance of adhering to the medication schedule.
4. Discuss the use of medications for symptom relief, i.e., expectorants, analgesics.
5. Discourage the use of cough suppressants for a productive cough.

PNM- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PNM-N NUTRITION

OUTCOME: The patient will understand how to modify the diet to conserve energy and promote healing.

STANDARDS:

1. Stress the importance of water intake to aid in liquefying sputum.
2. Discuss the importance of the food pyramid and maintaining a balanced diet to maintain health.
3. Discuss the essential role of protein in healing.
4. Discuss changing to frequent small meals to conserve energy during the acute phase of pneumonia as appropriate.

PNM-P PREVENTION

OUTCOME: The patient/family will understand actions that may be taken to prevent pneumonia.

STANDARDS:

1. Instruct patient to avoid contact with people with upper respiratory infections.
2. Encourage patient to maintain natural resistance to infection through adequate nutrition, rest, and exercise.
3. Encourage patient (particularly if elderly or chronically ill) to obtain immunizations against influenza and pneumococcus.

PNM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand actions that may be taken to control chest discomfort.

STANDARDS:

1. Encourage the patient to take analgesics as prescribed for chest discomfort.
2. Demonstrate how to splint the chest while coughing.

PNM-TE TESTS

OUTCOME: The patient will understand the test(s) to be performed.

STANDARDS:

1. Explain that pneumonia may be diagnosed by evidence on the chest x-ray.
2. Explain that the specific infective organism can be diagnosed from a sputum culture and gram stain. The most effective antibiotics to treat the pneumonia can be identified from a sensitivity test of the cultured organism.
3. Explain that blood cultures and blood counts may also assist in diagnosis and treatment.
4. Discuss the risks/benefits of tests ordered.

PNM-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate treatment for pneumonia and the importance of fully participating with the prescribed regimen.

STANDARDS:

1. Explain that antibiotics are necessary to obliterate the infective organisms. **Refer to PNM-M.**
2. Explain that sometimes oxygen is required during the acute phase of infection to maintain adequate oxygenation.

PDEP—Postpartum Depression

PDEP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand postpartum depression and its symptoms.

STANDARDS:

1. Explain that postpartum depression is a type of mood disorder, a biological illness caused by changes in brain chemistry, and is not the mother's fault or the result of a weak or unstable personality. It is a medical illness which professional treatment can help.
2. Explain that postpartum depression occurs in up to 80% of women who give birth, and that it is treatable.
3. Review some of the biological, psychological/social factors related to the development of postpartum depression:
    a. Biological: Sudden drop in hormones after birth and/or changes in prolactin levels.
    b. Psychological/social: Stressful life events such as financial problems, housing problems, lack of family interaction and support, new mothers facing new roles, lack of sleep, increased responsibility, single mothering, and/or marital problems.
    c. Family or personal history of depression or mood disorders with or without pregnancy.
4. Discuss that postpartum depression is often not recognized by the mother or family. Emphasize the importance of discussing mood/behavior changes with a health care provider.
5. Describe the varying degrees of postpartum depression that may occur- Postpartum Blues, Postpartum Depression, and Postpartum Psychosis:
    a. **PP Blues**: Occurs first three days after birth lasting to a few weeks - tearfulness, irritability, mood swings, nervousness, feelings of vulnerability, trouble sleeping, loss of appetite, lack of confidence, and feeling overwhelmed.
    b. **PP Depression**: Occurs within first 3-6 months up to a year after birth - sadness, loss of interest in normal activities, inappropriate guilt, anxiety, fatigue, impaired concentration/ memory, over concern for baby or non at all, inability to cope, despondency/despair, thoughts of suicide, hopelessness, panic attacks (numbness, tingling in limbs, chest pain, hyperventilation, heart palpitations), feeling "like I'm going crazy", bizarre or strange thoughts.

c. **PP Psychosis:** Rarest and most severe form occurring in only 0.1% of women who have given birth – Extreme confusion, incoherence, rapid speech or mania, refusal to eat, suspiciousness, irrational statements, agitation, hallucinations, or inability to stop an activity.

6. Explain that sometimes only a professional, through test interpretation, obtaining an appropriate history, and physical examination may be able to differentiate the degree of depression. Discuss the current knowledge of postpartum depression.
7. Emphasize that postpartum depression is reversible with early intervention and appropriate treatment. Refer as appropriate.

PDEP-FU FOLLOW-UP

OUTCOME: The patient/family will participate in the treatment plan and understand the importance of full participation with medications and observations.

STANDARDS:

1. Emphasize the importance of keeping appointments for postpartum, well child and postpartum depression care.
2. Review treatment plan with the patient/family. Discuss the procedure for obtaining follow-up care, the importance of taking medications as prescribed, and how to recognize any functional impairments (as evidenced by the avoidance of family or friends, an inability to attend to hygiene, or an inability to care adequately for the infant). Explain that patients with coexisting with substance abuse may need more rapid referral.
3. Explain that if the patient has considered a plan to act on suicidal thoughts or has thoughts about harming her infant, this is a medical emergency and hospitalization may be necessary. Discuss the procedure for obtaining urgent and rapid referrals.

PDEP-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about Postpartum Depression.

STANDARDS:

1. Provide patient/family with written information on Postpartum Depression.
2. Discuss the content of patient information literature with the patient/family.

PDEP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to decrease the risk for postpartum depression and maintain optimal health.

STANDARDS:

1. Advise that the patient may be able to decrease the risk for postpartum depression by preparing during the pregnancy for the changes in lifestyle that motherhood will bring.
2. Emphasize lifestyle adaptations that will help speed recovery from postpartum depression:
    a. Over-sleeping may be a symptom of depression but has also been shown to increase depressed feelings. Discourage remaining in bed or sleeping more than 8-hours a day.
    b. Advise that natural light and exercise have an antidepressant effect. Encourage the patient to exercise, for example take a walk out of doors for at least ½-hour between 11 AM and 2 PM to take care of the need for bright light and exercise.
    c. Emphasize the importance of TOTALLY abstaining from alcohol and recreational drugs. Alcohol and street drugs both induce depression and prevent antidepressants from working effectively. Advise your provider of all medications, drugs herbals and supplements you are taking to minimize this effect.
    a. Encourage the patient/family to accept the recommended help and assistance of others. There is no shame in asking for or accepting help.

PDEP-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of medication therapy and plan to follow the prescribed medication regimen.

STANDARDS:

1. Review the patient's medications. Reinforce the importance of knowing the drug, dose and the time interval of medications.
2. Review common side effects, signs of toxicity. Discuss what actions to take if a significant side effect or signs of toxicity occurs.
3. Emphasize the importance fully participating in the medication regimen. Explain that many medications for postpartum depression do not exert an immediate effect and must be used regularly to be effective.
4. Briefly explain the mechanism of action of the patient's medication as appropriate.
5. Discuss any significant drug/drug or food/drug interactions, including interaction with alcohol.
6. Explain that the patient's wish to breast-feed can be respected. The transfer of medication to the baby can be minimized by the mother breastfeeding before she takes her pills. Although many depression medications are excreted in breastmilk, no cases of deleterious effects have been noted in infants to date. Refer the patient to a physician or pharmacist who is knowledgeable in the use of medications during breastfeeding for more specific information.

PDEP- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PDEP-N NUTRITION

OUTCOME: The patient/family will understand how diet relates to postpartum depression.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between diet and depression.
3. Explain that even marginal deficiencies in the diet will negatively affect the nervous system, mood and breastfeeding. A daily multivitamin and mineral supplement may be recommended to help ensure an adequate intake.
4. Assist in developing an appropriate diet plan. Refer to dietitian or other local resources as available. Stress the importance of eating on a regular schedule and eating a variety of foods.

PDEP-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in postpartum depression.

STANDARDS:

1. Explain that uncontrolled stress is attributed to an increase in severity of the symptoms of postpartum depression.
2. Explain that uncontrolled stress can interfere with the treatment of postpartum depression.
3. Explain that effective stress management may help reduce the severity of the symptoms of depression, as well as help improve the health and well-being of the patient.
4. Emphasize the importance of seeking professional help as needed to reduce stress.
5. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the severity of the depression or the risk of suicidal/homicidal behaviors.
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. recruiting other family members or friends to help with child care
    d. talking with people you trust about your worries or problems
    e. setting realistic goals
    f. getting enough sleep (e.g., sleeping when the baby sleeps if possible)
    g. maintaining a reasonable diet
    h. exercising regularly
    i. taking vacations
    j. practicing meditation
    k. self-hypnosis
    l. using positive imagery
    m. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    n. spiritual or cultural activities
7. Provide referrals as appropriate.

PDEP-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available based on the specific disease process, test results, severity of symptoms, the preferences of the patient, and the response to treatment during previous episodes.

STANDARDS:

1. Assist the patient/family in understanding that postpartum depression may require long-term intervention which may include psychotherapy, medication, support groups or electro-convulsive therapy.
2. Review the nature of postpartum depression as a treatable condition.
3. Explain that both the patient AND family may need to participate in the treatment to help understand the symptoms and cope with the increased stress on the family.
4. Assist the family in the realization that left untreated, postpartum depression can have significant negative effects on the baby that can persist into adulthood. It is therefore very important to identify and treat postpartum depression as early as possible.
5. Urge the family/patient to find someone to stay with and assist the patient at all times. Family and friends may offer support, reassurance, hope, and validation of the new mother's abilities.
6. Explain that treatment may begin at any point, even prior to pregnancy depending on the circumstance.

PDM—Prediabetes

PDM-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand common or serious complications of abnormal fasting blood glucose level.

STANDARDS:

1. Explain that fasting blood glucose levels above 100 mg/dL but less than 126 mg/dL and 2 hour post prandial between 140-200 mg/dL are diagnostic of prediabetes and that prediabetes may progress to Type 2 Diabetes.
2. Emphasize that optimal control of blood sugar can reverse or prevent progression of PDM.
3. Emphasize that optimal control of blood sugar can reduce the risk of complications.
4. State that PDM is a disease that needs to be monitored for progression and complications. Routine examinations are essential.
5. Discuss higher risk factors of PDM, i.e., heart attack, stroke. **Refer to CVA, CAD, DM and PVD.**
6. Discuss complications that can occur if PDM develops into Diabetes, i.e., heart disease, stroke, eye problems, kidney damage.

PDM-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of PDM.

STANDARDS:

1. Briefly describe the pathophysiology of PDM.
2. Discuss the role of insulin resistance in PDM and Type 2 DM.
3. Describe risk factors for development and progression of PDM, i.e., including: family history, obesity, sedentary lifestyle, previous history of gestational diabetes, history of high blood pressure, high triglycerides.
4. Emphasize that PDM is a reversible, controllable condition, which requires permanent lifestyle alterations and continuous attention and medical care. **Refer to PDM-LA**.

PDM-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in reducing insulin resistance and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that increased physical activity will reduce the body's resistance to insulin.
2. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
3. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
4. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
5. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
6. Discuss medical clearance issues for physical activity.

PDM-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in preventing the progression of PDM . The patient/family will develop a plan to make and keep follow-up appointments.

