# INDIAN HEALTH SERVICE

# Patient and Family Education Protocols and Codes (PEPC)

# ADMINISTRATIVE CODES

## 11th Edition
## January 2005

**FOREWORD TO THE 11TH EDITION OF THE PATIENT EDUCATION PROTOCOLS**

# FOREWORD

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

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

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

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## FOREWORD TO THE 11TH EDITION OF THE PATIENT EDUCATION PROTOCOLS

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# Use and Documentation of Patient Education Codes

## Why Use the Codes?

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

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

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

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

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

## SOAP Charting and the Codes

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

## How to Use the Codes

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

The educator should document the education using the following steps:

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

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

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

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

## Recording the Patient's Response to Education

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

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

# Documenting Patient Education (Forms)

IHS-485
(3/98)

PCC INPATIENT SUPPLEMENT AND
DISCHARGE FOLLOW-UP RECORD

1 **Document Educational Assessment here**

PROBLEM LIST
A-AI-C #

PROBLEM LIST ADDITIONS OR CHANGES (PRINT ONLY IN THIS SECTION)

**Learning Preferences – TALK**
**HTN – N – G – XYZ – 5 min – GS—Patient will eat less salt**

Change to Inactive #

Change to Active #

REPRODUCTIVE FACTORS G P LC SA TA LMP FP METHOD DATE BEGUN

PROBLEM LIST NOTES
STORE NOTE FOR PROB. #
REMOVE PLAN #

STORE NOTE FOR PROB. #

B/P

A. DISCHARGE ORDER

DATE OF ORDER #

B. DIAGNOSES AND PROB...

2 **Document the Patient Education here**

Don't know how to document educational assessments?

Please refer to the IHS Patient Education Protocol Manual

#1 Educational Assessment

#2 Patient Education

C. OPERATIONS AND / OR PROCEDURES

D. CONDITION AT DISCHARGE

E. MEDICATION, SPECIAL EQUIPMENT, SUPPLIES FOR USE AT HOME

BREAST
RECTAL
HEP B#
HEP A#
OPV#
DTP#
DTaP#
DT
Td
MMR#
VARICELLA
INFLUENZA
Hib TITER/

F. FOLLOW-UP RECOMMENDATIONS, SPECIFIC INSTRUCTIONS, DIET, ACTIVITY, WORK TOLERANCE, REFERRALS, RETURN APPOINTMENT

I, ______ (Patient or Repr...
the above instructio...

It is important to place your provider code and signature on the bottom of the PCC form.

HRN # SSN#
NAME
B DATE SEX TRIBE
RESIDENCE
FACILITY DATE

ADMISSION
DISCHARGE
☐ REFERRING MD ☐ VILLAGE HEALTH AIDE
☐ OTHER

PROVIDER SIGNATURE
PROVIDER CODE AFN. Dis. Initials/Code

Signature EF X Y Z

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

PCC AMBULATORY ENCOUNTER RECORD

X Y Z

There are two places on the PCC form where it is appropriate to document patient education.

It is also important to place your provider code in the top right hand corner and to sign the bottom of the PCC form.

1 Document Educational Assessment here

Educational Assessments questions? Please refer to the IHS Patient Education Protocol Manual

PURPOSE OF VISIT (PRINT ONLY IN THIS SECTION; DO NOT ABBREVIATE)

Learning Preference - TALK
HTN – N – G – XYZ – 5 min – GS, patient will reduce salt intake

2 Document the Patient Education Here

2 Or Document the Patient Education and Assessment

MEDICATIONS / TREATMENTS / PROCEDURES / PATIENT EDUCATION

Learning Preference – TALK
HTN - N - G - XYZ - 5 min – GS, patient will reduce salt intake

Signature

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

«hdr» «timestamp» «provider»

Clinic Code _____ Appointment ____ Walk-in____

«h1» «h2» «h3» «h4» «h5» «h6» «h7» «h8» «h9» «h10»

«h11» «h12» «h13» «h14» «h15» «h16» «h17» «h18» «h19» «h20»

| Chief Complaint & Visit Plan |
|---|
| |
| |
| |
| |

«grav» «para» «lc» «ab» «fpm»

| Afl. | Discipline | | Initials | | |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | X | Y | Z |

| Vital Signs & Measurements | |
|---|---|
| Temp | Peak Flow |
| Pulse | $O_2$ Sat |
| Resp | LMP |
| BP | |
| Wt | Glucose |
| Ht | Pain (0 – 10) |
| Tobacco | Smoker in Home |
| ETOH | Dom Violence |

| Vision | | |
|---|---|---|
| Uncor | Corr | FT Check/Exam |
| R | R | Designated Prov |
| L | L | |

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

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

S/O

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

X-ray Labs

Provisional Dx

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

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

| Pharmacy Only | Screened: | Entered: | Checked: |
|---|---|---|---|

**«patient»** «agesex» «x29»
DOB: «dob» SSN:«ssn» «timestamp»
«b27» **#«chart»** VCN: «uid»

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

| Physical Exam | |
|---|---|
| ___Vital Signs | **«x14»** |
| ___General | ___ «x1» |
| **EYES** | ___ «x2» |
| ___ Conj/Lids | ___ «x3» |
| ___ Pupils | ___ «x4» |
| ___ Fundi | ___ «x5» |
| **ENT** | ___ «x6» |
| ___ Ext ear/Nose | ___ «x7» |
| ___ EAC/TMs | ___ «x8» |
| ___ Hearing | **ABDOMEN** |
| ___ Nasal mucosa | ___ Mass,tnderness |
| ___ Sinuses | ___ Liver, spleen |
| ___ Mouth | ___ Hernia |
| ___ Pharynx | ___ Rectal |
| **NECK** | ___ Stool Heme |
| ___ Thyroid | **MUSC/SKLTL** |
| ___ Masses | ___ Gait/Station |
| **RESP** | ___ Digits/Nails |
| ___ Effort | ___ Joints/Bones |
| ___ Percussion | ___ Muscles |
| ___ Palpation | Area Examined |
| ___ Breath Sounds | ___________ |
| **HEART / CV** | ___ Inspection |
| ___ Palpation | ___ Palpation |
| ___ PMI | ___ Range motion |
| ___ Sounds | ___ Stability |
| ___ Carotid | ___ Strength/Tone |
| ___ Abd Aorta | **SKIN** |
| ___ Femoral | ___ Rash/Lesion |
| ___ Pedal | ___ Indurate/Nodule |
| ___ Edema | **NEUROLOGIC** |
| **LYMPHATIC** | ___Cranial nerves |
| ___ Neck | ___Reflexes |
| ___ Axilla | ___Sensation |
| ___ Groin | **PSYCH** |
| ___ Other | ___ Judgment |
| **«X10»** | ___ Orientation |
| ___ «x11» | ___ Memory |
| ___ «x12» | ___ Mood/Affect |
| ___ «x13» | |

