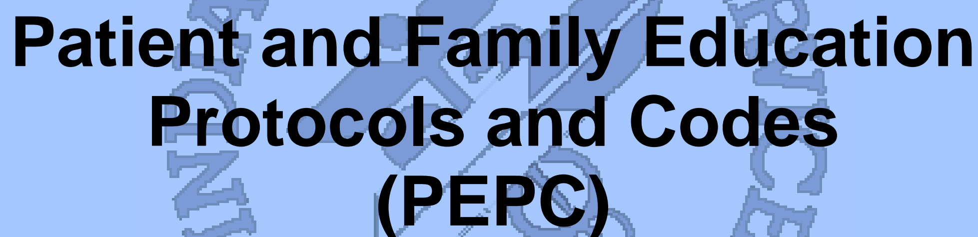
INDIAN HEALTH SERVICE



Patient and Family Education Protocols and Codes (PEPC)

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

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

Recording the Patient's Response to Education

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

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

Documenting Patient Education (Forms)

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 PROBLEMS

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

RECTAL
HEP B#
HEP A#
OPV#
DTP#
DTaP#
DT
Td
MMR#
VARICELLA
INFLUENZA
Hb TITER/ antiHBsAg

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

I, __________ have received 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

REFERRED TO VILLAGE HEALTH AIDE

OTHER

PROVIDER SIGNATURE

PROVIDER CODE Afft. Dis. Initials/Code

Signature

XYZ

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____

Afl.	Discipline		Initials		
			X	Y	Z

Chief Complaint & Visit Plan

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

«grav» «para» «lc» «ab» «fpm»

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…

Plans/Instructions/Appointments/Referrals

Notes for problem: Remove Note:
Notes for problem: Remove Note:
Notes for problem: Remove Note:

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) F 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
	AFN.	Dis.	Initials/Code	AFN.	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)

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 "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.

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

USE AND DOCUMENTATION OF PATIENT EDUCATION CODES

READINESS TO LEARN (RL Code)		PATIENT'S RESPONSE TO EDUCATION (Level of UNDERSTANDING)
Eager to Learn	**RL-EAGR**	**GOOD (G)** - Verbalized understanding. Verbalizes decision to change (plan of action indicated) able to demonstrate correctly.
Receptive	**RL-RCPT**	**FAIR (F)** - Verbalizes need for more education. Undecided about making a decision or change. Return demonstration indicates need for further teaching.
Unreceptive	**RL-UNRC**	**POOR (P)** - Does not verbalize understanding. Refuses to make a decision or needed changes. Unable to return demonstration.
Pain	**RL-PAIN**	**REFUSED (R)** - Refuses education.
Severity of Illness	**RL-SVIL**	**GROUP (GP)** – Group taught
Not Ready	**RL-NOTR**	
Distraction	**RL-DSTR**	
Assessed each teaching session		

LEARNING PREFERENCES (LP Code) **Assessed Yearly** **If Assessed Today, Today's Date:**	Talk (one-on-one)	**LP-TALK**
	Video	**LP-VIDO**
	Group	**LP-GP**
	Read	**LP-READ**
	Do/Practice	**LP-DOIT**

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

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

List measures taken to address above barriers:

Comments: ____

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

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

Signature:	Initials/Provider code:	

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

Important Aspects concerning Reimbursement for PATIENT EDUCATION

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

Documentation of Evaluation and Management (E/M) Services

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

BRIEF Sample - Office Visits, Established Patients

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

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

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

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

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

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

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

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

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.

AOD—Alcohol and Other Drugs

AOD-C COMPLICATIONS

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

STANDARDS:

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

AOD-CCA CONTINUUM OF CARE

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

STANDARDS:

1. Discuss with patient/family the concept of Continuum of Care in the treatment of AOD use disorders including the pre-treatment, treatment, sobriety maintenance, follow-up, and relapse prevention phases.
2. Provide assistance and advocacy to the patient/family in obtaining integrated Continuum of Care services.

