PROCESS DEVELOPMENT

PATIENT, FAMILY, and CARE GIVER

EDUCATION

POLICY and PROCEDURES

For HOSPITALS,

CLINICS and COMMUNITIES

Mary Wachacha & Revision Committee
Indian Health Service
June 2000

Acknowledgments

June 2000
Indian Health Service Revision Committee Members:
Mary Wachacha, Health Education, Nashville Area Office
Myrtle Patterson, Health Education, Lawton Service Unit
Sandra Miller, RN, CDE, Lawton Service Unit
Becky Grizzle, RD, Zuni Service Unit

The Health Education Program of the Indian Health Service would like to acknowledge and express our gratitude to several individuals who have assisted us in the development of this Manual.

Donna Leno, M.P.H
Former Chief, Health Education
IHS Headquarters
Rockville, Maryland

Dr. Beth Drabant, Former Director
Office of Health Programs
IHS Nashville Area Office
Nashville, Tennessee

Jerome C. Short, R.Ph., MPH
Former Facility Accreditation Manager
IHS Headquarters
Rockville, Maryland

Fran Stracqualursi, RN
Diabetes Educator
Aberdeen Area Diabetes Program
Rapid City, South Dakota

Karen Summers-Hayward, Ph.D.(c), R.N.
Idaho State University,
Pocatello, Idaho

Augusta Reimer, MPH
Former Director, Patient Education
Alaska Native Medical Center
Anchorage, Alaska

Henry A. Walden, Jr., MPH
Program Director
Gila River Health Care Corporation
Sacaton, Arizona

F. Louise Kiger, RN MN
Former Director, Division of Nursing
IHS Headquarters
Rockville, Maryland

The IHS Nashville Area Office of Health Programs Staff:

Dr. Betty Claymore	Mental Health	Robinson Myers	Nursing
Vickie Blythe	Alcohol/SA	Patricia Schumacher	Nutrition
Connie Overby	MCH	Harding Brewster	Alcohol/SA
Dr. Scott Presson	Dental	Teresa Cunningham	Dental
David Taylor	AIDS	Jim Mills	Pharmacy

Finally, we are indebted to many, many of our colleagues in health education and related disciplines in the Indian Health Service.

Table of Contents

	Page
Sample Organizational Chart	6
Introduction to Developing a Patient Education Policy and Process Manual	7
Sample Patient Education Objective Statement	11
STEP ONE - Commitment	
STEP ONE: Commitment	**13**
Orientation for All Staff	14
Appointment Of Coordinator(s) And Task Force Committee	15
Example of Education Task Force Committee Objectives	
Year One ...	16
Year Two ...	16
Example: Patient Education Mission Statement	16
Example: Philosophy of Patient Education	16
Example: Purpose and Objectives of Clinic/Hospital-Based Patient Education Program	17
Step One Checklist – Commitment	18
STEP TWO - Assessment	
STEP TWO: Assessment	**19**
Assessment Of Current Patient Education Efforts	20
Patient Education Assessment Chart	22
Developing a Client/Patient Satisfaction Survey	23
Step Two Check List – Assessment	24
STEP THREE - Planning	
STEP THREE: Planning	**28**
Planning to Implement Patient and Family Education	29
Developing Patient, Family and Caregiver Education Policy and Procedure Manuals	29
Step Three Check List	31

STEP FOUR - Implementation

STEP FOUR: Implementing **34**

In-Service Training for Staff: Preparing the Staff to Teach 36

Example: *Documentation of Hospital/Clinic Based Education Activities* 38

Questionnaire: *Future Directions for Patient and Family Caregiver Education* 39

Step Four Check List – Implementation 40

STEP FIVE - Evaluation

STEP FIVE: Evaluation **42**

Total Quality Management of Patient Education 43

Survey: *TQM Survey of Patient Education* 45

Step Five Check List – Evaluation 47

STEP SIX – Documentation and Coding of Patient Education

STEP SIX – Documentation and Coding of Patient Education **49**

Patient Care Component (PCC) of the Resource and Patient Management System (RPMS) 50

JCAHO and Other Accreditation Standards Addressing Patient and Family Education 51

How to Document Using the Patient Education Codes 52

Documentation Using the General and Specific Codes 54

Step Six Check List – Evaluation 56

STEP SEVEN – ORYX Indicators

STEP SEVEN – ORYX Indicators Patient and Family Education ORYX Indicators 57

Draft ORYX Indicators Patient and Family Education ORYX 60

Step Seven Check List – Evaluation 61

STEP EIGHT - Supplemental Section

62

Individual Departmental Questionnaires

Sample Departmental Survey: Confidentiality 63
Sample Departmental Survey: CHS 64
Sample Departmental Survey: Nursing 65

Sample Departmental Survey: Medical Records 67
Sample Departmental Survey: Health Education 68
Sample Departmental Survey: Physicians 69
Sample Departmental Survey: Nutritionist 70
Sample Departmental Survey: Dental 71
Sample Departmental Survey: Pharmacy 73
Sample Departmental Survey: CHR 74
Sample Departmental Survey: Alcohol/Substance Abuse 75
Sample Departmental Survey: Business Office 77
Sample Departmental Survey: Mental Health 78

Resource Collection on a Budget: Establishing a Patient Education Library 79

Survey: Assessment of Current Patient Education Library/File 82

Financing Patient Education 83

Diabetes Reimbursement: Coverage of Diabetes Outpatient Self-Management 88

SOAP Progress Notes 92

APC Reports from the PCC 93

PCC Ambulatory Patient Care Report 1A 94

Definition of an Ambulatory Care Visit 95

Provider (Services Rendered By) Codes 96

Clinic Code Definition 101

Developing a Policy and Procedure Manual 105

JCAHO Patient and Family Education (PFE) 2000 Standards 110

Developing a Client/Patient Satisfaction Survey 111

IHS Group Activity Form 113

Documenting Patient Education on the PCC 114

Acknowledgements 115

(INSERT CHART HERE)

INTRODUCTION TO PATIENT/FAMILY/CARE GIVER EDUCATION

Throughout this Manual, the education provided by the hospital, clinic or community programs to the Patient/Family /or CareGiver is referred to as PFCE.

This Manual is intended to assist all IHS/Tribal and Urban Health Programs in the development of a Policy and Procedure Manual for community and hospital based Patient and Family Education that is specific to your facility.

Patient/Family/Care Giver Education should be developed at all sites - regardless of size, budget or staff. All Sites, including and especially those with total Contract Health Services (CHS) or Ambulatory Care, should assess the clinic/hospital/community based PFCE services provided by IHS/Tribal and Urban Health Providers, Private Contract Providers and Referral Facilities. This assessment should begin the process to develop PFCE policies and procedures that govern and reflect the coordination of all health providers and the provision of community; hospital and clinic based educational services to Native American/Alaskan Natives.

This Process Manual is divided into eight categories:

1. Commitment
2. Assessment
3. Planning
4. Implementation
5. Evaluation
6. Documentation/Coding
7. ORYX Indicators
8. Supplemental Section

Commitment:

1. Commitment from Tribal and Facility Leadership is established to prioritize the development of a Patient/Family/Care Giver Education Policy and Procedure Manual within the facility and community.

2. The IHS and/or Tribal Hospital and/or Clinic obtain support, concurrence and commitment for the patient education project through a Resolution from the Tribal Leadership.

3. PFCE Coordinators/Managers is appointed from the present staff. The Coordinators/Managers shall make a commitment to planning, developing, implementing and evaluating PFCE.

4. A committed Task Force/Team is convened to manage the development of a Patient/Family/Care Giver Education Policy and Procedure Manual.

5. A Plan of Action is developed and implemented by the Task Force/Team. This Plan of Action includes:

    a. The mission statement concerning patient/family/care giver education.
    b. Philosophy of the Facility and/or Program
    c. Patient Education Goals and Objectives of the Facility and/or Program
    d. Provision for the establishment of a patient/family/care giver education library or resource area.
    e. Objectives that assure that hospital, clinic and/or community based education are statistically valid through standardized teaching, documentation, coding, and evaluation.

Assessment:

1. Assessment of current activities concerning what the Facility or Program staff is currently doing in the hospital, clinic or community in the area of patient/family/care giver education. Deficiencies will automatically show in review. This assessment will include:
   a. Looking at the clinic/hospital flow and its relationship to PFCE;
   a. Looking at the overall staff responsibility for providing PFCE;
   b. Looking at each individual department's responsibility for providing PFCE services;
      For example: How current services are delivered, where, and by whom;
      Resources available or needed;
      Assessing how patient and family education is documented, coded and evaluated;
   d. Determining the most common diagnosis;
   e. Studying patient flow patterns;
   f. Studying communication, collaboration, and coordination between all health disciplines both within the facility and in the community.

2. Patient's and client's satisfaction is surveyed to learn what their expectations are concerning patient education within the facility and community.

3. The Task Force/Team, in collaboration with supervisors, assesses staff's In-service Education needs for increasing staff patient education skills.

Planning:

1. Policy and Procedure Manuals are developed.
   a. Provisions include the development of a method to address:
      - "No Shows" "DNKA" missed appointments, etc.;
      - Scheduling and the re-scheduling of patient education appointments/sessions when providers are absent or on leave;
      - Analyses of methods by which health providers will provide appropriate patient education within time constraints.
      - Integration and aggregation of patient and family education data throughout the facility including community based programs.

2. Position Descriptions and Yearly Performance Appraisals are reviewed and/or revised to incorporate and reflect patient education criteria and standards.

Implementation:

1. Patient Education "lesson or teaching plans" are developed by the various disciplines/departments at your facility and in conjunction with community/tribal based health programs. Lesson or teaching plans will be included in your individual departmental Manuals that address all areas of patient and family education such as readiness to learn, literacy, educational levels, belief's, customs, values, etc.

2. All lesson or teaching plans should be developed based upon the protocol recommendations contained in the Indian Health Service Patient Education Protocols. (See the Indian Health Service's *Patient Education Protocols*.)

3. Lesson plans should follow a standardized format that has been accepted and established by the facility.

4. Lesson or teaching plans should adhere to the standardized coding recommended by the Indian Health Service. (See the Indian Health Service's *Patient Education Protocols*)

5. Documentation of PFCE services requires policies and procedures in place that govern documentation of the use of patient education protocols and coding.

Evaluation:

1. Performance Improvement**:** Each department and health discipline develops protocols, policies and procedures for the provision of PFCE services relevant to their discipline/department.

   PFCE policies and procedures are reviewed annually by the Task Force Team. Deficiencies will be corrected through Performance Improvement, by the clinical and/or medical staff and/or appropriate supervisory personnel.

   1a. Provisions for evaluation and audits of PFCE processes and outcomes
   2b. Provisions for updating and evaluating the Manual on an annual basis.

2. Performance improvement includes statistical accountability for patient and family education through an integrated and aggregate report such as the ORYX Indicators contained in Step 7.

3. Accreditation is facilitated through the development of a Patient and Family Education Policy and Procedure Manual. Development and implementation of a Patient Education Policy and Procedure Manual will assist your facility in meeting the various accreditation requirements to become and/or retain:

   - JCAHO, AAAHC and other accrediting and Regulatory Agencies,
   - Sites that desire to bill for Medicaid, Medicare, private insurance and other alternate resources may be required to document PFCE.

4. The Task Force/Team's completion of the PFCE Policy and Procedure Manual will end their role and the Task Force/Team may be disbanded. Responsibility may then be turned over to the appropriate Hospital/Clinic Committee or to the PI or to whichever management unit is most appropriate for the facility. It is their responsibility to ensure that the Manual is reviewed on an annual basis.

Documentation and Coding of Patient and Family Education

Health, patient and family education is an integral, multidisciplinary component of patient care. All Indian Health Service, Tribal, Urban and community programs are encouraged to use standardized documentation and coding of the health, patient and family education provided.

1. In order to standardize health, patient and family education within the facility, and, in fact, throughout the Indian Health Service, documentation should reflect the 5-7 standardized protocols contained in the Indian Health Service's *Patient Education Protocols* to assure that education is standardized through out the facility and community.

2. The 5-7 standardized protocols for each disease/condition should be used to develop lesson and teaching plans.

3. The education provided should be documented using the standardized codes from the Indian Health Service's *Patient Education Protocols*. These Protocols are incorporated into the Indian Health Service's RPMS/PCC system.

4. Documentation may be "generic or general" or specific (specific means specific as written in the Indian Health Service's *Patient Education Protocols*.) However, whether generic or specific documentation should adhere to 4 basic requirements:

   1. The disease state, condition or system being addressed must be listed;
   2. The specific education topic taught must be listed;
   3. The level of patient/family understanding of the material taught must be documented;

4. The initials of the provider who did the teaching/education must be written to authenticate the education provided.

ORYX Indicators

While not all sites are JCAHO accredited, following JCAHO requirements for patient and family education will assure that the accreditation standards for most accrediting and regulatory agencies are met - including AAAHC. All hospital and ambulatory clinics that are JCAHO accredited must use an JCAHO-approved performance measurement system to provide data about patient outcomes and other indicators of patient care. The Indian Health Service developed the Phoenix Project, ORYX, to meet this JCAHO requirement.

Measuring performance In-Patient and Family education can be completed using established ORYX Indicators to statistically "count" how much patient and family education is occurring in the facility and in the community.

Five specific ORYX Patient and Family Education Indicators have been selected to evaluate the patient and family education provided in Indian Health Service, Tribal and community programs.

Supplemental Section:

Pertinent information is included in the Supplemental Section of the Manual.

PATIENT EDUCATION
SAMPLE OBJECTIVE STATEMENT

Assess, develop, and implement a Patient/Family/Care Giver Education Policy and Process Manual for Health Providers that addresses all phases of hospital and community based Patient/Family/Care Giver Education.

I. Purpose of Objective:

"To establish a uniform method for all health providers, both clinical and non-clinical, in the provision of hospital and community based patient and family education."

II. Background Information:

All IHS and Tribal Clinic/Hospital sites are committed to providing quality health care. The provision of quality health care is dependent not only upon the competent performance by all health care personnel but also includes quality patient education services. The organization should strive to improve client services through the provision and monitoring of patient education services and activities to clients. The development of comprehensive patient education services and activities for clients should reflect a multi-disciplinary, culturally relevant approach that is specific to each site.

III. Needs Assessment:

Each facility should develop and conduct a Needs Assessments specific to their facility.

IV. Activities:

1. All sites, including total CHS sites, are encouraged to develop a Policy and Procedure Manual for community and hospital based Patient and Family Education for use at their Clinic/Hospital.

2. The *"Process For Developing A PFCE Policy And Procedure"* Manual is only a suggested tool that encompasses all phases of patient education and requires participation by all staff in the development of a comprehensive PFCE Policy and Procedure Manual.

3. In addition to the Indian Health Service *Patient Education Protocols* and the ORYX Indicators, the PFCE guidelines are divided into five categories:
   A. Commitment
   B. Assessment
   C. Planning
   D. Implementation
   E. Evaluation

   The Process Manual is applied at three levels:
   A. Administrative Level: Commitment, policies, procedures, management, etc.
   B. Program Level: Individual health disciplines and their programs
   C. Patient/Client Level: Meet the education needs of American Indians and Alaskan Natives.

V. Time Frame:

Determined by facility and/or program.

VI. Evaluation:

A. Site-specific PFCE Policy and Procedure Manuals will be developed at the Hospital/Clinic and in the community.

B. Site-specific PFCE Policy and Procedure Manuals will reflect a multi-disciplinary approach to patient education that is hospital/clinic and community-based.
C. Pre-Evaluation and Post-Evaluation Indicators that are hospital and community-based will be selected and monitored to determine the effectiveness of patient and family education.
D. The site-specific PFCE Policy and Procedure Manual will reflect the incorporation of JCAHO Patient and Family Education Standards, ORYX Indicators, and the Indian Health Service's *Patient Education Protocols*.

STEP ONE

Commitment

STEP ONE
MAKING A COMMITMENT TO PATIENT/FAMILY/CARE GIVER EDUCATION
LEADERSHIP RESPONSIBILITIES

The process of developing a Hospital/Clinic PFCE Policy and Procedure Manual *shall* be*gin* with the support and commitment of the Hospital/Clinic Leadership. Leadership should demonstrate commitment through a "Declaration of Intent" concerning the patient education project. The Hospital/Clinic should also obtain the support, concurrence and commitment for the patient education project through a Resolution from the Tribal Council. After the Leadership has committed to the development of a PFCE Policy and Procedure Manual an Orientation Meeting for all staff should be held.

ORIENTATION MEETING FOR ALL STAFF

What is Patient and Family CareGiver Education (PFCE)? PFCE is a problem-solving process that gives the patients and the families information that they need about their health or medical problem that helps them to make informed decisions.

PFCE is a process of:

- influencing behavior change,
- facilitating those changes required to prevent disease, maintain and/or improve health,
- acquiring information, skills, and/or attitudes to improve health.

Why is PFCE Important? Customers must assume a proactive role in the maintenance and/or improvement of their own health. As morbidity increasingly becomes the result of unhealthy choices in lifestyle behavior, self-generated positive health practices become imperative for supporting an increased life span and improved quality of life. A planned program can result in the following:

1. Improved quality care.
2. Improved utilization of Hospital/Clinic services
3. Fewer ambulatory clinic visits, fewer re-admissions to inpatient facilities with shorter lengths of stay.
4. Increased community support for the Health Programs because customers feel that the Health staff is interested in their health and well-being.
5. Increased staff communication and satisfaction.
6. Support of standards to meet the accreditation standards for hospitals and clinics.
7. Commitment to the development of a written policy and procedure Manual for PFCE means making a commitment to the American Indian/Alaskan Native population one delivers services to.

Who is responsible for Patient Education?

All staff members, both clinical and non-clinical, play a role in patient education.

Those departments that have direct contact with patients are, for example: medicine, nursing, medical social service, dietary, pharmacy, Community Health Representative's (CHR's), alcohol and substance abuse counselors, nutrition, youth coordinators, the dental staff, mental health staff, health educators, nurse educators, diabetes coordinators, physical therapists, Discharge Planners and other clinic personnel.

Other departments can assist with gathering, disseminating and documenting information as to the current status of patient education. For example, business office employees, Contract Health Services (CHS) staff (those employees that handle referrals to outside providers), Medical Records (coding, transcription), computer operations (Patient Care Component- PCC), Health Planners, and all other non-clinical staff.

To organize a planned education program that is all-encompassing and touches all hospital or clinic disciplines takes time and the designation of patient education as a health care program priority.

Before the hospital or the clinic management can determine staff responsibility and designate resources for patient education, an assessment of current patient activities should be made. This assessment should be structured to assess two distinct areas :

1. **Patient needs**, wants, and expectations in terms of:
   - Communication:
     - Readiness to learn
     - Ability to learn
     - Preference in learning i.e., reading, videos, demonstration, etc.
   - Information available to the patient and their family through the facility and the community.
   - Knowledge, Skills, Attitudes i.e., cultural and religious practices, emotional barriers, desire and motivation to learn.
   - All facility and community providers coordinate resources and activities for the patient and their families.

2. **Staff needs**, in terms of:
   - Skills needed currently and in the future,
   - future training,
   - resources to support staff needs.

Each facility shall develop it's own in-house survey of current PFCE activities.

APPOINTMENT OF A PATIENT EDUCATION COORDINATOR(s)

The next step for the hospital/clinic Administrator is the delegation of responsibility to one or two Coordinators and a designation of which staff and/or departments shall serve on the Hospital/Clinic Task Force/Team.

The Task Force Team now becomes responsible for the development of a Hospital/Clinic PFCE Policy and Procedure Manual. To begin this task, the Task Force Team develops a comprehensive, coordinated assessment of current patient education or process activities. It is recognized that many sites are one-person departments but this should not be a deterrent to the development of protocols, policies and procedures to govern patient education.

Patient Education Task Force Team
Method 1:

- The PFCE Coordinator works with the Hospital/Clinic Administrator to choose members from the Hospital/Clinic and community health programs/departments to serve on a "Task Force Team".
- The early responsibility and focus is identifying the current education being provided, in both the Hospital/Clinic and in the community, and how the PFCE is documented and coded in the client's medical record.
- Each department is responsible for the development and implementation of PFCE relevant to their department; therefore, each department works to gather information on what is currently being done in the area of PFCE within their department.
- This will include an assessment of resources currently used in the provision of PFCE, who is doing the teaching, the documentation and coding of education being provided, and assessing the time currently allocated for the delivery of patient education programs.

Method 2:

The Hospital/Clinic Administrator assigns responsibility for a Task Force Team on PFCE to an already established Committee/Team within the facility such as the Executive Committee, Discharge Planning, or Patient Care Committee.

Patient Education Task Force Team Objectives
Year One

The Patient Education Task Force/Team Members will:

1. Start the process for the development of a Plan of Action for PFCE. It is recommended that a Timetable for the development of PFCE be established.
2. Develop the hospital/clinic philosophy, goals, and objectives for PFCE.
3. Establish ground rules for the Task Force Team. The Task Force Team will decide if other individuals from external health program/activities and community health agencies need to meet with the Task Force Team on a regular basis to participate in the development of a Plan of Action for PFCE.

The Task Force Team can be empowered to appoint three additional Work Groups:

A. Appoints a Work Group to establish a Patient Education Resource File and/or Library Work Group. This Work Group will work to assemble a variety of education materials to be used in PFCE. This Work group will ensure that each health discipline/department will inventory, review, and scrutinize those educational materials that are currently being given to clients by their department (pamphlets, brochures, video's etc.) for appropriateness and literacy level.

B. Appoint a Work Group to work with the Managed Care Division to explore avenues of third-party reimbursement for PFCE patient education.

C. Promotes continuity of patient education by appointing a Work Group to develop a Discharge Planning System which will facilitate communication and services between the hospital/clinics and the client.

Education Task Force Team Objectives
Year Two

1. A Hospital/Clinic PFCE Education Policy and Process Manual is developed and put into place.
2. Follow-Up on PFCE is given to the Hospital/Clinic's PI/QA program, the Discharge Planning Committee, or, a Patient Education Advisory Committee.

The PFCE Task Force/Team should define the mission of the clinic-wide or hospital-wide patient education program. The program's mission should complement the Tribe's health mission, goals, and Strategic Plan (if a Strategic Plan has been developed) but not necessarily duplicate them. The mission statement says, "This is what we are, this is what we are here for, and this what we believe in and want to be known for."

Example of a Proposed Mission Statement on Patient/Family/Care Giver Education

The (Name of the Hospital/Clinic) PFCE program exists to ensure that every individual/receives the appropriate educational experiences needed to assist in coping with changes related to illness, and to provide an environment for learning, and for developing and reinforcing goal-directed health behavior.

Example of a Proposed Philosophy of Patient/Family/Care Giver Education

The philosophy of PFCE at (Hospital/Clinic) is based on the belief that the patient should receive the best care possible. (Hospital/Clinic) believes PFCE is an integral part of quality patient care.

It is our belief that the coordinated professional team approach is essential in providing information to patients and their families/care givers. While patient education is the responsibility of the total professional team, it is also the right of the individual patient and his or her family. A desired outcome of a deliberate, systematic patient education program is a patient who is knowledgeable about his or her health problem(s) and is able to participate in his/her continued self-care following discharge.

We further believe that:

PFCE programs developed should be able to be individualized and revised according to a patient's learning and functional needs.

PFCE should be a deliberate, planned effort rather than an intuitive, random effort.

PFCE programs, which are systemically planned, can result in improved patient care and better utilization of hospital professional staff.

PFCE programs should determine needs and objectives of each department so that a multidisciplinary approach to patient education can be developed.

The key concepts presented in PFCE include not only the patient but also includes the patient's family and/or significant other. Family and/or significant others should be provided education which enhances their health care experience; ensuring they receive maximum benefit from the health care interventions provided by (Facility/Program.)