STANDARDS:

1. Emphasize the importance of early intervention to prevent the progression of PDM to Type 2 Diabetes.
2. Discuss the procedure for making appointments.
3. Discuss any necessary preparation for lab test(s). **Refer to PDM-TE**.

PDM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about PDM.

STANDARDS:

1. Provide the patient/family with written patient information on PDM.
2. Discuss the content of the patient information with the patient/family.

PDM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family/caregiver will understand the lifestyle adaptations necessary to prevent or delay the progression of PDM and develop a realistic plan to accomplish this.

STANDARDS:

1. Emphasize that nutrition and exercise are the critical components in improving impaired glucose tolerance.
2. Emphasize that the complications (i.e., heart attack, stroke) result from the higher than normal blood sugar levels and that the goal of management is to keep blood sugar as near to normal as possible.

PDM- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PDM-N NUTRITION

OUTCOME: The patient/family will understand the importance of nutritional management in the control of PDM and develop a plan to meet nutritional goals.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation and intake.
2. Review the food pyramid and its role in meal planning. Refer to registered dietician or to other local resources as appropriate.
3. Emphasize the importance of reading food labels. Instruct the patient/family as necessary.
4. Discuss the merits of various food preparation methods, i.e., broiling or baking is preferred over frying, avoid gravies and sauces, rinsing or blotting excess grease.
5. Emphasize the importance of portion control (appropriate serving sizes).
6. Emphasize that extra caution or planning is required when eating out, using USDA commodities, or going to special events since these foods are usually high in fat and sugar and serving sizes are often inappropriately large.
7. Emphasize that carbohydrates (such as whole grains) and low-fat proteins are preferred and that sugars and fats should be limited.
8. Emphasize the importance of family involvement and early intervention.

PDM-P PREVENTION

OUTCOME: The patient/family will understand major risk factors for development of PDM and will develop a plan for risk reduction.

STANDARDS:

1. Discuss the risk factors for PDM and Type 2 DM, i.e., obesity, sedentary lifestyle.
2. Explain that following an appropriate meal plan and increasing activity levels will reduce the risk of progression of PDM to Type 2 Diabetes.
3. Emphasize the importance of regular screening. Discuss current recommendations for screening.

PDM-TE TESTS

OUTCOME: The patient/family will understand the test to be performed and the reasons for the testing.

STANDARDS:

1. Explain the test(s) ordered, i.e., FBS, $HgbA_{1C}$, Fasting Lipid Profile.
2. Explain any necessary preparation prior to the test(s).
3. Explain the indications, risks and benefits of the test(s).
4. Explain the meaning of test results in relation to what "normal" results are.
5. Explain the test as it relates to planning the course of treatment.

PN—Prenatal

PN-1T FIRST TRIMESTER

OUTCOME: The first trimester patient will understand the progression of pregnancy as related to fetal growth and development and changes in her body.

STANDARDS:

1. Explain the reproductive cycle. Identify and explain the functions of: the ovaries, ova, fallopian tubes, uterus cervix, placenta and vagina as it relates to pregnancy.
2. Discuss fetal growth and development during the first trimester.
3. Emphasize the importance of regular prenatal care, rest, prescribed vitamins, iron and good nutrition.
4. Explain the need for adequate folate intake before pregnancy and throughout the first trimester to help prevent fetal neural tube defects.
5. Emphasize the importance of complete abstinence from alcohol, tobacco, and other drugs. Point out that use of drugs and/or alcohol during pregnancy can result in birth defects or other complications. Evaluate the patient's use of substances and refer for treatment as appropriate. **Refer to AOD.**
6. Teach the patient to inform all health care providers of pregnancy prior to obtaining treatment, i.e., x-rays, medications.
7. Discuss the importance of good personal and dental hygiene as it relates to good health and positive self-image. **Refer to WL-HY.**
8. Discuss the dangers of fetal overheating in relation to hot baths, jacuzzis, sweat lodges, heating pads, etc.
9. Discuss relief measures for the discomforts of pregnancy.
10. Discuss sex during pregnancy. Encourage the patient to ask questions.
11. Emphasize the patient's responsibilities to herself and her growing child. Discuss the dangers of exposure to infectious diseases, i.e., measles, toxoplasmosis, STIs, parvovirus.
12. Emphasize the importance and encourage enrollment in prepared childbirth and parenting classes.

PN-2T SECOND TRIMESTER

OUTCOME: The patient/family will understand the progression of pregnancy as related to fetal growth and development and changes in the body.

STANDARDS:

1. Discuss fetal growth and development in the second trimester.
2. Discuss changes in the mother's body during the second trimester. Discuss exercise, rest, and relief measures for second trimester discomforts of pregnancy.
3. Encourage breastfeeding vs. bottle-feeding. Emphasize the advantages of breastfeeding for both mother and baby. **Refer to BF**.
4. Identify risks and warning signs for preterm labor (i.e., bleeding, cramping, unexplained abdominal pain).

PN-3T THIRD TRIMESTER

OUTCOME: The patient/family will understand the progression of pregnancy as related to fetal growth and development and changes in the body.

STANDARDS:

1. Discuss changes in the mother's body during the third trimester. Discuss exercise, rest, and relief measures for third trimester discomforts of pregnancy.
2. Discuss the anatomy and physiology of lactation and care of the breasts and nipples **Refer to BF.**
3. Discuss sex during the late stages of pregnancy and early postpartum period. Discuss methods of contraception. Emphasize the importance of partner participation in family planning.
4. Discuss the signs of impending labor. Discuss those events that require immediate attention e g., ruptured membranes, bleeding, fever. Emphasize the importance of knowing "when you are in labor" and when to seek medical attention.
5. Discuss the three stages of labor. Discuss the possibility of a C-section.
6. Review breathing exercises for labor. If feasible, refer the patient for childbirth education classes.
7. Discuss hospital admission routines e.g. fetal monitoring, IVs, induction.
8. Explain that a bacteria called *Group B strep* may be dangerous to the baby and explain your institutions screening procedure.
9. **Refer to CB-PRO**.

PN-PTL PRE-TERM LABOR

OUTCOME: The patient/family will understand and identify risks and warning signs of pre-term labor.

STANDARDS

1. Explain that preterm labor may not feel the same as term labor.
2. Emphasize the importance of seeking immediate medical attention for any abnormal feelings especially if they occur at regular interval (i.e., bleeding, cramping, backache, unexplained abdominal pain).
3. Explain that early medical intervention may prevent preterm birth.
4. Explain that the healthcare provider may prescribe bedrest.

PN-ADM ADMISSION

OUTCOME: The prenatal patient/family will understand the hospital admission process for delivery.

STANDARDS:

1. Discuss preparations for preadmission, as appropriate:
   a. What paper work to do in advance.
   b. When to come to the hospital.
   c. What to bring to the hospital.
   d. Where to go for admission. This may include a hospital tour.
   e. What to expect on admission.

PN-AOD ALCOHOL AND OTHER DRUGS

OUTCOME: The patient/family will understand the disease process of chemical dependency/substance abuse and its relationship to fetal development and develop motivation for change.

STANDARDS:

1. Emphasize the importance of complete abstinence from alcohol, inhalants, other drugs and tobacco. Point out that use of alcohol, inhalants and other drugs during pregnancy are associated with birth defects or other complications. Evaluate the patient's use of substances and refer for treatment as appropriate. **Refer to AOD.**
2. Administer CAGE or other screening instrument.
3. Discuss that alcohol use during pregnancy is directly associated with an identifiable syndrome in the child. This syndrome can cause developmental delay, hyperactivity, emotional and behavioral problems, mental retardation, learning disabilities, and decreased ability to function independently as an adult. This syndrome has been called fetal alcohol syndrome, fetal alcohol effect and pervasive developmental delay.
4. Review treatment options available.
5. Refer to community resources as available or appropriate.

PN-BH BEHAVIORAL HEALTH

OUTCOME: The patient/family will understand some of the mental and emotional changes that may take place during and after pregnancy.

STANDARDS:

1. Discuss that pregnancy is a state of hormonal flux and may result in rapid and unpredictable mood swings.
2. Discuss any pre-existing mental or emotional health conditions in the patient or the patient's family.
3. Explain that although some emotional changes may be normal, others may require medication and/or other forms of treatment.
4. Discuss the signs and symptoms of post-partum depression. **Refer to PDEP**.
5. Refer to mental health or other resources as appropriate.

PN-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of pregnancy and the appropriate action to take.

STANDARDS:

1. Discuss the symptoms of pre-term labor. Emphasize the importance of immediate evaluation by a physician if you think you may have pre-term labor. Explain that immediate treatment may decrease the risk of neonatal death or lost pregnancy. Discuss that even with appropriate treatment pre-term labor may have a catastrophic outcome.
2. Explain that any bleeding as heavy as a period should prompt an immediate evaluation by a physician. Explain that this bleeding may be an early sigh of miscarriage. Explain that immediate evaluation by a physician may in some cases reduce the risk of neonatal death or lost pregnancy.
3. Explain that decreased fetal movement should prompt an immediate evaluation in labor and delivery or in another appropriate setting.
4. Emphasize to the patient that pregnancy induced hypertension may be asymptomatic or may be accompanied by warning signs (persistent swelling, persistent headaches, visual changes, decreased fetal movement, sudden weight gain, nausea and vomiting in the third trimester). Stress that immediate medical attention should be sought if warning signs occur. **Refer to PN-PIH.**

PN-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PN-DC DENTAL CARIES

OUTCOME: The patient/family will understand how maternal oral hygiene and diet affect dental conditions in the mother and infant.

STANDARDS:

1. Explain that tooth decay (dental caries) is partially caused by bacteria in the mouth.
2. Explain that this bacteria can be transmitted from the mother to the infant.
3. Emphasize the importance of never putting bottle nipples, pacifiers, or any feeding utensils in any mouth except the infant's mouth.
4. Emphasize the importance of the prenatal patient having a dental exam and treating dental caries before the birth of the infant.
5. Discuss proper oral hygiene. **Refer to DC-P**.
6. Discuss the importance of early oral hygiene for the infant—even before eruption of the primary teeth.
7. Discuss the necessity of adequate calcium in the diet of prenatal patients to prevent calcium loss from bones and teeth.

PN-DV DOMESTIC VIOLENCE

OUTCOME: Patient/family will understand that domestic violence is a primary, chronic, and preventable disease.

STANDARDS:

1. Discuss the patient/family members' abusive/violent disorder.
2. Discuss the patient's and other family members' attitudes toward their dependency.
3. Explain co-dependency as it relates to domestic violence.
4. Identify risk factors and "red flag" behaviors related to domestic violence.
5. Discuss the role of alcohol and substance abuse as it relates to domestic violence.
6. Explain that the natural course of domestic violence is one of escalation and that without intervention it will not resolve.
7. Be sure family members and other victims are aware of shelters and other support options available in their area. Make referrals as appropriate.
8. Assist to develop a plan of action which will insure safety of all people in the environment of violence.

PN-EX EXERCISE

OUTCOME: The patient will understand the role of physical activity during pregnancy.