AOD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

AOD-DP DISEASE PROCESS

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

STANDARDS:

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

AOD-EX EXERCISE

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

STANDARDS:

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

AOD-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

AOD-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

AOD-M MEDICATIONS

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

STANDARDS:

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

AOD-N NUTRITION

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

STANDARDS:

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

AOD-P PREVENTION

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

STANDARDS:

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

AOD-PLC PLACEMENT

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

STANDARDS:

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

AOD-SCR SCREENING

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

STANDARDS:

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

AOD-SM STRESS MANAGEMENT

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

STANDARDS:

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

AOD-TE TESTS

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

STANDARDS:

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

AOD-WL WELLNESS

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

STANDARDS:

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

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.**

ADD—Attention Deficit Hyperactivity Disorder

ADD-DP DISEASE PROCESS

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

STANDARDS:

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

ADD-FU FOLLOW-UP

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

STANDARDS:

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

ADD-GD GROWTH AND DEVELOPMENT

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

STANDARDS:

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

ADD-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ADD-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

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

ADD-M MEDICATION

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

STANDARDS:

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

ADD-N NUTRITION

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

STANDARDS:

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

ADD-TE TESTS

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

STANDARDS:

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

ADD-TX TREATMENT

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

STANDARDS:

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

B

BH—Behavioral and Social Health

BH-ADL ACTIVITIES OF DAILY LIVING

OUTCOME: The patient/family will understand how the patient's ability to perform activities of daily living (ADLs) impact the care plan including in-home and out-of-home care.

STANDARDS:

1. Define activities of daily living (ADLs) (i.e., the everyday activities involved in personal care such as feeding, dressing, bathing, moving from a bed to a chair (also called transferring), toileting and walking) and discuss how the patient's ability to perform ADLs affects their ability to live independently
2. Assist the patient/family in assessing the patient's ability to perform activities of daily living.
3. Provide the appropriate information and referrals for services needed to increase, maintain, and/or assist with activities of daily living.

BH-ANA ABUSE AND NEGLECT – ADULT

OUTCOME: The patient/family will understand the definitions and warning signs of adult abuse and neglect and be aware of available medical treatment and social services for victims.

STANDARDS:

1. Discuss and define the different types of adult abuse and neglect including emotional, physical and sexual.
2. Emphasize the importance of reporting suspected incidents of adult abuse and neglect to the patient's health care provider and the proper adult protective and law enforcement agencies.
3. Discuss patient rights to privacy and confidentiality as it relates to patient/family safety and mandatory reporting laws for providers, as appropriate.
4. Identify methods and resources to enhance patient safety while maintaining the patient's autonomy and independence as appropriate.

BH-ANC ABUSE AND NEGLECT – CHILD

OUTCOME: The patient/family will understand the definitions and warning signs of child abuse and neglect and be aware of reporting requirements and the availability of immediate medical care and welfare/protective services.

STANDARDS:

1. Discuss and define the different types of child abuse and neglect including emotional, physical, and sexual.
2. Emphasize the importance of reporting suspected incidents of child abuse and neglect to the proper law enforcement and child welfare/protective agencies and the patient's health care provider.
3. Discuss patient rights to privacy and confidentiality as it relates to patient/family safety and mandatory reporting laws for providers.
4. Emphasize the importance of securing appropriate medical care, behavioral health and social services for victims of child abuse and their families with an emphasis on immediate safety and medical needs of the victim.

BH-CM CARE MANAGEMENT

OUTCOME: The patient/family will understand the importance of integrated care management in achieving optimal behavioral health.

STANDARDS:

1. Discuss the roles and responsibilities of each member of the care team including the patient, family and providers in the care management plan.
2. Explain the coordination and integration of resources and services in developing and implementing the care plan.
3. Explain the need to obtain the appropriate releases of information necessary to support integrated care management and to maintain patient privacy and confidentiality. **Refer to AF-CON.**

BH-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.

BH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the process of a behavioral health diagnosis or issue and develop a plan to participate in treatment.

STANDARDS:

1. Explain the behavioral health condition and causes. Reassure the patient.
2. Explain how the diagnosis is made (i.e., by symptoms, through testing), as applicable).
3. Discuss options for treatment, both short-term and long-term.

BH-EX EXERCISE

OUTCOME: The patient will understand the importance of increased physical activity in order to attain optimal behavioral health and wellness.

STANDARDS:

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

BH-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 to achieving the goals in the care plan.
2. Discuss the procedure for obtaining follow-up appointments.
3. Provide information about transportation assistance for follow-up appointments if needed and if available at your institution.

BH-HOU HOUSING

OUTCOME: The patient/family will understand the relationship between adequate and safe housing and optimal health and the options available for emergency shelter and/or affordable housing.

STANDARDS:

1. Provide the patient/family with current information on the availability of shelter services and/or affordable housing or housing assistance (i.e., subsidized housing, emergency rental assistance).
2. Provide the patient/family with assistance and advocacy as needed when attempting to secure shelter or housing services.

BH-IR INFORMATION AND REFERRAL

OUTCOME: The patient/family will receive information and referral for alternative or additional services as needed or desired.

STANDARDS:

1. Provide the patient/family with alternative or additional sources for care and services.
2. Provide the patient/family with assistance in securing alternative or additional resources as needed.

BH-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive information about behavioral health issue(s).