PFCE must be relevant to the culture and environment of the consumer.

Example: Purpose/Goals And Objectives Of (Hospital/Clinic-Based) Patient/Family/Care Giver Education Program

PURPOSE:

To provide planned educational experiences as an integral part of patient care. Through patient education the patient and family/care giver will be assisted in acquiring the knowledge, attitudes, and skills necessary to understand and participate in the continued management of their health wellness and to function as independently as possible.

OBJECTIVES;

The PFCE Program will:

1. Facilitate orientation for the patient, their families and significant others to the Hospital/Clinic and its services.
2. Provide structured educational activities relevant to the learning needs of patients (and/or families/care givers) with specific health problems and for promotion of wellness.
3. Include in the focus of patient teaching a plan for health maintenance and disease prevention.
4. Assist the staff in identifying the learning needs of the patient and in acquiring the knowledge and skills necessary to perform their function as patient educators.
5. Facilitate the team approach to PFCE, through team conferences, formulation of nursing care plans, utilization of checklists, and coordination with other health personnel.
6. A standard of care for each educational session will be developed which stipulates the minimum level of teaching that will be offered for each educational encounter. From this minimum standard, care can be individualized to meet the specific needs of the patient.
7. Provide for continuity of care through discharge planning.
8. Develop a teaching module method of patient education using goals and behavioral objectives, which can then be used as criteria for evaluation.
9. Create and/or identify and review commercial educational materials for use in the program.
10. Assist in the organization and implementation of self-help support groups (Fitness Club/Walking Group, Nutrition/Diet Group/Club, Diabetes Association, etc.) which can aid in the physical and psychosocial rehabilitation of the patient.
11. Assess and evaluate the effectiveness of patient education programs in meeting the learning needs of the patient and his family/care giver.

Step One
Check List
Commitment

___ Hospital/Clinic Administrator makes a commitment to PFCE.

___ During a full staff Orientation Meeting, the hospital/clinic Administrator announces PFCE as a priority for the Facility.

___ The hospital/clinic Administrator submits to staff a written "Declaration of Intent" to focus the hospital/clinic efforts on PFCE.

___ All staff completed some type of in-house survey to measure current PFCE activities.

___ Tribal support is gained through a Resolution submitted by the hospital/clinic to the Tribal Council.

___ For sites with both an IHS Service Unit Director and a Tribal Health Director, these two have met to pledge joint support and effort for this Project.

___ Hospital or Clinic Administrator:
- ___ appoints a Patient Education Coordinator, or
- ___ appoints Co-Coordinators for PFCE, or
- ___ designates one department or discipline as responsible for the development of PFCE

___ Patient Education Coordinator(s) meet with disciplines or department Supervisors for in-put regarding suggestion for staff membership for the Patient Education Task Force/Team.

___ Task Force/Team membership is selected and staff informed.

___ Task Force/Team and Coordinator(s) meet for Orientation meeting.

- ___ Duties and Task Force/Team responsibilities discussed and agreed upon.
- ___ Consensus on meeting time, dates, place
- ___ One member assigned as Recorder for minutes.
- ___ Discussion as to how to keep all staff informed of activities.
- ___ Task Force/Team develops a One-Year Plan of Action to accomplish project intent.
  - ___ Task Force/Team develops Mission Statement
  - ___ Task Force/Team develops Philosophy statement
  - ___ Task Force/Team develops Purpose/Goals and Objectives
  - ___ Task Force/Team appoints three additional work groups:
    - ___ Work Group to begin the establishment of a PFCE Resource File or Library
    - ___ Work Group to explore Managed Care and patient education reimbursement
    - ___ Work Group to work on Discharge Planning

STEP TWO

Assessment

Assessment
Step Two

Every health professional must take the time to do patient education and should share the educational workload directly related to their area of expertise.

Each health department/discipline should address all concerns relative to their profession when reviewing their department.

The Task Force/Team should then compile the accumulated information and prepare a PFCE review of the entire facility.

The structure of the Hospital/Clinic staff will need to be examined in order to view the overall picture for implementing a comprehensive patient education program.

1. The staffing patterns for the Hospital/Clinic and for each shift of the hospital will need to be studied.
2. Delineate which disciplines have PFCE responsibilities other than physician and nurses, and what times they are at the Hospital/Clinic.
3. Delineate student involvement in the Hospital/Clinic as a setting for student learning and determine student responsibilities as they relate to the PFCE setting. Are they involved in PFCE?

In this way, the entire staff will be involved in the overall view. Within any health care setting, you will find some health disciplines/employees that might argue that they are not responsible for PFCE. However, the focus of this Manual emphasizes that every Hospital/Clinic employee must recognize his or her role in the PFCE component of health care. The opportunity to provide PFCE begins when the patient enters the facility and may continue through discharge, therefore, all staff is involved in the process.

The following areas of staff responsibility should be covered and analyzed:

1. The number of the staff with clinical responsibilities, but are not specifically assigned patient care. This might includes ancillary staff.
2. What are the assignments of these ancillary staff?
3. Outline the staff responsible for Orientation for new employees and continuing education of staff responsible for providing PFCE.
4. Is the ability to provide and demonstrate competency in PFCE included in job descriptions or performance evaluations?
5. Who follows up on patients referred to outside physicians for services? Is it documented or is it assumed that they have received the appropriate PFCE?
6. Is there an established policy for in-house referrals? Does this policy stipulate?
    a. Who can make referrals for PFCE?
    b. Which employees are responsible for providing PFCE?
    c. Who will provide education in the event that the designated emp loyee is absent or out of the office?
    d. Whose responsibility is it to schedule appointments for PFCE?
    e. Whose responsibility is it to follow-up on "No Shows or DNKAs?"
    f. What is the Hospital/Clinic policy concerning all attempts to contact "No Shows or DNKA's?"
    g. How are in-house referrals documented in the chart?
7. Has the discipline or Hospital/Clinic looked into the issue of reimbursement for PFCE?

Assessment of Patient Flow

The patient flow pattern should be traced through the Hospital/Clinic system both within and outside the Hospital/Clinic. Information gained from documenting the patient flow pattern should include the following:

1. **Where** patients come into contact with health personnel.
2. The personnel **who** come into contact with the patients.

3. Amount of waiting **time** involved.
4. Approximate **number** of patients in one place at one time.
5. Examine the inpatient and outpatient setting. Establish timing for the education.

Plan For an Effective Patient Education Documentation System

To establish an effective patient education documentation system, a process of planned changed can be used. Ideally, going through this process will identify only minor weaknesses in the current system, and vastly improved patient education documentation can be achieved with only minor revision. In some instances, however, analysis of the current RPMS/PCC system reveals that documenting patient education seems to be an afterthought. Often a teaching-learning form for documentation is haphazardly developed and added to the overall system with little attention given to how to integrate it into the whole documentation system. The most effective system is one where patient education is valued as an integral part of patient care and documentation is thus integrated into the total record-keeping system.

Six major steps need to be considered when developing an effective patient education documentation system at Indian Health Service and Tribal Hospitals, Clinics and community health programs. They are:

1. Assess the current RPMS/PCC system to determine the current documentation of patient education.
2. Formulate goals and objectives for the planned change to document according to RPMS/PCC guidelines.
3. Develop strategies for the planned change.
4. Educate the staff to document patient education.
5. Obtain organizational supports for patient education documentation.
6. Evaluate the new or revised documentation system.

Individual Departmental Questionnaires

Individual Departmental Questionnaires have been developed (see the Supplemental Section) and completed by staff to assess all hospital/clinic department staff concerning their role in PFCE.

RPMS/PCC Computer Audits of PFCE

Is recommended that all sites complete a computer audit which will reveal what, how and who is currently documenting patient and family education.

Assess Patient and Family Education processes for current outcomes to improve patient health through:

- Assessing organization-wide PFCE programs and activities
- Formulate PFCE program goals;
- Allocating resources for PFCE;
- Determining and prioritizing specific patient educational needs; and
- Providing education to meet identified patient needs.

PFCE standards in your facility should be assessed to determine if they address activities involved in these processes:

- Promoting interactive communication between patients and providers;
- Improving patient's understanding of their health status, options for treatments, and the anticipated risks and benefits of treatment;
- Encourage patient participation in decision making about care;
- Increasing the likelihood that patients will follow their therapeutic plans of care;
- Maximizing patient self-care skills;
- Increasing the patient's ability to cope with his or her health status;
- Enchancing patient participation in continuing care;
- Promoting health lifestyles; and
- Informing patients about their financial responsibilities for treatment when known.

Note: *While JCAHO Standards recommend a systematic approach to education, they do not require any specific structure, such as an education department, a PFCE committee, or the employment of an educator. More important is a philosophy that views the educational function as an interactive one in which both parties are learners. JCAHO standards help the facility focus on how education is consistent with the patient's plan of care, level of care, the educational setting, and continuity of care.*

Assessment of Patient Education

Questions to Ask	How to Gather Data
1. What are the current PFCE programs, materials and participating staff?	Use surveys and/or interview department supervisors, and informal staff meetings concerning current and needed PFCE programs.
2. What organizational characteristics (structure) Of the hospital will support or hinder patient Education program development?	Review policies and procedures that affect PFCE.
3. What resources are available for PFCE? - Funds budgeted - Media Equipment - Current use of media and materials for patient education	Obtain examples from media department, library, Health Education and preview materials. Survey and/or interview staff currently doing patient teaching.
4. Which departments have goals that relate to patient education?	Review department goals, interview appropriate managers and Supervisors.
5. Are PFCE roles and responsibilities included in job descriptions, performance standards, and performance evaluations.	Review job descriptions and performance evaluation criteria of staff in all departments to ascertain which positions would have patient Education as a performance element.
6. What are the top 10 diagnoses of patients admitted to the hospital?	Medical records, DRG data
7. What are the average lengths of stay and ages of patients with these diagnoses?	Patient Statistics report, Medical Records
8. What problems have patients identified on Patient Satisfaction Surveys/Questionnaires	Review results of Patient Satisfaction Surveys
9. For what reasons are patients being readmitted?	Review Data from UR, medical records, morbidity statistics
10. What information is currently given to patients in the preadmission phase? When, by whom, and In what format?	Interview or survey admission department, patient registration data, outpatient services, referral agencies, and the ER.
11. What patient data is collected and could this information be useful in determining patient education needs?	Review of RPMS/PCC
12. What PFCE is included in the Discharge Summary?	Chart audit, QA/TQM indicators
13. What PFCE criteria are included in audits?	Chart audit, QA/TQM indicators
14. Do standard care plans include PFCE components?	Review standard of care of plans.
15. How are PFCE outcomes and activities Documented?	RPMS/PCC/Q-Man documentation procedures .
16. Has there been interdisciplinary involvement in PFCE planning and implementation?	Audit charts of specific patient populations.
17. How complete are existing PFCE programs for specific populations? - Written program policies and procedures with goals, objectives, and teaching plans developed? - Interdisciplinary involvement, coordinating mechanisms, staff orientation procedures to the program	Observe actual teaching activities Chart audits to determine if all components of patient education are included. - Documentation and communication procedures - Evaluation methods for PFCE outcomes and program effectiveness

Subject: Client/Patient Satisfaction Interview/Survey

Why has customer satisfaction become so important to business in general and to health care in particular? What happens when customers (or patients) become dissatisfied? How does one prevent or remedy dissatisfaction? Patient satisfaction should be a Hospital/Clinic objective. An aspect of assessment is to develop a Client/Patient Satisfaction Interview or Survey. More information on how to conduct client or patient satisfaction interviews or surveys is contained in the Supplemental Section.

Dimensions of Patient Satisfaction

Although most patients are generally satisfied with their service experience, they are not uniformly satisfied with all aspects of the care they receive, and therein lie the challenge to health care management. How much service is enough to elicit high satisfaction among customers and ultimately to keep them returning to the Hospital/Clinic with satisfaction, and just what kind of service is that?

What are the dimensions of patient satisfaction? According to a national survey the ranking is as follows:

1.	Highest priority:	Overall care
2.	Second priority:	Cleanliness
3.	Third:	Physicians
4.	Fourth:	Nurses
5.	Fifth:	Other health staff
6.	Sixth:	Concern of staff
7.	Seventh:	Admissions/Discharge
8.	Eighth:	Courtesy/helpfulness of clerical/secretarial/business staff
9.	Ninth:	Parking/Convenience
10.	Tenth:	Cost of Care

Patient Satisfaction Defined

Many health providers have complained that patient satisfaction is an ill-defined concept. Perhaps, in fact, it is difficult to define or describe patient satisfaction. A simplistic version of PFCE defined is "the positive evaluation of distinct dimensions of health care. The care being evaluated might be a single clinic visit, treatment through an illness episode, a particular health care setting or plan, or the health care system in general."

Sample questions for discussion:

1. How satisfied are patients?
2. Will service changes (for example, increasing or decreasing the number of staff, facility improvements, etc.) affect patient satisfaction?
3. Are patients more or less satisfied with the Prenatal Clinic as compared to Well-Child Clinic?
4. Has patient satisfaction changed over the past two years?
5. With what service aspects are patients more satisfied or less satisfied?

Step Two
Check List
Assessment

___ Review of the structure of the Hospital/Clinic

___ Staffing patterns for each shift, if applicable

___ Disciplines with PFCE responsibilities:

___	Physicians	___	Medical Records	___	Dental Staff
___	Health Educators	___	Medical Social Services	___	Physical Therapy
___	Pharmacy	___	CHR's	___	Nutrition
___	X-Ray	___	Lab	___	A/SA Program
___	Mental Health	___	Injury Prevention	___	Business Department
___	Nursing	___	Mid-Level Providers	___	PHN/CHN
___	ER	Other: _____			

___ Each discipline has reviewed those PFCE materials they distribute for appropriateness, literacy level, cultural aspects, etc.

___	Physicians	___	Medical Records	___	Dental Staff
___	Health Educators	___	Medical Social Services	___	Physical Therapy
___	Pharmacy	___	CHR's	___	Nutrition
___	X-Ray	___	Lab	___	A/SA Program
___	Mental Health	___	Injury Prevention	___	Business Department
___	Nursing	___	Mid-Level Providers	___	PHN/CHN
___	ER	Other: _____			

___ The "PFCE Resources/Library" Work Group has conducted a preliminary survey of all PFCE materials distributed within the facility.

___ The "PFCE Work Group on Managed Care and Patient Education " is working reimbursement
The "PFCE Work Group on Discharge Planning " has begun the develop of a Work Group to assess the facilities discharge planning.

__ Delineate which staff has clinical responsibilities but is not assigned to patient care:

___	Physicians	___	Medical Records	___	Dental Staff
___	Health Educators	___	Medical Social Services	___	Physical Therapy
___	Pharmacy	___	CHR's	___	Nutrition
___	X-Ray	___	Lab	___	A/SA Program
___	Mental Health	___	Injury Prevention	___	Business Department
___	Nursing	___	Mid-Level Providers	___	PHN/CHN
___	ER	Other: _____			

___ Have these staff assignments on patient education been explored?

___	Physicians	___	Medical Records	___	Dental Staff
___	Health Educators	___	Medical Social Services	___	Physical Therapy
___	Pharmacy	___	CHR's	___	Nutrition
___	X-Ray	___	Lab	___	A/SA Program
___	Mental Health	___	Injury Prevention	___	Business Department
___	Nursing	___	Mid-Level Providers	___	PHN/CHN
___	ER	Other: _____			

___ Orientation for new staff developed by each discipline

___	Physicians	___	Medical Records	___	Dental Staff
___	Health Educators	___	Medical Social Services	___	Physical Therapy
___	Pharmacy	___	CHR's	___	Nutrition
___	X-Ray	___	Lab	___	A/SA Program
___	Mental Health	___	Injury Prevention	___	Business Department
___	Nursing	___	Mid-Level Providers	___	PHN/CHN
___	ER	___	Contract Health Services	___	

Other: _____

___ Review of Position Descriptions/Performance Evaluations for PFCE standards/criteria

___	Physicians	___	Medical Records	___	Dental Staff
___	Health Educators	___	Medical Social Services	___	Physical Therapy
___	Pharmacy	___	CHR's	___	Nutrition
___	X-Ray	___	Lab	___	A/SA Program
___	Mental Health	___	Injury Prevention	___	Business Department
___	Nursing	___	Mid-Level Providers	___	PHN/CHN
___	ER	Other: _____			

___ Contract Health Services (CHS) begins Review of referrals to outside providers.

___ I/T/U Providers educate patient/family/care giver as to the necessity or reason for referral to an outside provider.

___ I/T/U Providers document in the patient's chart that education was given explaining the necessity of outside referral.

___ Contract Health Services (CHS) ensures that private provides gave the appropriate PFCE.

___ An appropriate agreement is on file between the Hospital/Clinic and outside providers stating that the private provider will ensure that the patient/family/care giver receives education appropriate to the need.

____ This agreement establishes definite timelines as to when the outside provider will return documented copies of the PFCE given.

___ Contract Health Services (CHS) surveys patients to determine if, in fact, they have received education concerning their medical condition.

___ Task Force/Team has developed and administered a *Client/Patient Satisfaction Interview or Survey*

___ In-House referrals are appropriately examined:

___ Physician only make referrals in-house YES NO

___ Are all referrals documented in writing? YES NO

___ Policies in place concerning whom can make referrals? YES NO

___ These providers can make in-house referrals:

___	Physicians	___	Medical Records	___	Dental Staff
___	Health Educators	___	Medical Social Services	___	Physical Therapy
___	Pharmacy	___	CHR's	___	Nutrition
___	X-Ray	___	Lab	___	A/SA Program
___	Mental Health	___	Injury Prevention	___	Business Department
___	Nursing	___	Mid-Level Providers	___	PHN/CHN
___	ER	Other: _____			

___ For In-house referrals, each department has in place policies with reciprocal agreements between departments?

___	Physicians	___	Medical Records	___	Dental Staff
___	Health Educators	___	Medical Social Services	___	Physical Therapy
___	Pharmacy	___	CHR's	___	Nutrition
___	X-Ray	___	Lab	___	A/SA Program
___	Mental Health	___	Injury Prevention	___	Business Department
___	Nursing	___	Mid-Level Providers	___	PHN/CHN
___	ER	Other: _____			

___ PFCE Policies have been established in each and every department.

___ Standing Orders in place for PFCE referrals - when, what, which department, etc.

___ Provision in departmental PFCE Manual for:

- ___ Who does scheduling for PFCE?
- ___ Absence/leave of staff
- ___ No-Shows. DNKA's
- ___ Follow-up for No Shows/DNKA's
- ___ In-house Referrals documented

___ These Departments reviewed time allotted for PFCE.

___	Physicians	___	Medical Records	___	Dental Staff
___	Health Educators	___	Medical Social Services	___	Physical Therapy
___	Pharmacy	___	CHR's	___	Nutrition
___	X-Ray	___	Lab	___	A/SA Program
___	Mental Health	___	Injury Prevention	___	Business Department
___	Nursing	___	Mid-Level Providers	___	PHN/CHN
___	ER	Other: _____			

___ These Departments reviewed staff needs for PFCE

___	Physicians	___	Medical Records	___	Dental Staff
___	Health Educators	___	Medical Social Services	___	Physical Therapy
___	Pharmacy	___	CHR's	___	Nutrition
___	X-Ray	___	Lab	___	A/SA Program
___	Mental Health	___	Injury Prevention	___	Business Department
___	Nursing	___	Mid-Level Providers	___	PHN/CHN
___	ER	Other: _____			

___ Policies establish:

- ___ When patient education is going to be done?
- ___ Who will be responsible for scheduling appointments if the provider is busy or not available to do the PFCE?
- ___ Who will schedule for a later time/date
- ___ If a patient fails to keep a scheduled PFCE session policy establishes how, when, and how many times the client will be contacted before giving up.
- ___ Policy dictates where PFCE is going to occur?
- ___ exam room
- ___ lobby
- ___ secluded area
- ___ health education office
- ___ specially designated office/room
- ___ What's going to be taught?
- ___ PFCE policies in place
- ___ lesson plans developed

___ most common diagnosis' documented
___ Evaluations of PFCE lesson plans are in place
___ Evaluation of professional performance criteria is in place

STEP THREE

Planning

Step Three
Planning to Implement Patient and Family Education

QUESTIONS TO CONSIDER:

1. **WHO**'s going to do PFCE?
   - A. Who has time?
   - B. Who has adequate staffing?
   - C. What is the role of (insert each staff position) in PFCE?
2. **WHO**'s going to select and/or develop and Inventory PFCE materials? (Pamphlets, etc.)
3. **WHEN** is PFCE going to be done?
   - A. Physician's orders?
   - B. Standing Order?
   - C. Initiated by Nurse other health professionals?
4. **WHERE** is PFCE going to occur?
   - A. Classroom/Conference Room?
   - B. Exam Room?
   - C. Lobby?
   - D. Other?
5. **What's** going to be taught?
   - A. What programs are going to be developed?
   - B. What input will each department have?
6. **HOW** will programs be evaluated? A key to successful PI is the continuous assessment of the outcomes.
   - A. How will outcomes be measured?
   - B. Who will develop recommendations for improved processes?

Developing PFCE Policy and Procedure Manuals

Policy and Procedure Manuals are developed according to the assessed needs of the population served. (See the Supplemental Section.) Each department will develop a departmental Policy and Procedure Manual on PFCE that addresses and incorporates:

1. Title Page
2. Introduction
3. Definition of Terms
4. Mission, Vision, Philosophy of Care
5. Purpose/Goals of Practice
6. Functions and Responsibilities
7. General Functions
8. Responsibilities of Clients, Informed Consent
9. Additional Sections for (as desired) date each page
   Procedures
   Standing Orders
   Protocols
10. Orientation Program
11. In-service Education, Continuing Education
12. Quality Assurance, TQM, PI
13. Policies and Procedures Approved by the Governing Board, Medical Staff and Administration
14. Copies Of Current Disaster and Fire Manual
15. Infection Control
16. Safety Policies
17. Preventive Maintenance/Electrical on any Program equipment
18. Organization Chart - Specific to the department with documented relationships to Medical Staff, if any, and Administration (direct or indirect). Dated. Narrative statement also recommended.
19. Organization chart - copy of current, dated, hospital-wide chart on file in the Policy and Procedure manual.
20. Hours of operation, weekends, after-hours, or on call-coverage method.
21. Job descriptions - for each employee, dated.

22. Record of licenses, registration numbers with dates of expiration, updated regularly and filed in Personnel according to clinic/hospital policy for ongoing verification of current licensure including any teaching or State licenses, certification, RN licensure, CPR, Red Cross, Etc.
23. Copies of respective sections of JCAHO - and other appropriate standards and regulations.

Suggested additional contents for a patient education policy and procedure manual.

Annual Patient Education Work Plan
Budget/Spending Plans for Patient Education
Clinic/Hospital Organizational Chart
Any Grant Proposals for Patient Education
Goals and Objectives Statement
Monthly Reports
Quarterly Reports
Year End Reports
Informed Consent
Patient Right's and Responsibilities
Personnel
Quality Assurance
Position Description
Scope of Work for Patient Education
Any Strategic Planning for Patient Education
Workshops/Training/In-Service Education documentation

Position Descriptions should contain:
1. Scope of Work on Patient, Family, Caregiver Education
2. Measurable criteria on patient education with specific performance standards.

STEP THREE
CHECK LIST
PLANNING

Planning to meet the following has been completed:

___ **WHO**'s going to do PFCE?
- ___ Time
- ___ Who will do PFCE
- ___ The role of each staff position in PFCE has been determined.

___ Each department has selected and/or develop and Inventory PFCE materials.
___ It has been determined **WHEN** is PFCE going to be completed.
___ Referral procedures have been developed.
___ **WHERE** is PFCE going to occur has been determined.
___ Lesson or teaching plans has been developed by every department.
___ A method of program evaluation is developed to provide continuous assessment of the outcomes.