STANDARDS:

1. Discuss the benefits of prenatal exercise.
2. Review the basic recommendations of an exercise program during pregnancy.
3. Explain that hormonal changes during pregnancy result in increased elasticity of tendons and may increase the risk of joint injuries.
4. Explain that, in general, a pregnant patient can maintain her previous level of physical activity but should contact her provider for specific instructions.
5. Discuss any physical activities that are contraindicated in this patient.
6. Review the exercise programs available in the community that would be appropriate for this patient.

PN-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

PN-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent(s)/family will understand the unborn infant's growth and development.

STANDARDS

1. Explain conception process, implantation, and cell division, as appropriate.
2. Discuss the functions of the placenta, the amniotic sac, and umbilical cord, as appropriate.
3. Give a basic overview of the unborn infant's growth and development.

PN-GDM GESTATIONAL DIABETES

OUTCOME: The patient/family will understand diabetes or carbohydrate intolerance during pregnancy and establish a plan for control.

STANDARDS:

1. Emphasize management of blood sugar.
2. Discuss careful monitoring and tracking of blood sugar.
3. Emphasize the need for an individualized meal plan by a registered dietitian.
4. Discuss that GDM increases the risk for developing Type 2 Diabetes.
5. Discuss the effect of gestational diabetes on the infant (hypoglycemia in the early neonatal period, respiratory distress, complications of delivery, increased incidence of obesity and future development of Type 2 diabetes.).
6. Explain that development of gestational diabetes in this pregnancy places the patient (mother) at high risk for development of gestational diabetes in the future pregnancies and emphasize that prenatal care for future pregnancies should begin prior to conception.
7. Explain that blood sugar control may be more difficult to obtain in the third trimester due to hormonal changes that elevate blood sugars and insulin may be needed even if it was not needed before.
8. Emphasize the need for follow-up care in the post partum period to monitor blood sugars as recommended.

PN-GEN GENETIC TESTING

OUTCOME: The patient/family will understand that some diseases or conditions are inherited and that testing may be recommended in certain circumstances.

STANDARDS:

1. Explain to the patient/family that some diseases or birth defects can be detected during pregnancy.
2. Explain that not all patients are at equal risk for these conditions.
3. Explain the tests that may be performed (i.e., ultrasound, blood tests, amniocentesis). Discuss the timing of tests as appropriate.
4. Administer the screening questionnaire that is standard for your institution (for example the ACOG antepartum genetic screening questionnaire.
5. Refer appropriate patients to a physician or other provider for further evaluation.

PN-HIV HUMAN IMMUNODEFICIENCY VIRUS

OUTCOME: The patient/family will understand risk factors for HIV (mother and child) and offer referral for testing.

STANDARDS:

1. Discuss risk factors for HIV (mother and child).
2. Offer referral for HIV testing.
3. Explain that early detection, early treatment and full participation with the medication regimen as well as maintaining a healthy lifestyle will often result in a better quality of life and slower progression of the disease and may have beneficial effects upon the delivery and longevity of the child.

PN-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about prenatal issue.

STANDARDS:

1. Provide the patient/family with written patient information literature on prenatal issue.
2. Discuss the content of the patient information literature with the patient/family.

PN - M MEDICATIONS

OUTCOMES: The patient/family will understand the type of medication being prescribed, dosage and administration of the medication.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication.
2. Emphasize the importance of taking medications as prescribed.
3. Instruct patient on proper administration of the drug.
4. Explain the proper storage of the medication.
5. Discuss potentially adverse interactions with other drugs (i.e., OTC medications, traditional/herbal medications) and the adverse effects of this medication when combined with certain foods.
6. Emphasize the importance of checking with a medical provider prior to starting any prescription, OTC, or herbal/traditional treatments.

PN- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PN-N NUTRITION

OUTCOME: The patient/family will understand the role of nutrition in pregnancy as related to maternal health, fetal growth, and development.

STANDARDS:

1. Explain the purpose of appropriate weight gain in pregnancy.
2. Explain the actions to correct constipation, nausea, vomiting or pica.
3. Encourage adequate calcium intake and calcium sources (i.e., milk and milk products, calcium supplements). **Refer to OS-N** for other sources of calcium.
4. Explain the benefits of healthy eating habits.
5. Explain that certain types of fish should be limited due to the risk of contamination (i.e., salmon, mackerel, tuna, sword fish)
6. Explain that breastfeeding in the postpartum period may result in a more rapid return to pre-pregnancy weight.
7. Encourage a limited intake of artificial sweeteners and other foods or beverages sweetened by these products.
8. Encourage liberal intake of water.
9. Discuss supplemental food programs (i.e., WIC, food distribution/commodity programs, food stamps).
10. Refer patients with GDM to a registered dietitian for an individualized meal plan.

PN-NJ NEONATAL JAUNDICE

OBJECTIVE: The family will understand the importance of monitoring for jaundice and the complications of unrecognized jaundice.

STANDARDS:

1. Explain that jaundice is the yellow color seen in the skin of many newborns which is caused by build up of bilirubin in the blood.
2. Explain that everyone's blood contains bilirubin, which is removed by the liver and that before birth, the mother's liver does this for the baby. Explain that many babies develop jaundice in the first few days after birth because it takes a few days for the baby's liver to get better at removing bilirubin.
3. Explain that the yellow skin color caused by bilirubin usually appears first in the face then moves to the chest, abdomen, arms and legs as the bilirubin level increases. Explain that the whites of the eyes may also be yellow.
4. Explain that mild jaundice is harmless but high levels of bilirubin may cause brain damage.
5. Explain that this brain damage can be prevented by treatment of the jaundice before the bilirubin level gets too high. Discuss that treatment options may include medical phototherapy or exchange transfusion.
6. Emphasize that parents should watch closely for jaundice and seek medical attention if jaundice is noticed.
7. Explain that medical personnel can check the level of bilirubin in the blood by blood tests or occasionally by a skin test.
8. Explain that all bilirubin levels must be interpreted in light of the infant's age and that term infants and older infants can tolerate higher levels of bilirubin than preterm infants and younger infants.
9. Explain that jaundice is more common in breastfed infants especially when the infant is not nursing well. Encourage nursing the infant a minimum of 8-12 times a day for the first week of life to increase milk production and keep bilirubin levels down. Emphasize that breastmilk is the ideal food for infants.

PN-PIH PREGNANCY INDUCED HYPERTENSION AND PRE-ECLAMPSIA

OUTCOME: The patient/family will understand the risk, symptoms, and treatment of pregnancy-induced hypertension and preeclampsia.

STANDARDS:

1. Explain the difference between systolic and diastolic blood pressure. Define normal ranges for the individual.
2. Review predisposing factors for hypertension (i.e., obesity, high sodium intake, high fat and cholesterol intake, lack of exercise).
3. Discuss the special condition of pregnancy as a contributing factor to hypertension - either by worsening existing hypertension of by new onset of preeclampsia.
4. Emphasize to the patient that pregnancy-induced hypertension may be asymptomatic or may be accompanied by warning signs (persistent swelling, persistent headaches, visual changes, decreased fetal movement, sudden weight gain, nausea and vomiting in the third trimester.) Stress that medical attention should be sought if warning signs occur.
5. Discuss complications and increased perinatal risk, i.e., maternal convulsions with attendant risk of maternal and/or fetal brain injury, premature birth.
6. Discuss that the healthcare provider may prescribe bedrest.

PN-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand some techniques for reducing the pains and discomforts which are sometimes associated with pregnancy.

STANDARDS:

1. Explain that headaches, abdominal pain, back pain, and certain other pains are common and expected in pregnancy.
2. Discuss types of pain which should prompt an immediate medical evaluation, i.e., pains which come and go at regular intervals, pain associated with bleeding, pain which is unrelieved by conservative measures.
3. Discuss measures which may relieve pain, i.e., warm bath, change of activity, massage.
4. Explain that most pain medications should not be used in pregnancy, but that the patient's provider can recommend and/or prescribe pain medication if necessary.

PN-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand safety measures specific to pregnancy.

STANDARDS:

1. Discuss the regular use of seat belts and children's car seats, obeying the speed limit. Explain that seatbelts clearly save lives and should be worn by all persons including pregnant women.
2. Discuss that seatbelts should be worn low on the hips and the shoulder belt should lie above the pregnant abdomen.
3. Review the dangers inherent in the use of wood-burning stoves, "charcoal pans", kerosene heaters, and other open flames.
4. Review the safe use of electricity and gas.
5. Discuss the proper disposal of waste, including sharps and hazardous materials.
6. Review the proper handling, storage and preparation of food.
7. Review the importance of uncontaminated water sources. Discuss the importance of purifying any suspect water by boiling or chemical purification.
8. Identify which community resources promote safety and injury prevention. Provide information regarding key contacts for emergencies, i.e., 911, Poison Control, hospital ER, police.
9. Discuss the dangers of fetal overheating in relation to hot baths, jacuzzis, sweat lodges, heating pads, etc.

PN-SCR SCREENING

OUTCOME: The patient/family will understand the screening device.

STANDARDS

1. Explain the screening device to be used.
2. Explain why the screening is being performed.
3. Discuss how the results of the screening will be used.
4. Emphasize the importance of follow-up care.

PN-SF INTRODUCTION OF THE INFANT TO SOLID FOODS

OUTCOME: The parent/family will understand the appropriate ages to introduce various solid foods. (teach any or all of the following as appropriate to this infant/family)

STANDARDS:

1. Explain that infants should not routinely be fed foods other than breastmilk or formula prior to 4 months of age except under the advice of a healthcare provider.
2. Emphasize that, for some time after the introduction of solid foods, breastmilk/formula will still be the infant's primary source of nutrition.
3. Emphasize that foods should never be given from a bottle or infant feeder and must always be fed from a spoon.
4. Explain that infants may be fed cereal mixed with breastmilk or formula not sooner than 4 months of age. Rice cereal is generally the preferred first solid food. It is normal for an infant to take very small amounts of solid foods for several months. Discard any uneaten food after each meal.
5. Emphasize the need to wait 3-5 days between the addition of new foods to watch for adverse events from the foods.
6. Explain that pureed/or finely mashed vegetables and fruits should be started no earlier than 6 months of age.
7. Explain that some foods such as peanut butter, chocolate, eggs, strawberries, cow or goat milk and citrus should not be fed until the infant is one year of age due to the highly allergenic nature of these foods. Explain that honey and syrups may contain botulism toxin and should not be fed before one year of age.
8. Explain that infants 14-16 moths of age will have a decreased appetite and will become more picky eaters.
9. Emphasize that some foods are easy to choke on and should be avoided until 4 years of age, i.e., nuts, hard candies, gum, carrot sticks, meat on a bone, grapes, popcorn, hot dogs, unpeeled apples, slices of orange.
10. Discuss the importance of offering foods at the appropriate ages but do not insist that infants eat foods when they are not hungry:
    a. Baby knows how much to eat
    b. It is important to go along with the baby when they feel they have finished eating
    c. Some days babies eat a lot other days not as much
    d. No two babies eat the same
11. Explain how to assess readiness, an infant:
    a. who exhibits tongue thrusting is not ready to eat solids.

b. will give you cues to readiness when they open their mouths when they see something coming

c. will close lips over a spoon

d. will keep food in their mouth instead of spitting it out

e. will sit up alone without support

12. Explain that the body of knowledge regarding infant feedings has changed dramatically and advice from family/friends may no longer be appropriate; talk to your healthcare provider.