STANDARDS:

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

BH-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of medication management.

STANDARDS:

1. Discuss proper use, benefits, common side effects, and length of therapy for the prescribed medications.
2. Emphasize full participation and continuation of therapy as prescribed even if improvement is not seen immediately. Emphasize taking medications, including injectable medications, administered at the correct time.
3. Emphasize the importance of communication with the physician and pharmacist about other medications currently being taken and any new medications prescribed while taking this medication.
4. Emphasize that many traditional medicines, herbal remedies, and over-the-counter medicines can have dangerous interactions with psychiatric drugs. Reinforce the importance of talking to the physician and/or pharmacist before taking any non-prescription or prescription treatment while on this medicine.
5. Inform the patient that if their medication is changed, there may be a few days to a few weeks waiting period before a new medication is started.
6. Inform the patient that alcohol is contraindicated while taking medications and that use of recreational drugs may make the medications ineffective.

BH-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 healing.
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.

BH-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.

BH-SM STRESS MANAGEMENT

OUTCOME: The patient/family will understand the role of stress management in mood disorders and behavioral health issues.

STANDARDS:

1. Explain that uncontrolled stress is linked with the onset and exacerbation of behavioral health issues.
2. Explain that uncontrolled stress can interfere with the treatment of behavioral health issues.
3. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as help improve the health and well-being of the patient.
4. Emphasize the importance of seeking professional help as needed to reduce stress.
5. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other drug (AOD) use as well as inappropriate eating, all of which may increase the severity of anxiety and increase the risk of depression and harm to self and/or harm to others.
6. Discuss various stress management strategies which promote 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 meaningful and measurable goals
   e. Getting enough sleep
   f. Making healthy food choices
   g. Regular physical activity
   h. Taking vacations
   i. Practicing meditation
   j. Self-hypnosis
   k. Using positive imagery
   l. Practicing relaxation methods such as deep breathing or progressive muscular relaxation
   m. Spiritual or cultural activities.
7. Provide referrals as appropriate.

BH-TE TEST/SCREENING

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

STANDARDS:

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

BH-TH THERAPY

OUTCOME: The patient/family will understand the goals and process of therapy

STANDARDS:

1. Review the reason for the initial referral for therapy as part of the care plan.
2. Explain that therapy may include individual, group, psycho-educational/therapeutic, talking circles, or other modalities.
3. Explain that the therapist and the patient will jointly establish the treatment method, frequency and duration, treatment guidelines, and goals and objectives.
4. Emphasize that for therapy to be successful the patient/family must fully participate with the treatment plan.

BH-TLM TELE-MENTAL HEALTH

OUTCOME: The patient/family will be aware of the option of receiving tele-mental health.

STANDARDS:

1. Explain that tele-mental health services are an alternative to face-to-face care when the patient/family lives in a geographically remote area or the needed service does not exist locally.
2. Explain the risk and benefits of the service offered and informed consent must be obtained. Explain that patients are fee to refuse tele-mental health services; however, there may not be any other services available.
3. Discuss the process of tele-mental health including the use of telecommunication equipment, the role of the distant consulting clinician and the proximate treating clinician and the plans for clinical management (i.e., level of support at the originating site, where prescriptions can be filled, and emergency services if needed.).

BH-TR TRANSPORTATION

OUTCOME: The patient/family will understand the options available to them in securing reliable, affordable and accessible transportation in order to keep health care and other appointments.

STANDARDS:

1. Provide the patient/family with information regarding transportation options which may include transportation covered by insurance, public, handicap accessible, and tribal or other community transportation services.
2. Assist the patient/family in determining eligibility requirements, obtaining and completing applications and securing documentation as needed to attain transportation services.

BH-WL WELLNESS

OUTCOME: The patient/family will understand the behaviors and lifestyle choices that contribute to wellness.

STANDARDS:

1. Explain healthy food choices are an important component of behavioral and emotional health. Refer to WL-N.
2. Emphasize the importance of stress reduction and increased physical activity in behavioral and emotional health.
3. Discuss that behavioral and emotional problems may result from unhealthy patterns of social interaction.
4. Emphasize that the use of alcohol and other drugs (AOD) can be extremely harmful to behavioral and emotional health.
5. Encourage the patient/family to identify and participate in healthy family, social, cultural, and community activities.
6. Provide the patient/family with appropriate patient information and referrals to obtain further information and services in order to make healthy choices and promote wellness.

C

CD—Chemical Dependency

Refer to AOD-Alcohol and Other Drugs.

D

DV—Domestic Violence

DV-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.

DV-DP DISEASE PROCESS

OUTCOME: Patient/family will understand that domestic violence is a primary, chronic, and preventable disease.