___ Position Descriptions have been assessed for a Scope of Work on PFCE
___ Position Descriptions have measurable criteria on patient education with specific performance standards.

Departmental Policy and Procedure Manuals are being developed that contain the following:

___ Title Page
___ Introduction
___ Definition of Terms
___ Mission, Vision, Philosophy of Care
___ Purpose/Goals of Practice
___ Functions and Responsibilities
___ General Functions
___ Responsibilities of Clients, Informed Consent
___ Additional Sections (as desired) Date each page
- ___ Procedures
- ___ Standing Orders:
- ___ Protocols

___ Orientation Program
___ In-service Education, Continuing Education
___ Quality Assurance
___ Policies and Procedures Approved by the Governing Board, Medical Staff and Administration
___ Copies Of Current Disaster and Fire Manual
___ Infection Control
___ Safety Policies
___ Preventive Maintenance/Electrical on any Program equipment
___ Organization Chart - Specific to the department with documented relationships to Medical Staff, if any, and Administration (direct or indirect). Dated. Narrative statement also recommended.
___ Organization chart - copy of current, dated, hospital-wide chart on file in the Policy and Procedure manual.
___ Hours of operation, week-ends, after-hours, or on call-coverage method.
___ Job descriptions - for each employee, dated.
___ Record of licenses, registration numbers with dates of expiration, updated regularly and filed in Personnel according to clinic/hospital policy for ongoing verification of current licensure including any teaching or State licenses, certification, RN licensure, CPR, Red Cross, Etc.
___ Copies of respective sections of JCAHO - and other appropriate standards and regulations.

Suggested additional contents for a patient education policy and procedure manual

___ Annual Patient Education Work Plan
___ Budget/Spending Plans for Patient Education
___ Clinic/Hospital Organizational Chart
___ Any Grant Proposals for Patient Education

___ Goals and Objectives Statement
___ Monthly Reports
___ Quarterly Reports
___ Year-End Reports
___ Patient Right's and Responsibilities
___ Personnel File
___ Quality Assurance
___ Position Descriptions
___ Scope of Work for Patient Education
___ Any Strategic Planning for Patient Education
___ Workshops/Training/In-Service Education documentation

STEP FOUR

Implementation

Implementation of PFCE Activities

By Step Four, the Hospital/Clinic has completed a planned, systematic assessment of the current Hospital/Clinic PFCE process.

This assessment may be accomplished by the use of questionnaires with the staff physicians, and all department supervisors, and patients. Based on the information obtained departmental goals and objectives for the PFCE program may be written.

In assessing the current situation as to patient care, all departments should explore:

1. Look at the Hospital/Clinic statement of departmental policies, philosophy, and goals for patient care. Can these goals be met without PFCE? Obtain documents from administration and/or department heads stating the Hospital/Clinic's expectations in these areas.
2. Examine the goals and objectives of the Hospital/Clinic's departments. Which departments have goals that relate to PFCE? Leadership and/or department heads may provide information and/or documentation in this area.

PATIENT/FAMILY CARE GIVER PROCESS

The following areas concerning patients/clients should be covered and analyzed within each department:

1. What are the most common diagnoses of patients that come to the Hospital/Clinic? Obtain this information from the computer operations department (Patient Care Component {PCC}), Contract Health Services department that handles Contract Health Services (CHS), and/or the medical records department. (This should be easily obtained from IHS data.)
2. If hospitalization is required, what is the average length of stay and age of patients with these diagnoses? (This should be easily obtained from IHS data)

The following areas on the patient care process should be examined in each department when developing the individual departmental questionnaire:

1. What information is collected during the patient screening process concerning past health history?
2. What part of this information could be helpful in determining the PFCE needs?
3. Who determines patient care goals?
4. How are the goals revised? Interviewing or requesting completion of questionnaires by the providers of patient care units will be helpful.
5. What information is included in your discharge summary?
6. If your Hospital/Clinic has developed standard care plans, what are their PFCE components?
7. What staff is included in your process of chart audits? Define their roles. Interviewing the members of the audit workgroup will be valuable in the completion of the audit process.
8. How are the populations for development of criteria for chart audits determined?
9. Is PFCE criteria part of the audit?
10. In your completed chart audits, was the PFCE standard met?

The following areas of resources should be examined:

1. What media and materials are currently being used for PFCE? Has the readability level been assessed? Where are they housed? If some of the materials are purchased, where do the funds come from?
2. What media equipment does the hospital own? Could it be used for PFCE? Does the staff know how to use the equipment? Appropriate managers will be able to supply this information.
3. Are funds budgeted for PFCE, staff education, and/or public relations? Leadership should be able to cover this area.
4. What Tribal and local health agencies provide resources, which are available to the Hospital/Clinic?
5. What PFCE activities are performed by private physicians and their office (and/or the Hospital where patients are referred) when they receive a referral from the I/T/U Hospital/Clinic?

The information gathered should be organized so that long-range and short-range goals can be determined. Based on the findings thus far, the following questions should be answered:

1. Which PFCE needs are presently being met?
2. Which PFCE needs are not being met?
3. What are the priorities among the needs determined in the assessments?
4. What groups of patients should be first to have education programs?
5. What members of the staff are particularly interested in PFCE education?
6. Does the Hospital/Clinic have their full complement of staff?
7. Who is responsible/accountable for PFCE?
8. Is the staff aware of the need for confidentiality in PFCE?

Departmental Assessment of Current Patient/Family Care Giver Activities

The Supplement contains examples of Questionnaires that should be completed by each Hospital/Clinic department. These Questionnaires are suggested examples. Each Hospital/Clinic may wish to develop their own Questionnaires.

Purpose Of Interview with Each Department Head

The purpose of an interview about Patient Education with each Department Head is two-fold:

1. To assess current PFCE activities in all departments of any Hospital/Clinic.
2. To help determine future directions for PFCE activities at any Hospital/Clinic.

Interview or use questionnaires of departments to find out what the staff defines as PFCE activities currently being implemented and any changes they would like to see. This could also be accomplished during meetings of department heads, managers, and Hospital/Clinic groups such as the staff nurse meeting. Request what new PFCE programs the Coordinator or members of the committee would like to see implemented.

All employees should answer the Questionnaire concerning confidentiality.

Obtain information, as to: when, by whom and in what form information is being provided to patients as they receive services at the Hospital/Clinic.

Also, ask what information is being asked during the Patient Registration process concerning such issues as third-party insurance, Medicare and Medicaid, alternate resources.

Complete information should be obtained as to what staff has contact with patients during clinic visits, hospital admissions or referrals to outside providers.

Each Department Head might administer two Surveys to staff:

- Sample Survey on "Confidentiality" located in Supplemental Section
- Sample Survey on "Future Directions for PFCE"

SUBJECT: IN-SERVICE TRAINING OF STAFF
Preparing the Staff to Teach

PFCE can and should be provided by any number of health staff -- no one should be excluded from providing this service whether it is the physician or the CHR. Decisions about who will be required to do the teaching to the staff depend on the mission, philosophy, goals and objectives of the facility. Developing policies and procedures concerning PFCE will assist in the coordination of PFCE. For example, the Health Educator can teach a newly diagnosed hypertension patient the basic education concerning high blood pressure. The pharmacist can teach the patient about any effects of the high blood pressure medicine, the dietitian can teach about its relationship to diet, and the CHR or Community/Public Health Nurse can follow-up on the patient's progress at home.

All staff can be helpful patient educators when:

- they know exactly what they are to teach
- they are limited to instructional activities rather than *random counseling;*
- as Patient Family, and Caregiver Educators, they are carefully prepared, supervised and guided by established policies and procedures.

Those staff members directly involved in teaching activities need to have a clear understanding of what is expected of them. They should be adequately prepared to do the job and must be evaluated on their performance. Providing patients with planned learning opportunities requires skill that most health professionals do not possess. Personnel that do the actual teaching need an effective orientation to the PFCE system in your facility and preparation in how to implement it. They also need to know how to use any related resources available to them.

The process used to prepare teaching staff is basically the same as that used in educating patients. Writing a staff development teaching module for a target group of personnel responsible for doing the actual teaching is an excellent foundation upon which to build the staff development program you will need.

The educational goals and learning objectives for a sample staff development program are listed below. The content, teaching strategies and evaluation methods can be listed in a teaching plan for the staff target group selected. Special classes, small group discussions, slide/video in-service programs, and "on-the-job" observations are some teaching methods that can be used in implementing the staff development teaching module. The program needs to be repeated on a regular basis for orientation of new staff and reorientation of "old" staff who need to renew their skills.

Example: Educational goals and learning objectives for a Staff Development Module for PFCE teaching staff.

Items with an asterisk (**) are learning objectives that must be fulfilled as minimal preparation for the staff member to become a PFCE teacher. The remaining objectives provide knowledge and skills that improve their ability and increase their effectiveness.

GOAL 1: The staff will be familiar with the PFCE system used by this facility.

At the end of this unit, the staff will be able to:
- discuss the mission, philosophy, and purpose of PFCE in this facility
- recognize the goals and objectives of PFCE in this facility

** • describe the PFCE system used in this facility
- describe the purpose of a PFCE Lesson Plan

** • list the major components of a PFCE Lesson Plan

GOAL 2: The staff will be familiar with the basic principles of education.

GOAL 3: The staff will understand the education process used in teaching patients and their families.

At the end of this unit, the staff will be able to:

** • assess patient's learning needs
** • implement teaching methods appropriate to the patient's learning needs
** • evaluate what the patient has learned
** • document the educational event

The following questions should be answered concerning the In-Service PFCE training of Staff

1. Who will do the training and what are the credentials of the instructor?
2. How can In-Service PFCE training for personnel are combined with the schedule of the staff?
3. How will you consistently document and track all In-Service training for staff?

The health care institution should include health education functions in their description of appropriate staff positions and should ensure that the staff filling these positions is prepared to carry out their health education function.

Development of PFCE skills should be an integral part of staff orientation and continuing education.

1) Documentation: Administration will determine who will maintain, and where, a Master File documenting all hospital/community/clinic-based educational activities will be kept according to specific educational activity, department and individual attendance. After the educational activity has been completed, the department/service sponsoring the activity will submit this documentation to the Master File with a copy to the employee. Each department/service sponsoring the educational activity will also maintain on file documentation of need assessment, objectives, evaluation and attendance. In addition to their signature, all staff should use a unique identification number when signing for CEU/CME's such as a Social Security Number.
2) The tracking of all training, all In-Service attended, copies of certificates and/or Continuing Education Units and Continuing Medical Education obtained and copies of renewal of licenses or certification should be aggregated into the one central file, the Master File.
3) All persons who come into contact with the patient population should take part in staff training sessions – this includes everyone from housekeeping to the physician.
4) Evaluation: The general purpose of evaluation is to determine the value of the education provided to the learner. Evaluation of in-house educational activities may be completed on a variety of dimensions but will be in part, based on learner objectives.
5) Scheduling: All in-house educational activities will be scheduled through Administration and the specific department/service that is sponsoring the educational activity. Each department is requested to submit a monthly schedule of educational activities to management and administration. A calendar/schedule of departmental activities will be distributed each month.

If the PFCE program is to be for persons with a specific disease, the staff should be educated about etiology of the disease as well as the therapy used and reasons behind its use. Education of the patient, family and/or caregiver should be presented as part of enabling the patient to understand his or her disease and to carry out his or her therapy.

Most medical/clinical staff will probably not be familiar with the principles of education. Some staff may have never had to develop goals and objectives. And although some staff may have participated in the development of goals and objectives, they have probably never written a lesson plan that precisely defines learner objectives. Many staff will find the process of evaluation difficult. Only through In-Service training will some of these staff find assistance.

Example

DOCUMENTATION OF HOSPITAL/CLINIC/COMMUNITY-BASED EDUCATION ACTIVITIES

DEPARTMENT/DISCIPLINE _____

MANDATORY TRAINING YES NO MEETING PLACE _____

TITLE OF PRESENTATION: _____

DATE OF PRESENTATI0N: _____ TIME: _____ TO: _____

UNDERLINE: MULTIPLE TIMES PRESENTATION OR SINGLE PRESENTATION?

PRESENTER NAME _____

PRESENTER'S TITLE/SSN#:(and signature)_____

IS THIS PRESENTATION A RESULT OF ANY OF THE FOLLOWING: (Please Specify by underlining.) Hospital/Clinic Data or Adverse Outcome Data, Morbidity & Mortality Statistics, Audit or Peer Review Data, Health Records Statistics, Pharmacy, Patient Education, QA, TQM, Infection Control, Safety, Annual Mandatory Training, Other: _____

THE PURPOSE OF THIS PRESENTATION IS:
_____ New Medical/Pharmacy/Nursing Knowledge
_____ Patient, Family or Caregiver Education needs
_____ Continuing Education
_____ Consultant or Expert Presentation
_____ Presented as a result of evaluations of prior Educational Activities
_____ In response to a Questionnaire/Survey of Target Audience
_____ New Products or Services Available
_____ IHS/Area/Clinic Emphasis Plan
_____ Other: _____

At the completion of this presentation, participants should be able to:
_____
_____

TESTING: Was a Test Administered to Participants? ____YES ____ NO

Number of Continuing Education Units or Continuing Medical Education obtained. _____

EVALUATION: _____ Objectives Met _____ Objectives Not Met

(On the back of this form there should be space for the following information)

STAFF Printed Name:	SSN#	Signature	Test Score (If Applicable)

FUTURE DIRECTIONS FOR PATIENT and FAMILY CARE GIVER EDUCATION QUESTIONNAIRE

The following questionnaire should be completed by all members of the staff as to the future directions for PFCE:

1. In what direction would you like to see patient education proceed here at the Hospital, Community, and Clinic? (If not sufficient space, continue writing your answer on the back of this page.)

2. What specific projects in the area of PFCE would you like to see your department work on in the future? (List in order of priority. Continue on the back of this page if you need additional space.)

3. YES NO DON'T KNOW The requirement of providing PFCE should be in all Positions Descriptions.

4. YES NO DON'T KNOW Should we have a PFCE Task Force Team at this Hospital/Clinic?

If so, what would its purpose be? Who should be on such a Team?

_____

_____

6. Who should be responsible/accountable for PFCE?

_____

_____

7. In your opinion what groups of patients should be first to have PFCE education programs? (Prioritize your answer. Use as much space as necessary on this page or on the back of this page.)

1st_____

2nd_____

3rd_____

4th_____

5th_____

6th_____

Step Four
Check List
Implementation

___ Most common diagnoses of patients determined

___ Average length of stay and age of patients with these diagnoses?

___ Information is collected during the patient screening process concerning past health history?

___ It has been determined what part of this information could be helpful concerning PFCE needs.

___ Patient care goals determined.

___ Are goals revised.

___ Relevant information is included in discharge summary

___ Standard care plans include PFCE components

___ Staff is included in chart audits

___ Populations for development of criteria for chart audits are determined

___ PFCE criteria is part of the audit

___ In chart audits, the PFCE standard are met

___ Media and materials currently being used for PFCRE were examined.

___ Media equipment is inventoried.

___ PFCE budget is developed.

___ It has been determined what Tribal and local health agencies are available to the Hospital/Clinic?

___ PFCE activities performed by private physicians and their office (and/or the Hospital where patients are referred) are scrutinized.

Departmental Manuals

___ PFCE needs currently being met

___ PFCE needs are not being met

___ Priorities among the needs determined in the assessments are analyzed.

___ It has been determined which groups of patients should be first to have PFCE programs

___ Hospital/Clinic has their full complement of staff

___ Who is responsible/accountable for PFCE

___ Staff is aware of the need for confidentiality in PFCE

___ Task Force/Team and/or departments or supervisors have administered the survey: *"Future Directions for Patient Education"*

___ The staff is familiar with the PFCE system used by this facility.
- ___ Discuss the mission, philosophy, and purpose of PFCE in this facility;
- ___ Recognize the goals and objectives of PFCE in this facility
- ___ Describe the PFCE system used in this facility
- ___ Describe the purpose of a PFCE Lesson Plan
- ___ List the major components of a PFCE Lesson Plan

___ Staff know exactly what they are to teach.

___ Staff are limited to instructional activities rather than random counseling

___ As patient educators, they are carefully prepared, supervised and guided by established policies and procedures.

___ Facility has established policies and procedures for Hospital/Clinic based (in-house) PFCE

___ Staff attended In-Service training specific to developing lesson plans:
- ___ Assess patient's learning needs
- ___ Write a teaching plan for individual patients
- ___ How to develop goals and objectives
- ___ Implement teaching methods appropriate to learning objectives, related content and the patient's situation
- ___ Evaluate what the patient has learned
- ___ Document the educational event

___ Teaching or lesson plans are centered on the most common diagnoses

___ Teaching or Lessons plan format is compatible with all the plans in the facility as to type of format form and content.

___ Teaching or Lessons Plans include:

- ___ The Learner
- ___ Goals
- ___ Measurable Objectives
- ___ A teaching plan
- ___ Evaluation
- ___ Documentation
- ___ A Support Package
- ___ How to determine and develop a Resource Support Packet

___ Staff is familiar with the basic principles of education.

___ In-Service patient Education training for personnel has been incorporated with the schedule of the staff

___ All In-Service training for staff is documented.

___ A form that is acceptable to all disciplines has been developed to document In-Service Education provided by this facility.

STEP FIVE

EVALUATION

(TQM)

SUBJECT: EVALUATING PATIENT EDUCATION
TOTAL QUALITY MANAGEMENT - TQM

STEP FIVE

Before a tribal clinic or hospital can implement Total Quality Management (TQM) as it relates to patient education, there must be a commitment to the program by all staff. This involves an unending, intense focus on patients' needs, wants, expectation, and requirements, and a commitment to satisfying them. A successful TQM program requires a commitment from administration, management, nurses, physicians, and all other staff involved in the delivery of care to the patient. Quality health care delivery begins when the patient enters the facility.

Total Quality Management in patient education will require a continuous evaluation of the processes involved in the delivery of educational programs. The focus then, will be on process improvement dependent on a multi-disciplinary team approach to the delivery of patient education. The patient will be viewed as an active partner in the educational process with a staff focus on influencing his or her behavior to produce changes in knowledge, attitudes, and skills required to maintain or improve health status.

TQM means making constant ongoing improvements in processes and performance to achieve better results consistently and facilitate:

a. quality patient care delivery with an emphasis on education, supporting efforts toward being the provider of choice

b. improved financial strength through the identification of process problems in the delivery of educational programs; and provide

c. an environment which is supportive of staff and enhances morale through involvement in the development and delivery of quality services

In order to implement a TQM program focused on patient education services, a starting point is to clearly understand and make a commitment to quality guided by the state of the philosophy of the tribal clinic or hospital. Further, a statement should be developed addressing the purpose of patient education, which will direct activities toward developing specific goals and objectives for prioritized educational offerings.

Quality Management of Patient Education

To assess quality effectively in the patient education process, failures in the delivery of the service are usually related to process problems or how the programs are developed and implemented. In order for the educator to participate in process analysis of patient education services, key components need to be divided into distinct task, which allow the educator to:

1. Link major educational program components
2. Detect weak areas in the service delivery and
3. Determine ways to strengthen the process of patient education

Steps in Process Analysis of Patient Education

Four key steps are involved in the process analysis of patient education programs.

Step #1 - Development of a Standard of Care for the Education Offering

This will define the minimum level of education to be provided, and establish a basis of comparison for measuring quality and value to the patient. From this standard, an individualized approach to patient education can be developed based on wants and needs of the particular patient and/or family.

Step #2 - Development of Specific Goals and Objectives for the Education Program

These will be developed and assessed on a continuous basis for those directly involved in the patient education process. Goals and objectives should be based on a thorough assessment of patient needs, wants, and preferences. Further, goals and objectives may be outlined for the patient, family, physician, and nurse who participate in a team approach to incorporating education into health care delivery.

Step #3 - Assess Implementation of the Program Including Program Scope

Identify the key individuals whom are involved in the patient education process. Assess the time involved in delivery of the program to meet specified goals and objectives. Develop a listing of resources used to implement the educational program. In order to assess cost of poor quality, look for areas of duplication and waste that may be addressed to prevent unnecessary expense, and support financial strength.

Step #4 - Develop Evaluation/Outcome Criteria

These will include criteria for measuring and evaluating outcomes for specified goals and objectives. Both objective (quantitative data) and subjective (Quantitative and qualitative data) can be obtained through tools developed to measure specific outcomes. The key is to assess the relationships between patient education intervention and progress toward meeting specified goals as outcomes.

Assessment of the quality of the processes used in the patient education functions can be done by looking at process problems. It is important to remember that quality improvement occurs at the lowest task level. The educator needs to ask questions about whether the right processes are in place.

It is recommended that a quality improvement team be developed for identifying, diagnosing, and solving problems in the patient education process. This team should be multidisciplinary and contribute to the development of statistical tools for measuring patient education outcomes.

All Staff should complete this TQM Survey - **Sample TQM Survey for All Departments**

SUBJECT:	Evaluating Patient Education Total Quality Management - TQM

For additional space please use the back of this page.

1. List current developed educational programs in the tribal clinic or hospital in which you are employed;

2. Who is involved in the patient education process?
(Check all those that apply)

____ Physician _____ Nutritionist

____ Nurse _____ Ancillary staff

____ Patient care Coordinator _____ Other; Please list:

3. List current methods for measuring outcomes;

4. Describe weaknesses as you see them in the patient education processes currently in place;

5. List strengths as you see them that the health care team can expand upon in the current educational processes being implemented.

6. What types of health professionals are available to your facility to serve on a multidisciplinary quality improvement team? (Check those that applies)

____ Physician _____ Health Educator

____ Nurse _____ Social Worker

____ Nutritionist _____ Public Health Nurse

____ Patient Care Coordinator _____ Other: Please list;

7. Are you using any specific instruments now for the assessment of outcomes related to patient education implementation?

YES NO

8. Which of the following are key components of total quality approach to patient education? (Check those that applies)

____ A focus on patient needs, wants and preferences
____ Specific attention to physician goals and objectives
____ Multidisciplinary approach to delivery of services
____ Focus on process improvement
____ Continuous assessment and evaluation of outcomes
____ Short-term problem solving
____ Ongoing improvement efforts for educational offerings

9. Do you feel you hold an adequate understanding of the concept of total quality management for implementation of a program to monitor outcomes?

10. If no, what would help you to develop a TQM approach for your educational programs?

STEP FIVE
CHECK LIST
EVALUATION

___ Staff has developed a Standard of Care for the Education Offering

- ___ Staff has defined the minimum level of education to be provided.
- ___ Staff has establish a basis of comparison for measuring quality and value to the patient.
- ___ Staff has developed an individualized approach to patient education based on wants and needs of the particular patient and/or family.

___ Staff has developed specific goals and objectives for the Education Program

- ___ Goals and objectives are assessed on a continuous basis.
- ___ Goals and objectives are based on a thorough assessment of patient needs wants, and preferences.
- ___ Goals and objectives are outlined for the patient, family, physician, and nurse who participate in a team approach to incorporating education into health care delivery.

___ Assessed implementation of the Program includes Program Scope

- ___ Key individuals are identified and involved in the patient education process.
- ___ The time involved has been assessed in delivery of the program to meet specified goals and objectives.
- ___ Staff has developed a listing of resources used to implement the educational program.
- ___ Staff has looked for areas of duplication and waste in order to assess the cost of poor quality.

___ Staff has developed Evaluation/Outcome Criteria

- ___ Staff has developed criteria for measuring and evaluating outcomes for specified goals and objectives.
- ___ Tools have been developed to measure specific outcomes
  - ___ Objective (quantitative data)
  - ___ Subjective (Quantitative and qualitative data)

___ Staff supports the concept of quality patient care delivery with an emphasis on education and supporting efforts toward being the provider of choice

___ Staff will improve financial strength through the identification of process problems in the delivery of educational programs.