PN-SHS SECOND-HAND SMOKE

OUTCOME: The patient and/or family will understand the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define "passive smoking", ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls
2. Discuss harmful substances in smoke
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances)
3. Explain the increased risk of illness in children and adults when exposed to cigarette smoke either directly or via second-hand smoke, i.e., increased colds, asthma, ear infections, pneumonia, lung cancer.
4. Emphasize that the infants who live in the homes where people smoke in the house are three times more likely to die of SIDS than infants who live in a home where no one smokes in the house.
5. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the child is not in the room at the time that the smoking occurs.
6. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure such as smoking outside and wearing a smock which is removed prior to returning to the house.
7. Encourage smoking cessation or at least never smoking in the home or car.

PN-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in overall health and well-being.

STANDARDS:

1. Explain that uncontrolled stress may cause release of stress hormones which interfere with general health and well-being.
2. Explain that effective stress management may help the patient have a more positive experience with pregnancy and childbirth.
3. Discuss that stress may exacerbate adverse health behaviors such as tobacco, alcohol or other substance use as well as inappropriate eating all of which have been shown to have an adverse effect on the developing baby.
4. Emphasize the importance of seeking professional help as needed to reduce stress.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

PN-SOC SOCIAL HEALTH

OUTCOME: The patient/family will understand social services available.

STANDARDS:

1. Discuss the patient's living situation including access to adequate housing, electricity, refrigeration, sanitation, running water, and adequate and nutritional foods.
2. Discuss the patient's access to transportation. Refer to community resources as available.
3. Discuss the patient's eligibility for state, federal or tribal resource programs, i.e., WIC, state Medicaid, food stamps, commodities, housing assistance. Emphasize that IHS and/or ITU programs may not be able to meet all of the patient's needs therefore she should apply for all programs for which she may be eligible.
4. Discuss adoption, abortion, miscarriage, as appropriate.
5. Refer to Community Resources, Behavioral Health, and/or Social Services as appropriate.

PN-STI SEXUALLY TRANSMITTED INFECTIONS

OUTCOME: The patient and partner will understand risk factors, transmission, symptoms and complications of causative agent(s).

STANDARDS

1. Discuss specific STIs.
2. Explain how STIs are transmitted, i.e., semen, vaginal fluids, blood, mother to infant during pregnancy or child birth, or breastfeeding.
3. Explain how STIs cannot be transmitted, i.e., casual contact, toilet seats, eating utensils, coughing.
4. Explain that there are no vaccines against STIs and that there is no immunity to STIs. List curable and incurable STIs. Stress the importance of early treatment.
5. Explain that infection is dependent upon behavior, not on race, age, or social status.
6. Describe how the mother/fetus is affected.
7. List symptoms of disease and how long it may take for symptoms to appear.
8. List complications that may result if disease is not treated including complications in the unborn child.
9. Review the actions to take when exposed to an STI.

PN-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain any necessary preparation for the test.
3. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
4. Explain how the test relates to the course of treatment.
5. Explain the meaning of the test results, as appropriate.

PN-TO TOBACCO

OUTCOME: The patient/family will understand the dangers of tobacco or nicotine use during pregnancy and make a plan for immediate smoking cessation.

STANDARDS:

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.
2. Discuss the dangers of tobacco use during pregnancy:
   a. Low birth weight infants
   b. Intrauterine growth retardation
   c. Nicotine withdrawal in the newborn
   d. Increased incidence of asthma and pneumonia in the child
   e. Spontaneous abortion or miscarriage
   f. Placental insufficiency
   g. Explain nicotine addiction.
3. Discuss the common problems associated with tobacco use and the long term effects of continued use of tobacco, i.e., COPD, cardiovascular disease, numerous kinds of cancers including lung cancer.
4. Review the effects of tobacco use on all family members- financial burden, second-hand smoke, greater risk of fire and premature death of a parent or bread winner.
5. Explain dependency and co-dependency.
6. Discuss that smoking is a serious threat to health. Encourage tobacco cessation. **Refer to TO**.

PN-VBAC VAGINAL BIRTH AFTER CESAREAN SECTION

OUTCOME: The patient and labor partner/coach will understand that VBAC is possible, as well as the processes, risks, and benefits associated with VBAC.

STANDARDS

1. Explain that there is a high success rate of VBAC.
2. Explain the importance of having prior medical records to determine whether the patient is a candidate for VBAC.
3. Discuss that there is a faster recovery after VBAC than a repeat C-section.
4. Explain that close monitoring of the labor process will be necessary and that if complications arise a C-section may be necessary.
5. Explain that significant risks from VBAC include uterine rupture, failure to progress in labor, and C-section.

PSR—Psoriasis

PSR-BH BEHAVIORAL HEALTH

OUTCOME: The patient will understand that psoriasis has a physical impact on the skin, but it also affects feelings, behaviors, and experiences.

STANDARDS:

1. Discuss the importance of recognizing and acknowledging the social effects of psoriasis in order to cope with the disease.
2. Explain that psoriasis marks people as different because the skin looks different from other people's skin. Some people may react with insensitivity and ignorance to people with psoriasis.
3. Discuss that ways to cope with psoriasis will vary with individuals, and that there is no "best" way to cope with psoriasis. Coping might include discussing this condition with family and friends.
4. Discuss emotions associated with psoriasis, i.e., frustration with the condition, embarrassment, anger.
5. Discuss ways to cope with the emotional aspects of psoriasis:
    a. Learn the facts about psoriasis
    b. Practice responses to people who may comment on your skin
    c. Join (or start) a psoriasis support group
    d. Expect negative experiences but anticipate that each time it will get easier
    e. Fill life with a positive focus
    f. Remember that there is much more to life than just the skin disease
6. Refer to community resources as appropriate.

PSR-DP DISEASE PROCESS

OUTCOME: The patient will understand the basic pathophysiology, symptoms, and prognosis of psoriasis.

STANDARDS:

1. Explain that psoriasis is not contagious, there is no cure, and will require lifelong treatment. Psoriasis comes and goes in cycles of remission and flare-ups.
2. Explain that a variety of factors – ranging from emotional stress, trauma to the skin, dry skin and streptococcal infection – can induce an episode of psoriasis. Recent research indicates that some abnormality in the immune system likely plays a role.
3. Explain that in people with psoriasis; the immune system is mistakenly "triggered," causing skin cells to grow too fast. The rapidly growing cells pile up in the skin's top layers, leading to the formation of silvery lesions on the surface.
4. Explain that genetics may play a role and that psoriasis may be exacerbated by:
    a. Emotional stress
    b. Injury to the skin
    c. Reaction to certain drugs
    d. Some types of infection
5. Explain that psoriasis is a skin disease that causes dry, red, scaly patches to appear on the skin. It can show up on any part of the body. In most cases, it occurs on the elbows, knees, scalp, or torso.
6. Discuss the forms of psoriasis as indicated for this patient.
    a. Plaque psoriasis (most common): patches of raised, red skin covered by a flaky white or silver build-up called scale.
    b. Guttate psoriasis: sometimes preceded by strep throat. Small, red dots on the skin usually appear on the arms, legs, and trunk.
    c. Three less common forms of psoriasis:
        i. Erythrodermic – intense inflammation with bright, red skin that looks "burned" and sheds or peels.
        ii. Inverse – smooth, dry patches that are red and inflamed, often in the folds or creases of the skin, such as the armpits or groin, between the buttocks or under the breasts. Inverse psoriasis is more common in those who are overweight.
        iii. Pustular – blister like spots filled with liquid, surrounded by red skin. The blisters will often come and go in cycles. This form of psoriasis can appear on specific areas, like the hands or feet, or on larger areas of skin.
7. Later manifestations of psoriasis may include:

a. Palmer/Plantar psoriasis: red, scaly, cracked skin with tiny pustules on the palms of the hands or the soles of the feet.

b. Psoriatic arthritis:

i. Stiffness, pain, and tenderness of the joints

ii. Reduced range of motion

iii. Nail changes such as pitting, which is found in up to 80% of people with psoriatic arthritis

8. Explain that usually people have one kind of psoriasis at a time. However, one kind of psoriasis can turn into another kind.

9. Psoriasis can be:

a. Mild - up to 3% of your body

b. Moderate – 3 to 10% of your body

c. Severe – more than 10% of your body

PSR-FU FOLLOW UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

PSR-L PATIENT INFORMATION LITERATURE

OUTCOME - The patient/family will receive written information about psoriasis.

STANDARDS:

1. Provide patient/family with written patient information on psoriasis
2. Discuss the content of patient information literature with the patient/family.

PSR-M MEDICATIONS

OUTCOME: The patient will understand some of the medications available in the treatment of psoriasis.

STANDARD:

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of full participation with medication regimen.
3. Discuss the mechanism of action as needed.
4. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter medications.
5. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies, to the provider.
6. Explain that the severity of psoriasis will determine which medication is needed.
7. Explain that no single medication works for everyone and that the goal is to find medications that work best with the fewest side effects.
8. Explain that different kinds of prescription and over-the-counter treatments can help with psoriasis.
9. Explain that Methotrexate and other immune modifying agents can provide dramatic results: however, may result in severe liver damage, immune suppression, and other complications and may require frequent blood tests.

PSR- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PSR-N NUTRITION

OUTCOME: The patient/family will understand the need for a healthy diet pertaining to psoriasis.

STANDARDS:

1. Review normal nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Explain that vitamin D and E and Zinc may have some benefit.
4. Refer to a dietitian as needed.

PSR-P PREVENTION

OUTCOME: The patient will understand that avoiding psoriasis triggers can lessen the impact of the condition.

STANDARDS:

1. Explain that the patient should avoid skin injuries that result in a break in the skin which can exacerbate or trigger flare-ups, i.e., insect bites, cuts and scrapes, and burns. Emphasize that care should be taken to wear protective clothing to protect the skin.
2. Explain that other triggers that may exacerbate psoriasis include shaving, adhesive taping, tattoos, chafing, blisters, and boils.
3. Explain that common preventive measures include avoiding hot showers and perfumed lotions and soaps.
4. Explain that it is difficult to separate job and family-related stress from the psychological stress of living with psoriasis. One cause of stress probably reinforces the others. Clinical studies have supported the facts that psychological stress can worsen psoriasis. **Refer to PSR-SM.**

PSR-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management with psoriasis.

STANDARDS:

1. Explain that uncontrolled stress can contribute to increased outbreaks.
2. Explain that effective stress management may reduce the adverse consequences of psoriasis, as well as help improve the health and well-being of the patient.
3. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    d. becoming aware of your own reactions to stress
    e. recognizing and accepting your limits
    f. talking with people you trust about your worries or problems
    g. setting realistic goals
    h. getting enough sleep
    i. maintaining a reasonable diet
    j. exercising regularly
    k. taking vacations
    l. practicing meditation
    m. self-hypnosis
    n. using positive imagery
    o. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    p. spiritual or cultural activities
4. Provide referrals as appropriate.