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

«hdr» «timestamp» «provider»

| X | Treatment/Procedures | CPT | Supplies | Qty | CPT | X | Injection/Infusion | CPT | X | Immunization | CPT |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | «t1» | «t1a» | «z1» | | «z1a» | | «s1» | «s1a» | | «i1» | «i1a» |
| | «t2» | «t2a» | «z2» | | «z2a» | | «s2» | «s2a» | | «i2» | «i2a» |
| | «t3» | «t3a» | «z3» | | «z3a» | | «s3» | «s3a» | | «i3» | «i3a» |
| | «t4» | «t4a» | «z4» | | «z4a» | | «s4» | «s4a» | | «i4» | «i4a» |
| | «t5» | «t5a» | «z5» | | «z5a» | | «s5» | «s5a» | | «i5» | «i5a» |
| | «t6» | «t6a» | «z6» | | «z6a» | | «s6» | «s6a» | | «i6» | «i6a» |
| | «t7» | «t7a» | «z7» | | «z7a» | | «s7» | «s7a» | | «i7» | «i7a» |
| | «t8» | «t8a» | «z8» | | «z8a» | | «s8» | «s8a» | | «i8» | «i8a» |
| | «t9» | «t9a» | «z9» | | «z9a» | | «s9» | «s9a» | | «i9» | «i9a» |
| | «t10» | «t10a» | «z10» | | «z10a» | | «s10» | «s10a» | | «i10» | «i10a» |
| | «t11» | «t11a» | «z11» | | «z11a» | | «s11» | «s11a» | | **Point of Care Lab** | **CPT** |
| | «t12» | «t12a» | «z12» | | «z12a» | | «s12» | «s12a» | | Finger Stick Glucose | 82948 |
| | «t13» | «t13a» | «z13» | | «z13a» | | «s13» | «s13a» | | Hemoccult Stool | 82270 |
| | «t14» | «t14a» | «z14» | | «z14a» | | | | | Hemoglobin | 85018 |
| | «t15» | «t15a» | «z15» | | «z15a» | | | | | Urine Dip w/o Micro | 81000 |
| | «t16» | «t16a» | | | | | | | | | |
| | «t17» | «t17a» | | | | | | | | | |

Purpose of Visit — Prioritize POV = ["1-2-3…"] Add Active Problems= ["A"] Inactivate Problem= ["I"] Remove Problem= ["R"]

| A / I / R | ICD-9 | Active Problems & POVs | A / I / R | ICD-9 | ICD-9 Pick List | A / I / R | ICD-9 | ICD-9 Pick List |
|---|---|---|---|---|---|---|---|---|
| | «p1c» | «p1» | | «d1c» | «d1» | | «d20c» | «d20» |
| | «p2c» | «p2» | | | | | «d21c» | «d21» |
| | «p3c» | «p3» | | | | | «d22c» | «d22» |
| | «p4c» | «p4» | | | | | «d23c» | «d23» |
| | «p5c» | «p5» | | | | | «d24c» | «d24» |
| | «p6c» | «p6» | | | | | «d25c» | «d25» |
| | «p7c» | «p7» | | «d7c» | «d7» | | «d26c» | «d26» |
| | «p8c» | «p8» | | «d8c» | «d8» | | «d27c» | «d27» |
| | «p9c» | «p9» | | «d9c» | «d9» | | «d28c» | «d28» |
| | «p10c» | «p10» | | «d10c» | «d10» | | «d29c» | «d29» |
| | «p11c» | «p11» | | «d11c» | «d11» | | «d30c» | «d30» |
| | «p12c» | «p12» | | «d12c» | «d12» | | «d31c» | «d31» |
| | «p13c» | «p13» | | «d13c» | «d13» | | «d32c» | «d32» |
| | «p14c» | «p14» | | «d14c» | «d14» | | «d33c» | «d33» |
| | «p15c» | «p15» | | «d15c» | «d15» | | «d34c» | «d34» |
| | «p16c» | «p16» | | «d16c» | «d16» | | «d35c» | «d35» |
| | «p17c» | «p17» | | «d17c» | «d17» | | «d36c» | «d36» |
| | «p18c» | «p18» | | «d18c» | «d18» | | «d37c» | «d37» |
| | «p19c» | «p19» | | «d19c» | «d19» | | «d38c» | «d38» |

Educational Assessment questions? Please refer to the IHS Patient Education Protocol Manual

| A / I / R | Additional Purpose o |
|---|---|
| | |
| | |
| | |
| | |
| | |

Notes for problem: Remove Note:

Notes for problem: Remove Note:

Notes for problem: Remove Note:

**Plans/Instructions/Appointments/Referrals**

RTC: APPT LENGTH:

**1** Document Educational Assessment in the Learning Preferences, Barriers to Learning, and Readiness to Learn fields.

**Patient Education (Circle or Write in Responses for Each Column)**

| Learning Preferences | TALK | Barriers to Learning | HEAR | Readiness to Learn | EAGR |
|---|---|---|---|---|---|

| Diagnosis or Code | Topic | Level of Understanding | Provider | Time (min) | Goals | Comments |
|---|---|---|---|---|---|---|
| HTN | LA | (G) P Group Refused | XYZ | 5 | GS | Plans to reduce salt intake |
| | | G F P Group Refused | | | | |
| | | G F P Group Refused | | | | |
| | | G F P Group Refused | | | | |

**2** Document the Patient Education in this table.

| X | Preventative Med | New | Estbl | X | E&M Visit Level | New | Estbl |
|---|---|---|---|---|---|---|---|
| | Infant (< 1 yr.) | 99381 | | | el w/ an "X" and CIRCLE whether NEW or ESTABLISHED patient. | | |
| | Early childhood (1-4 yrs.) | | | | ROS 0, 1 organ sys/ body area | 99202 | 99212 |
| | Late childhood (5-11 yrs.) | | | | ROS 1, 2-7 o.s./ b.a. | 99203 | 99213 |
| | Adolescent (12-17 yrs.) | | | | ROS 2-9, 2-7 o.s./ b.a. | 99204 | 99214 |
| | 18-39 yrs | 99385 | | | ROS 10-14, 8-12 o.s./ b.a. | 99205 | 99215 |
| | 40-64 yrs | 99386 | | | | | 99211 |
| | 65 yrs & > | 99387 | 99397 | | Counseling: ___15 min. / ___30 min. / 45 min. | | 9940 |

I HAVE RECEIVED THE ABOVE MEDICATION AND HAVE BEEN OFFERED/RECEIVED COUNSELING

Provider Signature — Signature

**«patient»** «agesex»
DOB: «dob» SSN: «ssn» «timestamp»
«b27» **#«chart»** VCN: «uid»

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

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

IHS-367 (4/94)

## PCC GROUP PREVENTIVE SERVICES

P.L. 96-511 N.A.

| DATE | | | | | | | |
|---|---|---|---|---|---|---|---|
| LOCATION | PROVIDER CODE | | | PROVIDER CODE | | | SERVICES PROVIDED |
| | AFFL. | Dis. | Initials/Code | AFFL. | Dis. | Initials/Code | |

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

In this column, ask participants to write their name.