STANDARDS:

1. Discuss the patient/family member's abusive/violent disorder.
2. Discuss the patient's and family members' attitudes toward their dependency.
3. Explain co-dependency as it relates to domestic violence.
4. Identify risk factors and "red flag" behaviors related to domestic violence.
5. Discuss the role of alcohol and substance abuse as it relates to domestic violence.
6. Explain that the natural course of domestic violence is one of escalation and that without intervention it will not resolve.

DV-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.

DV-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

DV-P PREVENTION

OUTCOME: The patient/family will understand risk factors and behaviors that predispose to domestic violence and develop a plan to avoid relationships and situations which may result in domestic violence.

STANDARDS:

1. Explain predisposing risk factors for domestic violence, including a pathological need for control, alcohol and/or substance abuse, history of child abuse and/or domestic violence in the family of origin, etc.
2. Explain that environmental stressors, physiologic changes, and illnesses may precipitate violent behavior in persons who are predisposed to violent behaviors.
3. Discuss the progression of domestic violence from verbal/emotional abuse such as shouting and name-calling to physical violence such as shoving to injury and death.
4. Explain that the natural course of domestic violence is one of escalation and that without intervention it will not resolve.
5. Develop a plan of care to avoid violent relationships.

DV-PSY PSYCHOTHERAPY

OUTCOME: The patient will understand the goals and process of psychotherapy.

STANDARDS:

1. Emphasize that for the process of psychotherapy to be effective they must keep all their appointments. Emphasize the importance of openness and honesty with the therapist.
2. Explain to the patient that the therapist and the patient will jointly establish goals, ground rules, and duration of therapy.

DV-S SAFETY AND INJURY PREVENTION

OUTCOME: Patient, family members, and other victims will understand the pattern of domestic violence, make a plan to end the violence, develop a plan to insure safety of everyone in the environment of violence, and implement that plan as needed.

STANDARDS:

1. Be sure family members and other victims are aware of shelters and other support options available in their area. Make referrals as appropriate.
2. Review co-dependency. **Refer to DV-DP**.
3. Assist to develop a plan of action that will insure safety of all people in the environment of violence.

DV-SCR SCREENING

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

STANDARDS

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

DV-SM STRESS MANAGEMENT

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

STANDARDS:

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

DV-TX TREATMENT

OUTCOME: The patient/family will understand that domestic violence as a chronic disease will require long-term intervention which may include psychotherapy, medication, and support groups.

STANDARDS:

1. Review the nature of domestic violence as a primary, chronic, and treatable disease.
2. Explain that both patient and family need to acknowledge, admit, and request help.
3. Review treatment options available, including individual, family counseling, group advocacy, etc.

E

ELD—Elder Care

ELD-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

ELD-DP DISEASE PROCESS/AGING

OUTCOME: The patient/family will understand the normal aging process and will develop an action plan to maintain optimal health while aging.

STANDARDS:

1. Explain the normal anatomy and physiology of the aging process:
   a. it is normal to slow down as one ages
   b. some lapses in short-term memory are common
   c. some decrease in sex drive and ability to perform are common
   d. changes in sleeping patterns are common
   e. presbyopia (far sightedness) is nearly universal as humans age.
2. Explain that older individuals often have several chronic diseases that may need special attention in light of their advanced age.
3. Depression is common and may be difficult to diagnose. Family and caregivers should be instructed to watch for signs of depression, i.e., loss of appetite, social withdrawal.

ELD-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.

ELD-EX EXERCISE

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

STANDARDS:

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

ELD-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand their responsibility in health maintenance and the importance of keeping follow-up appointments.

STANDARDS:

1. Explain the procedure for obtaining follow-up appointments. Emphasize the importance of having appointments with the same health care provider when possible.
2. Emphasize the importance of keeping appointments.
3. Discuss the importance of bringing all medications to each visit.
4. Stress the importance of full participation with the health maintenance plan between visits.
5. Emphasize the importance of regular health screening for older adults, i.e., colonoscopy, mammograms, pap smears, PSAs.
6. Refer to community resources as appropriate, i.e., meals on wheels, elder transportation vans, Medicare.

ELD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family caregiver will receive written information about aging or elder health care issues.

STANDARDS:

1. Provide the patient/family/caregiver with written patient information about aging or elder health care issues.
2. Discuss the content of the patient information literature with the patient/family/caregiver.

ELD-LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient/family/caregiver will understand the lifestyle adjustments needed to maintain optimal health and will develop a plan o modify behavior where needed.