PSR-TX TREATMENT

OUTCOME: The patient will understand that psoriasis usually responds to treatment but is not curable.

STANDARDS:

1. Explain that a simple treatment for psoriasis is to soak in a warm bath for 10-15 minutes, then immediately apply a topical ointment such as petroleum jelly, which helps the skin retain moisture.
2. Explain that topical ointments include salicylic acid ointments, steroid-based creams, and ointments containing calcipotriene, which is related to vitamin D.
3. Explain that coal-tar ointments and shampoos can alleviate symptoms but these may also cause side effects, such as folliculitis.
4. Explain that light therapy treatment is sometimes recommended for persistent, difficult-to-treat cases of psoriasis. However, the use of light therapy can be risky due to the possibility of skin damage from the ultraviolet light itself.
5. Explain that when these treatments fail, some doctors prescribe oral medications to treat psoriasis. Some of these medications affect the immune system and body organs and require careful monitoring.

PL—Pulmonary Disease

PL-BIP BILEVEL (OR CONTINUOUS) POSITIVE AIRWAY PRESSURE VENTILATION

OUTCOME: The patient/family will have a basic understanding of BiPAP or CPAP ventilation, as well as the risks, benefits, alternatives to BiPAP or CPAP and associated factors affecting the patient.

STANDARDS:

1. Explain that the patient does not require intubation with an endotracheal tube or tracheostomy tube in order to receive BiPAP or CPAP. BiPAP or CPAP is delivered utilizing a tight-fitting mask over the nose and/or mouth.
2. Explain the basic mechanics of BiPAP or CPAP, including the risks and benefits of receiving BiPAP or CPAP and the adverse events which might result from refusal.
3. Discuss alternatives to BiPAP or CPAP, including expectant management, endotracheal intubation or tracheostomy as appropriate.
4. Explain that patient cooperation is vital to successful BiPAP or CPAP management.

PL-C COMPLICATIONS

OUTCOME: The patient will understand how to prevent complications of pulmonary disease.

STANDARDS:

1. Discuss that the most common complications of pulmonary disease are exacerbation or infection. These complications often result from failure to fully participate with treatment regimens (i.e., medications, peak flows) or from exposure to environmental triggers or infections.
2. Emphasize early medical intervention for minor URI's, fever, cough, and shortness of breath.
3. Stress the importance of fully participating in the treatment plan.

PL-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

PL-DP DISEASE PROCESS

OUTCOME: The patient will understand the etiology and pathophysiology of their pulmonary disease.

STANDARDS:

1. Review the anatomy and physiology of the respiratory system.
2. Discuss how factors such as: environmental triggers, age, smoking, COPD, and asthma affect the ability of the respiratory system to exchange O_2/CO_2 and resist infection.
3. Discuss the pathophysiology of the patient's specific disease process.

PL-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient's status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

PL-EX EXERCISE

OUTCOME: The patient/family will understand the role of increased physical activity in this patient's disease process and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

1. Explain that the goal is at least 150 minutes of physical activity a week, for example, walking:
   a. 30 minutes 5 days per week
   b. 15 minutes bouts 2 times a day 5 days per week
   c. 10 minutes bouts 3 times a day 5 days per week
2. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
3. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
4. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
5. Discuss medical clearance issues for physical activity.

PL-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of regular follow-up and will strive to keep scheduled appointments.

STANDARDS:

1. Discuss the importance of regular follow-up care in the prevention of complications and adjustment of medications.
2. Encourage full participation in the treatment plan. Assess the patient's understanding of the treatment plan and acceptance of the diagnosis.
3. Provide positive reinforcement for areas of achievement.
4. Refer to PHN or community resources as appropriate.
5. Emphasize the importance of consistent peak flow measurement if appropriate.

PL-HM HOME MANAGEMENT

OUTCOME: The patient and/or family will understand the home management of their disease process and make a plan for implementation.

STANDARDS:

1. Discuss home management plan and methods for implementation of the plan.
2. Explain the importance of following a home management plan, i.e., fewer emergency room visits and fewer hospitalizations.

PL-INT INTUBATION

OUTCOME: The patient/family will have a basic understanding of endotracheal intubation, as well as the risks, benefits, alternatives to endotracheal intubation and associated factors affecting the patient.

STANDARDS:

1. Explain the basic procedure for endotracheal intubation, including the risks and benefits of endotracheal intubation and the adverse events which might result from refusal.
2. Discuss alternatives to endotracheal intubation, including expectant management, as appropriate.
3. Explain that the patient will be unable to speak or eat while intubated.

PL-IS INCENTIVE SPIROMETRY

OUTCOME: The patient will understand the reason for use of the incentive spirometer and demonstrate appropriate use.

STANDARDS:

1. Explain that regular and appropriate use of the incentive spirometer according to instructions reduces the risk of respiratory complications including pneumonia.
2. Explain that the optimal body position for incentive spirometry is semi-Fowler's position which allows for free movement of the diaphragm.
3. Instruct the patient to exhale normally and evenly inhale maximally through the spirometer mouthpiece.
4. Encourage the patient to hold the maximal inspiration for a minimum of three seconds to allow for redistribution of gas and opening of atelectatic areas.
5. Instruct the patient to exhale slowly and breathe normally between maneuvers.
6. Instruct the patient to repeat this maneuver as frequently as prescribed.

PL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about pulmonary disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on pulmonary disease.
2. Discuss the content of the patient information literature with the patient/family.

PL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of pulmonary disease and prolong life.

STANDARDS:

1. Discuss lifestyle changes which the patient has the ability to make: cessation of smoking, dietary modifications, weight control, participation in treatment and exercise.
2. Re-emphasize how complications of pulmonary disease can be reduced or eliminated by such changes.
3. Review the community resources available to help the patient in making such lifestyle changes.
4. Identify and avoid environmental triggers (i.e., cigarette smoke, stress, environmental smoke, pollen, mold, dust, roaches, insecticides, paint fumes, perfumes, animal dander, cold air, sulfites, aspirin) as appropriate for the patient.

PL-M MEDICATIONS

OUTCOME: The patient and/or family will understand the goal of drug therapy and be able to demonstrate and explain use of the prescribed regimen.

STANDARDS:

1. Review the patient's medications. Reinforce the importance of knowing the drug, dose, and dosing interval of medications.
2. Review common side effects, signs of toxicity, and drug interactions of medication(s).
3. Discuss the difference between bronchodilator and anti-inflammatory medications.
4. Explain the difference between maintenance and rescue drugs.
5. Emphasize full participation with the treatment plan and explain how effective use of medications can facilitate a more active life style for the pulmonary disease patient.
6. Emphasize the importance of consulting with a health care provider prior to using any OTC medication.

PL-MDI METERED-DOSE INHALERS

OUTCOME: The patient will be able to demonstrate correct technique for use of MDIs and understand their role in the management of pulmonary disease.

STANDARDS:

1. Instruct and demonstrate steps for standard or alternate use procedure for metered-dose inhalers and ways to clean and store the unit properly.
2. Review the importance of using consistent inhalation technique.

PL- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

PL-N NUTRITION

OUTCOME: The patient will understand how to modify diet to conserve energy and promote nutritional balance.

STANDARDS:

1. Assess the patient's current nutritional patterns. Review how these patterns might be improved.
2. **Refer to WL-N.**
3. Stress the importance of water intake to aid in liquefying sputum.
4. Explain how meal planning may need to be individualized for specific pulmonary disorders. Consider eliminating milk because it increases mucous production. Foods which are gas producing may hinder diaphragmatic movement. Several small meals instead of three large meals may be indicated to reduce respiratory effort. Refer to dietitian as appropriate.

PL-NEB NEBULIZER

OUTCOME: The patient will be able to demonstrate effective use of the nebulizer device, discuss proper care and cleaning of the system, and describe its place in the care plan.

STANDARDS:

1. Describe proper use of the nebulizer including preparation of the inhalation mixture, inhalation technique, and care of equipment.
2. Discuss the nebulizer treatment as it relates to the medication regimen.

PL-O2 OXYGEN THERAPY

OUTCOME: The patient and/or family will understand the need for and be able to demonstrate the proper use of oxygen administration equipment.

STANDARDS:

1. Discuss the dangers of ignition sources around oxygen, i.e., cigarettes, sparks, flames.
2. Emphasize the importance of regular maintenance checks of oxygen equipment.
3. Emphasize that O2 flow rate should not be changed except upon the order of a physician, since altering the flow rate may worsen the condition.
4. Discuss use, care, and cleaning of all equipment.
5. Explain the reason for O_2 therapy and the anticipated benefit.

PL-PF PEAK-FLOW METER

OUTCOME: The patient will be able to demonstrate correct use of the peak-flow meter and explain how its regular use can help achieve a more active lifestyle.

STANDARDS:

1. Discuss use and care of the peak flow meter as a tool for measurement of peak expiratory flow rate (PEFR) and degree of airway obstruction. Discuss peak flow zones in management of airway disease.
2. Explain how monitoring measurement of PEFR can provide an objective way to determine current respiratory function.
3. Emphasize how a regular monitoring schedule can help determine when emergency care is needed, prevent exacerbations through early intervention, and facilitate management of the pulmonary disease.

PL-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM.**
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain that other medications may be helpful to control the symptoms of pain, nausea and vomiting.
4. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
5. Explain non-pharmacologic measures that may be helpful with pain control.

PL-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure(s), as well as the risks, benefits, alternatives to the proposed procedure(s) and associated factors affecting the patient.

STANDARDS:

1. Explain the specific procedure(s) to be performed, including the risks and benefits of performing the procedure and the adverse events which might result from refusal of the procedure.
2. Discuss alternatives to the proposed procedure(s), including expectant management, as appropriate.
3. Discuss the expected patient/family involvement in the care required following the proposed procedure(s).

PL-SHS SECOND-HAND SMOKE

OUTCOME: Provide the patient and/or family with an understanding of the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting exposure of nonsmokers to tobacco smoke.

STANDARDS:

1. Define “passive smoking”, ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls.
2. Discuss harmful substances in smoke
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness in the pulmonary patient when exposed to cigarette smoke either directly or via second-hand smoke.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the pulmonary patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage smoking cessation or at least never smoking in the home or car.

PL-SPA SPACERS

OUTCOME: The patient will be able to demonstrate the correct use of spacers and understand their importance in delivery of medications.

STANDARDS:

1. Instruct and demonstrate proper technique for spacer use.
2. Discuss proper care and cleaning of spacers.
3. Explain how spacers improve the delivery of inhaled medications.

PL-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

PL-TO TOBACCO (SMOKING)

OUTCOME: The patient and/or family will understand the dangers of smoking or exposure of the pulmonary patient to cigarette smoke and develop a plan to eliminate said exposure.