___ Administration will facilitate an environment, which is supportive of staff and enhances morale through involvement in the development and delivery of quality services

Quality Management of Patient Education

___ In order for the educator to participate in process analysis of patient education services, key components are divided into distinct tasks, which allow the educator to:

- ___ Link major educational program components
- ___ Detect weak areas in the service delivery
- ___ Determine ways to strengthen the process of patient education

STEP SIX

Documentation and Coding

Step Six
Documentation and Coding

Patient Care Component (PCC) of the
Resource and Patient Management System (RPMS)

The Resource and Patient Management System (RPMS) of the Indian Health Service is an integrated group of automated data systems designed to operate on micro- and mini-computers located in any IHS or Tribal health facility. The primary objective of the RPMS is to integrate patient care and cost data in a single automated data processing system that collects and stores a core set of health and management data that cuts across disciplines and facilities. A typical RPMS configuration in a health facility might include these systems: Patient Registration, Pharmacy, Dental, Maternal and Child Health, Contract Health Services, Laboratory and the Patient Care Component.

The Patient Care Component (PCC) provides for the collection, integration, and storage, on local RPMS computers, of a broad range of health data resulting from inpatient, outpatient, and field visits at IHS, tribal, contract and community sites. It is designed to support health care delivery, planning, management, and research.

Purpose Of Effective Patient Education Documentation
There are two main reasons why documentation needs to be done. The first is to meet complex legal requirements, and the second is to meet the standards of the JCAHO and other accrediting organizations. In addition, effective documentation provides a meaningful way for the team members to communicate with each other, thereby enhancing the team's patient education efforts and collaboration.

The basis for patient education documentation encompasses professional practice acts, standards of practice from professional associations, institutional policies; informed consent, quality and continuity of care issues, and program evaluation considerations.

In today's era of health care, simply having provided the education is not sufficient. In order to get credit for education and certainly to better meet the requirements for possible reimbursement for PFCE, it is necessary that patient and family education be properly documented and coded. However, better patient and family education translates to support for prevention and wellness of the patient and their family.

Each Indian Health Service Hospital, clinic and community health programs are encouraged to build a health and PFCE program using the documentation from the Indian Health Service's *Patient Education Protocols*. Where can the Indian Health Service's *Patient Education Protocols* (and Codes) be found? There are no printed copies available. Due to the prohibitive cost of printing for 500+ Native American and Alaskan Native Hospitals, Clinics, and Community Health programs, these protocols and codes can be found and downloaded from the Indian Health Service's Web Page on the Internet.

Professional Practice Acts
Virtually all health care care providers have language in their professional practice acts that set a legal precedent for them to render adequate and relevant patient education. *Health care providers can be held liable for negligence if a patient does not understand what is necessary for effective management of his or her health condition.* This liability challenges health care professionals to develop accurate and reliable methods to evaluate a patient's understanding and to document their educational efforts.

Standards of Practice from Professional Associations
Standards of practice delineated by the various professional associations often outline the responsibilities of a particular professional group to teach the patient and family information about their specific health care needs and how to appropriately modify behavior. Again, implicit in providing information to help patients make decisions and choices about promoting, maintaining, and restoring health is documentation of these educational efforts and their results. If patient education is not documented, it is considered not done. These statements and standards for practice from professional organizations provide a basis upon which the professional will be held accountable should there be a question of practice in a court of law.

Institutional Policies
Most clinics and all hospitals have policies and procedures or standards within the various departments that guide health care providers in delivering care. Often these standards and policies include the professionals' role and responsibilities in providing patient education and documenting the process. These documents are important to discuss with staff to help change the mind-set, so that patient education documentation is seen as an expectation of performance and, therefore, is more likely to valued.

Informed Consent
Informed consent is the legal duty of disclosure and is primarily a liability issue for physicians. It is based on the principle of self-determination. That is, self-determination is a person's right to decide what should be done to his or her body. It occurs when an individual voluntarily agrees to allow someone else to do something to him or her after information is received. For the individual to exercise this right to decide, appropriate information must be provided about the kind and purpose of the treatment or procedure and its expected outcomes; the benefits and risks or complications of the procedure; any alternatives and their risks and benefits; and the prognosis if treatment is refused. As part of this education process, the physician must determine the patient's ability to understand the explanation.

Involvement of staff, other than the physician, in the informed-consent process includes the following three elements:

INFORMED CONSENT

1. Observing the interaction between the physicians and the patient, thereby witnessing the signatures.
2. Validating that the patient had the capacity to understand and was not coerced to consent.
3. Assessing the patient's understanding and clarifying any misunderstandings.

To validate understanding of the information, staff need to ask the patient to explain in his or her own words what the physician said. If there seems to be a basic misunderstanding about diagnosis or treatment and prognosis, the physicians should be asked to explain all the information once more. Staff should document the results of this process and any actions taken.

Quality of Care Issues - Chart Audits
A foremost method used to monitor the quality of care provided in Tribal clinics and by the IHS is to audit patient charts and patient medical records. Audits of records to identify patient education documentation have shown major deficiencies in the medical records of many clinics and hospitals. *Accrediting agencies list lack of documentation about education for self-care and preparation for discharge as the most common charting deficiencies.* Chart audits help define strengths and weaknesses in all patient education efforts, not only the problems of documentation.

Continuity of Care Issues
Effective documentation provides direction for all interdisciplinary team members so that there is continuity and consistency in their patient education efforts. To achieve this goal, documentation records need to be interdisciplinary in scope. Separate care plan documentation sheets for each discipline can no longer be afforded if continuity of care is achieved. A patient education documentation system must also be developed to communicate the relevant information in an understandable way to those persons responsible for the patient's care after discharge.

Program Evaluation Considerations
Aspects of the patient education process can be studied by using the documentation to help define actual practice against standard criteria. For example, physicians may want to know what assessment data are being collected by nurses to identify a knowledge deficit or what methods are being used by staff to evaluate patient response to teaching. The answers to such questions as these can often be determined by auditing the medical record. Results from this process can be used to help formulate changes in a patient education program and the way it is implemented.

JCAHO and Other Accreditation Standards Addressing Patient/Family Education Documentation
Hospitals: The goal of patient and family* education function is to improve patient health outcomes by promoting healthy behavior and involving the patient in care and care decisions. While the standards in the JCAHO Standards of Patient and Family Education recommend a systematic approach to education, they do not require any specific

structure, such as an education department, a PFCE committee, or the employment of an educator. More important is a philosophy that views the education function as an interactive one in which both parties are learners. These standards help the hospital or clinic focus on how education is consistent with the patient's plan of care, level of care, the educational setting, and continuity of care. The overall focus is on the instructions given for self-care and the patient's understanding of these instructions at discharge. The standards state that specific knowledge and/or skills must be provided to meet the patient's ongoing health care needs including teaching safe and effective use of medication and medical equipment, potential drug-food interactions, diet counseling, rehabilitation techniques, community resources and when and how to obtain further treatment, if needed.

* Family: The person(s) who plays a significant role in the individual's life. This may include a person(s) not legally related to the individual. This person(s) is often referred to as a surrogate decision-maker if authorized to make care decisions for an individual should the individual lose decision-making capacity.

Documenting Patient Education as Reflected in JCAHO Standards:

1. Relevant and Adequate Information for Self-Care

Evidence in the medical record needs to indicate that the patient's education needs pertaining to self-care are assessed, identified, and addressed. Relevant and adequate information for self-care includes the following elements:

- Explanation of the condition
- What to do to manage the condition and how to do it
- When the physician should be consulted
- When the treatment regimen should be discontinued
- Special precautions to take
- What to do when the regimen is not followed
- What to do if new symptoms occur
- How to get clarification of instructions

2. How the Teaching was Done

Standard PF.1.1 states that the educational received is given "in ways understandable to the patient and/or his or her significant other." This suggests that how the teaching is done is an important factor. It is not sufficient to simply hand out instructional material or have patients watch audiovisual aids as the sole method of teaching. Evidence needs to be documented that learning differences among patients were considered when giving patient education information. Use of the word *taught* does not enable staff who read the patient's medical record to adequately follow-up using an appropriate teaching method. Words such *explained, discussed, read, demonstrated, reviewed, practice* and *problem-solved* more accurately describe how the teaching was done. Health care professionals must be available to answer questions the patient may have and to give needed explanations.

3. Evaluation of Learning

Even if the information given is relevant and communicated well, the patient's understanding and ability to apply the information for effective self-care needs to be documented. Specific measurable evidence of learning outcomes or the attempted evaluation of learning must be documented. Examples of terms used to indicate measurable, behavioral outcomes includes s*tates, identifies, applies, independently performs, chooses, verbalizes,* and *returns demonstration*. If the patient is unable to answer question or perform a skill, a statement that there was no evidence of learning and a proposed reason as to why needs to be written.

4. Characteristics of Educational Process

Throughout the standards, the identification of specific learning needs is stressed. Measurable goals or expected outcomes, stated in behavioral terms, are formulated from this assessment. The educational plan needs to be individualized, and reflect patient and family involvement in the development and implementation of the plan.

Use and Documentation of Patient Education Codes. Using the PCC. 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 realities of our busy clinics and hospitals often require us to do this in a more abbreviated fashion. The codes allow the educator a quick method of documenting the fact 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 has had a certain amount of education. 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 on a diabetic patient might show the following history of patient education:

07/19/90:	DM: Diet, poor understanding
10/27/90:	DM: Foot Care, good understanding
02/07/91:	DM: Exercise, good understanding
05/10/91:	DM; Diet, Fair understanding

A reasonable interpretation of this summary tells you that this patient is trying to understand dietary management of their diabetes but does not yet fully grasp the concepts. It should lead subsequent providers to spend more time reinforcing dietary guidelines.

SOAP Charting and the Codes

Use of the codes *does not* preclude 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 education 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 does 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 educator should document the education using the following steps:

Step 1. Log onto the PCC form using the sign-in box in the upper right-hand corner. Circle "Patient Education" in the section marked "Medications/Treatments/Procedures/Patient Education" (Some sites prefer to use the POV section of the PCC Form.)

Step 2. Relevant and Adequate Information for Self-Care:

- Using the four parameters of documentation, select the most appropriate code and enter it, e.g., DM-C (Diabetes-Complications), followed by a comma (,). If you discuss more than one topic, separate each of the topic codes with a comma. In do so you will have documented correctly by writing down the disease state, condition or system being addressed; (DM, HTN, etc.)

Step 3. Document by using the specific education topic. (Exercise, diet, complications, etc.)

Step 4. Evaluation: Document the level of understanding of the patient and/or their family of the education provided; (Good (G), Fair (F), Poor (P), Refused (R), or Group Education (G). Specific measurable evidence of learning outcomes or the attempted evaluation of learning must be documented. Examples of terms used to indicate measurable, behavioral outcomes includes *states, identifies, applies, independently performs, chooses, verbalizes,* and *returns demonstration.* If the patient is unable to answer question or perform a skill, a statement that there was no evidence of learning and a proposed reason as to why needs to be written.

- Initial your entry.

It is *very important to remember* that the level of understanding does not reflect how well you taught the information. Rather, it indicates how well *you believe* the patient understood it. Obviously, this will vary with patients and with circumstances.

The PCC coders can only select "good, fair, or poor" for level of understanding. Remember, this section is meant for speedy documentation of brief education 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.

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 demonstration of understanding 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 demonstration

Refuse (R): Refuses education

Group (GP): Education provided in a group.

Documenting Patient Education Using General Codes and Specific Codes

There are two methods for documenting PFCE using PCC PFCE codes. Providers are encouraged to select the method of documentation that best meets their time and needs while ensuring that the education is adequately documented. This documentation may be using the General Codes or the Specific Codes. The first method, or the General Coding method, has the advantage of being quick and easy, but it is not as specific and does not provide as much information as the second, Specific Codes.

General Codes:

- 17 topic areas, which are applicable to most disease states or condition which, will be encountered in a health care setting.
- In order for these general codes to be captured by the computer, the first element must be associated with or used in conjunction with a valid ICD-9 diagnosis
- General Codes:

1.	AP	Anatomy and Physiology	9.	M	Medication
2.	C	Complications	10.	N	Nutrition
3.	DP	Disease Process	11.	P	Prevention
4.	EQ	Equipment	12.	PRO	Procedures
5.	EX	Exercise	13.	S	Safety
6.	FU	Follow-up	14.	TE	Testing
7.	HM	Home Management	15.	TX	Treatment
8.	HY	Hygiene	16.	L	Literature

- General Code Documentation:
  1st Part = diagnosis (written out)
  2nd Part = education topic
  3rd Part = level of understanding
  4th Part = Provider initials

Specific Codes:

- The Specific Codes are found in the Indian Health Service *Patient Education Protocols.*
- No fixed number of codes
- Can cover any topic for which protocols are written
- General Code Documentation:
  1st Part = Disease state, condition or system being addressed
  2nd Part = education topic
  3rd Part = level of understanding
  4th Part = Provider initials

Why bother to learn anything more than the general codes if the provider can use the general codes for everything? The Specific Codes are found in the *Patient Education Protocols* and these Specific Codes contain more information available through the protocols, which were written specifically for that subject. Also some topics do not have an

associated ICD-9 diagnosis and cannot be recorded with general codes; e.g. nutrition or wellness. If the education encounter is consistently entered into the patient's Health Summary, the education improves both from provider to provider and from one visit to another. Furthermore, this method of documentation meets JCAHO requirements for documentation of patient and family education.

What Happens to this Information?

Providers enter the codes on the PCC at the time of the education encounter. Data Entry inputs the codes on RPMS. This translates as an entry on the PCC Health Summary. Using Q-Man, data can be retrieved for performance improvement, JCAHO Surveys, ORYX Indicators or any other purpose. Since the codes are entered by providers at the time of the patient visit, data retrieved should be an accurate reflection of the education happening at a given facility.

STEP 6
CHECK LIST
DOCUMENTATION AND CODING

___ All staff providing PFCE have received information concerning the legal requirements concerning Patient Education Documentation:
____ Professional Practice Acts
____ Standards of Practice from Professional Associations
____ Institutional Policies

___ All staff providing PFCE have received information concerning the accreditation requirements concerning Patient Education Documentation

___ Staff has received education on Informed Consent

___ Staff has participated in patient education chart audits to help define strengths and weaknesses in all patient education efforts, including documentation.

___ Continuity of Care Issues are resolved through care plans that involve each discipline to communicate the relevant information in an understandable way to those persons responsible for the patient's care after discharge.

___ Aspects of the patient education process have been studied by using the documentation of patient education to help define actual practice against standard criteria.

JCAHO and Other Accreditation Standards Addressing Patient/Family Education Documentation

___ Evidence in the medical record indicates that the patient's education needs pertaining to self-care are assessed, identified, and addressed. Relevant and adequate information for self-care includes the following elements:
- ___ Explanation of the condition
- ___ What to do to manage the condition and how to do it
- ___ When the physician should be consulted
- ___ When the treatment regimen should be discontinued
- ___ Special precautions to take
- ___ What to do when the regimen is not followed
___ What to do if new symptoms occur
- ___ How to get clarification of instructions

___ How the teaching was completed is evidenced by the documentation that learning differences among patients were considered when giving patient education information

___ The evaluation of learning, or the attempted evaluation of learning, is documented through specific measurable evidence of learning .

___ Measurable goals or expected outcomes, stated in behavioral terms, are formulated from the facilities' accepted assessment method.

___ Educational plan and the patient's needs are individualized, and reflect patient and family involvement in the development and implementation of the plan.

___ In-Service Education has been provided that encompasses all aspects of accountability such as logging in correctly on the PCC, documenting correctly on the PCC, and initialing all patient education provided.

___ In-Service Education has been provided that encompasses all aspects of documentation such as the use of education protocols, codes, and evaluation.

___ In-Service Education on how to documenting Patient Education using the General Codes has been provided.

___ In-Service Education on how to documenting Patient Education using the Specific Codes has been provided.

STEP SEVEN

ORYX INDICATORS

ORYX Indicators and Health Education,
Patient and Family Education (PFE)

Dimensions of Performance

Performance has multiple dimensions that help to direct individual and team thinking about how to design, measure, assess and improve processes and outcomes. We can usually identify global process or system dysfunction with ease but have more difficulty conceptualizing specifically why processes or systems **may not be working.** What is consistently true across all the performance dimensions is that each is **definable, measurable** and **improvable.** Performance is **what** is done and **how** well it is done to provide health care.

The level of performance in health care is:

- The degree to which **what** is done is **efficacious** and **appropriate** for the individual patient; (Doing the right thing); and
- The degree to which it is **available** in a timely manner to patients, who need it, **effective, continuous** with other care and care providers, **safe, efficient**, and **caring and respectful** of the patient. (Doing the right thing **well**.)

In the past, JCAHO looked at all phases of the Hospital or Clinic but Health Education/Patient Education, was not an area of Review until a new JCAHO Standard, Patient and Family Education (PFE) was introduced in 1993. Since the introduction of that new PFE Standard the Indian Health Service's Health Education Program has been encouraging the active participation of the Health Education discipline with the Clinical disciplines. It is hoped that this partnership will assist IHS and Tribal Hospital and Clinics to work together to achieve higher JCAHO scores on PFE. The achievement of higher JCAHO scores is only one phase of good management and better health care. To prove that good management is occurring, statistical facts can reinforce good management practices. The statistical indicators of measurement for better patient education are proven through use of ORYX Indicators.

Health Educators, by training in education, should possess the expertise to assist the clinical disciplines to develop and offer better educational processes. Furthermore, Health Educators, in fact, all educators need to ensure that they receive credit for the community, group, or individual patient education they are conducting. They can only receive credit if they are documenting the Patient and Family protocols/codes on the PCC form. And only the documentation of patient and family education can prove that education is, in fact, taking place within the facility.

The JCAHO would like to see *spatulas and clinics without walls."* In other words, are your health services extending beyond the hospital/clinic and reaching the community at-large? Can all disciplines document the PFCE that is being provided in all healthcare settings, i.e., inpatient, outpatient, Community or Public Health Nursing, Community Health Education, Nutrition, Public Health Education, etc?

What is ORYX?

Moving into the computer information age, the JCAHO is looking at statistical Outcome Indicators for care. While JCAHO Surveyors can physically come on-site and look at programs, patient charts, etc., they now have asked all sites seeking JCAHO Accreditation to select some type of statistical Outcome Indicators system to provide to them factual, statistical numbers on patient care. Private companies and some hospitals have come up with their own method for statistical reporting for JCAHO. The Phoenix Area of the IHS developed a system for reporting statistical Outcome Indicators called ORYX. Each IHS Area had to make a decision to buy-into the ORYX System developed by the Phoenix Area or to purchase or participate in a different type of Outcome Indicator process. Some IHS Areas selected ORYX; other IHS Areas choose systems other than ORYX. Regardless of whether your site is participate in the IHS ORYX system or not, your site is using some type of Outcome Indicator system. IHS (and many Tribal Hospital and Clinics) continue to use the Patient Care Component (PCC). Even though your site may have chosen not to use the ORYX system, the information presented here continues to apply to your site by virtue of the fact that your site is probably using the PCC. The Outcome Indicators will help you obtain statistical data from the PCC.

ORYX meets the JCAHO requirements because ORYX is:

$ a Data Driven accreditation process
$ a Performance Measurement system
$ and is unique to the Indian Health Service because the data comes from the PCC

Measurement

Purpose:
Ongoing measurement
Intensive Measurement
Measurement to determine improvement

Priorities for Measurement:
Important functions (individual-focused and organizational)
High volume, high risk, problem prone and high cost
Functions/processes of special concern (to patients, staff, organization mission)

Types of Measures:
Process
Outcome
Satisfaction (Patients and other needs)
Staff views

Measuring Success of Performance Improvement
Denominator defines the large number of patients or events that you are looking at.
Numerator defines the smaller number or the specific patients or events you are measuring.

The Selection of five (5) Patient and Family Education ORYX Indicators
The Outcome Indicators selected for Patient and Family Education (PFE) needed to meet or were defined by the following criteria:

- **$** Are the Indicators measurable?
- **$** Are the Indicators retrievable?
- **$** Is the Indicators specific?
- **$** Indicators must be high volume, high-risk, problem-prone
- **$** If one element of the equation (numerators/denominators) falls out, the opportunity to improve cannot be identified which results in useless data
- **$** Inpatient and outpatient indicators have been separated for the same reason
- **$** ICD-9 codes must be available for the indicator
- **$** Taxonomies will need to be built according to drugs used at each facility
- **$** The Indicator selected must reach/affect 20% of the population at your Service Unit.

The five Outcome Indicators that were selected for Patient and Family Education (PFE) were selected because they met the above criteria *and* met:

- **$** either a JCAHO Standard,
- **$** a GPRA Objective,
- **$** clearly reflected a health problem/area where Health Educators were/should be working

Every Health Provider (physicians, nurses, nutritionists, pharmacists, CHR, physical therapists, health educators, Public health nurses, EVERYONE) should use the Patient and Family Education (PFE) Protocols and Codes.
If everyone will use the IHS Patient Education Protocols/Codes, it is hoped that comprehensive, multidisciplinary patient education will ensure that our clients are receiving the best care possible!

Draft* PATIENT AND FAMILY EDUCATION INDICATORS
TO MEET JCAHO ORYX REQUIREMENTS

INDICATOR #1: Tobacco
Number of Patients with Patient Education (PED) TO-Quit or TO-LA (1 Year)
Number of Patients with ICD-9 Code(s) of Health Factor (HF) Tobacco/Passive Smoker (1 Year)

Pts. With PED TO-QUIT or TO-LA (1 Year)
Pts. With ICD-9 Code(s) HF

INDICATOR #2: Diabetes
Number of Patient Education (PED) DM/DM2-Exercise (1 Year)
Number of Patients with ICD-9 Code(s) 250.00-250.93

# of Pts. With PED DM/DM2 - EX
# of Pts. With ICD-9 Code(s) 250.00-250.93

INDICATOR #3: Breast Self-Exam
Number of Patients with Patient Education (PED) Code Women Health (WH)-Breast Self-Exam(BSE) (2 Years)
Number of Women Patients with Clinical BSE (2 Years)

# of Pts With PED WH-BSE
# of Pts With BSE

INDICATOR #4: Breast Feeding
Number of Patients with Intrauterine Pregnancy AND Breast Feeding Patient Education Code
Number of Patients with ICD-9 Codes for Intrauterine Pregnancy or Post-Partum (6 Weeks)

# of Pts. IUP and BF PED
# of Pts. With ICD-9 Codes for IUP or Post Partum 6Wks

# of Pts. BF PED
# of Pts. With ICD-9 Codes for Post Partum 6Wks

INDICATOR # 5: Medications
Number of Patients with Medications (M) Patient Education (PED) Codes
Number of Patient who receive Medications

Pts with M-PED
Pts. Who receive Medications

* Draft: Subject to JCAHO approval and acceptance

STEP SEVEN
CHECK LIST
ORYX INDICATORS

The Outcome Indicators selected for Patient and Family Education (PFE) needed to meet or were defined by the following criteria:

___ Are the Indicators measurable?
___ Are the Indicators retrievable?
___ Are the Indicators specific?
___ Indicators must be high volume, high-risk, problem-prone
___ If one element of the equation (numerators/denominators) falls out, the opportunity to improve cannot be identified which results in useless data
___ Inpatient and outpatient indicators have been separated for the same reason
___ ICD-9 codes must be available for the indicator
___ Taxonomies will need to be built according to drugs used at each facility
___ The Indicator selected must reach/affect 20% of the population at your Service Unit.