STANDARDS:

1. Discuss the patient/family/caregiver level of understanding and acceptance of the aging process.
2. Refer to Social Services, Mental Health, Physical Therapy, Rehabilitative Services and/or other resources as appropriate.
3. Review the lifestyle areas that may require adaptations, i.e., diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships, transportation issues, isolations issues.
4. Explain that as people age they may require more assistance from other sources than previously. Assist in identifying a support system.

ELD-M MEDICATIONS

OUTCOMES: The patient/family/caregiver will develop a plan for the patient taking prescribed medications correctly.

STANDARDS:

1. Review the patient's medication regimen.
2. Suggest techniques to ensure that medications are taken correctly, i.e., weekly medicine dispensing boxes, written lists.
3. Emphasize the importance of taking all medications to each visit.
4. Emphasize the importance of fully participating in the medication regimen.
5. Consider community health nursing referral to assess the elder patient's ability to fully participate with taking their medications correctly, as appropriate.

ELD-N NUTRITION

OUTCOME: The patient/family/caregiver will understand dietary requirements for optimal health in this patient.

STANDARDS:

1. Assess nutritional status using 24-hour diet recall or other tool.
2. Discuss this patient's specific nutrition plan.
3. Identify problems such as dental or gum disease, financial limitations, cognitive limitations or other conditions which may limit the patient's ability to achieve good nutrition. Refer as appropriate.

ELD-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

1. Explain the importance of body mechanics in daily living to avoid injury, i.e., proper lifting techniques.
2. Assist the patient/family/caregiver in identifying ways to adapt the home to improve safety and prevention injuries, i.e., remove throw rugs, install bars in tub/shower, secure electrical cords, install ramps.
3. As appropriate, stress the importance of mobility assistance devices, i.e., canes, walkers, wheel chairs, therapeutic shoes.
4. Discuss the current/potential abuse of alcohol or drugs.
5. Emphasize the importance of NEVER smoking in bed. Refer to smoking cessation programs as appropriate.
6. Discuss the potential for elder abuse/neglect (including financial exploitation) and ways to identify abuse/neglect. Refer as appropriate.

ELD-SM STRESS MANAGEMENT

OUTCOMES: The family member will understand the role of stress management when taking care of the elderly.

STANDARDS:

1. Explain that uncontrolled stress can contribute to physical illness, emotional distress, and early mortality of the caregiver.
2. Emphasize the importance of seeking professional help as needed to reduce stress.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality of both the caregiver and the elder.
4. Explain that effective stress management may help to improve the health and well-being of the family member.
5. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
    a. becoming aware of your own reactions to stress
    b. recognizing and accepting your limits
    c. talking with people you trust about your worries or problems
    d. setting realistic goals
    e. getting enough sleep
    f. maintaining a reasonable diet
    g. exercising regularly
    h. taking vacations
    i. practicing meditation
    j. self-hypnosis
    k. using positive imagery
    l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
    m. spiritual or cultural activities
6. Provide referrals as appropriate, i.e., respite care, behavioral or mental health professionals.

EOL—End of Life

EOL-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

EOL-DP DISEASE PROCESS

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

STANDARDS:

1. Explain the basic anatomy and physiology of the patient's disease and the effect upon the body system(s) involved.
2. Discuss signs/symptoms of worsening of the patient's condition and when to seek medical care.

EOL-EQ EQUIPMENT

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

STANDARDS:

1. Discuss indications for and benefits of prescribed medical equipment to be used during the hospital stay and after discharge, as appropriate.
2. Discuss and/or demonstrate proper use and care of medical equipment, including safety and infection control principles.
3. Assist in return demonstration by patient/family.

EOL-GP GRIEVING PROCESS

OUTCOME: The patient/family will understand the grieving process, recognize the sense of loss, and embrace the importance of preparing for the end of life emotionally and spiritually.

STANDARDS:

1. Explore the various losses and feelings that affect the patient and his/her loved ones when faced with a terminal illness. Explain that grief and a sense of loss become more intense when a patient is dying.
2. Discuss fears, myths and misconceptions of the dying process with the patient/family.
3. Discuss the importance of keeping open communication and promoting social interaction in preserving the dignity of the patient.
4. Explain that the five major losses experienced by a dying patient are; loss of control, loss of identity, loss of achievement, loss of social worth, and loss of relationships.
5. Explore how separation and mourning are aspects of the bereavement process.
6. Explain that bereavement coincides with the patient's imminent death and continues through the actual death event and the period of time immediately thereafter.
7. Explain that the need to repeatedly verbalize feelings is a normal part of grieving.

EOL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the patient's specific disease process, hospice care, end of life issues, advanced directives, support groups or community resources as appropriate.