STANDARDS:

1. Explain the increased risk of illness in the pulmonary patient when exposed to cigarette smoke either directly or via second-hand smoke.
2. Explain that cigarette smoke gets trapped in carpets and upholstery and still increases the risk of illness even if the pulmonary patient is not in the room at the time that the smoking occurs.
3. Encourage smoking cessation or at least NEVER smoking in the home or car.
4. **Refer to TO.**

PL-VENT MECHANICAL VENTILATION

OUTCOME: The patient/family will understand mechanical ventilation, as well as the risks, benefits, alternatives to mechanical ventilation and associated factors affecting the patient.

STANDARDS:

1. Explain that the patient must be intubated with an endotracheal tube or tracheostomy tube in order to receive mechanical ventilation.
2. Explain the basic mechanics of mechanical ventilation, including the risks and benefits of receiving mechanical ventilation and the adverse events which might result from refusal.
3. Discuss alternatives to mechanical ventilation, including expectant management, as appropriate.
4. Explain that the patient will be unable to speak or eat while intubated and receiving mechanical ventilation.
5. Explain that the patient will be sedated during intubation and the initiation of mechanical ventilation.
6. Discuss the possibility that the patient may require restraints to prevent accidental extubation.

R

RD—Rheumatic Disease

RD-C COMPLICATIONS

OUTCOME: The patient will understand how to lessen complications of rheumatic disease.

STANDARDS:

1. Review the common complications associated with the patient's disease.
2. Review the treatment plan with the patient. Explain that complications are worsened by not participating with the treatment plan.

RD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of rheumatic disease.

STANDARDS:

1. Review the disease process of the patient's rheumatic disease.
2. Review the physical limitation that may be imposed by the patient's disease.
3. Explain that treatments are highly individualized and may vary over the course of the disease.
4. Refer to the Arthritis Foundation or community resources as appropriate.

RD-EQ EQUIPMENT

OUTCOME: The patient/family will have an understanding and demonstrate (when appropriate) the proper use and care of equipment.

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.

RD-EX EXERCISE

OUTCOME: The patient will maintain an optimal level of mobility with minimal discomfort.

STANDARDS:

1. Emphasize that exercise is an important component of the treatment plan. Stress the importance of balancing rest and exercise.
2. Explain that exercise, when done correctly, can help reduce rheumatic disease symptoms, including the following:
    a. Preventing joint stiffness
    b. Keeping muscles strong around the joints
    c. Improving joint flexibility
    d. Reducing pain
    e. Maintaining strong and healthy bone and cartilage tissue
    f. Improving joint alignment
    g. Improving overall fitness
3. Emphasize that exercise can also help with weight reduction and contributes to an improved sense of well-being, enhance sleep, and reduce stress and depression.
4. Review the different types of exercises including active and passive range of motion, muscle strengthening and endurance exercises.
5. If applicable, review and demonstrate the prescribed exercise plan.
6. Emphasize the importance of "warm-ups and cool-downs". Explain how the application of heat or cold prior to beginning exercise may reduce joint discomfort. Explain that people who have poor circulation should talk to their healthcare provider before using hot or ice packs.
7. Caution the patient not to overexert. Stress the importance of taking a break when experiencing pain or fatigue.

RD-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of fully participating in the treatment plan and regular follow-up.

STANDARDS:

1. Discuss the patient's responsibility in managing rheumatic disease.
2. Review treatment plan with the patient/family, emphasizing the need for keeping appointments and adhering to medications regimens.

RD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about rheumatic disease.

STANDARDS:

1. Provide the patient/family with written patient information literature on rheumatic disease.
2. Discuss the content of the patient information literature with the patient/family.

RD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle changes necessary to optimize performance of everyday activities.

STANDARDS:

1. Discuss that treatment for arthritis is usually a combination of rest and relaxation, exercise, proper diet, medication, joint protection and ways to conserve energy. Discuss way to pain management. **Refer to RD-PM**.
2. Review activity limitation and the importance of avoiding fatigue.
3. Discuss ADL aids. Make a referral to social services for assistance in procuring such devices.
4. Explain how exercise and social involvement may decrease the depression and anger often associated with rheumatoid disease.
5. Discuss how self-image, pain, fatigue, inflammation, limited joint mobility, and medications can alter sexual desire and sexual activity.
6. Assess level of acceptance and offer support and referral to social services and community resources as appropriate.
7. Discuss the importance of relaxation to minimize stress, thus minimizing symptoms. A relaxed body means the muscles are relaxed, relieving some of the pain associated with rheumatic disease.
8. Discuss the techniques that may reduce stress and depression such as meditation, imagery, prayer, hypnosis, and biofeedback.
9. **Refer to WL**.

RD-M MEDICATIONS

OUTCOME: The patient/family will understand the proper use of anti-rheumatic medications.

STANDARDS:

1. Review the mechanism of action of the prescribed medication.
2. Discuss proper use, benefits and common side effects of prescribed medications.
3. Explain that some medications may have long-term effects which require regular monitoring and follow-up.
4. Explain the importance of consulting with a health care provider prior to using OTC medications, or other non-prescribed or illicit drugs. **Refer to CPM and PM.**
5. Discourage the use of alcohol, since it worsens most rheumatic diseases in the long term.
6. Explain that many rheumatic diseases are chronic, making long-term management of pain and symptoms of the disease very important.

RD- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

RD-N NUTRITION

OUTCOME: The patient will strive to achieve and maintain a safe weight level through a nutritionally balanced diet.

STANDARDS:

1. Assess the patient's current nutritional patterns and review improvements which can be made. **Refer to WL-N.**
2. Explain that a well-balanced diet helps to manage body weight and provides the body with the nutrients it needs to stay healthy.
3. Refer to a Registered Dietitian.

RD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the patient's pain management program.

STANDARDS:

1. Stress the need to fully participate with the prescribed treatment plan.
2. Emphasize the importance of rest and avoidance of fatigue.
3. Discuss the use of heat and cold.
4. Discuss the techniques that may reduce stress and depression such as meditation and bio-feedback.
5. Emphasize the role of exercise in reducing pain, maximizing mobility, and reducing stress/anxiety.
6. Refer to physical therapy as appropriate.

RD-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

U

UC—Ulcerative Colitis

UC-C COMPLICATIONS

OUTCOME: The patient/family will understand the signs of complications of ulcerative colitis and will plan to return for medical care if they occur.

STANDARDS:

1. Explain that some possible complications of ulcerative colitis are colon perforation, hemorrhage, toxic megacolon, abscess formation, stricture, anal fistula, malnutrition,, anemia, electrolyte imbalance, skin ulceration, arthritis, ankylosing spondylitis, and cancer of the colon.
2. Explain that complications may be delayed, minimized or prevented with prompt treatment of exacerbation.
3. Discuss the symptoms of exacerbation that trigger the need to seek medical attention, i.e., unusual abdominal pain, blood in stools, fever, weight loss, change in frequency of stools, joint pain.

UC-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

UC-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of their specific bowel disease.

STANDARDS:

1. Explain that ulcerative colitis is an inflammatory disease of the mucosa and, less frequently, the submucosa of the colon and rectum.
2. Explain that the exact cause of ulcerative colitis is unknown, but may be related to infection, stress, allergy, autoimmunity and familial predisposition.
3. Explain that this disease is most common during young-adulthood to middle life.
4. Explain that the symptoms are diarrhea, abdominal cramping, weight loss, anorexia, nausea, vomiting and abdominal pain.
5. Explain that ulcerative colitis is characterized by remissions and exacerbations.
6. Explain that careful medical management may eliminate/postpone the need for surgical intervention.

UC-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

UC-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the specific bowel disease.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding colon disease.
2. Discuss the content of the patient information literature with the patient/family.

UC-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication regimen and its importance.

STANDARDS:

1. Describe the proper use, benefits, and common or important side effects of the patient's medications. State the name, dose, and time for administration as applicable.
2. Discuss any significant drug/drug or drug/food interactions, including interaction with alcohol.
3. Discuss with the patient/family the need to complete the full course of antibiotics, as prescribed.
4. Caution the patient/family against utilizing over-the-counter medications for constipation without consulting his/her provider.

UC- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient’s nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient’s nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

UC-N NUTRITION

OUTCOME: The patient/family will understand how dietary modification may assist in the control of bowel function and develop an appropriate plan for dietary modification.

STANDARDS:

1. Assess current nutritional habits.
2. Advise the patient to avoid dairy products if the patient is lactose intolerant.
3. Encourage the patient/family to maintain a well-balanced, low-residue, high-protein diet.
4. Assist the patient/family to identify foods which cause irritation and encourage them to eliminate or minimize these in the diet.
5. Advise the patient to avoid cold or carbonated foods or drinks which increase intestinal motility.
6. Assist the patient/family in developing appropriate meal plans. Encourage frequent, small meals and chew food thoroughly.
7. Explain that supplementation with vitamins and minerals may be necessary.
8. Refer to dietitian as appropriate.

UC-P PREVENTION

OUTCOME: The patient/family will understand and make a plan for the prevention of colon disease.

STANDARDS:

1. Discuss the effects of a fatty, low fiber diet on the colon.
2. Provide and review a list of low fat, high fiber foods.
3. Assist the patient/family in meal planning that includes low fat, high fiber foods and avoids high fat, low fiber foods.
4. Explain that the etiology of Crohn's disease is unknown and there is no known prevention, but an appropriate diet may prevent or slow progression of the disease.

UC-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Discuss the plan for sedatives and tranquilizers to provide, not only for rest, but to decrease peristalsis and subsequent cramping.
2. Instruct the patient in careful cleansing and protection of the perianal skin to provide comfort and prevent painful excoriation.
3. Explain that short term use of narcotics may be helpful in acute pain management.
4. Advise the patient not to use over the counter pain medications without checking with his/her provider.

UC-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in ulcerative colitis.

STANDARDS:

1. Explain that uncontrolled stress is linked with increased exacerbations of ulcerative colitis.
2. Explain that uncontrolled stress can interfere with the treatment of ulcerative colitis.
3. Explain that effective stress management may reduce the number of relapses, as well as help improve the patient's health and well-being.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use, all of which can increase the risk of morbidity and mortality from ulcerative colitis.
5. Explain that stress may cause inappropriate eating which will exacerbate the symptoms of ulcerative colitis. **Refer to UC-N.**
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. becoming aware of your own reactions to stress
   b. recognizing and accepting your limits
   c. talking with people you trust about your worries or problems
   d. setting realistic goals
   e. getting enough sleep
   f. maintaining a reasonable diet
   g. exercising regularly
   h. taking vacations
   i. practicing meditation
   j. self-hypnosis
   k. using positive imagery
   l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   m. spiritual or cultural activities
7. Provide referrals as appropriate.

UC-TE TESTS

OUTCOME: The patient/family will understand the tests to be performed.