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

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

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

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

**DIRECTIONS**

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

PROVIDER SIGNATURE

# INPATIENT EDUCATION FORM

| READINESS TO LEARN (RL Code) | PATIENT'S RESPONSE TO EDUCATION (Level of UNDERSTANDING) |
|---|---|
| Eager to Learn **RL-EAGR**<br>Receptive **RL-RCPT**<br>Unreceptive **RL-UNRC**<br>Pain **RL-PAIN**<br>Severity of Illness **RL-SVIL**<br>Not Ready **RL-NOTR**<br>Distraction **RL-DSTR**<br>**Assessed each teaching session** | **GOOD (G)** - Verbalized understanding. Verbalizes decision to change (plan of action indicated) able to demonstrate correctly.<br>**FAIR (F)** - Verbalizes need for more education. Undecided about making a decision or change. Return demonstration indicates need for further teaching.<br>**POOR (P)** - Does not verbalize understanding. Refuses to make a decision or needed changes. Unable to return demonstration.<br>**REFUSED (R)** - Refuses education.<br>**GROUP (GP)** – Group taught |
| **LEARNING PREFERENCES (LP Code)**<br>**Assessed Yearly**<br>**If Assessed Today, Today's Date:** | Talk (one-on-one) **LP-TALK**<br>Video **LP-VIDO**<br>Group **LP-GP**<br>Read **LP-READ**<br>Do/Practice **LP-DOIT** |

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

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

List measures taken to address above barriers:

**Comments:** ______________________________

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

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

White – Chart Yellow- Billing Pink- Data Entry

# INPATIENT EDUCATION FORM

| Signature: | Initials/Provider code: | |
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White – Chart   Yellow- Billing   Pink- Data Entry

# Reimbursement for Patient Education

## Preventive Medicine Services

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

## Reimbursement for Patient Education

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

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

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

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

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

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

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

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

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

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

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

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

## Documentation Requirements:

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

## Coordination of Care

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

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

# REIMBURSEMENT FOR PATIENT EDUCATION

## Important Aspects concerning Reimbursement for PATIENT EDUCATION

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

## Documentation of Evaluation and Management (E/M) Services

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

**BRIEF Sample -** Office Visits, Established Patients

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

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

## REIMBURSEMENT FOR PATIENT EDUCATION

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

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

# REIMBURSEMENT FOR PATIENT EDUCATION

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

# REIMBURSEMENT FOR PATIENT EDUCATION

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

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

# General Education Codes

## Guidelines For Use

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

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

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

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

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

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

For example:

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

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

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

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

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

# General Education Topics

## AP - ANATOMY AND PHYSIOLOGY

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

**STANDARDS:**

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

## C - COMPLICATIONS

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

**STANDARDS:**

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

## DP - DISEASE PROCESS

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

**STANDARDS:**

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

## EQ - EQUIPMENT

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

**STANDARDS:**

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

## EX - EXERCISE

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

**STANDARDS:**

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

## FU - FOLLOW-UP

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

**STANDARDS:**

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

## HM - HOME MANAGEMENT

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

**STANDARDS:**

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

## HY - HYGIENE

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

**STANDARDS:**

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

## L - PATIENT INFORMATION LITERATURE

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

**STANDARDS:**

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

## LA - LIFESTYLE ADAPTATIONS

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

**STANDARDS:**

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

## M - MEDICATIONS

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

**STANDARDS:**

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

## N - NUTRITION

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

**STANDARDS:**

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

## P - PREVENTION

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

**STANDARDS:**

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

## PRO - PROCEDURES

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

**STANDARDS:**

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

## S - SAFETY

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

**STANDARDS:**

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

## TE - TESTS

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

**STANDARDS:**

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

## TX - TREATMENT

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

**STANDARDS:**

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

# MNT—Medical Nutrition Therapy

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

MNT involves the assessment of the nutritional status of patients with a condition, illness, or injury that puts them at risk. Assessment must include review and analysis of medical and diet history, lab values, and anthropometric measurements. MNT is based on assessment, nutrition modalities most appropriate to manage the condition or treat the illness or injury.

MNT plays a key role throughout the continuum of care in all practice settings and phases of the life cycle, from prenatal care to care of the elderly. After nutrition screening identifies those at risk, appropriate MNT leads to improved health outcomes resulting in improved quality of life and cost savings.

The Dietetic Practitioner also referred to, as a Registered Dietitian is the only member of the health care team uniquely qualified to provide MNT.

REGISTERED DIETICIAN: An individual who has completed the minimum of a baccalaureate degree granted by a U.S. regionally accredited college or university or foreign equivalent, has met current minimum academic requirements and complete pre-professional experience, has successfully completed the Registration Examination for Dietitians, and has accrued 75 hours of approved continuing professional education every 5 years.