STANDARDS:

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

EOL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the physiological, emotional and spiritual lifestyle adjustments necessary to cope with their terminal illness. They will understand that the plan of care will be based on the patient's wishes and the family's needs to enhance comfort and improve the quality of the patient's life.

STANDARDS:

1. Explain that the patient/family's values and beliefs will be respected and that the patient/family will be included in the decision making process.
2. Explain the need to remain active and the need to participate in familial, social, traditional, cultural and religious/spiritual activities and interactions when possible.
3. Explain the requirement for increased rest and sleep.
4. Assist with appropriate grieving strategies based on the provider's assessment of the patient/family's level of acceptance.
5. Refer to Social Services, Mental Health, Physical Therapy, Occupational Therapy, hospice, and/or community resources as appropriate.
6. Review lifestyle areas that may require adaptations (i.e., diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships). Discuss lifestyle changes in relation to his/her disease progression.
7. Inform the patient/family of local resources to accommodate their need for privacy and family gatherings if available.
8. Explain the importance of safety and infection control as applicable.

EOL-LW LIVING WILL

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

STANDARDS:

1. Review the option of Advanced Directives/ Living Will with the patient and his/her family. Explain treatment options and answer questions in a manner the patient/family will understand.
2. Refer to appropriate services to assist the patient in making a living will, i.e., Social Services, Clergy, Lawyer.
3. Discuss giving designated persons access to the patient’s complete health record and care management, including all necessary legal documents.

EOL-M MEDICATION

OUTCOME: The patient/family will understand the role of medication in control of pain and other discomforts. The patient/family will verbally summarize the medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Discuss the medication treatment plan.
3. Explain that pain, nausea and other discomforts can usually be controlled with medication. Discuss the use of adjunctive medication, if indicated, to control analgesic side effects, i.e., anti-emetics, laxatives, antacids.
4. Emphasize the importance of the patient/family's active participation with the provider in treatment decisions.
5. Explain that acute, severe or breakthrough pain should be immediately reported to the provider.
6. Discuss patient/family concerns about addiction. Explain that addiction is not an issue for terminally ill patients.
7. Discuss the importance of full participation with the medication regimen in order to assure optimal comfort levels. For example, round-the-clock dosing of pain medication is more effective in the treatment of chronic pain than medications that are taken after the pain recurs.
8. Explain that insomnia is often a significant problem for end of life patients. Emphasize the importance of developing a plan with the provider to address this issue as appropriate.
9. Explain that spiritual pain is a reality and cannot be controlled with medications.
10. Explain that excess sedation and euphoria are not goals of palliative pharmacologic therapy.
11. Explain that to some extent, pain may counteract the sedative and respiratory depressant effects of opiates.

EOL-N NUTRITION

OUTCOME: The patient/family will understand the importance of a nutritionally balanced diet in the treatment of their disease and the support of the terminal patient.

STANDARDS:

1. Assess the patient's current nutritional habits. Review how these habits might be improved.
2. Emphasize the necessary component - WATER - in a healthy diet.
3. Explain that constipation is a common side-effect of opiates. Dietary measures such as increased water, increased fiber, increased fruit juices and decreased intake of milk products may be helpful. Other control measures should be discussed with the provider prior to initiation.
4. Encourage ingestion of small, frequent meals and/or snacks.
5. Emphasize the importance of mouth care as appropriate.
6. If a specific nutrition plan is prescribed discuss this with the patient/family.
7. Discuss that failure to thrive may be a sign of impending death and may be seen in spite of adequate nutritional intake.

EOL-PM PAIN MANAGEMENT

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

STANDARDS:

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

EOL-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand that grief reactions are common at the end of life and that depression may be seen.

STANDARDS:

1. Discuss symptoms of grief reaction, i.e., vigilance, trouble concentrating, hyperattentiveness, insomnia, distractibility.
2. Explain that the patient/family may need additional support, sympathy, time, attention, compassion and communication.
3. Explain that if anti-depressant drugs are prescribed by the provider, full participation with the treatment regimen is important to maximize effectiveness of the treatment.
4. Refer to community resources as appropriate, i.e., bio-feedback, yoga, Healing Touch, Herbal Medicine, laughter, humor, Traditional Healer, guided imagery, massage, acupuncture, acupressure.
5. Explain that many mechanisms for dealing with grief and depression are available, i.e., support groups, individual therapy, family counseling, spiritual counseling. Refer as appropriate.

EOL-SM STRESS MANAGEMENT

OUTCOMES: The patient/family member will understand the role of stress management in end of life situations.