STANDARDS:

1. Proctosigmoidoscopy and Colonoscopy
    a. Explain that proctosigmoidoscopy and colonoscopy may be utilized to directly visualize the inside of the colon and enable biopsies to be obtained. The information from the colonoscopy may be necessary to diagnose the specific type of bowel disease.
    b. Explain that the procedure involves introducing a flexible tube through the anus and rectum.
    c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.
2. Upper gastrointestinal barium studies
    a. Explain that the upper GI barium study is an x-ray to assess the degree and extent of the disease.
    b. Explain that barium liquid will be swallowed and radiographs taken.
3. Barium Enema
    a. Explain that the barium enema is an x-ray to assess the extent of the disease, identify lesions, detect pseudo polyps, carcinoma, and strictures.
    b. Explain that barium liquid will be introduced by enema and radiographs taken.
    c. Explain that the preparation for the test is usually a liquid diet, cathartics and enemas.

UC-TX TREATMENT

OUTCOME: The patient/family will understand the appropriate treatment for ulcerative colitis and have a plan to fully participate in the treatment regimen. The patient/family will further understand the risk/benefit ratio of the testing proposed as well as alternatives to testing and the risk of non-testing.

STANDARDS:

1. Discuss the specific treatment plan, which may include the following:
    a. Bedrest
    b. IV fluid replacement to correct dehydration
    c. Clear liquid diet, or in severe cases, parenteral hyperalimentation to rest the intestinal tract and restore nitrogen balance
    d. Sulfasalazine, for its antibacterial and anti-inflammatory effects
    e. Corticosteroids, systemically or by rectal instillation, to decrease inflammation
    f. Colectomy.
2. Discuss the risk/benefit ratio and alternatives to treatment as well as the risk of non-treatment.

UTI—Urinary Tract Infection

UTI-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand basic anatomy and physiology as it relates to UTIs.

STANDARDS:

1. Discuss the basic anatomy and physiology of the urinary tract as it relates to UTIs. As appropriate, discuss the difference between male and female anatomy.
2. As appropriate, discuss the role of foreskin in recurrent UTIs.

UTI-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of a urinary tract infection.

STANDARDS:

1. Discuss the basic anatomy and physiology of the urinary tract.
2. Discuss factors that increase the risk for developing a urinary tract infection, i.e., bladder outlet obstruction, hygiene factors, pelvic relaxation.
3. Discuss some signs and symptoms of urinary tract infection, i.e., dysuria, frequency, nocturia.

UTI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care, including test of cure as appropriate.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

UTI-HY HYGIENE

OUTCOME: The patient/family will understand how personal hygiene affects acquiring UTIs and prevention of UTIs.

STANDARDS:

1. Review the aspects of good personal hygiene as it relates to prevention of UTIs:
   a. Wipe only from anterior to posterior (front to back).
   b. Avoid bubble baths.
   c. Keep the perineal region clean.
2. Discuss the role of foreskin hygiene as appropriate.
3. Discuss, as appropriate, the role of sexual intercourse in acquiring UTIs.

UTI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about urinary tract infections.

STANDARDS:

1. Provide patient/family with written patient information literature.
2. Discuss the content of the patient information literature with the patient/family.

UTI-M MEDICATION

OUTCOME: The patient/family will understand their medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications. **Refer to M**.
3. Discuss importance of full participation with the medication regimen in order to promote healing and assure optimal comfort levels.
4. Discuss the importance of completing the entire course of antibiotics to decrease the risk of development of resistant organisms.
5. Inform patient/family that kidney damage is irreversible and special care needs to be taken to reduce the risk of recurrent infections.

UTI- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
5. Review the basic nutrition recommendations for the treatment plan.
6. Discuss the benefits of nutrition and exercise to health and well-being.
7. Assist the patient/family in developing an appropriate nutrition care plan.
8. Refer to other providers or community resources as needed.

UTI-N NUTRITION

OUTCOME: The patient/family will understand the importance of a nutritionally balanced diet as related to UTIs.

STANDARDS:

1. Assess current nutritional habits and needs.
2. Emphasize the necessary component - WATER - in a healthy diet. Decrease consumption of colas and caffeinated beverages.

UTI-P PREVENTION

OUTCOME: The patient/family will understand precipitating factors for UTIs and will make a plan to minimize recurrence.

STANDARDS:

1. Discuss importance of fully participating in treatment plan.
2. Discuss the role of good hygiene in reducing the risk of UTIs.
3. Discuss the role of prophylactic medications in reduction of future UTIs as indicated.
4. Discuss other lifestyle factors that may help prevent UTIs, i.e., frequent urination, void after sexual intercourse, monogamy, drink plenty of water, eliminate bubble baths.

UTI-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Explain that medications may be helpful to control the symptoms of pain, nausea and vomiting as applicable.
3. Explain that administration of fluids may be helpful with pain relief and resolution of symptoms.
4. Explain non-pharmacologic measures that may be helpful with pain control.

UTI-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in sexually transmitted infections.

STANDARDS:

1. Explain that uncontrolled stress is linked with an increased recurrence of symptomatic outbreaks with many sexually transmitted infections, such as genital herpes and human papilloma virus.
2. Explain that effective stress management may help reduce the frequency of outbreaks, as well as help improve the patient's health and well-being.
3. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals in small attainable increments
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation or prayer
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
4. Provide referrals as appropriate.

UTI-TE TESTS

OUTCOME: The patient/family will have basic understanding of the tests to be performed including indications, risks, benefits and consequences of non-intervention.

STANDARDS:

1. Explain the test ordered including indication(s), risks, benefits, information to be obtained and consequences of non-intervention.
2. Explain that the treatment decision will be made by the patient and medical team after reviewing the results of the diagnostic tests.
3. Explain any preparation that must be done prior to testing, i.e., NPO, have a full bladder, void prior to test.

W

WL—Wellness

WL-ADL ACTIVITIES OF DAILY LIVING

OUTCOME: The patient/family will understand how the patient's ability to perform activities of daily living (ADLs) impact the care plan including in-home and out-of-home care.

STANDARDS:

1. Define activities of daily living (ADLs) (i.e., the everyday activities involved in personal care such as feeding, dressing, bathing, moving from a bed to a chair (also called transferring), toileting and walking) and discuss how the patient's ability to perform ADLs affects their ability to live independently
2. Assist the patient/family in assessing the patient's ability to perform activities of daily living.
3. Provide the appropriate information and referrals for services needed to increase, maintain, and/or assist with activities of daily living.

WL-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

WL-EX EXERCISE

OUTCOME: The patient will relate exercise and/or physical fitness to health promotion and disease prevention.

STANDARDS:

1. Review the benefits of regular exercise.
2. Discuss the three types of exercise: aerobic, flexibility, and endurance.
3. Review the basic recommendations of any exercise program:
4. If any chronic health problems exist, consult with a health care provider.
5. Start out slowly.
6. Exercise a minimum of three times a week.
7. Review the exercise programs available in the community.

WL-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up care and develop a plan to make appointments as appropriate.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Review the procedure for obtaining follow-up care.
3. Emphasize the importance of keeping appointments.

WL-HY HYGIENE

OUTCOME: The patient will recognize personal routine hygiene as an important part of wellness.

STANDARDS:

1. Review bathing habits, paying special attention to face, pubic hair area and feet. Discuss hygiene as part of a positive self image.
2. Review the importance of daily dental hygiene, with attention to brushing and flossing.
3. Discuss the importance of hand-washing in infection control especially in relationship to food preparation/consumption, child care and toilet use.
4. Discuss the importance of covering the mouth when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

WL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about wellness.

STANDARDS:

1. Provide the patient/family written information about wellness.
2. Discuss the content of the written information with the patient/family.

WL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will be able to explain at least one lifestyle change necessary to improve mental or physical health.

STANDARDS:

1. Review the concept that health or wellness refers to the whole person (mind, body and spirit) and is a positive state of health which results from appropriate habits and lifestyle.
2. Review lifestyle aspects/changes that the patient has control over - diet, exercise, safety and injury prevention, and avoidance of high risk behaviors (e.g. smoking, alcohol and substance abuse, sex with multiple partners).
3. Discuss wellness as an individual responsibility to:
    a. Learn how to be healthy.
    b. Be willing to change.
    c. Practice new knowledge.
    d. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

WL- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

WL-N NUTRITION

OUTCOME: The patient will relate diet to health promotion and disease prevention.

STANDARDS:

1. Assess current nutritional habits.
2. Discuss the importance of the food pyramid.
3. Review the relationship of calories to energy balance and body weight.
4. Emphasize the importance of limiting snack foods, fatty foods, red meats, reducing sodium consumption and adding more fresh fruits, fresh vegetables, and fiber to the diet.
5. Emphasize the necessary component —WATER— in a healthy diet. Reduce the use of colas, coffee and alcohol.
6. Review which community resources exist to assist with diet modification and weight control.
7. Stress the importance of being a smart shopper.

WL-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient will be able to identify at least one way to reduce injury risk.

STANDARDS:

1. Discuss the importance of vehicle safety:
    a. regular use of seat belts and children's car seats, obeying the speed limit, and avoiding the use of alcohol while in a vehicle.
    b. wear personal protective equipment when operating recreational vehicles (i.e., boats, snow mobiles, sea dos, ATVs, skateboards, bicycles.), and horses.
    c. **never** leave children unattended in a vehicle.
    d. never ride on the hood, bumper, or in the cargo compartment of any vehicle.
2. Discuss the importance of poisoning prevention:
    a. Discuss poison prevention: i.e., proper storage and safe use of medicines, cleaners, auto products, paints.
    b. Discuss current recommendations for use of ipecac syrup.
    c. Discuss common poisonous plants.
3. Discuss the importance of fire safety and burn prevention:
    a. Review the dangers inherent in the use of wood-burning stoves, "charcoal pans", kerosene heaters, and other open flames.
    b. Encourage the use and proper maintenance of smoke detectors, carbon monoxide detectors, and fire suppression systems.
    c. Encourage routine practices of fire escape plans, chimney cleaning, and fireworks safety.
    d. Review the safe use of electricity and natural gas.
    e. Encourage hot water heater no hotter than 120 degrees Fahrenheit to avoid scalding.
    f. Cook on the backburners of the stove and turn panhandles toward the back of the stove.
    g. Avoid the use of kerosene or gasoline when burning debris piles.
4. Discuss the proper handling, storage, and disposal of hazardous items and materials:
    a. firearms and other potentially hazardous tools.
    b. waste, including sharps and hazardous materials.
    c. Chemicals, including antifreeze

d. lead based materials, i.e., pre-1970 paint, pottery, smelting, pre-1993 window blinds, solder, old plumbing

e. never store hazardous chemicals in food containers

5. Discuss the importance of water safety:

   a. Never swim alone

   b. Never leave a child unattended in a bathtub, swimming pool, lake, river, or other water source.

   c. Always close toilets, mop buckets, and other water containers to avoid toddler drowning.

6. Discuss the importance of food and drinking water safety:

   a. proper handling, storage, and preparation of food, i.e., original preparation, reheating to a proper temperature (165°F).

   b. importance of uncontaminated water sources. Discuss the importance of purifying any suspect water by boiling or chemical purification.

   c. prevention of botulism, salmonella, shigella, giardia, listeria, E-coli, etc.

7. Identify which community resources promote safety and injury prevention. Provide information regarding key contacts for emergencies, e.g., 911, Poison Control, hospital ER, police.