STEP EIGHT

SUPPLEMENTAL SECTION

Sample Survey for All Departments

Subject: Confidentiality
The Privacy Act

1.	YES NO	Can you keep records of patients that they don't know about?
2.	YES NO	Patients have a right to know what information is being kept about them.
3.	YES NO	Patients have a right to know how the information that is being kept about them is being used.
4.	YES NO	Patients have a right to access the information about them that has been collected.
5.	YES NO	Patients have a right to correct or amend factual inaccuracies in their records.
6.	YES NO	Patient information generally may be disclosed without the patients' authorization for purposes other than for which it was collected.
7.	YES NO	Patient's relatives, friends, and government leaders are implicitly authorized to access patient information because of their beneficial relationship.
8.	YES NO	Parents can access their minor children's health records if the parents consent to the care.

Sample Survey for Individual Departments

SUBJECT: CONTRACT HEALTH OR BUSINESS DEPARTMENT QUESTIONS

If you need additional space, please use the back of this paper.

ADMISSIONS

1. What information is currently being given to patients before they are sent out for contract health care or before they enter the hospital? When, by whom and in what format is this information being given?

2. What staff members have contact with the patient during admission that might present relevant patient education?

3. Do you see a role for admissions in the patient education process? What problems would you anticipate?

4. Patients should receive instructions about any follow-up care needed and how to obtain that care through Contract Health. What is the process for follow-up referrals to outside Providers and/or Special Clinics?

Sample Survey for Individual Departments

SUBJECT: NURSING QUESTIONS:	**Community/Public Health Nursing**
InPatient Outpatient Nursing	
	LPN's, CNA

1. Where do you provide nursing services? Indicate those that apply:
   ___ Inpatient ___ Public/Community Health Nursing
   ___ Outpatient ___ Other

2. YES NO Does your nursing program provide individual patient education?

3. YES NO Do you have written specific guidelines and/or curriculum for nursing staff to use during individual patient education activities?

4. Which nursing staff members provide individual patient education? Circle those that apply:

   Nurse Educator RN
   Nurse Supervisor LPN
   Public/Community Health Nurse NA
   Clinic Nurse Other: _____
   Specialty Nurse (Diabetes)_____

5. Is patient education documented in the medical record? Yes or No

   If Yes, indicate how often would you estimate patient education is documented in the medical record:

   ___ 10% of the time
   ___ 25% of the time
   ___ 50% of the time
   ___ 75% of the time
   ___ 100% of the time

6. What are perceived barriers to providing patient education to individuals? (Check those that apply)

   ___ Time
   ___ Privacy: No room to provide confidentiality
   ___ Not enough staff
   ___ Minimal teaching aids/resources
   ___ Other: _____

7. YES NO Do you provide patient education in groups?

8. YES NO Do you currently utilize nursing care plans?

9. YES NO If you currently utilize nursing care plans, are they standardized?

9. YES NO Are teaching plans a part of the nursing care plans?

10. What patient education programs have you developed which contain a *written* curriculum targeting specific groups, i.e., diabetes, hypertensives, prenatals, etc.?

___	Diabetes	___	Hypertension	___	STD's
___	Prenatal	___	Tobacco	___	AIDS
___	Birth Control	___	Well Child	___	Cancer
___	Exercise	___	Arthritis	___	A/SA
___	Heart Disease	___	Nutrition	___	Other:

_____
_____

11. YES NO Is a multidisciplinary approach used in providing education? If so, which disciplines are involved? Please list.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Please circle the appropriate response:		Disagree				Strongly Agree
12.	Patient Education can improve patient health status.	1	2	3	4	5
13.	Nursing is an important link in the patient education process.	1	2	3	4	5
14.	To be truly effective, patient education should be a planned, comprehensive session provided by specific individuals with the time necessary to do the job correctly.	1	2	3	4	5
15.	Nurses have the responsibility for assuring that patient education is provided.	1	2	3	4	5

Sample Survey for Individual Departments

SUBJECT: MEDICAL RECORDS QUESTIONS

1. What are patients told about the contents of their health records?

   Who tells them? When? How often?

2. What are patients told about the purposes of the contents of their health records?

   Who tells them? When? How often?

3. What are patients told about the disposition of their health records?

   Who tells them? When? How often?

4. What are patients told about the confidentiality of their health records and about whom has access to them?

   Who tells them? When? How often?

5. What are patients told about the release of information from their health records and who has access to them?

   Who tells them? When? How often?

6. What are patients told about their rights to access their health records?

   Who tells them? When? How often?

Additional comments should be written on the back.

Sample Survey of Individual Departments

SUBJECT:	**Health Education**

YES NO 1. Do you think health education should be included in the process of patient education?

YES NO 2. Do you see a role for Health Education in the patient care process?

YES NO 3. Standards suggest that at least 25% (1-2 hours per day) of the Health Educator's time should be spent on patient education and I agree.

YES NO. 4. Patient Education teaching sessions have been developed by this Health Education department.

YES NO 5. I would feel comfortable in providing patient education sessions.

6. *For each of the following where you currently provide group or patient education: Put a one (1) in front of those where you currently provide education; Put a two (2) in front of those where you would like to increase your patient education activities. If you are not involved in any of the following departments or if your Tribe does not have these departments, please put a Zero. (0)*

___WIC/Nutrition
___Well Child Clinic
___Day Care Centers
___Middle/junior schools
___Diabetes
___Substance Abuse
___Parenting Programs
___Other: Please Identify: _____

___ Elder organizations
___ Head Start
___ Elementary Schools
___ High Schools
___ Injury Prevention
___ Cancer Prevention/Screenings
___ State, County, Tribal or local health organizations

7. What problems do you foresee in the provision of patient Education?

_____
_____

8. Please check any of the following that are true concerning patient education and the Health Education Program in your facility.

Answer YES or NO to the following. If it is not applicable, answer with a zero (0).

1.___ Patient Education referrals **are made** to the Health Education Program. If the answer is YES, please answer
the following three questions. If the answer is NO, move to question 2.
___ But, very few health professionals make referrals to the Health Educator for patient education.
___ If referrals are made to Health Education, the referrals are in writing and documented on the patient's chart/record.
___ If referrals are made to Health Education, they are usually verbal.

2.___ Patient Education referrals **are not made** to the Health Education Program.
___ Health professionals do not make referrals to the Health Educator for patient education .
___ It is not our policy to make referrals to Health Education for patient education.
___ My Health Education Program does provide some patient education.
___ My Health Education Program does not provide patient education.
____ I would like to see Health Education provide more patient education.
____ I prefer that the Health Education program continue to provide Community-based programs rather than concentrate on individual or group patient education.

Sample Survey of Individual Departments

SUBJECT: Physicians

Please take a few moments to complete this survey to help the Health Education Committee provide patient education services that meet the needs of our providers and our community.

Who provides patient education for patients in your Clinic? Check all that apply:

___ Doctors ___ Nurses ___ Nutritionist/Dietitian
___ CHR's ___ No One ___ Health Educator
___ Other: Please Specify: _____

Please circle the appropriate response:

		Strongly Disagree				Strongly Agree
1.	Patient Education can improve patient health status.	1	2	3	4	5
2.	Doctors do not have enough time to provide patient education during clinic visits.	1	2	3	4	5
3.	Our Clinic has a simple and effective process in place for me to refer patients for health education.	1	2	3	4	5
4.	Nurses should have primary responsibility for providing patient education.	1	2	3	4	5
5.	Our patient education program provides the scope and quality of services I need for my patients.	1	2	3	4	5

To ascertain the need for developing comprehensive patient education sessions, please rank the following topics in order of their usefulness and importance to you and your patients.

1 = Most useful
9 = Least useful

___ hypertension
___ prenatal care
___ Well Child Care
___ alcohol/substance abuse
___ Diabetes- General info
___ AIDS/STD's
___ cancer prevention (tobacco cessation, PAP's, etc.)
___ Diabetes- nutrition
___ family planning
Other: _____

Please write additional comments or suggestions on reverse.

Thank You.

Sample Survey of Individual Departments

SUBJECT: Nutritionist (to be completed by staff Nutritionist/Dietitian)

1. Approximately what percentage of your time is spent providing patient education?
____ Less than 5% ___ 5-10% ___ 11% -15% ____Over 15%

Of the total percentage you identified above, what proportion is spent on:
a. individual patient education sessions:
____ Less than 25% ____25%- 50% ____50% - 75% _____Over 75%
b. group patient education sessions:
____ Less than 25% ____25%- 50% ____50% - 75% _____Over 75%

3. Do you feel that other staff members/paraprofessionals can play an active role in providing basic nutrition education to patients? ___ YES ___ NO

3. Who at your facility provides patient education on nutrition? (Check all that apply.)
___ Registered Dietitian/Nutritionist ___ Dietetic Technician
___ Nutrition Aides/RN ___ Nursing Staff (RN/LPN's)
___ Medical Providers (MD's,PA's FNP's) ___ Dental Staff
___ WIC ___ Other: Please Identify:

4. Have nutrition-oriented lesson plans/teaching sessions been developed or purchased for use in providing patient education? ___ YES ___ NO

If yes, in what topic areas? (Check all that apply.)

___Diabetes and Nutrition ___Fat/Cholesterol
___Child Nutrition ___Sodium
___Infant Nutrition ___Weight Control
___Prenatal Nutrition ___"Basic" Nutrition
___Other: Please Specify: _____

5. Do Nutrition Program staff at your facility provide patient education on any non-nutrition related subjects? ___ YES ___NO
If yes, in what topic areas? (Check all that apply)
___Fitness/Exercise ___Diabetes (Non-Nutrition related)
___Smoking Cessation ___Other: Please Specify:

6. How do you feel patient education could be better coordinated between the different departments/ programs within your facility?

_____

_____

Sample Survey of Individual Departments

SUBJECT: Dental (to be completed by Dental staff)

1. Approximately what percentage of dental staff time is involved in oral health promotion and patient education?
   ___ Less than 5% ___ 5%-10% ___ 11%-15% ___ Over 15%
   Of the total percentage you identified above, what proportion is spent on:
   a. individual patient education sessions:
      __Less than 25% __25%-50% __50%-75% __ Over 75%
   b. group oral health promotion/education sessions:
      __Less than 25% __25%-50% __50%-75% __ Over 75%
2. What types of health professionals are available to your facility for consultation/referrals/joint projects for oral health education/ promotion? Check all that apply.

___ Physician	___ Health Educator	___ PA
___ Nutritionist	___ Social Worker	___ CHR
___ Sanitarian	___ Public Health Nurse	___ RN

   ___ Other: Please Specify: _____

3. Do you use a process or instrument to assess individual patient education needs?
   ___ YES ___ NO

4. Does your health facility have a designated Patient Education Coordinator? Answer Yes or No Below: If the answer is No, please go to question #5.
   ___ YES our facility has a designated patient education Coordinator.
   ___ The dental program finds the service valuable
   ___ but does not use the services

5. Does your health facility have a designated patient education Coordinator? Answer Yes or No:
   ___ NO, our facility does not have a designated PFCE Coordinator.
   ___ The dental program would utilize such services if available
   ___ probably would not utilize the services

6. Is the dental program involved with any of the following programs or agencies?

   Put a one (1) in front of those presently involved with; Put a two (2) in front of those that you would like to increase your involvement with.

___WIC/Nutrition	___ Elder organizations
___Well Child Clinic	___ Head Start
___Day Care Centers	___ Elementary Schools
___Middle/junior schools	___ High Schools
___Diabetes	___ Injury Prevention
___Substance Abuse	___ Cancer Prevention/ Screenings
___Parenting Programs	___ State, County, Tribal or local health organizations

   ___Other: Please Identify: _____

7. Do you have adequate oral health education materials on the following topic areas? Please write a Yes or No.

___Diabetes	___ Oral hygiene
___Sealants	___ BBTD
___Oral Health for Special Needs Patients	___ Fluorides/fluoridation
___Pregnancy and oral health	___ Nutrition
___Children's oral health	___ Periodontal disease
___ Tobacco and Oral health	___ Other:

Please list those topic areas where you think you have adequate health education materials:

_____
_____
_____

7. How important are the following items in the oral health promotion/ education materials you use:

Number choices from (1) to (7), with 1 being the most important.

___	AI/AN Specific	___	reading level
___	overall visual appeal	___	pictures/artwork
___	humor	___	scientific accuracy
___	limited to 1-2 main messages		

8. How do you feel patient education could be better coordinated between the different departments/programs within your facility?

_____
_____

Sample Survey for Individual Departments

SUBJECT: PHARMACY

Pharmacy Education Assessment Tool

1. All patients receiving medicine will receive education counseling about:

A.	Use of drug - how to take it.	Yes	No
B.	Any expected side effect of drug.	Yes	No
C.	Storage of Drug	Yes	No
D.	Any other drug or other related potential reaction.	Yes	No

2. All patients receiving any special apparatus or dispensing packet:

A.	Will be given explicit directions.	Yes	No
B.	Will be asked to demonstrate that they understand and know not to use.	Yes	No

3. Any cautionary label which serves as a reminder to patients to abide by, will be attached to the medicine container. Yes No

4. Any special handout pamphlet pertaining to drug use or caution, will be shared with the patient. Yes No

5. Documentation will be entered into the medical chart denoting counsel/education performed and pharmacist will sign chart. Yes No

6. Does pharmacy participate in special projects, HPDP activities, Clinics and/or other aspects of health care sponsored by the Hospital/Clinic? (Other than the dispensing of medication.) Yes No

Examples: _____

_____

7. Pharmacy would welcome the opportunity to participate all patient education endeavors. Yes No

Sample Survey for Individual Departments

SUBJECT: CHR'S

1. How can Community Health Representatives assist in the patient education process?
Please check any of the following that apply:
_____ Ensuring that patient education is provided to the patient and his/her family.
_____ Assist in follow-up for No Shows or DNKA's.
_____ Provide period up-dates to staff on client's specific conditions, etc.
_____ Patients shall receive instructions about any follow-up care needed and how to obtain that care.

2. Who is responsible for providing follow-up care information to patients? (This may involve more than one department/discipline.)
_____

3. How could the provision of follow-up care information be documented?
_____

3. Where in the patient's health record/chart will follow-up care instructions be documented and by whom?
_____

6. YES NO Information about discharge instructions given to the patient is provided to those CHR's responsible for the continuing care of patient.

7. YES NO CHR's should have patient education teaching/lesson plans.

8. Who is responsible for providing copies of discharge instructions to patient families?
_____

to physicians and other individuals providers?
_____

to organizations/facilities responsible for continuing care?
_____

b. How could the provision of this information to the client by the CHR's be documented in the patient's health record/chart?
_____

c. Where in the patient's health record/chart will the provision of this information be documented?
_____

and by whom?
_____

Sample Survey for Individual Departments

SUBJECT: Alcohol and Substance Abuse

Within the A/SA Program, who provides health/patient education for patients in your Program?

Check all that apply:

___ Doctors ___ Nurses ___ Nutritionist/Dietitian
___ CHR's ___ No One ___ Health Educator
___ A/SA staff ___ I am not aware of patient/health education in the A/SA Program
Other: Please Specify: _____

Please circle the appropriate response:

		Strongly Disagree				Strongly Agree
1.	Patient Education can improve patient health status.	1	2	3	4	5
2.	A/SA Counselors do not have enough time to provide patient education during visits.	1	2	3	4	5
3.	A/SA Counselors do not have the expertise to provide patient education during clinic visits.	1	2	3	4	5
4.	Our Clinic has a simple and effective process in place for me to refer A/SA clients for health/patient education.	1	2	3	4	5
5.	A/SA staff should have primary responsibility for providing patient/health education.	1	2	3	4	5
6.	Our patient education program provides the scope and quality of services I need for my A/SA clients	1	2	3	4	5
7.	Our A/SA Program works closely with the Mental Health Program.	1	2	3	4	5
8.	Our A/SA Program works closely with all disciplines in our in our Hospital/Clinic.	1	2	3	4	5
9.	I think we do a good job of covering the educational needs of our clients.	1	2	3	4	5

Please check which of the following topics are useful and important to you and your A/SA clients.

___ hypertension
___ prenatal care
___ Well Child Care
___ Nutrition
___ family planning
___ Mental Health
___ AIDS/STD's
___ cancer prevention (tobacco cessation, PAPs, etc.)
___ Gay/lesbian issues
___ FAS
___ Diabetes- General info
___ TB

10. How often do you make patient education referrals to Health Education or other patient educators?
_____ Seldom _____ Sometimes _____ Frequently

11. If you have checked seldom or sometimes, select the most common reason:
_____ Access to patient education services is inconvenient
_____ Patient Education services are not in the same building
_____ Never thought of it
_____ The current Patient education given by our Program is sufficient.
_____ Not clear as to the duties of other health providers
_____ Other: _____

12. What would it take to enhance coordination with patient education services?
_____

_____

Sample Survey of Individual Departments

SUBJECT: Business Office

For additional space please use the back of this page.

1. What information is given to patients at the Patient Registration Process? Who is giving this information? How often is this information given?

2. What information is given to patients during the Admission process? Who is giving the information?

3. What information is given to patients by the Patient Benefits Coordination regarding their role? How often is this information given?

3. What information is given to patients by the Patient Accounting Technicians regarding billing Third Party Insurance Carriers?

4. What information is given to patients as to why the Business Office asks the questions they do? How often? Who informs the patients of this information?

5. Do you think the Business Office has a role in providing Patient Education? Briefly explain your answer.

Sample Survey of Individual Departments

SUBJECT: Mental Health

1. How are you documenting the mental health services you provide? Check which applies.
   _____ PCC
   _____ Independent Mental Health records

2. What type of patient education and/or psycho educational counseling are you providing? Check those that apply.
   _____ Bibliotherapy or Self-Help
   _____ Wellness
   _____ Skills (Parenting techniques, stress management)
   _____ Family Information (care of patients with Alzheimer's and MI, etc.)
   _____ Topic oriented groups
   _____ Medication management
   _____ Informational handouts (Depression, FAS/FAE, CA/N, etc.)
   _____ Resource Information (related services)
   _____ Other: _____

3. How often do you make patient education referrals to Health Education or other educators?
   _____ Seldom _____ Sometimes _____ Frequently

3a. If you have checked seldom, select the most common reason:
   _____ Access to patient education services is inconvenient
   _____ Patient Education services are not in the same building
   _____ Never thought of it
   _____ The current Patient education given by our Program is sufficient.
   _____ Patient education given is integral part of Mental Health therapy.
   _____ Not clear as to the duties of other health providers
   _____ Other: _____

4. What would it take to enhance coordination with patient education services? (Write your anwer on the back)

Resource Collection on a Budget: Establishing a Patient Education Library

Introduction
Few health providers will argue against the importance of patient education.

The development of a patient education resource library should be and can be developed at all sites - regardless of clinic or hospital size, or staffing. Sites with total Contract Health Services should also develop a Patient Education File/Library. Too often Contract Health Service sites assume that the private physician or provider is providing adequate patient education services. The truth is private providers usually offer random patient education services -- incorrectly assuming that the Indian Clinic or Hospital has educated the patient before they came to their office or assuming that someone at the Indian Clinic or Hospital will talk to them after they leave their private office.

There are many commonly voiced concerns by the Health providers prior to commencement of a patient education library project -- most concerns and objections will center on money. This section of the Manual provides some guidelines to meet the challenge of funding.

Common concerns of the staff:

- *"Where will we do patient education? There is no patient education "room," - therefore, there is no "convenient area" in which to provide patient education."*
- The Clinic or Hospital does not have an empty room or unused area near the examining rooms - *"We will need more space."*
- *"There is no place for privacy or confidentiality."*
- There is no audio-visual equipment (such as VCR's) or projectors or staff requests expensive new equipment. *"No audio-visual equipment."*
- Staff estimates that they will need several thousand dollars to purchase printed patient education materials and videos. *"Money!"*
- Staff points out that printed pamphlets, brochures and other information is conveniently placed in the waiting area for patients to freely take. Perhaps a video is also shown on the waiting room TV. *"Isn't this patient education?"*
- And last, but not least, in importance is the often heard refrain that there are *no "Indian -specific "* materials available.

Often the barrier to the provision of comprehensive patient education is not rooms, pamphlets nor money. The largest barrier to the provision of patient education is time. Commitment to the importance of patient education, the management of time through the development of policies and procedures to govern patient education and the organizational structure of the health clinic or hospital are just some of the obstacles to overcome in order for patient education to become a reality.

Administrators' commitment to patient education will most assuredly be tested.

Purpose
Patient Education is a planned learning experience, which can be achieved by using a combination of three methods that influence patient knowledge and health behavior:

- teaching and demonstrating,
- counseling, and
- behavior modification.

This process demands time and effort that can be difficult to manage in a busy hospital or clinic. Many health professionals attempt to shorten the teaching process by providing written materials to patients so they can educate themselves on their own time. Although printed and non-printed materials are important tangible supplements, they should not be construed as a substitute for planned education.

Comprehensive patient education is more than handing a prenatal client a plastic bag "stuffed" with various printed pamphlets and materials on pregnancy and childbirth.

The abundance and variety of educational materials can be overwhelming. It is not possible to collect, organize and store ***all*** teaching resources. A patient education library or file for a hospital or clinic must contain those materials that will yield the greatest benefit for the teacher and learner alike. In addition, without a financial grant or unlimited financial resources there is a need to be fiscally responsible.

Education resource collections can be developed to serve different purposes. One such purpose is to assemble a limited variety of education materials about a prevalent health problem. For example, a clinic that has large numbers of hypertensive patients may choose to focus on resources dealing with the nature, diagnosis, and therapy of hypertension. The materials may include video tapes, pamphlets, and audio tapes.

Another purpose is to assemble a comprehensive set of all available materials dealing with a particular subject that is common to Native Americans - such as diabetes.

It can be frustrating to health professionals and patients alike when there is a scarcity of information on file concerning a patient's medical problem. The physician or Health Provider can consult a medical journal or personal files -- where and what is available to the patient to help them understand their condition? This may be another reason for develop resource collection -- to provide ready access to educational materials during patient visits. This allows the practitioner to take advantage of the "teachable moment" and the opportunity to link clinical and educational information. Learning impact is lost if the materials are not immediately accessible. In addition, having multiple and varied resources on hand avoids duplication of the practitioner's time and effort in developing educational media.

Process

A resource collection can be solicited, collected, organized and sorted more easily if the process boundaries are specific enough. Goals and objectives should reflect the intent, extent and specificity of purpose, and a time frame defined for resource collection and library completion.

Unfortunately, there is not an abundance of Indian-specific educational materials available. Studies have shown that Native Americans react more favorably when educational materials such as videos, posters, or pamphlets include Native Americans in the content.

An individual health professional can establish a resource collection, but the team approach provides benefits from collective expertise, discussion, and task delegation. A higher quality product is often the result. Each team member should have specific duties. Among the staff, for example: who contacts potential contributors, who reads and evaluates the material, who determines the classifications, who is responsible for storing the resources?

Many materials are free and a wealth of materials can be collected from many sources. The common ones include:

- government agencies,
- pharmaceutical companies,
- commercial vendors,
- self-help support organizations,
- non-profit organizations,
- professional peer organizations,
- consumer magazines
- newspapers,
- health publications
- and, physicians and nursing journals,

There are many excellent diagrams, illustrations, models, posters, audio and video sources, though most materials are print media. One material source often will lead to others, which then contributes to the beginning of a collection.

Appropriately defining and classifying resource materials is a critical process. Definitions may be arbitrary, and for our purpose, materials are defined as "information," "instruction," and "comprehensive." Classifications may be by author, title, publisher, key word, anatomical organ, disease, procedure, operation, therapy, media type or language. Others may be CPT or ICD codes, NLM or LC classification or listings according to the Index Medicus.

Items should be defined, analyzed, rated, then catalogued. Again, these parameters can be arbitrary, but must be consistent throughout.