STANDARDS:

1. Explain that uncontrolled stress can contribute to a faster decline in physical health and cause further emotional distress for the patient, as well as contribute to physical illness, emotional distress, and early mortality of the caregiver.
2. Explain that effective stress management may help to improve the patient's outlook, as well as the health and well-being of both the patient, caregiver and family members.
3. Emphasize the importance of seeking professional help as needed to reduce stress.
4. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the risk of morbidity and mortality of both the caregiver and the patient.
5. Discuss various stress management strategies which may maintain or improve quality of life. Examples for patient, caregiver and family members may include:
   a. becoming aware of your own reactions to stress
   b. recognizing and accepting your limits
   c. talking with people you trust about your worries or problems
   d. setting realistic goals
   e. getting enough sleep
   f. maintaining a reasonable diet
   g. exercising regularly
   h. practicing meditation
   i. self-hypnosis
   j. using positive imagery
   k. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   l. spiritual or cultural activities
6. Provide referrals as appropriate.

EOL-TX TREATMENT

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

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of a treatment plan.
2. Explain what signs/symptoms should prompt an immediate call to the provider.
3. Explain the difference between palliative and curative treatments.
4. Explain that end of life treatments will typically not prolong the patient's life but are meant to improve the quality of life by increasing patient comfort.

F

FP—Family Planning

FP-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient will have a basic understanding of anatomy and physiology and it relationship to reproduction.

STANDARDS:

1. Identify and explain the functions of the reproductive system.
2. Discuss the menstrual cycle.
3. Discuss conception vs. contraception.

FP-DIA DIAPHRAGM

OUTCOME: The patient will understand the safe and effective use of a diaphragm.

STANDARDS:

1. Discuss the method of insertion.
2. Emphasize the use of spermicide.
3. Discuss the amount of time the diaphragm must be left in place.
4. Emphasize that the diaphragm must be used each time intercourse takes place.
5. Emphasize that the diaphragm must be refitted if there is a 10 pound weight loss or gain, and after childbirth.

FP-DPO DEPOT MEDROXYPROGESTERONE INJECTIONS

OUTCOME: The patient will understand risks, benefits, side effects, and effectiveness of depot medroxyprogesterone injections.

STANDARDS:

1. Explain the method of action and effectiveness of depot medroxyprogesterone.
2. Discuss the method of administration and importance of receiving the medication on time (typically every 3 months).
3. Discuss the contraindications, risks, and side effects of the medication.

FP-EC EMERGENCY CONTRACEPTION (POST-COITAL)

OUTCOME: The patient/family will understand risks, benefits side effects, safety and effectiveness of Emergency Contraception.

STANDARDS:

1. Explain the methods of possible actions and effectiveness of Emergency Contraception.
2. Identify indications for use - a potential candidate is a reproductive-age woman who has had unprotected sexual intercourse within 72 hours of presenting herself for medical care, independent of the time of the menstrual cycle. Most common reasons for seeking the treatment are failure of a barrier method or failure to use any method.
3. Discuss the safety: there are no contraindications to EC pill due to the small overall hormone dose and the short duration of use. (Some studies excluded women from participating if they had an absolute contraindication to taking oral contraceptives). EC has no adverse affect on a fetus, if taken inadvertently. EC may be used during breastfeeding without effect on milk quantity or quality.
4. Review side effects, and management:
   a. Levonorgestal-only regimen: Nausea occurs in approximately 23 percent of women and vomiting occurs in about 6 percent, usually limited to the first three days after treatment.
   b. Combined estrogen-progestin (Yuzpe) regimen: Nausea and vomiting occur in about 43 and 16 percent, usually limited to the first three days after treatment.
   c. Both side effects can be minimized by the use of anti-emetic pre-treatment.
   d. A small number of women may experience irregular bleeding or spotting after taking ECs, this is not their menses. Most women will have their menstrual period within one week before or after the expected time.
   e. Breast tenderness can occur after EC treatment.

FP-FC FOAM AND CONDOMS

OUTCOME: The patient will have a basic understanding of the safe and effective use of foam and condoms.

STANDARDS:

1. Discuss proper use and application of foam and condoms.
2. Emphasize the importance of use each time intercourse takes place.
3. Emphasize why condoms must be applied before penetration.
4. Emphasize that male must withdraw before erection subsides.
5. Advise concomitant use of spermicidal foam as recommended by the medical provider.
6. Discuss use of spermicidal suppositories and intravaginal films.
7. Discuss that condoms provide possible protection against STIs.

FP-FU FOLLOW-UP

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

STANDARDS:

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

FP-IC IMPLANT CONTRACEPTION

OUTCOME: The patient will understand the safe and effective use of implantable contraceptives.