WL-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening test including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening test, i.e., guaiac, blood pressure, hearing, vision, development, mental health.
2. Explain the process and what to expect after the test.
3. Emphasize the importance of follow-up care.

WL-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in overall health and well-being.

STANDARDS:

1. Explain that uncontrolled stress may cause release of stress hormones which interfere with general health and well-being.
2. Explain that effective stress management may help prevent progression of many disease states, as well as help improve the patient's health and well-being.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the risk of morbidity and mortality from many disease states.
4. Emphasize the importance of seeking professional help as needed to reduce stress.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

WL-SX SEXUALITY

OUTCOME: The patient will understand how sexuality relates to wellness.

STANDARDS:

1. Review sexuality as an integral part of emotional and physical health.
2. Discuss how sexual feelings play a part in each person's personal identity.
3. Discuss sexual feelings as an important part of interpersonal relationships.
4. Discuss how sexuality varies with gender, age, life-stage, and relationship status.
5. Explain the preventive measures for STIs (**refer to STI-P**), including abstinence and monogamy.
6. Review the community resources available for sexual counseling or examination.

WL-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, including indications and impact on further care.

STANDARDS:

1. Explain the test ordered.
2. Explain the necessity, benefits and risks of the test to be performed, as applicable, including possible complications that may result from not having the test performed.
3. Explain how the test relates to the course of treatment.
4. Explain any necessary preparation for the test.
5. Explain the meaning of the test results, as appropriate.

WH—Women's Health

WH-AP ANATOMY AND PHYSIOLOGY

OUTCOMES: The patient/family will have a basic understanding of the female breast, reproductive system and genitalia.

STANDARDS:

1. Explain the normal anatomy and physiology of the breast. Discuss the areola, nipple, ducts and glands.
2. Explain the normal anatomy and physiology of the female reproductive system. Identify the functions of the ovaries, ova, fallopian tubes, uterus, cervix and vagina.
3. Explain the normal anatomy and physiology of the female genitalia. Identify the labia, vagina, and perineal area.

WH-BE BREAST EXAM

OUTCOME: The patient will understand the importance of monthly breast self-examination, annual clinical breast exam, and mammograms as appropriate.

STANDARDS:

1. Discuss breast anatomy and the normal changes that occur with pregnancy, menstruation and age.
2. Explain that fibrocystic changes of the breast are a normal finding and become more common with increasing age. Explain that fibrocystic changes may be exacerbated by intake of caffeine.
3. Emphasize the importance of monthly examination in early detection of breast cancer. Survival rates are markedly higher when cancer is detected and treated early.
4. Teach breast self-exam. Have the patient give a return demonstration.
5. Discuss indications for mammography and current recommendations for screening mammograms. Patients who have first degree relatives (mother, sister or daughter) with breast cancer are at higher risk and are encouraged to follow a risk-specific mammogram schedule.
6. Discuss the importance of routine annual clinical examination.

WH-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

OUTCOME: The patient/family will understand the impact and influences cultural and spiritual traditions, practices, and beliefs have on health and wellness.

STANDARDS:

1. Explain that the outcome of disease processes may be influenced by choices related to health and lifestyles, i.e., diet, exercise, sleep, stress management, hygiene, full participation to the medical plan. (Stoic Fatalism)
2. Discuss the potential role of cultural/spiritual traditions, practices and beliefs in achieving and maintaining health and wellness.
3. Explain that traditional medicines/treatments should be reviewed with the health care provider to determine if there are interactions with prescribed treatment.
4. Explain that the medical treatment plan must be followed as prescribed to be effective and that some medications/treatments take time to demonstrate effectiveness.
5. Discuss that traditions, such as sweat lodges may affect some conditions in detrimental ways. Healing customs or using a traditional healer may have a positive effect on the patient's condition.
6. Refer to clergy services, traditional healers, or other culturally appropriate resources.

WH-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up and make a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

WH-HY HYGIENE

OUTCOME: The patient will recognize good personal hygiene as an aspect of wellness.

STANDARDS:

1. Review aspects of good personal hygiene such as regular bathing, paying special attention to perineal area. Review the importance of wiping front to back to prevent bacterial contamination of the vagina and urethra.
2. **Refer to WL-HY**.

WH-KE KEGEL EXERCISE

OUTCOME: The patient will understand how to use Kegel exercises to prevent urinary stress incontinence and improve pelvic muscle tone.

STANDARDS:

1. Review the basic pelvic floor anatomy.
2. Define stress incontinence and discuss its causes.
3. Teach Kegel exercises. Encourage frequent practice of Kegel exercises.

WH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about women's health.

STANDARDS:

1. Provide the patient/family written information about women's health.
2. Discuss the content of the written information with the patient/family.

WH- MNT MEDICAL NUTRITION THERAPY

OUTCOME: The patient and family will understand the specific nutritional intervention(s) needed for treatment or management of this condition, illness, or injury.

STANDARDS:

1. Explain that Medical Nutrition Therapy (MNT) is a systematic nutrition care process provided by a Registered Dietitian (RD) that consists of the following:
   a. Assessment of the nutrition related condition.
   b. Identification of the patient's nutritional problem.
   c. Specific nutrition intervention therapy plan.
   d. Evaluation of the patient's nutritional care outcomes.
   e. Reassessment as needed.
2. Review the basic nutrition recommendations for the treatment plan.
3. Discuss the benefits of nutrition and exercise to health and well-being.
4. Assist the patient/family in developing an appropriate nutrition care plan.
5. Refer to other providers or community resources as needed.

WH-MP MENOPAUSE

OUTCOME: The patient/family will understand the etiology, symptomatology, and relief measures of menopause.

STANDARDS:

1. Explain that around age 45-55 the normal decline in the levels of estrogen and progesterone signals the start of menopause, the permanent cessation of ovulation and menstruation which results in eventual infertility.
2. Review how fluctuating hormone levels may result in the following physical and emotional symptoms: "hot flashes" (dilation of the blood vessels), headaches, dizziness, tachycardia, breast tenderness, fluid retention, decreased vaginal lubrication, unpredictable mood changes, sleep disturbances, fears about changing sexuality, anxiety and depression. These symptoms are troublesome in approximately 20 percent of menopausal women.
3. Review relief measures which include hormone replacement therapy, vaginal lubricants, reducing salt and caffeine, staying active, and seeking psychological support as necessary.
4. Explain that pregnancy is still a risk and that contraception should be used until there has been no menses for 12 consecutive months.

WH-MS MENSES

OUTCOME: The patient will understand the menstrual cycle.

STANDARDS:

1. Discuss comfort measures for dysmenorrhea.
2. Discuss the importance of good menstrual hygiene. Discuss the use and frequent changing of tampons and napkins. Discourage use of super absorbent tampons.
3. Explain that exercise and sex need not be curtailed during menses but that additional hygiene measures should be taken.
4. Explain that it is normal for menstrual cycles to be irregular for several years after menarche.

WH-N NUTRITION

OUTCOME: The patient will relate diet to health promotion and disease prevention.

STANDARDS:

1. Assess current nutritional habits.
2. Discuss the importance of the food pyramid.
3. Review the relationship of calories to energy balance and body weight.
4. Emphasize the importance of limiting snack foods, fatty foods, red meats, reducing sodium consumption and adding more fresh fruits, fresh vegetables, and fiber to the diet. Emphasize that there is a special need for adequate calcium in the diet. **Refer to OS.**
5. Emphasize the necessary component —WATER— in a healthy diet. Reduce the use of colas, coffee and alcohol.
6. Review which community resources exist to assist with diet modification and weight control.
7. Stress the importance of being a smart shopper.

WH-OS OSTEOPOROSIS

OUTCOME: The patient will understand the etiology, symptomatology, prevention and treatment of osteoporosis.

STANDARDS:

1. Discuss the causes of osteoporosis including loss of bone density secondary to reduced estrogen levels and low intake of calcium.
2. Emphasize the importance of prevention. Explain that peak bone density occurs about age 30 and that without intervention, progressive bone loss is typical.
3. Review the risk factors: Low dietary intake of calcium, sedentary lifestyle, familial history, smoking, stress, age over 40, gender, race, stature, and calcium binding medications such as laxatives, antacids, and steroids.
4. Emphasize that treatment is limited to preventing osteoporosis and/or slowing the progression of the disease. It is very important to prevent osteoporosis by a calcium-rich diet, regular weight-bearing exercise, decreased stress, not smoking, reduced alcohol intake, and estrogen replacement as appropriate.
5. Discuss the sequelae including stooped shoulders, loss of height, back, neck and hip pain, and susceptibility to fractures.

WH-PAP PAP SMEAR

OUTCOME: The patient will understand the importance of routine Pap testing after onset of sexual activity or 18 years of age, whichever comes first.

STANDARDS:

1. Explain that the purpose of the Pap test is to screen for precancerous conditions.
2. Emphasize that precancerous conditions of the cervix are highly treatable.
3. Emphasize the importance of routine Pap tests. Encourage the patient to associate the Pap routine with an important date such as her birthday.
4. If this is other than an annual Pap test, explain the reason(s) for the test and the follow-up recommended. Discuss the results of the original test as appropriate.

WH-PMS PREMENSTRUAL SYNDROME

OUTCOME: The patient/family will understand the symptoms and relief measures for Premenstrual Syndrome (PMS).

STANDARDS:

1. Discuss Premenstrual Syndrome. Explain that it is a combination of physical and emotional symptoms resulting from fluctuations in the levels of estrogen and progesterone that occur 5-10 days before the onset of the menstrual period.
2. Review relief measures which include: physical activity, limiting intake of fat and salt, increasing water intake to 8 glasses daily, no limitation of sexual activity, supplemental vitamin B6 or calcium. Diuretics may help relieve some of the symptoms of PMS.

WH-PRO PROCEDURES

OUTCOME: The patient/family will understand the proposed procedure including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed procedure.
2. Explain the process and what to expect after the procedure.
3. Emphasize the importance of follow-up care.

WH-RS REPRODUCTIVE SYSTEM

OUTCOME: The patient/family will understand the normal anatomy and physiology of the female reproductive system.

STANDARDS:

1. Review the reproductive anatomy and discuss the reproductive cycle.
2. Discuss the importance of good hygiene.
3. Explain that sexually transmitted infections can impair fertility. **Refer to STI**.
4. Because the risk of cervical cancer is increased by early sexual activity and multiple partners, encourage abstinence or monogamy as appropriate.

WH-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in overall health and well-being.

STANDARDS:

1. Explain that uncontrolled stress may cause release of stress hormones which interfere with general health and well-being.
2. Explain that effective stress management may help prevent progression of many disease states, as well as help improve the patient's health and well-being.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the risk of morbidity and mortality from many disease states.
4. Emphasize the importance of seeking professional help as needed to reduce stress.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate.

WH-STI SEXUALLY TRANSMITTED INFECTIONS (REFER TO CODES FOR STI)

WH-TE TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered.
2. Explain the necessity, benefits, and risks of test(s) to be performed. Explain any potential risk of refusal of recommended test(s).
3. Inform patient of any advance preparation required for the test(s).