# EDUCATION NEEDS ASSESSMENT CODES

**INDIAN HEALTH SERVICE**
**EDUCATION NEEDS ASSESSMENT CODES**

## BAR—Barriers to Learning

### BAR-BLND BLIND

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

**STANDARDS:**

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

### BAR-COGI COGNITIVE IMPAIRMENT

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

**STANDARDS:**

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

### BAR-DEAF DEAF

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

**STANDARDS:**

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

6. Assess and document the on-set of deafness.

## BAR-DNRE DOESN'T READ

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

**STANDARDS:**

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

## BAR-EMOI EMOTIONAL IMPAIRMENT

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

**STANDARDS:**

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

## BAR-FIMS FINE MOTOR SKILLS DEFICIT

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

**STANDARDS:**

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

## BAR-HEAR HARD OF HEARING

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

**STANDARDS:**

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

## BAR-INTN INTERPRETER NEEDED

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

**STANDARDS:**

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

## BAR – NONE NO BARRIERS

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

**STANDARDS:**

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

## BAR-STRS SOCIAL STRESSORS

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

**STANDARDS:**

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

## BAR-VALU VALUES/BELIEF

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

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

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

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

**STANDARDS:**

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

## BAR-VISI VISUALLY IMPAIRED

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

**STANDARDS:**

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

# LP—Learning Preference

## LP-DOIT DO/PRACTICE

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

**STANDARDS:**

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

## LP-GP SMALL GROUP

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

**STANDARDS:**

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

## LP-READ READ

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

**STANDARDS:**

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

## LP-TALK TALK

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

**STANDARDS:**

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

## LP-VIDO VIDEO

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

**STANDARDS:**

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

# RL—Readiness to Learn

## RL-DSTR DISTRACTION

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

**STANDARDS:**

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

## RL – EAGR EAGER TO LEARN

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

**STANDARDS:**

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

## RL – RCPT RECEPTIVE

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

**STANDARDS:**

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

## RL-PAIN PAIN

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

**STANDARDS:**

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

## RL-SVIL SEVERITY OF ILLNESS

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

**STANDARDS:**

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

## RL-UNRC UNRECEPTIVE

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

**STANDARDS:**

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

# A

## AF—Administrative Functions

### AF-B BENEFITS OF UPDATING CHARTS

**OUTCOME:** The patient will be able to identify some benefits to themselves and to the clinic/hospital as the result of keeping charts updated.

**STANDARDS:**

1. Identify benefits to the patient, i.e., insurance deductible without a co-payment, increased services at this facility.
2. Identify benefits to the hospital/clinic, i.e., increase of services through third party collections.
3. Refer the patient to benefits coordinator or other resources as appropriate.

### AF-CON CONFIDENTIALITY

**OUTCOME:** The patient/family will understand that their health information will be kept confidential.

**STANDARDS:**

1. Briefly explain the institution's policies regarding confidentiality and privacy of protected health information under the current regulations.
2. Explain the instances where patient information might be divulged, (third-party billing, continuation of care, transfer to another facility) and what information will be divulged.
3. Explain that a "Release of Information" will be obtained prior to release of medical information except when related to continuation of care, billing, or transfer to another facility.
4. Explain that information will not be provided to others, including family and friends, without written permission from the patient.
5. As indicated, emphasize the importance of respecting the right to confidentiality and privacy of other patients.

## AF-FU FOLLOW-UP

**OUTCOME:** The patient/family will keep the business office updated regarding their demographic data at every visit.

**STANDARDS:**

1. Discuss the importance of maintaining updated information in order to enable the physician or other provider to contact the patient in case of emergency or lab results which need immediate attention.
   a. Address
   b. Telephone number
   c. Emergency contact
   d. Third party payers if any
   e. Name changes
2. Discuss the procedure for providing updated and current information as soon as it becomes available.
3. Explain that updated information will improve the delivery of care and treatment at the IHS Clinic/Hospital.
4. Explain that no discrimination will occur based on availability of third party payment resources.
5. Discuss the importance of follow-up care and the requirement to notify contract health services of any future appointments and procedures by the private sector. Referrals are for one visit only.

## AF-REF REFERRAL PROCESS

**OUTCOME:** The patient/family will understand the referral process and financial responsibilities. (Choose from the following standards as appropriate.)

**STANDARDS:**

1. Emphasize that referrals to outside providers by Indian Health Service primary providers typically will be processed by Contract Health Services.
2. Explain that the procedure for the referral to the private sector is usually based on a priority system and/or waiting list.
3. Explain that coverage by insurance companies and Medicare/Medicaid packages will be utilized prior to contract health service funds in most cases. The Indian Health Service is a payer of last resort.
4. Discuss the rules/regulations of Contract Health Services.
5. Refer as appropriate to community resources for Medicaid/Medicare enrollment, i.e., benefits coordinator.
6. Explain that future and/or additional referrals must be approved prior to the appointment.
7. Explain the institution's process for appealing Contract Health denials.
8. Discuss the institution Contract Health process for dealing with after hours emergency room/urgent care visits.

## AF-RI PATIENT RIGHTS AND RESPONSIBILITIES

**OUTCOME:** The patient/family will understand patient rights and responsibilities.

**STANDARDS:**

1. Explain to the patient/family their rights and responsibilities.
2. Discuss patient's rights to privacy and confidentiality with exceptions for patient safety and harm to self/harm to others as appropriate.
3. Explain to the patient/family the process for addressing conflict resolution and grievance.

# ADM—Admission to Hospital

## ADM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

**STANDARDS:**

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

## ADM-EQ EQUIPMENT

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

**STANDARDS:**

1. Discuss the indications for and benefits of the specific hospital equipment.
2. Discuss the types and features of hospital equipment as appropriate.
3. Instruct the patient regarding necessary involvement and cooperation in the use of equipment, as appropriate.
4. Emphasize safe use of the equipment, i.e., no smoking around O2, use of gloves, electrical cord safety.
5. Discuss proper disposal of associated medical supplies as appropriate.
6. Identify any equipment (i.e., IVs, monitors) utilized for patient care and explain their basic functions and or purposes as appropriate.
7. Emphasize the importance of not tampering with patient care equipment.

## ADM-OR ORIENTATION

**OUTCOME:** The patient/family will have a basic understanding of the unit policies and the immediate environment.

**STANDARDS:**

1. Provide information regarding the patient's room, including the location of the room, the location and operation of toilet facilities, televisions, radios, etc. and any special information about the room as applicable.
2. Identify the call light or other method for requesting assistance and explain how and when to use it.
3. Explain how the bed controls work.
4. Identify the telephone (if available) and explain how to place calls and how incoming calls will be received. Explain any restrictions on telephone use.
5. Explain the reason for and use of bed side rails in the hospital setting. Discuss the hospital policy regarding side rails as appropriate.
6. Explain the unit visiting policies, including any restrictions to visitation.
7. Explain the hospital smoking policy.
8. Discuss the hospital policy regarding home medications/supplements brought to the hospital.

## ADM-PM PAIN MANAGEMENT

**OUTCOME**: The patient/family will understand their rights and responsibilities regarding pain management.

**STANDARDS:**

1. Explain that it is the patient's right to have their pain assessed and addressed.
2. Explain that pain management is specific to the particular disease process and may be multifaceted.
3. Discuss the patient's responsibility in reporting pain and the effect of pain relief therapies to the provider or Nursing staff.