The reading level should be determined by applying readability formulas. Most computers come with a readability program included in the software or you can purchase these software programs for $50-$75 extra. These work only on material already in the computer so anything you write yourself can be analyzed. The Fry Readability formula is accurate at lower reading levels. One can use the FRY formula on material not in the computer. The Word Perfect 6.0 package contains *Grammatik - Interactive Check.* For additional information on how to use the FRY formula, contact your local health educator or check with your local elementary school reading teacher.

This process can be simplified by using a computer scanner and a software package of readability formulas. This determination is important because it is preferable to communicate at the sixth to eight grade reading level.

It may not be enough to provide information and assume the learner will absorb it with a resultant change in behavior. Therefore, it is necessary to determine if the learner understands and assimilates the contents. Sample questions can be written for the patient to answer in order to determine his level of understanding. The addition of questions and the patient's response (verbal and written) can be included in the patient's record and serves as evidence of informed consent. Many current education materials include questions accompanying the resource. This may be adapted to audio and video as well. Interactive videos already employ this concept.

At larger sites, a data software program can be used for cataloging. Resources are then easily indexed and retrieved by key words. Catalog citations can be changed using the same program. Reproduction of citations can be generated on the computer for distribution to patients to select materials. A checkoff sheet indicating resources provided to a patient can be filled in the patient's chart. Filing actual materials in the library or filing cabinet should be set up for ease of retrieval. The catalog and collection should be frequently updated to stay current and weed out resources made obsolete by new medical advances.

Budget

Developing a specialized library can be cost effective. All of the team member tasks can be accomplished during ordinary working hours. Equipment cost can be minimized as most hospitals and clinics have access to a Xerox machine, computer and printer. One useful software program to consider purchasing includes a database and a scanner to decrease the time needed to determine the educational reading level. Usually a filing cabinet and folders can house the accumulated materials.

In summary, a patient library is feasible and beneficial to patients and health professionals alike. Setting goals, objectives, and determining the process at the beginning expedites development and leads to an appropriate and useful library collection.

ASSESSMENT OF PATIENT EDUCATION MATERIALS

I. Who are the professional clinicians and what is their interest and dedication to patient education?

II. Staff Profile:

Name Title/Training Special Area of Interest/or expertise

III. Patient Profile:

A. Number of patients
B. Age/sex distribution
C. Morbidity report (20 most common diagnoses)
D. Past years' history of services

1. Health maintenance visits (including OB-Gyn, Yearly PE)
2. Laboratory/procedures (EKG, Pulmonary function, blood sugar, Cholesterol.)
3. Facility health maintenance procedures (flex. sign. etc.)

IV. Community Resource Profile

A. Agencies or professionals to whom patients are referred
B. Community involvement by facility personnel for HPDP

V. Facility Resources

A. Personnel currently involved in various aspects of education: Responsibilities
B. Space in the office being used for patient education
C. Types of materials currently being used now, or would like to add for patient education
D. Primary sources of educational materials
E. Criteria used for selecting materials
F. Personnel responsible for selecting materials
G. Storage arrangement for materials
H. Audio-visual teaching aids available
I. Availability of computer, copier, word processor, document storage
J. Budget available for education
K. How to recover cost of education

VI. Setting practice goals

A. Assessment
B. Planning/development
C. Staff orientation
D. Evaluation

VII. Identify constraints

Financing Patient Education

Excerpts from:

Managing Hospital-Based Patient Education

Barbara E. Giloth

and

Financing Patient and Family Education at the Hospital Level

Sue Pritchett:

In the past, whatever health/patient education received ("whenever" and "if ever,") was received when we went to the doctor's office, a clinic, or a hospital. Now we are being encouraged to take the "whatever, whenever, and if ever" out of patient education and we are being encouraged to provide education that is "for sure," consistent, organized, and accountable.

Clinic Health Directors and Hospital Administrators are encouraged to look at what they are doing now and many are saying, "To do this right is going to cost money; who is going to pay for it?" The fact that patient education can also contribute to cost containment is of little help at first, because it usually does require money (in terms of more staff time, and in many instances -- more staff) to bring patient education to reality.

Current Status of Reimbursement for Patient Education Services

Although the financing of health care has changed substantially since the landmark document *Financing for Health Education in the United States* was written in 1980, there has basically been little change in the overall status of reimbursement for patient education. Patient education that is integral to care, part of the treatment plan, and delivered under the supervision of a physician has been and continues to be allowable as an administrative expense under nearly all third-party payer policies; yet it is still rare to find specific patient education programs, other than diabetes patient education, reimbursed as a separate service.

Although *Current Procedural Terminology* (CPT) codes currently exist for group counseling sessions, most public and private insurance plans do not provide separate coverage for these services. Codes only establish a mechanism for billing; they cannot guarantee third-party reimbursement.

Medicaid: Medicaid is the federal-state government program that finances health care for specified low-income individuals. By federal mandate, certain basic services must be offered by states to all categorically needy Medicaid enrollees.

Several key reimbursement problems are specific to Medicaid. First, many states have set reimbursements rates so low that hospitals and clinics lost money for every Medicaid patient they service. It is currently estimated that on the average Medicaid pays $.80 for every dollar of care provided. Second, the Medicaid programs currently cover a smaller and smaller percentage of those below the federal poverty level; in 1976 35 percent of such persons were not covered. By 1991, this figure had soared to 60 percent. Therefore, no matter what policies the actual state Medicaid programs chooses to implement, a growing percentage of the poverty population has no coverage for basic medical care, let alone patient education services.

Medicare: Medicare is the federal government program that provides health care to elderly and disabled individuals. Since its inception in 1965, Medicare reimbursements have been limited to care that is "reasonable and necessary for the treatment of an illness or injury." In general, Medicare does not cover primary preventive services for people who are well.

Although more than 450 Bills have been introduced since 1965 that have sought to add various preventive benefits under the Medicare program, the only Bills that have been enacted reflect a bias toward immunization and screening rather than education and counseling. Currently the only preventive services covered broadly include immunizations for beneficiaries at high risk of contracting hepatitis B, Pneumococcal pneumonia immunizations, pap smears, and mammograms.

Medicare will expand access to preventive services for eligible patients using Federally Qualified Health Centers receiving a grant under Sections 329, 330, and 340 of the Public Health Service Act. According to regulations published in the June 12, 1992 *Federal Register*, preventive primary services - including nutritional assessment, preventive health education, and immunizations - will be covered when provided in these settings. Specifically excluded are group or mass information programs, health education classes, or group education activities including media productions and publications.

The introduction in 1983 of the prospective pricing system and diagnosis-related groups (DRGs) essentially put an end to hopes that inpatient education might be reimbursable as a separate line item. Concern about patients being discharged "quicker and sicker," however, has resulted in more attention being paid to discharge preparation. Although never enacted, legislation introduced in 1992 - the Medicare Prevention Benefits Act - would provide reimbursement for risk assessment, preventive interventions, and counseling for persons first becoming eligible for Medicare.

As with Medicaid programs, hospitals and clinics can expect to lose a significant amount of money caring for Medicare patients. Newly released data suggests that hospitals and clinics can expect to pay out more than they receive for taking care of hospitalized Medicare patients.

Private Health Insurance Plans

Traditionally, private health insurance plans have covered patient education and related services in one of four ways. Most commonly, such services have been covered through incorporation into administrative costs. Less frequently, insurers have offered a benefit package that includes specified patient education benefits, for example, cardiac rehabilitation. They may also offer incentives to maintain healthy behavior or provide health education program.

In 1991, Blue Cross and Blue Shield Association issued guidelines designed to serve as the basis for a model preventive services benefit. Based on screening guidelines developed by the U.S. Public Health Service and the American College of Physicians, coverage includes well-baby care, childhood immunizations, and routine adult medical screening tests for cancer, heart disease, and other preventable illnesses.

Statements made by various health insurance groups all agree that patient education that is integral to the patient's treatment plan is a legitimate cost of patient care and should be reimbursed under existing reimbursement mechanisms. Many hospitals and clinics have interpreted this to mean that separate charges could be made for patient education and reimbursed by third-party payers. Some hospitals and clinics have hired "patient educators" to teach patients on a referral basis and established a charge of something like $10 per hour for this service. This method of improving patient education has disadvantages -- only one of which is that the charge is not usually reimbursable and the patient is then required to pay for it out of pocket.

If you talk to a major third-party payer and ask if they cover patient education, they will probably say, "Yes, we do. We consider patient education to be a basic part of patient care and we have always reimbursed for it through the basic rate. If we paid for it as a separate charge, we would be paying for it twice." They know that in reality education may or may not be provided but they shrug and state they are already paying for patient education.

Although there has been some disagreement about how this cost should be reimbursed, most insurance companies have agreed that any increased costs for patient education should be incorporated into the hospital or clinic's normal charge or rate. "If it costs more money - change the rate but not the rate structure. If it means increasing the education budget or the patient care budget, do it, and let it be subjected to the same scrutiny as all other elements of reimbursement."

Strategies to Increase Third-Party Reimbursement

Although the overall third-party reimbursement climate is not favorable for the separate reimbursement of patient education, there are some opportunities to increase payments for services that are largely education in nature. The following five steps offer suggestions on assessing opportunities for reimbursement.

1. *Assess extent of current patient education reimbursement.* This first step involves data collection to determine the current status of reimbursement for patient education services offered by the hospital or clinic. The following data should be gathered:

- What charges are currently generated from patient education services?
- Are any of the charges for patient education service submitted for third-party reimbursement?
- Of the charges submitted for third-party reimbursement is any portion reimbursed?
- Do any of the managed care contracts negotiated by the hospital include PFCE services? If so, was any consideration given to the amount of resources required to implement these services?
- Does the Health Director/Administrator think it would be useful to pursue additional reimbursement for patient education services?

2. *Assess the overall payer environment*. This information is critical to identifying opportunities for potential expansion of reimbursement. Strategic planning may have identified data regarding local employers and their health care benefit plans. The Chamber of Commerce may be sources of local employer information. State, local and county health departments may provide data on the existence of state-mandated benefits. The following data should be gathered:

- What is the clinic or hospital's payer mix? Are patients primarily covered by public programs, or is there substantial private coverage?
- Who are the largest insurers for the clinic or hospital's major services? Be as specific as possible.
- Do any employer groups comprise a significant component of the clinic or hospital's inpatient or Outpatient caseload?
- To what extent is managed care plans a significant component of the clinic's market share?
- How are EPSDT services provided in the community? EPSDT: Under the Early Periodic Screening, Diagnostic, and Treatment Program enacted by Congress in 1967, states are required to provide health assessments and examinations and immunizations to all Medicaid-eligible children under the age of 21. Many states have done a limited job of informing eligible parents of the availability of this program, and restrictions on access to services and provider qualifications have limited the number of children receiving services.
- Are there state-mandated patient education prevention service benefits?
- To what extent are the major employers, including the hospital, self-insured?
- To what extent do the physicians on the staff offer patient education services, and to what extent are they reimbursed for them?

3. *Assess payer interest*. Although the third-party payer policies represent overall directions for reimbursement, individual commercial insurers and individual insurance companies set local priorities. State Medicaid plans differ, and the fiscal intermediaries for Medicare often interpret regulations different. Any initial strategy in reaching theses payers is to meet with the appropriate staff members to gather the following information:

- How does each payer view the scope and importance of patient education?
- Does the payer reimburse for an education service, such as a smoking cessation program, if it is a part of cardiac rehabilitation?
- Would the payer consider reimbursing for a patient education service in the future?
- Would the payer consider a pilot project to look at such reimbursements?
- Do local payers offer patient education or health promotion services directly to subscribers? If so, is there an opportunity to contract with hospital or clinic staff as providers?

- Are local payers willing to support hospital or clinic-sponsored patient education or community health education programs through financial or in-kind contributions?

4. *Focus on patient education services with a high likelihood for reimbursement.* Reimbursement is most likely for outpatient chronic disease services that seek to ensure that the patient and family have the skills they need to manage the condition in question.

5. *Integrate patient education into outpatient care*. A large percentage of outpatient education services are activities that should be integrated into the routine delivery of outpatient care, especially primary care. Quality patient education requires assessment, problem solving, and reinforcement over time at every visit. The clinic or hospital staff should examine their current services to ensure that these services are integrated efficiently and consistently. No third-party payer will seriously consider any present or future reimbursement unless it can be demonstrated that patient education occurs on a planned, consistent basis.

Strategies to Increase Resources

1. Clarify the hospital or clinic's financial goals
2. Specify needed resources
3. Increase administrative support for patient education.
4. Identify other management opportunities to influence the budget
5. Increase efficiency
6. Collaborate internally and externally
7. Diversify by tapping into other funding sources
8. Train volunteers

When we talk about improving patient and family education, we are not referring only to special disease categories such as diabetes. Patient education means clear and complete information exchanged between all patients and all staff members during the routine course of treatment -- when a new procedure is about to be performed, when the patient is being screened, or when a patient asks a question. It means making sure that the patient knows about home care, and it means documenting this on the chart in a meaningful way.

Improved patient education is achieved in a number of ways:

(1) by helping staff stay up-to-date in the various diseases and conditions of the patients they treat so that they are comfortable with the content of what patients need to know;
(2) by helping staff become more sensitive to patient education and information needs and better able to communicate with patients;
(3) by organized responsibility with multidisciplinary involvement -- to insure that all patients receive the education they need with no contradictions and no gaps;
(4) by hospital or clinic administrative commitments.

One additional consideration needs scrutiny and this concerns the employment of a full-time “Patient Educator” versus patient education being provided by all the staff.

Sometimes a facility hires a full-time “Patient Educator,” usually a nurse or health educator, with the responsibility of patient teaching. Some see patients on a referral basis and make a separate charge. In most instances, this has been found to be very limited because they can only see a few patients a day and it sometimes actually deprives many patients of instruction they would have received prior to the employment of a full-time Patient Educator. The result is that staff who would routinely have provided this service (when they had time) discontinued any attempt to teach the patients because it was now somebody else’s job. Hospitals and clinics that employ such a position are in the process of changing to a true collaboration role where the educator works primarily with staff in organizing and supporting education efforts and in identifying education needs at the hospital or clinic-wide level so that activities/efforts can be directed toward meeting the most critical areas of need.

The same general rules for outpatient services apply with third-party coverage. If the charge for education is built into the basic service or visit charge, it should be eligible for reimbursement as any other basic service charge and should be considered on the same basis as an inpatient charge. Medicare has indicated that they expect to pay for education on an outpatient basis or even home visits just as they would for inpatients if the education is integral to the treatment plan.

Part of our problem is that we do not figure in the educational or communication time involved in treatments and procedures when we establish fees for outpatient services. Further, most Administrators do not set aside any funds for patient education even though they assume that the clients using their facilities are receiving patient education.

Hospital and Clinic Administrators need to consider taking a certain percentage right off the top of the budget that could be allocated to patient education services. Hospital and Clinic Administrators also need to consider billing for other services, such as nutrition counseling -- especially if the nutritionist is a licensed or Registered Dietitian. There are some private insurance companies that will reimburse for certain types of patient education/counseling **IF** the provider is licensed or registered in their profession.

Finally, Institutions need to eliminate the use of the phrase; "I don't have time to teach because I'm busy treating other patients." Education is treatment. If a person is sick with an infection, the treatment is antibiotics; if the person is sick because of ignorance, the treatment is education.

Diabetes Reimbursement

Coverage of Diabetes Outpatient Self-Management Training Services: Effective July 1, 1998
The Balance Budget Act of 1997

Section 4105 of the Balanced Budget Act of 1997 permits Medicare coverage of diabetes outpatient self-management training services when these services are furnished by a certified provider who meets certain quality standards.

A diabetes outpatient self-management and training service is a program which education beneficiaries in the successful self-management of diabetes. An outpatient diabetes self-management and training program includes education about self-monitoring of blood glucose, diet, and exercise, an insulin treatment plan developed specifically for the patient who is insulin-dependent, and motivates patients to use the skills for self-management.

Outpatient self-management training services may be covered under Medicare only if the physician who is managing the beneficiary's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the beneficiary's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) in the management of the beneficiary's condition.

Certified Providers: The statute states that a "certified" provider is a physician or other individual or entity designated by the Secretary that, in addition to providing outpatient self-management training services, provides other items and services for which payment may be made under Title XVIII, and meets certain quality standards. For initial implementation of this benefit we are designating as a certified provider those physicians, individuals or entities that are paid under the physician-fee schedule. These certified providers must meet the National Diabetes Advisory Board Standards (NDAB) as subsequently revised.

Along with physicians we will designate as certified providers other nonphysician practitioners who meet NDAB standards and whose services are paid for under the physician's fee schedule. These services may be provided in two ways:

1) First, the services performed by non-physician practitioners may be incident-to a physician's professional services, must be an integral, although incidental part of the physician's personal professional services, and must be performed under the physician's direct personal supervision.
2) Second, a non-physician practitioner such a Physician Assistant or Nurse Practitioner may be licensed under State law to perform a specific medical procedure and may be able to perform the procedure without a physician's supervision and have the services separately covered and paid for directly by Medicare as a Physician's Assistant or Nurse Practitioner service. Medicare only covers procedures and services that are performed in accordance with State license.

In keeping with the requirements of the legislation, services provided by individuals other physicians will be covered when they are provided within the current coverage requirements. These include: Physician Assistants (PAs), Nurse Practitioners (NPs), Nurse Midwives (NMs), Clinical Psychologists (CPs), and Clinical Social Workers (CSWs).

HCFA-Pub. 60-AB
The rules for Billing and payment to Non-Physician Practitioners Providing Diabetes Outpatient Self-Management and Training.

Employers of PAs must bill Part B of the Medicare program for professional services furnished by the PA, as well as services furnished as an incident-to the professional services of a PA. The PA's physician supervision (or a physician designated by the supervising physician or employer as provided under State law or regulation) is primarily responsible for the overall direction and management of the PA's professional activities and for assuring that the services provided are medically appropriate for the patient. Pursuant to section 4512 (c) of the Balanced Budget Act Medicare payment for PA services is made only to the PA's employer regardless of whether the PA is employed as a W-2 employee or whether the PA is acting as an independent contractor. Also, while a PA has an

option in terms of selecting employment arrangements, only the employer can bill a carrier or intermediary for the PA's services.

Any service furnished by a PA must be furnished under the general supervision of a physician. General supervision does not require the physician to be present on the premises and immediately available while all services are being furnished. Rather, the physician may be reached by telephone in care of an emergency. However, any services furnished incident-to the professional services of the PA must be furnished while the PA is present on the premises and immediately available in case of an emergency while these ancillary services are being furnished. Accordingly, any service furnished incident to the professional services of a PA must comply with all of the "incident-to" requirements mentioned above.

Clinical Nurse Specialist's and NPs may bill the Medicare Part B program directly for services that are performed in collaboration with a physician. They may also bill the program directly for services furnished as an incident to their professional services in which case the direct supervision requirement in particular and all the incident-to requirements apply.

We are requiring that CNs, NPs, and the employers of PAs must submit claims to the Part B carrier under their own respective billing numbers for their professional services furnished in facilities or toerh provider settings except in the case where the services of these nonphysician practitioners are furnised to patients in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs). Payment for these services of these nonphysician practitioners in the RHC/FQHC setting is bundled under the facility cost payment that is made by the intermediary under the all inclusive rate.

Coding and Payment: When a provider bills for diabetes self-management training services they should use the following CPT codes:

G0108 – Diabetes outpatient self-management training services, individual session, per 60 minutes of training.

G0109 - Diabetes outpatient self-management training services, group session, per 60 minutes of training.

We will allow $55.41 (practice expense relative value unit (RVU) of 1.51) per hour for an individual session and $32.62 (RVU of .89) per beneficiary per hour in a group session. Like other services paid under the physician fee schedule, the actual payment amounts will vary among geographic areas to reflect differences in costs of practice as measured by the Geographic Practice Cost Indexes.

Standards that certified providers must meet: (Currently under revision)

1. Structural Standards

   A. Organizational Support by Sponsoring Organizations
      - Standard 1: Maintain written policy affirming education as an integral component of diabetes care.
      - Standard 2: Provide education resources needed to achieve objectives for target population, including adequate space, personnel, budget and instructional materials.
      - Standard 3: Clearly define and document organizational relationships, lines of authority, Job descriptions, staffing, and operational policies.

   B. Community Needs Assessment
      - Standard 4: Assess service area to define target population and determine appropriate Allocation of personnel and resources

   C. Program Management
      - Standard 5: Establish standing advisory committee including at least a physician, nurse Educator, dietitian, behavioral science expert, consumer, and community Representative to oversee the program.
      - Standard 6: The Advisory committee should participate in annual planning to determine Target population, program objectives, participant access, and follow-up Mechanisms, instructional methods, resource requirements and program

Evaluation.

- Standard 7: Professional program staff should have sufficient time and resources for Lesson planning, instruction, documentation, evaluation and follow-up.
- Standard 8: Assess community resources periodically.

D. Program Staff

- Standard 9: Designate a coordinator responsible for program planning, implementation, and Evaluation.
- Standard 10: Program instructors should include at least a nurse educator and dietitian with Recent didactic and experiential training in diabetes clinical and educational Issues. Certification as a Diabetes Educator by the National Certification Board of Diabetes Educators is recommended.
- Standard 11: Professional program staff should obtain continuing education about diabetes, Educational principles, and behavioral change strategies.

E. Curriculum

- Standard 12: The program must be capable of offering, based on target population needs, Instruction in the following 15 Content Areas:
  1. diabetes overview
  2. stress and psychosocial adjustment
  3. family involvement and social support
  4. nutrition
  5. exercise and activity
  6. medications
  7. monitoring and use of results
  8. relationships among nutrition, exercise, medication, and glucose levels
  9. prevention, detection and treatment of acute complications
  10. prevention, detection and treatment of chronic complications
  11. foot, skin, and dental care
  12. behavior change strategies, goal setting, risk factor reduction, and problem-solving
  13. benefits, risks and management options for improving glucose control
  14. preconception care, pregnancy, and gestational diabetes
  15. use of health care systems and community resources
- Standard 13: Use instructional methods and materials appropriate for the target population.

F. Participant Access

- Standard 14: Establish a system to inform the target population and potential referral sources of availability and benefits of the program.
- Standard 15: The program must be conveniently and regularly available.
- Standard 16: The program must be responsive to requests for information and referral sources Of availability and benefits of the program.

II. Process Standards

A. Assessment

- Standard 17: Develop and update an individualized assessment for each participant, including Medical history and health status; health services utilization, risk factors; diabetes Knowledge and skills; cultural influences; health beliefs; attitudes; behavior and Goals, support systems; barriers to learning; and socioeconomic factors.

B. Plan and Implementation

- Standard 18: Develop an individualized education plan, based on the individualized assessment, In collaboration with each participant.
- Standard 19: Document the assessment, intervention, evaluation, and follow-up for each Participant, and collaboration and coordination among program staff and other Providers, in a permanent record.

B. Follow-Up

- Standard 20: Offer appropriate and timely educational interventions based on periodic

Reassessments of health status, knowledge, skills, goals, and self-care behaviors.

III. Outcome Standards
   A. Program
      - Standard 21 The advisory committee should review program performance annually, and use The results in subsequent planning and program modification.
   B. Participant
      - Standard 22: The advisory committee should annually review and evaluate predetermined Outcomes for program participants.

Carrier Billing Requirements
Providers should bill for their professional services using CPT code G0108 and G0109 on the form HCFA-1500. When billing for these codes the certified provider must on the first claim, provide you with a copy of its "Certificate of Recognition" from the American Diabetes Association that affirms they are a recognized provider. For the initial office visit the provider should bill an evaluation and management code. Thereafter, one of the new diabetes self-management education codes should be used. The statute requires that physicians and other individuals must provide other items and services for which payment may be made under title XVIII. However, this does not prevent new physicians or entities who did not previously possess a billing number from simultaneously obtaining a billing number and becoming a certified provider.