## ADM-POC PLAN OF CARE

**OUTCOME:** The patient/family will have a basic understanding of the plan of care.

**STANDARDS:**

1. Explain the basic plan of care for the patient, including the following:
   a. Probable length of stay and discharge planning
   b. Anticipated assessments
   c. Tests to be performed, including laboratory tests, x-rays and others
   d. Therapy to be provided, i.e., medication, physical therapy, dressing changes.
   e. Advance directives. Refer to ADV.
   f. Plan for pain management
   g. Nutrition and dietary plan including restrictions if any
   h. Restraint policy and conditions for release from restraints as applicable
2. Discuss the expected outcome of the plan.

## ADM-RI PATIENT RIGHTS AND RESPONSIBILITIES

**OUTCOME:** The patient/family will have a basic understanding of their rights and responsibilities as well as the process for conflict resolution.

**STANDARDS:**

1. Review the facility's Bill of Rights and Responsibilities with the patient. Provide a copy of this Bill of Rights to the patient/family.
2. Briefly explain the process for resolving conflicts if the patient/family believe that their rights have been violated.
3. Discuss availability of cultural/spiritual/psychosocial services as appropriate.

## ADM-S SAFETY AND ACCIDENT PREVENTION

**OUTCOME:** The patient/family will understand the necessary precautions to prevent injury during the hospitalization.

**STANDARDS:**

1. Discuss this patient's plan of care for safety based on the patient-specific risk assessment. **Refer to FALL.**

# ADV—Advance Directives

## ADV-I INFORMATION

**OUTCOME:** The patient/family will understand that an Advance Directive is either a Living Will or a Durable Power of Attorney for Health Care.

**STANDARDS:**

1. Explain that an Advance Directive is a written statement that is completed by the patient in advance of serious illness, regarding how he/she wants medical decisions to be made.
2. Discuss the two most common forms of Advance Directives:
   a. Living Will
   b. Durable Power of Attorney for Health Care.
3. Explain that a patient may have both a living will and a durable power of attorney for health care.

## ADV-L PATIENT INFORMATION LITERATURE

**OUTCOME:** The patient/family will receive and understand the contents of literature regarding Advance Directives.

**STANDARDS:**

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

## ADV-LW LIVING WILL

**OUTCOME:** The patient/family will understand that a Living Will is a document that states the type of medical care a patient wants or does not want in the event he/she becomes unable to make decisions for him/herself and is revocable.

**STANDARDS:**

1. Explain that a Living Will is a document that generally states the kind of medical care a patient wants or does not want in the event he/she becomes unable to make decisions for him/herself.
2. Explain that the Living Will may be changed or revoked at any time the patient wishes.
3. Explain that the Living Will is a legal document and a current copy should be given to the health care provider who cares for the patient.

## ADV-POA DURABLE POWER OF ATTORNEY FOR HEALTH CARE

**OUTCOME:** The patient/family will understand that a Durable Power of Attorney for Health Care is a document that names another person as proxy for health care decisions and is revocable.

**STANDARDS:**

1. Explain that in most states, a Durable Power of Attorney for Health Care is a signed, dated, witnessed document naming another person, such as a husband, wife, adult child or friend as the agent or proxy to make medical decisions in the event that the patient is unable to make them for him/herself.
2. Explain that instructions can be included regarding ANY treatment/procedure that is wanted or not wanted, such as surgery, a respirator, resuscitative efforts or artificial feeding.
3. Explain that, if the patient changes his/her mind, the Durable Power of Attorney for Health Care can be changed in the same manner it was originated. Explain that a Durable Power of Attorney for Health Care may be prepared by an attorney, but this may not be required in some states.
4. Explain that a Durable Power of Attorney for Health Care pre-empts any other advance directive. Example: The Durable Power of Attorney for Health Care can authorize the person named in the document to make the decision to apply full resuscitation measures even in the presence of a living will if the patient is incapable of making a decision at the time.

## ADV-RI PATIENT RIGHTS AND RESPONSIBILITIES

**OUTCOME:** The patient/family will understand their rights and responsibilities regarding Advance Directives.

**STANDARDS:**

1. Inform the patient of his/her right to accept, refuse, or withdraw from treatment, and the consequences of such actions.
2. Inform the patient of his/her right to formulate an Advance Directive and appoint a surrogate to make health care decisions on his/her behalf.
3. Explain that an Advance Directive may be changed or canceled by the patient at any time. Any changes should be written, signed and dated in accordance with state law, and copies should be given to the physician and others who received the original document.
4. Explain that it is the patient’s responsibility to give a copy of the Advance Directive to the proxy, the health care provider, and to keep a copy in a safe place.

# ALZ—Alzheimer's Disease

## ALZ-DP DISEASE PROCESS

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

**STANDARD:**

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

## ALZ-FU FOLLOW-UP

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

**STANDARDS:**

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

## ALZ-HM HOME MANAGEMENT

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

**STANDARDS:**

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

## ALZ-L PATIENT INFORMATION LITERATURE

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

**STANDARDS:**

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

## ALZ-LA LIFESTYLE ADAPTATIONS

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

**STANDARDS:**

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

## ALZ-LW LIVING WILL

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

**STANDARDS:**

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

## ALZ-M MEDICATIONS

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

**STANDARDS:**

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

## ALZ-N NUTRITION

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

**STANDARDS:**

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

## ALZ-PLC PLACEMENT

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

**STANDARDS:**

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

## ALZ-S SAFETY AND INJURY PREVENTION

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

**STANDARDS:**

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

## ALZ-SM STRESS MANAGEMENT

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

**STANDARDS:**

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

## ALZ-TE TESTS

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

**STANDARDS:**

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

## ALZ-TX TREATMENT

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

**STANDARDS:**

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

# D

## DCH—Discharge from Hospital

### DCH-EQ EQUIPMENT

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

**STANDARDS:**

1. Discuss indications for and benefits of prescribed home medical equipment.
2. Discuss types and features of home medical equipment as appropriate.
3. Discuss and/or demonstrate proper use and care of home medical equipment, participate in return demonstration by patient/family.
4. Discuss signs of equipment malfunction and proper action in case of malfunction.
5. Emphasize safe use of equipment, i.e., no smoking around O2, use of gloves, electrical cord safety, disposal of sharps).
6. Discuss proper disposal of associated medical supplies.

### DCH-FU FOLLOW-UP

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

**STANDARDS:**

1. Discuss the importance of follow-up care following hospitalization.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize the importance of keeping appointments.

### DCH-HM HOME MANAGEMENT

**OUTCOME:** The patient/family will understand the home management of their disease processes following hospital discharge and make a plan for implementation.

**STANDARDS:**

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

## DCH-L PATIENT INFORMATION LITERATURE

**OUTCOME:** The patient/family will receive written information regarding their discharge plans including medical therapies, follow up appointments, and contact information.