Apply the deductible and coinsurance.

Billing Requirements for Intermediaries
The provider bills for diabetes self-management training services on the HCFA-1450 or its electronic equivalent. The cost of the service is billed under revenue code 51X in FL 42 "Revenue Code." The provider will report CPT codes G0108 or G0109 in FL 44 "HCPCS/Rates." The definition of the CPT codes used should be entered in FL 43 "Description." As mentioned above, when a provider bills for these codes, they must on the first claim, provide you with a copy of its "Certificate of Recognition" from the American Diabetes Association that affirms they are a recognized carrier.

Apply the deductible and coinsurance.

Applicable Bill Types

The appropriate bill types are 11X, 12X, 13X, 71X, (Provider-based and independent), 72X, 73X, (Provider-based and freestanding), 83X and 85X.

Medicare Summary Notice (MSN) and Explanation of your Medicare Benefits (EOMB) Messages
Intermediaries and carriers that have not yet converted to MSN should utilize the following EOMB messages.

Intermediaries who have converted to MSN should utilize the following EOMB messages.

If the claim is denied because the procedure code or revenue is invalid, use the following message:

"The item or service was denied because the information required to make payment was incorrect." (MSN message 9.4) or "Medicare cannot pay for this because your provider used an invalid or incorrect procedure code and/or modifier for the service you received. (EOMB message 9.21)

SOAP PROGRESS NOTES

SOAP NOTES

A. Definition of SOAP

S - SUBJECTIVE DATA

Includes information from the client, such as the client's description of pain or the acknowledgment of fear. Including subjective input from the client aids in his participation in the plan of care.

O - OBJECTIVE DATA

Objective data is data that can be measured. Physical examinations, laboratory data, observations, and results of x-ray examinations are sources of objective information.

A - ASSESSMENT

The assessment is an interpretation of the client's condition or level of progress. The conclusions made in the assessment are more than a restatement of the original problem. The assessment determines whether the problem has been resolved or if further care is required.

P - PLAN

Plans may include specific orders designed to manage the client's problem, collection of additional data about the problem, individual or family education, and goals of care. The plan in each SOAP note is compared with the plan in previous notes. A decision is made to revise, modify, or continue previously proposed interventions.

_____

I - INTERVENTION

This section of the SOAP note is optional and can be used as a continuation of the original SOAP note. It may include the client's response to the intervention.

E - EVALUATION

This section is commonly used to conclude the SOAP note. It includes a brief summary of the plan. Evaluates if the plan was effective or needs revision. If the plan needs to be revised, it will be stated in the evaluation section and a new SOAP note will then be written.

Sample SOAP Note:

Isolation - lives alone.

S - "I just don't have any friends or family close by to help take care of me. I'm afraid I may make a mistake when I give myself a shot."

O - Client is learning to self administer insulin injections. Has no resources at home to supervise injections. Client has the psychomotor skills needed to perform injections correctly. Has been able to correctly administer injection for the last 2 days.

A - Client fearful of returning home without available resources to supervise injections.

P - A plan of action to call Home Health to refer client. Continue practice sessions with injections and offer encouragement appropriately. Assist client in planning for acquisition of necessary syringes and supplies.

APC Reports from PCC Files

This set of reports examines PCC files and counts all APC visits in a given time frame for the facility that you select. The following reports are available:

APC Reports	
1A	PCC-Ambulatory Patient Care Report 1A
DATE	APC Visit Counts by Date of Visit
CLN	APC Visit Counts by Clinic
DISC	APC Visit Counts by Provider Discipline
PROV	APC Visit Counts by Individual Provider
DX	APC Visit Counts by Primary Diagnosis (APC Code)
LOC	APC Visit Counts by Location of Service

Entry of all date into the PCC includes a designation of Location of Visit, Type of visit, and Service Category. Location of Visit consists of the facility name where the visit occurred (e.g. Crownpoint Hospital, Yakama Clinic, etc.) Types of Visit include the following:

IHS	Other
Contract	638 Program
Tribal	VA

and the Service Categories are:

Ambulatory	Not Found
Hospitalization	Day Surgery
In-Hospital Care	Observation
Chart Review	Event (Historical)
Telecommunications	Nursing Home Care

These three visit attributes, plus the Clinic Type designation for outpatient clinic visits, are used together to determine whether or not a visit is an "official APC visit" for inclusion in the IHS data system. The criteria for inclusion are listed below. Data displayed on this set of "APC Reports from PCC files" should correspond very closely to the reports received from the IHS Data Center. However, please be aware that for Service Unit management purposes, a similar set of reports containing more complete data, such as Not Found Visits, CHN Home Visits, and Telephone Calls may be found in the set of reports entitled "PCC Ambulatory Visit Counts," which are described in the next section of this manual.

In order to be considered an APC Visit, the Visit must meet the following criteria:

1. The visit must fall within the date range specified by the user.
2. The visit must have other medical data linked to the visit record.
3. The visit must be for one of the following service categories:
   Ambulatory
   IHS
   638 Program
   Day Surgery
   Observation
   Nursing Home
4. The visit must be one of the following Visit Types:
   IHS
   638 Program
   Tribal

Other

5. The visit must have a primary Purpose of Visit entered. (POV cannot be uncoded DX - .9999.
6. The visit must have a valid location pointer.
7. The visit cannot be to one of the following clinics:
   Mail
   Telephone Call
   Chart Review
   Follow-up Letter
   Radio Call
   Dental
   Education Class
   Employee Health
8. The visit must have a valid primary provider entered.
9. If the primary provider discipline is 13 (CHN) or 32 (CHR) and the location of the visit is other than an IHS facility (code >49), the visit is excluded.

The user is prompted to enter the visit date range to be used in calculating the number of visits and also will be asked whether visits for ALL locations should be included or whether visits for one particular location should be included.

PCC
AMBULATORY PATIENT CARE
REPORT 1A [A]

This report is generated from PCC files and is very similar to the 1A report generated by the APC System at the Data Center in Albuquerque. The report will display Fiscal Year-to-date APC Visit counts by Month of Service. Totals will be generated for each month as well as for each provider discipline. Percent totals are displayed for each discipline. total Primary Care Provider visits are subtotaled.

Primary Care Providers are defined as a primary provider with one of the following discipline codes:

00 -	Physician	44	-	Physician (Tribal)
11 -	Physician Assistant	70-90	-	Physician Specialist
16 -	Pediatric Nurse Practitioner	18	-	Contract Physician
17 -	Nurse Midwife	25	-	Contract Podiatrist
21 -	Nurse Practitioner	41	-	Contract OB/GYN
33 -	Podiatrist			

The user is prompted for the FY for which to run the report and for the facility for which the report should be run.

A sample Report 1A is displayed on the next page.

Estimated Run Time:

On a Class "A" Altos computer, running without competition from other users (i.e., after hours), this job takes approximately 1.3 minutes per 1,000 visits being processed.

DEFINITION OF AN AMBULATORY CARE VISIT

Definition: An encounter between a patient and health care provider in an organized clinic within an IHS (638 included) facility where service resulting from the encounter is not part of an inpatient stay.

Requirement: Patient or his/her representative must be physically present at the time of service.

* Representative only to pick-up prescriptions.

Note written in the medical record by a licensed or credentialed provider found to be qualified and approved for privileges by the medical staff and facility administrator.

The date of the visit is the date the visit was initiated. e.g., Patient enters ER at 2330 and departs at 0100.

The following service is considered an Ambulatory Care Visit:

Patient served by physical or other provider within an IHS (or 638) facility where such service is documented and authenticated within the medical record.

NOTES: The category or provider must be listed within the IHS Standard Code Book.

A visit to two ORGANIZED APPROVED IHS (638) clinics on the same day counts as two Ambulatory Care Visits.

A visit to two physicians within the same IHS (638) clinic counts as one Ambulatory Care Visit.

Renal dialysis provided by contract provider in an IHS (638) facility will be counted as a physician provided Ambulatory Care Visit.

A dental prescription filled in the pharmacy is a pharmacy visit.

The following services <u>are not</u> an Ambulatory Care Visit:

- A prescription change based upon telephone conversation between provider and patient is not an Ambulatory Care Visit.
- Follow-up communication by telephone or letter is not an Ambulatory Care Visit.
- A letter written by a physician or other provider on behalf of a patient.
- A visit to provide patient care within a nursing home.
- Patient Care provided to patients in any non-IHS (638) facility.
- Patient care that is not documented and authenticated in the medical records.
- Patient care provided by Community Health Representatives. (CHR's)

CONTRACT HEALTH REPORTING
Similar encounters in the private sector that are purchased by the IHS will be counted as CHS visits.

DENTAL VISITS
Dental visits are not defined as Ambulatory Care Visits for purposes of the IHS statistical reporting.

Dental visits that are purchased by the IHS will be counted as CHS Dental visits.

This form is used to record services provided in group settings for entry into the PCC. Examples include blood pressure 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 (SERVICES RENDERED BY) CODES

1. Services Rendered by:
   - A Two Digits
   - B Designates who renders service.
   - C The Provider Codes and Definition are as follows:

00 - MD A doctor of medicine or doctor of osteopathy who, by virtue of education, training, and demonstrated competence, is granted clinical privileges by the organization to perform specific diagnostic or therapeutic procedure(s) and who is fully licensed to practice medicine.

01 - CLINIC RN - An individual who is qualified by an approved postsecondary program or Baccalaureate or higher degree in nursing and licensed by the state, commonwealth, or territory to practice professional nursing.

02 - ENVIRONMENTAL HEALTH

03 - HEALTH AIDE

04 - HEALTH EDUCATOR

05 - LICENSED PRACTICAL NURSE (LPN) - A nurse who has completed a practical nursing program and is licensed by a state to provide routine patient care under the direction of a registered nurse or a physician.

06 - MEDICAL SOCIAL WORKER

07 - NUTRITIONIST - An individual who is a specialist in nutrition.

8 - OPTOMETRIST - An individual who is a specialist in optometry. The profession of examining the eyes and measuring errors in refraction and of prescribing glasses to correct the defects.

09 - PHARMACIST - who has a degree in pharmacy and is licensed and registered An individual to prepare, preserve, compound, and dispense drugs and chemicals.

10 - PHYSICAL THERAPIST - An individual who is a graduate of a physical therapist education program accredited by a nationally recognized accrediting body; who meets any current legal requirements of licensure or registration or who has the documented equivalence in training, education, and experience; and is currently competent in the field. Physical therapists assess, evaluate, and treat movement dysfunction and pain resulting from injury, disease, disability, or other health-related conditions.

11 - PHYSICIAN ASSISTANT

12 -- PSYCHOLOGIST - An individual who specialized in psychological research, testing, or therapy; deals with the emotional and mental processes, consciousness, sensation, ideation, and memory.

13 - PUBLIC HEALTH NURSE

14 - SCHOOL NURSE - An individual who is either a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) who is identified as a school nurse.

15 - OTHER

16 -- PEDIATRIC NURSE PRACTITIONER

17 -- NURSE MIDWIFE

18 - CONTRACT PHYSICIAN

19 - MENTAL HEALTH

20 - MEDICAL STUDENT

21 - NURSE PRACTITIONER

22 - NURSE ASSISTANT

23 - LABORATORY TECHNICIAN

24 - CONTRACT OPTOMETRIST

25 - CONTRACT PODIATRIST

26 - INHALATION THERAPIST

27 - STUDENT NURSES

28 -AUDIOLOGIST - A specialist in evaluation, habitation, and rehabilitation of those whose communication disorders center in whole or in part in the hearing function. An individual who has a master's degree from an audiology program approved by a nationally recognized professional accrediting body; who has completed a supervised clinical fellowship year and passed a national examination in audiology or has the documented equivalent in education, training, or experience; and who meets any current legal requirements for licensure.

29 - DIETITIAN - An individual who is an expert in dietetics; one versed in the practical application of diet in the prophylaxis and treatment of disease. An individual who completed the minimum of a Baccalaureate degree granted by a U.S. regionally accredited college or university; meets current academic requirements (Didactic Program in Dietetics) as approved by the American Dietetic Association; successfully completed the Registration Examination for Dietitians; and accrues 78 hours of approved continuing education every five years.

30 - PHARMACY PRACTITIONERS

31 - OPTOMETRIC ASSISTANT

32 - CONTRACT PUBLIC HEALTH NURSE

33 - PODIATRIST - An individual who has received the degree of doctor of podiatry medicine and who is licensed to practice podiatry.

34 - TRIBAL/CONTRACT NUTRITIONIST

35 - OUTREACH WORKER

36 - EYE CARE SPECIALIST

37 - FAMILY PLANNING COUNSELOR

38 - EMT/PARAMEDIC

39 -- SPEECH THERAPIST

40 -- AMBULANCE DRIVER - An individual who performs the duty as an ambulance driver.

41 - CONTRACT OB/GYN

42 - SPEECH/LANGUAGE PATHOLOGIST - An individual who holds either a master's or degree; the Certificate of Clinical Competence (CCC) of the American Speech-Language Association (ASHA); or has the documented equivalent education, training, or experience, and, where applicable, state licensure.

43 - AUDIOMETRIC TECHNICIAN

44 - TRIBAL PHYSICIAN

45 - OSTEOPATHIC MEDICINE

46 - DENTAL HYGIENIST - An individual who is skilled in the science of dental health. A dental health educator permitted by law to give dental prophylaxis and other preventive treatment. Professional education, 2 years for certificate, and 4 years for BS degree.

47 - CRNA

48 - ALCOHOLISM/SUB ABUSE COUNSELOR

49 - CONTRACT PSYCHIATRIST

50 - CONTRACT PSYCHOLOGIST

51 - PAPAGO NUTRITION PROGRAM

52 - DENTIST - An individual qualified by law to practice dentistry. The healing science and art concerned with the care and health of all the tissues comprising the mouth. Emphasis is placed on (1) the prevention, diagnosis and treatment of diseases of the teeth and gingivae; (2) the replacement of missing teeth; (3) the correction of irregularities in the structure of the teeth and jaws; and (4) the study and care of non-dental disease affecting the superficial and deep structures of the oral cavity.

53 - COMMUNITY HEALTH REPRESENTATIVE

54 - DENTAL ASSISTANT (PRENATAL)

55 - DISEASE CONTROL PROGRAM

56- HEALTH RECORDS - Individuals who are employees of the Medical Records/Health Records or Health Information Department.

57 --ADMINISTRATIVE- Individuals who are employees of the Administrative department.

58 - SPEECH THERAPY-DISCONTINUED

59 - XRAY TECHNICIAN

60 - DENTAL ASSISTANT

61 - DENTAL LAB

62 - LICENSED MEDICAL SOCIAL WORKER - An individual who either has met the requirements of a graduate curriculum (leading to a master's degree) in a school of social work that is accredited by the Council on Social Work Education or has the documented equivalent in education, training, or experience.

63 -- CONTRACT SOCIAL WORKER

64 - NEPHROLOGIST - An individual who specialize with the branch of medicine dealing with the kidney.

65 - OPTOMETRY STUDENT - An individual who is a student within the optometry program.

66 - CASE MANAGERS

67 - CLINICAL PHARMACY SPECIALIST - Pharmacists designated as CPS has medication prescribing authority and deliver primary care. Pharmacists designated as CPS are those pharmacists with a Doctor of Pharmacy degree (Pharm. D), pharmacists who have completed a pharmacy residency program, specialty board certified pharmacists with at least two years of equivalent.

68 - EMERGENCY ROOM PHYSICIAN

69 - CHIROPRACTOR - An individual who employs the doctrine and dogma of chiropractic. The science and art of restoring or maintaining health, based on the theory that disease is caused by interference with nerve function, and employing manipulation of the body joints, especially of the spine, in seeking to restore normal nerve function.

70 - CARDIOLOGIST - An individual having special knowledge and experience in the branch of medicine dealing with the heart, its functions, and its diseases.

71 - INTERNAL MEDICINE

72 - OB/GYN

73 - ORTHOPEDIST

74 - OTOLARYNGOL

75 - PEDIATRICIAN

76 - RADIOLOGIST - an individual who is a graduate of a radiological technology program accredited by an accreditation body recognized by the U.S. Department of Education; is currently certified as a radiologists; meets any current legal requirements of licensure or registration or has the documented equivalent in education, training, and experience; and is currently competent in the field.

77 - SURGEON

78 - UROLOGIST

79 - OPHTHALMOLOGIST

80 - FAMILY PRACTICE

81 - PSYCHIATRIST - A physician who specializes in assessing and treating persons having psychiatric disorders; is certified by the American Board of Psychiatry and Neurology or has the documented equivalent in education, training, or experience; and is fully licensed to

practice medicine in the state in which he or she practices.

82 - ANESTHESIOLOGIST

83 - PATHOLOGIST

84 -- PEDORTHIST - A person skilled in pedorthics and practicing its application in individual cases.

85 -- NEUROLOGIST

86 -- DERMATOLOGIST

87 -ULTRASOUND TECHNICIAN - A person trained in and expert in the performance of ultrasound technical procedures.

88 - CODING/DATA ENTRY

89 -- AUDIOLOGY HEALTH TECHNICIAN - A person trained in and expert in the performance of audiology technical procedures who assists the ENT practitioner.

90 -- OCCUPATIONAL THERAPIST - A person skill in the therapeutic use of self-care, work and play development, and the environment to enable the patient to achieve maximum independence and to enhance the quality of the patient's life.

91 -- PHN DRIVER/INTERPRETER - A person who provides assistance to the PHN.

92 -- PSYCHOLOGIST - A person who provides treatment of mental disorders and behavioral disturbances using such psychological techniques as support, suggestion, persuasion, re-education, reassurance, and insight in order to alter maladaptive patterns or coping and to encourage personality growth.

93-- TRADITIONAL MEDICINE PRACTITIONER - A person who is trained in a Native American community, applies culturally specific knowledge and skills in the diagnosis, treatment, or referral of patients to promote their well-being physically, mentally, socially, and spiritually.

94 -- MENTAL HEALTH SPECIALIST (BS/BA Only) - An individual who has a Bachelor of Art (BA) or Bachelor of Science (BS) Degree in Mental Health.

95 -- MENTAL HEALTH SPECIALIST (MASTERS DEGREE ONLY) - An individual who has a Masters Degree in Mental Health.

96 -- FAMILY THERAPIST - An individual who has a degree or is skilled in the treatment of group therapy of members of a family, with exploration of family relationships and processes as potential causes of mental disorder in one or more members of the family.

97 - NUTRITION TECHNICIAN

98 - FOOD SERVICE SUPERVISOR

99 - DIETETIC TECHNICIAN

A1 -- SPORTS MEDICINE - The role of a sports medicine physician addressed the physical, emotional and spiritual needs of the athlete in the context of sport and the needs of the team. This individual should be a primary care physician with additional training and experience in sports medicine.

CLINIC CODE DEFINITION

1. Type of Clinic Codes

A. Two Digit Codes
B. Type of Clinic Codes
C. The Codes and Definition are as follows:

01 CARDIAC - A prescheduled organized clinic that provides major diagnostic, medical treatment pertaining to the heart.
03 CHEST AND TB - A prescheduled organized clinic that provides major diagnostic, medical treatment pertaining to the chest and tuberculosis.
04 CRIPPLED CHILDREN -
05 DERMATOLOGY - A prescheduled organized clinic that deals with the branch of medicine that has to do especially with the study of the skin, its chemistry, physiology, histopathology, cutaneous lesions, and the relationship of cutaneous lesions to systemic disease.
06 DIABETIC
07 ENT (Ears, Nose and Throat) -
08 FAMILY PLANNING
09 GROUPED SERVICES - Use this code number when an "Ambulatory Patient Care Report Form" is prepared for an Indian or Alaska Native patient found with abnormal findings in a "Group Services" Clinic. See Indian Health Manual 4-3-1; Appendix 1, Section III for definition.
10 GYNECOLOGY (GYN) - A prescheduled organized clinic that deals with the branch of medicine which has to do with the diseases peculiar to woman, primarily those of the genital tracts, as well as female endocrinology and reproductive physiology.
11 HOME CARE
12 IMMUNIZATION
13 INTERNAL MEDICINE
14 MENTAL HEALTH (PSYCHIATRY)
15 OBESITY -
16 OBSTETRICS (OB) - A prescheduled organized clinic that deals with the branch of medicine that has to do with the care of the pregnant woman during pregnancy, parturition, and the puerperium.
17 OPHTHALMOLOGY - A prescheduled organized clinic that deals with the branch of medical science that has to do with the eye, its diseases of refractive errors.
18 OPTOMETRY - A prescheduled organized clinic that provides for refractive errors.
19 ORTHOPEDIC - A prescheduled organized clinic that deals with the medical specialty concerned with the preservation, restoration, and development of form and function of the extremities, spine, and associated structures by medical, surgical, and physical methods.
20 PEDIATRIC - A prescheduled organized clinic that deals with the branch of medical science that treats of children in their hygienic, physiologic, and pathologic relations; the specialty of the diseases of children.
21 REHABILITATION - A prescheduled organized clinic that deals with the restoration, following disease, illness, or injury, of ability to function in a normal or near normal manner.
22 SCHOOL - A prescheduled organized clinic that provides services to school age children.
23 SURGICAL - A prescheduled organized clinic that deals with the branch of medicine that has to do with external diseased and all other diseases and accidents amenable to operative or manual treatment.
24 WELL CHILD - A prescheduled organized clinic that provides services to well children.
25 OTHER - Include any "Organized Specialty" Clinic not identified above in addition to all patients whoa re seen outside of regularly scheduled clinic hours, and special situations defined in the Indian Health Manual 4-3.1A.2C.
26 HIGH RISK
27 GENERAL PREVENTIVE
28 FAMILY PRACTICE
29 in life or prevent critical consequences and that should be performed immediately.

31 HYPERTENSIVE
32 POSTPARTUM
33 INHALATION THERAPY
34 PHYSICAL THERAPY
35 AUDIOLOGY
36 W. I. C.
37 NEUROLOGY
38 RHEUMATOLOGY
39 PHARMACY
40 INFANT STIMULATION
41 INDIRECT
42 MAIL
43 ALCOHOL AND SUBSTANCE
44 DAY SURGERY - Also know as Ambulatory Surgery, Short-Stay Surgery, One-Day Surgery. A day surgery clinic for the performance of elective surgical procedures on patients who are classified as outpatients and typically are released from the surgery unit on the day of surgery.
45 PHN CLINIC VISIT - A patient encounter with the Public Health Nurse (PHN) only.
46 NIH CLINIC - For use only by Phoenix Indian Medical Center.
47 FETAL ALCOHOL SYNDROME (FAS) -
48 MEDICAL SOCIAL SERVICES
49 NEPHROLOGY - A prescheduled organized clinic that deals with the branch of medical science that deals especially with the kidneys.
50 CHRONIC DISEASE - A prescheduled organized clinic that deals with the branch of medical science that deals especially with chronic diseases.
51 TELEPHONE CALL - Contacts with individuals over the telephone.
52 CHART REV/REC MOD - Chart review(s) or a patient record modification is conducted.
53 FOLLOW-UP LETTER - A patient is sent a follow-up letter.
54 RADIO CALL - Contacts with individuals over a radio call.
56 DENTAL
57 EPSDT
58 CANCER SCREENING
59 VENEREAL DISEASE
60 EDUCATION CLASSES
61 DEVELOPMENTAL ASSESSMENT
62 CANCER
63 CAST ROOM - An area or location where a patient is provided follow-up care.
64. CHEMOTHERAPY
63 RADIOLOGY - The science that treats of radiant energy; of the chemical and other actions of rays proceeding from luminous bodies, from radium and other radioactive substances, and from x-rays; and of the sources of these rays.
64 RETINOPATHY - A prescheduled organized clinic that provides services for non-flammatory degenerative disease of the retina.
65 PODIATRY - A prescheduled organized clinic that deals with the specialty that includes the diagnosis and/or treatment medical, surgical, mechanical, physical, and adjunctive treatment of the diseases, injuries, and defects of the human foot.
66 ULTRASOUND - Ultrasonic waves, used in medical diagnosis and therapy.
67 DIETARY - The delivery of care pertaining to the provision of optimal nutrition and quality food service for individuals.
68 EMPLOYEE HEALTH UNIT - A prescheduled organized clinic defined to provide health care services to local facility employees usually for employment related conditions.
69 ENDOCRINOLOGY - A prescheduled organized clinic that deals with the science dealing with the internal secretions and their physiologic and pathologic relations.
70 WOMEN'S HEALTH SCREENING - A general health screening clinic for the female patient, related to female gender disease. A prescheduled organized clinic in which female gender health screening is performed for the early detection of disease or disease precursors in apparently well

female so that health care can be provided early in the course of the disease or before the disease becomes manifest.