**STANDARDS:**

1. Provide patient/family with written patient information regarding their discharge plans including:
   a. Medical therapies prescribed
   b. Follow up appointments
   c. Follow up lab work
   d. Assessments required
   e. Cautions regarding the discharge plans
   f. Contact information
2. Discuss the discharge plan with the patient/family.

## DCH-LA LIFESTYLE ADAPTATIONS

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

**STANDARDS:**

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

## DCH-M MEDICATIONS

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

**STANDARDS:**

1. Discuss proper use, benefits, common side effects, and common interactions of prescribed medications. Review signs of possible toxicity and appropriate follow-up as indicated.
2. Discuss the importance of following the medical regimen.
3. Discuss the importance of informing your providers and pharmacists of any allergies or adverse medication reactions that you may have experienced.
4. Discuss the importance of being able to identify any discharge medications.
5. Discuss the importance of being able to take the appropriate amount of medication. Ensure dosage forms can be obtained (i.e., breaking tablets in half or using a pill cutter) and that appropriate measuring devices (oral syringes, droppers) are provided and instruction on their use given.

## DCH-N NUTRITION

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

**STANDARDS:**

1. Review nutritional needs for optimal health.
2. Discuss current nutritional habits. Assist patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to the specific disease states.

## DCH-POC PLAN OF CARE

**OUTCOME:** The patient/family will have a basic understanding of the discharge plan for care, including the plans for pain management.

**STANDARDS:**

1. Explain the basic plan of care for the patient, including the following:
   a. Plan for continued home treatment
   b. Anticipated assessments
   c. Tests to be performed, including laboratory tests, x-rays, and others
   d. Therapy to be provided, i.e., medication, physical therapy, dressing changes
   e. Advance directives
   f. Plan for pain management
   g. Nutrition and dietary plan including restrictions if any
   h. Follow-up plans

## DCH-PRO PROCEDURES

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

**STANDARDS:**

1. Discuss the indications, risks, and benefits and alternatives for the proposed procedure(s) as well as the risk of not undergoing the procedure.
2. Explain the process and what to expect after the procedure.
3. Discuss pain management as appropriate.
4. Emphasize post-procedure management and follow-up.
5. Discuss procedure findings and implications as appropriate.

## DCH-REF REFERRAL

**OUTCOME:** The patient/family will understand the referral process and financial responsibilities.

**STANDARDS:**

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

## DCH-RI PATIENT RIGHTS AND RESPONSIBILITIES

**OUTCOME:** The patient/family will have a basic understanding of their rights and responsibilities as well as the process for conflict resolution.

**STANDARDS:**

1. Discuss the patient’s responsibility to follow the agreed upon plan of care and to keep follow-up appointments.
2. Briefly explain the process for resolving conflicts if the patient/family believe that their rights have been violated.
3. Discuss availability of cultural/spiritual/psycho social services that may be available as appropriate.

## DCH-S SAFETY

**OUTCOME:** The patient/family will understand the necessary precautions to prevent injury following hospital discharge.

**STANDARDS:**

1. Discuss the mutually agreed upon plan of care for safety based on the patient-specific risk assessment.
2. Emphasize safe use of equipment. **Refer to DCH-EQ.**

## DCH-TE TESTS

**OUTCOME:** The patient/family will understand the test(s) to be performed at the time of or following hospital discharge including indications and its impact on further care.

**STANDARDS:**

1. Explain the test(s) ordered.
2. Explain the necessity, benefits, and risks of the test to be performed.
3. Explain the testing process to help the patient understand what he/she might experience during the test.
4. Explain the meaning of the test results, as appropriate.

## DCH-TX TREATMENT

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

**STANDARDS:**

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

# L

## LAB—Laboratory

### LAB-DRAW PHLEBOTOMY

**OUTCOME:** The patient/family will understand the phlebotomy procedure.

**STANDARDS:**

1. Discuss the method of phlebotomy to be used for this lab draw.
2. Discuss common and important side effects or consequences of phlebotomy.

### LAB-FU FOLLOW-UP

**OUTCOME**: The patient/family will understand the conditions that would require follow-up and how to obtain follow-up.

**STANDARDS:**

1. Discuss the findings that will signify a serious complication or condition.
2. Discuss the procedure for obtaining follow-up appointments.

### LAB-L LITERATURE

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

**STANDARDS:**

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

### LAB-S SAFETY

**OUTCOME**: Explain the procedure used to protect the patient and staff.

**STANDARDS:**

1. Discuss the use of personal protective equipment (i.e., gloves) and their role in preventing transmission of disease to the patient and the staff.
2. Discuss that needles and other lab draw equipment are single patient use and will be discarded after this draw.
3. Discuss the procedure for accidental needle-stick of the patient or the staff as appropriate.

## LAB-TE TESTS

**OUTCOME**: The patient/family will understand the test to be performed.

**STANDARDS:**

1. Explain the test that has been ordered.
2. Explain the necessity, benefits, and risks of the test to be performed. Refer to the primary provider as necessary.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the procedure for obtaining test results.
5. If the patient will obtain the specimen explain the procedure for properly obtaining the specimen and the storage of the specimen until it is returned to the lab.

# M

## MEDS—Medical Safety

### MEDS-C COMPLICATIONS

**OUTCOME:** The patient and/or family will understand the importance of preventing and managing medical errors.

**STANDARDS:**

1. Discuss with patients/family members that it is important for them to take an active role in their health care.
2. Discuss with the patient/family how to contact the appropriate health care provider with questions regarding medical therapy or potential medical errors.
3. Discuss with the patient/family when it is appropriate to go to the emergency room if a medical error, medication side-effect, or other emergency situation occurs as a result of medical treatments.

### MEDS-FU FOLLOW-UP

**OUTCOME:** The patient and/or family will understand the importance of maintaining follow up care.

**STANDARDS:**

1. Discuss the importance of maintaining follow-up appointments to minimize the risk of medical errors.
2. Discuss the importance of reviewing follow-up information such as laboratory results and other test results.

### MEDS-I INFORMATION

**OUTCOME**: The patient/family will be able to identify their primary provider and the condition(s) for which the patient is being treated.

**STANDARDS:**

1. Emphasize the importance of knowing the identity of the physician in charge of the total care.
2. Assist the patient/family in identifying their primary physician.
3. Discuss the conditions for which the patient is being treated and methods of treatment being used as well as options available.
4. Refer to reliable resources for more information as appropriate.

## MEDS-L PATIENT INFORMATION LITERATURE

**OUTCOME:** The patient and/or family will receive written information regarding medical therapies, contact information, and health concerns.

**STANDARDS:**

1. Provide written information describing medications that are being prescribed/dispensed, common side effects of medications dispensed, and contact information for patients in case they experience a side effect from their medication.
2. Provide written information describing treatment plans that are being prescribed/dispensed, cautions to therapy, and contraindications to therapy.
3. Provide written information describing procedures or surgeries that are being prescribed/dispensed, cautions of therapy, and contraindications of therapy.
4. Discuss the content of written information with the patient/family.

## MEDS-M MEDICATIONS

**OUTCOME:** The patient/family will understand that medications are a potential source for medical errors.

**STANDARDS:**

1. Discuss with patients/family members that it is important for them to take an active role in their health care.
2. Discuss the importance of informing providers of all medical therapies that you are taking. This includes:
   a. Prescribed medications
   b. Alternative therapies, i.e., traditional medicine
   c. Herbal medications
   d. Oral nutritional supplements, vitamins and minerals
   e. Over-the-counter medications
3. Discuss the importance of informing your providers of any allergies or adverse medication reactions that you may have experienced.
4. Discuss the importance of being able to identify any medications that your provider has written and knowing what medications are being prescribed.
5. Discuss the importance of obtaining understandable medication information. Also ensure that directions on medication labels are clear and easily understood. Discuss that this information should be provided every time your prescription is filled.
6. Discuss the importance of having the pharmacist verify that this is the medication that was prescribed by your provider.
7. Instruct the patient to check the medication label to verify the patient's name on the medication.
8. Discuss the importance of being able to take the appropriate amount of medication. Ensure dosage forms can be obtained (i.e., breaking tablets in half or using a pill cutter) and that appropriate measuring devices (i.e., pill boxes, oral syringes, droppers) are provided and instruction on their use given.

## MEDS-P PREVENTION

**OUTCOME:** The patient/family will understand ways to prevent medical errors.

**STANDARDS:**

1. Discuss the types of medical errors:
   a. medicine
   b. surgery
   c. diagnosis
   d. equipment
   e. lab reports
2. Explain that medical errors can occur anywhere in the health care system including the hospital, clinic, outpatient surgery center, doctor's office, nursing home, pharmacy, patient's home, and referral services.
3. Discuss with patients/family members that it is important for them to take an active role in their health care.
4. Discuss the importance of knowing who the patient may contact for medical advice and information.
5. Discuss the importance of all health care workers being aware of your health and care and having your medical record available.
6. Instruct patient that if necessary, a family member or friend may accompany them to their appointment.
7. Explain that when possible, you should select a hospital that has experience in the procedures that you need.
8. Emphasize the importance of proper hand washing in the prevention of disease transmission. Encourage the patient to ask the health care worker about hand washing if there are any concerns.

## MEDS-TE TESTS

**OUTCOME**: The patient/family will understand the importance of knowing what test(s) will be performed, why they will be performed, and how to obtain the results.

**STANDARDS:**

1. Explain to the patient/family the procedure of asking about tests that are ordered and the reasons for them. Emphasize the importance of knowing what tests will be done and why they will be done.
2. Explain to the patient how to obtain test results if they have not been provided.

# R

## XRAY—Radiology/Nuclear Medicine

### XRAY-C COMPLICATIONS

**OUTCOME**: The patient/family will understand the common and important complications that may result from this procedure.

**STANDARDS**

1. Explain that some patients may have adverse reactions to contrast media or other medications used during radiographic/nuclear medicine procedures.
2. Discuss common and important complications as they apply to the procedure to be performed.
3. Discuss the procedure that will be undertaken if adverse events occur.

### XRAY-FU FOLLOW-UP

**OUTCOME**: The patient/family will understand the conditions that would require follow-up and how to obtain follow-up.

**STANDARDS:**

1. Discuss the findings that will signify a serious complication or condition.
2. Discuss the procedure for obtaining follow-up appointments.

### XRAY-L LITERATURE

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

**STANDARDS:**

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

## XRAY-M MEDICATIONS

**OUTCOME**: The patient/family will understand the goal of medication therapy as it relates to the procedure to be performed.

**STANDARDS:**

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

## XRAY-PRO PROCEDURE

**OUTCOME**: The patient/family will understand the radiographic/nuclear medicine procedure to be performed.

**STANDARDS:**

1. Discuss the method of the radiographic/nuclear medicine procedure that has been ordered.
2. Discuss the indications, risks, and benefits for the proposed procedure.
3. Explain the process and what to expect after the procedure.
4. Explain the necessary preparation, i.e., bowel prep, diet instructions, bathing.
5. Discuss pain management as appropriate.
6. Emphasize post-procedure management and follow-up.

## XRAY-S SAFETY

**OUTCOME**: Explain the procedure used to protect the patient and staff.

**STANDARDS:**

1. Discuss the use of personal protective equipment (i.e., lead shields, gloves) and their role in preventing transmission of disease or unnecessary radiation exposure.
2. Demonstrate the proper use of equipment to be used.
3. Discuss as appropriate that needles and other infusion equipment are single patient use and will be discarded.
4. Discuss the procedure for accidental needle-stick of the patient or the staff as appropriate.

## XRAY-TE TESTS

**OUTCOME**: The patient/family will understand the test to be performed.

**STANDARDS:**

1. Explain the test that has been ordered.
2. Explain the necessity, benefits, and risks of the test to be performed. Refer to the primary provider as necessary.
3. Explain any necessary preparation for the test, i.e., fasting.
4. Explain the procedure for obtaining test results.

# RST—Restraints

## RST-EQ EQUIPMENT

**OUTCOME:** The patient/family will be instructed on the type of restraint used.

**STANDARDS:**

1. Explain the hospital policy and procedure to the patient/family.
2. Explain that use of restraint is a last resort and is required to improve the patient's safety and well-being and other less restrictive measures have been found to be ineffective to protect the patient from harm.
3. Explain the alternative interventions that were attempted but proved ineffective prior to the use of a physical restraint, i.e., frequent reorientation, position change, modify environment, modifying behavior, scheduled toileting, pain/comfort measures, places closer to nurse's desk, fall risk assessment, encourage family to stay, or there may be no appropriate intervention.
4. Explain the type of restraint to be used on the patient (waist, vest, wrists, ankles, or leather restraints).
5. Explain that nursing assessments will be completed as the hospital policy dictates.
6. Explain to patient/family the necessary conditions for early release from restraints.

## RST-L PATIENT INFORMATION LITERATURE

**OUTCOME:** The patient/family will receive written information about the clinical justification necessitating the restraint of the patient.