71 COMPUTED TOMOGRAPHY

72 MAMMOGRAPHY - Examination of the breast for diagnostic purposes by means of roentgen rays, the record of the findings is impressed upon a photographic plate.

73 GENETICS - A prescheduled organized clinic that deals with the branch of science dealing with heredity.

74 SPEECH PATHOLOGY

75 UROLOGY - A prescheduled organized clinic that deals with the branch of medical science that embraces the study, diagnosis, and treatment of diseases of the genitourinary tract.

76 LABORATORY SERVICES - Pathology and clinical laboratory services. The services that provide information on diagnosis, prevention, or treatment of disease through the examination of the structural and functional changes in tissues and organs of the body that cause or are caused by disease.

77 CASE MANAGEMENT SERVICES - Case management services provided in clinics and community settings to the chronic mentally ill patients.

78 OVER THE COUNTER MEDICATIONS - An encounter that occurs for patients who receive over the counter (OTC) medications.

79 TRIAGE - A nurse visit only to determine priority of need and proper place of treatment. Usually, the patient is given an appointment to return at another date and time. If the patient is referred, from triage, to a specific clinic then the appropriate clinic code will be assigned.

80 URGENT CARE - The encounter is usually a walk-in and non-emergent in nature. A mid-level provider (CPA, FNP, etc) usually provides the care. With full nursing staff support. This service is not provided in the Emergency Room; usually another area of the facility is designated to provide urgent care. It is different from an Emergency Room encounter in that the definition for emergency room encounter "any patient that is screened, evaluated and/or treated in the Emergency Room, and the care is documented on the EVR (IHS-114) form.

81 MEN'S HEALTH SCREENING - A general health screening clinic for the male patient, related to male gender disease. A prescheduled organized clinic in which male gender health screening is performed for the early detection of disease or disease precursors in apparently well men so that health care can be provided early in the course of the disease or before the disease comes manifest.

82 DAY TREATMENT PROGRAM - A general clinic that provides major diagnostic, medical, psychiatric psycho-social and pre-vocational treatment modalities in a defined day treatment program setting.

83 LABOR AND DELIVERY - When a pregnant patient present directly to the OB Inpatient Unit for outpatient services, i.e., fetal monitoring, non-stress test, contraction stress tests, biophysical profiles, amniotic fluid assessment, and ultrasound performed by obstetrics providers as opposed to a radiology or ultrasound technician. NOTE: If the patient is subsequently admitted as an inpatient, the patient will be admitted to the OB services (08) or Nurse-Midwifery Services (22).

84 PAIN REDUCTION - A prescheduled organized clinic defined as any visit to a clinic "primarily for the purpose of" pain reduction using anesthesia or other appropriate service. This may include acupuncture or other pain reduction techniques.

85 TEEN CLINIC - A prescheduled organized clinic defined to provide medical and counseling service to adolescence, age range from 11-19.

86 TRADITIONAL MEDICINE - A setting where the traditional medicine practitioner provides their respective services.

87 OBSERVATION: An observation patient is a patient who presents with a medical condition with a significant degree of instability and patient disability who needs to be monitored, evaluated and assessed for admission to inpatient status or discharged for care in another setting. An observation patient can occupy special beds set aside for this purpose or may occupy beds in any unit in a hospital. Medicare guidelines note that this type of patient should be evaluated against inpatient standard criteria and if the patient is expected to need hospital care for more that 24 hours, then the patient should be admitted as an inpatient. If the patient meets the inpatient criteria, then the patient should be admitted. If not, then plans should be made for discharge to an appropriate setting. Inpatient status is not determined by the length of stay but by the physician's intent at the

time of admission. The length of the observation period should not be longer than approximately 36-48 hours.

88 SPORTS MEDICINE - Sports Medicine is a rapidly growing medical specialty. The American Board of Medical Specialties defines the field of sports medicine as a broad area of health care which includes: (1) exercise as and essential component of health care throughout live; (2) medical management and supervision of recreational and competitive athletes and others who exercise, and (3) exercise prevention and treatment of disease and injury.

89 EVENING - An organized evening clinic, between the hours of 5:00 p.m. to 10:00 p.m., that would normally be General (01) during the day.

90 TELE-MEDICINE - The provision of consultant services by off-site physicians to health care professionals on the scene, as by means of closed-circuit television.

91 TELE-RADIOLOGY - The provision of radiology services, diagnoses, consultation, treatment and transfer of medical data through interactive audio, video or data communications that occur in the physical presence of the patient.

92 DIALYSIS - The treatment of patients by an IHS provider at the dialysis site/room/annex.

DEVELOPING A POLICY AND PROCEDURE MANUAL FOR HEALTH PROVIDERS/PROGRAMS

Introduction

Most every professional is aware of the need for policies and procedures. However, there are many professionals that are unable to differentiate between a policy, a procedure, and a Standing Order. Also, many professionals are not certain of which items should be included in a policy and procedure manual. This brief section will present guidelines for policies and procedures and will also present a sample Table of Contents (or guidelines) on what items should be contained in a policy and procedure manual.

Polices and procedures support the goals and objectives of the organization by providing the means for accomplishing the goals and objectives of an organization. Policies and procedures clarify and standardize the discipline or program's guiding rules. Policies will answer the **why** and **what** concerning the discipline or program and its role in the organization. Generally, policies pertain more to administrative matters.
Procedures tell **how** the policies will be carried out. Generally, in the health field, procedures pertain more to clinical matters.

Standing Orders are specific treatment (usually a medication but it can be another type of therapy) to be used under specific instances. Every procedure must have a policy but not all policies have a procedure.

Every Health program or discipline faces the task of developing a policy and procedure manual (PPM). The primary purpose for developing a PPM is to enhance communication:
- with other health providers and staff,
- with other accrediting agencies and organizations,
- and, with clients and the community.

In some cases the components of a PPM may be required by state law, accreditation standards (JCAHO or AAAHC, CARF, etc.), professional practice acts, Standards of Practice from professional associations, from institutional policies, quality of care issues, program evaluation considerations and to ensure continuity of care.

POLICIES

Policies flow from planning and are a very useful connection between goals and action. With the development of clear plans, policies can be set to give useful guidelines for making decisions and implementing plans.

Policies explain how the goals of the organization will be achieved and serve as guides that define the general course and scope of activities permissible for goal accomplishment. They serve as a basis for future decisions and actions, help coordinate plans, control performance and increase consistency of action by increasing the probability that different managers will make similar decisions when independently facing similar situations. Policies also serve as a means by which authority can be delegated.

Policies can be implied or expressed. Implied policies are not directly voiced or written but is established by patterns of decisions. They may have either favorable effects or unfavorable effects and represent an interpretation of observed behavior. Express policies may be written or oral. Oral policies are more flexible than written ones and can be easily adjusted to changing circumstances. However, they are less desirable than written ones because all staff may not know them.

Policies can emerge in several ways – originated (internal), appealed, or imposed (external). The originated policies are usually developed by top management to guide subordinates in their function.

PROCEDURES

A procedure is a system that describes in detail, the process or steps taken in order to accomplish a job. Procedures supply a more specific guide to action than policy does. They emphasize detail while policies concentrate on more general principals. Procedures help achieve a high degree of regularity by

enumerating the chronological sequence or steps taken. Procedures are interdepartmental or intradepartmental and consequently do not affect the entire organization to the extent that policy statements do.

Improvement in operating procedures increases productivity. Waste in performing work can be decreased by applying work simplification that strives to make each part of a procedure productive. First one decides what work needs simplification by identifying problem areas. Next the work selected is analyzed carefully and in detail. Charts that depict the components of the work and the workflow are useful for motion or procedural analysis.

Writing procedures demands a consistent format that considers the definition; purpose; materials needed, and how to locate, requisition, and dispose of them; steps in the procedure; expected results; precautions; legal implications; and responsibilities. Each step in the procedure leading to the accomplishment of a goal should be necessary and in proper relationship to other steps. Balance between flexibility and stability should be maintained. Each procedure should be easily replaced with a revised one.

Procedures:

- Describe what, who, where, when, and why
- Define terms
- Explain how to use the procedure
- Has a header:
- Subject
- Purpose
- Scope/Staff Governed
- Effective date
- Date Reviewed/Revised
- Approved by
- Distribution
- Parts, Forms Needed
- Cautions, Notes
- Summary
- Describe the Process
- Arrange the steps in order
- Assign the actions
- Describe each step
- Establish requirements – equipment, materials and other prerequisites
    - Identify decisions and verifications
    - Note special conditions and cautions

Definition of Terms

A clear definition of terms should be included in any policy and procedure manual.

Creed- A belief or faith that lacks precision but serves as a foundation upon which policies are developed.

Law - A statement of an order that is invariable under given conditions. Laws are rigid statements providing a framework for policy promotion.

Policy - An understanding by members of a group that makes the actions of each member more predictable to other members. A policy clearly defines the range within which individual decisions can be made and encourages clear and forceful decisions. Policy can also be described a standard of practice or prudent practice; a line or course of action. Policies pertain more to administrative matters.

Practice - The usual mode of handling a given problem. A practice stresses expediency and things, as they are, a policy stresses direction and things as they should be.

Practice Guidelines - Descriptive tools or standardized specification for care of the typical patient in the typical situation, developed through a formal process that incorporates the best scientific evidence of effectiveness with expert opinion. Synonyms or near synonyms include criteria, parameters, protocol, algorithm, review criteria, preferred practice pattern, and guideline.

Practice Parameters – Strategies for patient management, developed to assist practitioners in clinical decision making. Practice parameters include standards, guidelines, and other management strategies.
Principle - A universal statement that remains true even when conflicting statements may be claimed to be valid. A principle is valid and cannot be good or bad; a policy may be good or bad; but it is valid only in the sense that someone has decided that it is to be used as a guide.
Procedure – A system that describes, in detail the steps to be taken in order to accomplish a job. Procedures emphasize details; policies concentrate on basic general principles. In the health field,
procedures pertain more to clinical matters.
Process - A goal-directed, interrelated series of actions, events, mechanisms, or steps.
Protocol -- The customs and regulations dealing with the management of certain specific situations.
Rule - A statement of precisely what is to be done (or not done) in the same way every time with no permitted deviation. Rules allow no range for decision-making; policy encourages decision-making by offering guides.
Standards - A statement of expectation that defines the structures and processes that must be substantially in place in an organization to enhance the quality of care.
Standing Order -- Specific treatment (usually a medication but can be another type of therapy) to be used under specific instances.

From these definitions it can be seen that policies and procedures are general, generic guidelines for practice, while protocols and standing orders are specific guidelines for specific instances.

Advantages and Disadvantages of Written Policies
Although the overall purpose of written PPM is communication, several advantages and disadvantages of this communication can be identified, and indicated below:

Advantages of Written Policies and Procedures:
1. They define the scope of practice for an individual, discipline or program of Health Providers.
2. They provide guidelines for new Health Providers or students.
3. They help set the standards of care for the commu nity in which the Health facility practices.
4. They provide documentation of the role and responsibilities of Health Providers and the organization.
5. They help the Health Provider, program or organization interface between physicians, nurses, other staff, clients and the community.

Disadvantages of Written Policies and Procedures:
1. It is time-consuming to write them.
2. They must be updated as needed to reflect any changes.
3. They document what you *must do* in a given circumstance, OR
2. If you ever decide to deviate from the written policy, you must provide adequate justification and documentation in writing.
3. A PPM that is not revised regularly as your program skills and abilities increase may limit the practice of your particular health discipline and can also limit your department.

Anatomy of a PPM

The following information suggests components to be contained in a PPM. All sections may not be necessary in your manual. Policy and Procedure Manual's vary according to the Health Provider's skills and practice setting.

Title Page and Date
A title page is not essential but adds to the professional appearance of the document. Include the date each time the PPM is updated.
Introduction
The introduction contains a paragraph or two on why you are doing what you are doing. It answers such questions as: Does *the community need this Health Provider, program, and discipline? Why are you writing this document?*
Who was involved in preparing this material? Discuss any unusual or culturally relevant community needs; purposes of writing this document and who was involved.

Mission and Vision Statement of Patient Education

Philosophy of Care
The philosophy of care section contains statement(s) of your beliefs and the guiding principles that determine the practice of _____ at your facility. It should be consistent with the philosophy of pertinent health professional organizations and/or the Tribal hospital and clinics where you practice.

Key content areas include the following:
1. Beliefs/principles relating to client care such as quality, safety, awareness of consumer rights and responsibilities;
2. A framework that integrates your profession or program into one larger picture. For example, where does your _____Program fit into the community? the Clinic? the Hospital? the IHS Area Program? the national IHS Program?
3. A discussion of the professional commitments you are making regarding the "currentness" of your Program, responsibilities, competency, and accountability.

Purposes/Goals of Practice
Purposes of general goals of your program should be outlined in this section. What do you plan to do for your clients and their families? What differences can your care make? Although goals can be general, try to make some of them measurable outcomes so they can be evaluated later. Most of your purposes should be congruent with those other Health Programs but they should also reflect the unique purposes of your program based on your own unique skills, location and/or population.

Functions and Responsibilities of the Health Provider, Program or Discipline
This is one of the most critical sections of the PPM as it defines the scope of profession. Therefore, it is important to spend some time on this section and draw from examples from other well-written Policy and Procedure Manuals.

Definition of Terms
Briefly define important terms that you will use in the PPM.

Responsibilities of Clients
A section on the responsibilities of clients might be included in order to clarify your expectations of clients. This section can be used as a tool when discussing the operation of your health discipline with clients. It may list client responsibilities such as:

1. Participation in their own care by keeping appointments, listening to advice and asking questions;
2. Participation in the educational process by reading appropriate pamphlets, brochures, viewing of video's, etc.;
3. Agreeing, if necessary, to participate in evaluations;
4. Recognizing the limitations of educators and accepting physician/hospital care as needed.

WORKING OUTLINE FOR PREPARATION OF A POLICY AND PROCEDURE MANUAL

1. Title Page
2. Introduction
3. Definition of Terms
4. Mission, Vision, Philosophy of Care
5. Purpose/Goals of Practice
6. Functions and Responsibilities
7. General Functions
8. ponsibilities of Clients
9. Additional Sections (as desired) date each page
   Procedures
   Standing Orders:
   Protocols

10. Orientation Program
11. In-service Education, Continuing Education
12. Quality Assurance
13. Policies and Procedures Approved by the Governing Board, Medical Staff and Administration
14. Copies Of Current Disaster and Fire Manual
15. Infection Control
16. Safety Policies -
17. Preventive Maintenance/Electrical on any Program equipment
18. Organization Chart - Specific to the department with documented relationships to Medical Staff, if any, and Administration (direct or indirect). Dated. Narrative statement also recommended.
19. Organization chart - copy of current, dated, hospital-wide chart on file in the Policy and Procedure manual.
20. Hours of operation, weekends, after-hours, or on call-coverage method.
21. Job descriptions - for each employee, dated.
24. Record of licenses, registration numbers with dates of expiration, updated regularly and filed in Personnel according to clinic/hospital policy for ongoing verification of current licensure including any teaching or State licenses, certification, RN licensure, CPR, Red Cross, Etc.
25. Copies of respective sections of JCAHO - and other appropriate standards and regulations.

SUGGESTED ADDITIONAL CONTENTS FOR A PATIENT EDUCATION POLICY AND PROCEDURE MANUAL

Annual Patient Education Work Plan
Budget/Spending Plans for Patient Education
Clinic/Hospital Organizational Chart
Any Grant Proposals for Patient Education
Goals and Objectives Statement
Monthly Reports
Quarterly Reports
Year End Reports
Patient Right's and Responsibilities
Personnel
Quality Assurance
Position Description
Scope of Work for Patient Education
Any Strategic Planning for Patient Education
Workshops/Training/In-Service Education Doumentation

JCAHO Patient and Family Education (PFE) 2000 Standards

PF.1	The patient's learning needs, abilities, preferences, and readiness to learn are assessed.
PF.1.1	The assessment considers cultural and religious practices, emotional barriers, desire and motivation to learn, physical and cognitive limitations, language barriers, and the financial implication of care choices.
PF.1.2	When called for by the age of the patient and the length of stay, the hospital assesses and provides for patient's academic education needs.
PF.1.3	Patients are educated about the safe and effective use of medication, according to law and their needs.
PF.1.4	Patients are educated about the safe and effective use of medical equipment.
PF.1.5	Patients are educated about potential drug-food interactions, and provide counseling on nutrition and modified diets.
PF.1.6	Patient are educated about rehabilitation techniques to help them adapt or function more independently in their environment.
PF.1.7	Patients are taught that pain management is a part of treatment.*
PF.1.8	Patients are informed about access to additional resources in the community.
PF.1.9	Patients are informed about when and how to obtain and further treatment the patient may need.
PF.1.10	The hospital makes clear to patients and families what their responsibilities are regarding the patient's ongoing health care needs, and gives them the knowledge and skills they need to carry out their responsibilities.
PF.1.11	With due regard for privacy, the hospital teaches and helps patients maintain good standards for personal hygiene and grooming, including bathing, brushing teeth, caring for hair and nails, and using the toilet.
PF.2	Patient Education is interactive
PF.3	When the hospital gives discharge instructions to the patient or family, it also provides the instructions to the organization or individual responsible for the patient's continuing care.
PF.4	The Hospital plans, supports, and coordinates activities and resources for patient and family education.
PF.4.1	The hospital identifies and provides the educational resources required to achieve its educational objectives.
PF.4.2	The patient and family educational process is collaborative and interdisciplinary, as appropriate to the plan of care.

Subject: Client/Patient Satisfaction Interview/Survey

Why has customer satisfaction become so important to business in general and to health care in particular? What happens when customers (or patients) become dissatisfied? How does one prevent or remedy dissatisfaction? Patient satisfaction should be a Hospital/Clinic objective.

Dimensions of Patient Satisfaction

Although most patients are generally satisfied with their service experience, they are not uniformly satisfied with all aspects of the care they receive, and therein lie the challenge to health care management. How much service is enough to elicit high satisfaction among customers and ultimately to keep them returning to the Hospital/Clinic with satisfaction, and just what kind of service is that?

What are the dimensions of patient satisfaction? According to a national survey the ranking is as follows:

1.	Highest priority:	Overall care
2.	Second priority:	Cleanliness
3.	Third:	Physicians
4.	Fourth:	Nurses
5.	Fifth:	Other health staff
6.	Sixth:	Concern of staff
7.	Seventh:	Admissions/Discharge
8.	Eighth:	Courtesy/helpfulness of clerical/secretarial/business staff
9.	Ninth:	Parking/Convenience
10.	Tenth:	Cost of Care

Patient Satisfaction Defined

Many health providers have complained that patient satisfaction is an ill-defined concept. Perhaps, in fact, it is difficult to define or describe patient satisfaction. A simplistic version of PFCE defined is "the positive evaluation of distinct dimensions of health care. The care being evaluated might be a single clinic visit, treatment through an illness episode, a particular health care setting or plan, or the health care system in general."

There are ten constructs or elements that can be used to determine patient satisfaction:

1.	Accessibility/Convenience	6.	Humanness
2.	Availability of resources	7.	Information gathering
3.	Continuity of care	8.	Information giving
4.	Efficacy/outcomes of care.	9.	Pleasantness of surroundings
5.	Finances	10.	Quality/competence

Survey Administration

Most surveys must rely on three basic methodologies:

1. Surveys administered *in-person*,
2. Surveys conducted with individuals over the *telephone*
3. Surveys using a *mail-out* and return-response mechanism.

Survey Questions

There are four "rules" to bear in mind when developing a survey:

1.	Length of the survey:	Surveys being too long or too short
2.	Question format:	Avoiding double-barreled questions ("Did Admissions staff serve you *promptly <u>and</u> courteously?*)
3.	Appropriateness of Questions	Does the question ask what it was intended to ask?
4.	Follow-up Questions:	*In-Person* or *telephone* interviewers should probe with follow-up questions: "Is there anything else?" Written surveys should provide space for comments.

Research Design

1. Determining Research Objectives:

Before collecting data, it is essential that the researcher establish with management the purpose or objectives of the study. It is not uncommon for management to initiate a research project with a question as vague as "How do I know how satisfied patients are with the care we are providing?" Before attempting to answer such a question, the researcher needs to clearly understand which patients, departments, or services management wishes to study and why. It is an error to assume that one study can answer all of management's questions.

The next question to consider is what management means by patient satisfaction -- what they really want to know and why. Some managers may equate satisfaction with patient complaints, or lack thereof, believing that as complaints decrease, satisfaction increases.

2. Selecting the Methodology: Patient satisfaction research can be divided into two general categories:

A. Qualitative Methods:

Qualitative research describes both the service received and patient's experience of it. To get this information, the researcher must enter the patient's world and experience the service from the patients' perspective. To gain this perspective, the researcher immerses himself or herself in the service as if he or she were a patient. In addition to observing the service, informal and in-depth patient interviews are conducted, as well as focus groups. Clinical staff is also interviewed to gain their perspective of the patients' experience. Quite often, qualitative research is the first stage in a research project because it affords an opportunity to explore the patient's world.

Appropriate Uses for Qualitative Methods:

1. Management is unclear about what they want to know about the service, and why.
2. Management is primarily interested in obtaining information that will be helpful in understanding how to improve the service.
3. The researcher does not fully understand the service, the characteristics of the patients, or their problems, language, expectations, and needs.
4. It is unclear how to interpret quantitative patient satisfaction data.

B. Quantitative Methods:

Quantitative research measures patient satisfaction by counting or by using scales. Counts are made on the number of patients who complained, the number indicating they were satisfied, etc.

Another form of quantitative research involves the use of various types of scales on which respondents are asked to rate various service attributes on an evaluation continuum (scale):

Rate the overall care 1 2 3 4 5

Appropriate Uses for Quantitative Methods:

1. How satisfied are patients?
2. Will service changes (for example, increasing or decreasing the number of staff, facility improvements, etc.) affect patient satisfaction?
3. Are patients more or less satisfied with the Prenatal Clinic as compared to Well-Child Clinic?

ACKNOWLEDGEMENTS

How to Design and Use a Patient Teaching Module ,; Myrna R. Spicer, RN. Pritchett & Hull Associates.

Blue Cross/Blue Shield Plan Support for Health Education Services; A Discussion of Issues, AHA, 1982.

Financing Patient and Family Education at the Hospital Level,. Pritchett and Hull, 1976.

Measuring and Managing Patient Satisfaction, Steiber and Krowinski, AHA ,1990.

Managing Hospital-Based Patient Education,. Giloth, AHA, 1993

Hospital Patient Education Policy and Procedure Manual, Stanley, Hospital and Physician Consulting Service Inc., 1991

A Resource Collection on a Budget- Establishing a Specialized Patient Education Library, Urich, 1993.

Managing Hospital-Based PFCE by: Sandra J. Cornett