**STANDARDS:**

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

## RST-M MEDICATIONS

**OUTCOME:** The patient/family will understand any medications to be used as a chemical restraint or during the use of mechanical restraints.

**STANDARDS:**

1. Discuss the use of medications as chemical restraints if appropriate. Discuss common and important side effects.
2. Discuss medications used during the restraint process as appropriate. Discuss common and important side effects.

## RST-S SAFETY AND INJURY PREVENTION

**OUTCOME:** The patient/family will understand possible safety risks and inform the nursing staff immediately if the patient seems compromised.

**STANDARDS:**

1. Explain common and important safety risks associated with the type of restraint being used.
2. Explain the importance of not tampering with restraint devices or releasing the patient without informing staff.
3. Emphasize to the patient/family/caregiver the importance of immediately reporting any concern or adverse effect of the restraint, i.e., cold or blue limbs, restraints around the neck, patient slipping down in the bed.
4. Explain that the patient will need assistance with nutritional, range of motion, hygiene, and elimination needs.

# T

## TO—Tobacco Use

It is important to screen tobacco use and to record the responses appropriately in the Health Factors. Listed below are the definitions for tobacco use:

- Non-Tobacco Use – *Never* used *any* tobacco products
- Current Smoker – Smokes. Ask number of cigarettes/packs smoked per day
- Current Smokeless – Uses smokeless. Ask number of Cans/plugs per day
- Cessation Smoker – Former smoker, now quit. Document Quit Date ______
- Cessation Smokeless – Former smokeless user, now quit. Document Quit date____
- Previous Smoker – Smoker who smoked for ____years. Now Quit.
- Previous Smokeless – Smokeless user for ___ years. Now Quit.
- Non-Smoker but smoker in home, i.e., exposed to second hand smoke
- Environmental Exposure – Works in environment (casino, Bingo) with exposure to smoke.
- Ceremonial/Traditional use of tobacco

### TO-C COMPLICATIONS

**OUTCOME:** The patient/family will understand how to avoid the slow progression of disease and disability resulting from tobacco use.

**STANDARDS:**

1. Discuss the common problems associated with tobacco use and the long term effects of continued use of tobacco, i.e., COPD, cardiovascular disease, numerous kinds of cancers including lung cancer.
2. Review the effects of tobacco use on all family members- financial burden, second-hand smoke, asthma, greater risk of fire, early death of a bread-winner.
3. Discuss the possible implications of tobacco use on newborns, infants and children, as well as being a possible link to SIDS.

## TO-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

**STANDARDS:**

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

## TO-DP DISEASE PROCESS

**OUTCOME:** The patient/family will understand the slow progression of disease and disability associated with tobacco use.

**STANDARDS:**

1. Review the current factual information regarding tobacco use. Explain that tobacco use in any form is dangerous.
2. Explain nicotine addiction.
3. Explain dependency and co-dependency.

## TO-EX EXERCISE

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

**STANDARDS:**

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

## TO-FU FOLLOW-UP

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

**STANDARDS:**

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

## TO-L PATIENT INFORMATION LITERATURE

**OUTCOME:** The patient/family will receive written information about tobacco use or cessation of use.

**STANDARDS:**

1. Provide the patient/family with written patient information literature on tobacco use or cessation of use.
2. Discuss the content of the patient information literature with the patient/family.

## TO-LA LIFESTYLE ADAPTATIONS

**OUTCOME:** The patient/family will see tobacco abstinence as a way of life.

**STANDARDS:**

1. Discuss the patient's use/abuse of tobacco.
2. Discuss tips for stress relief and healthy "replacement habits".
3. Discuss the difference between recreational use of tobacco versus traditional or ceremonial use of tobacco.

## TO-M MEDICATIONS

**OUTCOME:** If applicable, the patient/family will understand the importance of fully participating with a prescribed medication regimen.

**STANDARDS:**

1. Review the proper use, benefits and common side effects of the prescribed medication.
2. Briefly review the mechanism of action of the medication if appropriate.
3. Explain that medications can help only if the patient is ready to quit and that medications work best in conjunction with counseling and lifestyle-modification education.
4. Explain that some medications may not work right away but will require a few days to a few weeks to take effect.
5. Emphasize that there may be dangers in using medications in conjunction with smoking and that some medications may be addictive, so it is important to have a dose-tapering regimen and keep to it.

## TO-QT QUIT

**OUTCOME:** The patient/family will understand that smoking is a serious threat to their health, that they have been advised by health professionals to quit, and how participation in a support program may prevent relapse.

**STANDARDS:**

1. Discuss the importance of quitting tobacco use now and completely.
2. Establish a quit date and plan of care.
3. Review the treatment and support options available to the patient/family.
4. Review the value of close F/U and support during the first months of cessation.

## TO-RTC READINESS TO CHANGE

**OUTCOME**: The patient/family will understand

**STANDARDS**

RTC 1 The patient has no interest in making the recommended change. Precontemplation (Ready in more than 6mos)

RTC 2 The patient has begun to show interest in making the recommended change. Contemplation (Ready in 1-6 mo)

RTC 3 The patient is beginning to make preparations to make the change. Preparation (Ready in 30 days or less)

RTC 4 The patient is actively making a change. Action (Quitting 0-6mo)

RTC 5 The patient has continued to Maintenance (quit for at least 6 months or more)

## TO-SCR SCREENING

**OUTCOME**: The patient/family will understand the screening device.

**STANDARDS**

1. Explain why the screening is being performed.
2. Discuss how the results of the screening will be used.
3. Emphasize the importance of follow-up care.

## TO-SHS SECOND-HAND SMOKE

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

**STANDARDS:**

1. Define “passive smoking”, ways in which exposure occurs:
   a. smoldering cigarette, cigar, or pipe
   b. smoke that is exhaled from active smoker
   c. smoke residue on clothing, upholstery, carpets or walls.
2. Discuss harmful substances in smoke
   a. nicotine
   b. benzene
   c. carbon monoxide
   d. many other carcinogens (cancer causing substances).
3. Explain the increased risk of illness in people who are exposed to cigarette smoke either directly or via second-hand smoke. Explain that this risk is even higher for people with pulmonary diseases like COPD or asthma.
4. Explain that cigarette smoke gets trapped in carpets, upholstery, and clothing and still increases the risk of illness even if the patient is not in the room at the time that the smoking occurs.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Discuss not smoking around infants and children, including in the home and in the car. Second hand smoke increases the risk of SIDS. Encourage smoking cessation.

## TO-SM STRESS MANAGEMENT

**OUTCOMES**: The patient will understand the role of stress management in tobacco abuse and its effect on tobacco cessation.

**STANDARDS:**

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