STANDARDS:

1. Discuss and review all birth control methods with the patient.
2. Explain the insertion procedure and mechanism of action including duration of effectiveness.
3. Discuss contraindications, risks, and side effects, including the possibility of pregnancy.
4. Stress the importance of yearly follow-up.

FP-IUD INTRAUTERINE DEVICE

OUTCOME: The patient will understand the safe and effective use of the IUD.

STANDARDS:

1. Explain why IUDs are more easily retained in multiparous vs. nulliparous women.
2. Explain how IUDs work.
3. Emphasize the importance of monthly string checks.
4. Emphasize the importance of reporting abnormal vaginal discharge, fever, or pain with intercourse.
5. Discuss contraindications to placement of IUDs.
6. Explain that the copper IUD's need periodic replacement.

   NOTE: IUDs may be UNAVAILABLE from time to time due to medicolegal reasons.

FP-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

FP-MT METHODS

OUTCOME: The patient will receive information regarding the available methods of birth control.

STANDARDS:

1. Discuss the reliability of the various methods of birth control.
2. Discuss how each method is used in preventing pregnancy.
3. Discuss contraindications, benefits, and potential costs of each method.

FP-N NUTRITION

OUTCOME: The patient will understand the role of folic acid in the prevention of neural tube defects and the importance of a balanced diet.

STANDARDS:

1. Identify the amount of folic acid required.
2. Explain that to be maximally effective, folic acid should be given before conception.
3. Identify food sources and supplemental forms of folic acid.
4. Discuss the importance of a balanced diet.

FP-OC ORAL CONTRACEPTIVES

OUTCOME: The patient will understand the safe and effective use of oral contraceptives.

STANDARDS:

1. Explain how the “pill” inhibits ovulation.
2. Discuss the methods of taking oral contraceptives.
3. Discuss the contraindications, risks, and side effects.
4. Discuss the signs and symptoms of complications.
5. Specifically counsel on potential drug interactions, especially that antibiotics may make the contraceptive ineffective.

FP-ST STERILIZATION

OUTCOME: In order to make an informed decision about irreversible contraception, the patient will receive information about sterilization.

STANDARDS:

1. Explain tubal ligation vs. vasectomy. Emphasize that these are PERMANENT methods of contraception.
2. Explain laparoscopic (LEC) procedures: Anesthesia, CO2, incision, vaginal bleeding.
3. Explain vasectomy procedures.
4. Discuss the possible side effects and risks: Infection, pain, failure, and bleeding at incision site.
5. Explain that IHS and the state may have specific legal criteria that must be met in order to be eligible for sterilization.
6. Review availability of other methods that can prevent or delay pregnancy as an option to permanent sterilization.
7. Offer behavioral health follow-up as appropriate.

FMS—Fibromyalgia Syndrome

FMS-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.

FMS-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of fibromyalgia.

STANDARDS:

1. Review fibromyalgia (FMS) as a collection of complex symptoms characterized by achy pain and stiffness in soft muscle tissues, including muscles, tendons, and ligaments. The pain and stiffness of FMS may be widespread throughout the body or localized, especially along the spine.
2. Explain that there is currently no reliable laboratory test available to make the diagnosis of FMS and that the examining physician must rely on a patient's medical history and physical findings of tender points on examination.
3. Discuss the patient's specific conditions, including anatomy and physiology as appropriate.
4. Explain that FMS is disruptive, but not life threatening. Women are more likely to have fibromyalgia.
5. Symptoms may include sleep disturbance, depression, fatigue, headaches, diarrhea and/or constipation, numbness in hands and feet, weakness, memory changes and dizziness.
6. Review lifestyle factors that may worsen or aggravate the symptoms (i.e., overweight, obesity, sedentary lifestyle, higher levels of emotional stress, and ineffective coping skills)

FMS-EX EXERCISE

OUTCOME: The patient will understand the importance of exercise in enhancing physical and psychological well-being.

STANDARDS:

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

FMS-FU FOLLOW-UP

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

STANDARDS:

1. Provide positive reinforcement for areas of achievement.
2. Emphasize the importance of follow-up care to prevent complications and adjustments of medications.
3. Encourage active participation in the treatment plan.
4. Explain the procedure for obtaining appointments.

FMS-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

1. Provide patient/family with written patient information literature on FMS.
2. Discuss the content of patient information literature with the patient/family.
3. Point out to the patient/family the numerous professional organizations that are knowledgeable about FMS pain management.

FMS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand what lifestyle adaptations are necessary to cope with FMS.

STANDARDS:

1. Explain that the patient has a responsibility to make lifestyle adaptations in controlling pain. It is a process of making wise choices and changes that will positively affect the overall state of health.
2. Emphasize the importance of rest and avoidance of fatigue.
3. Discuss the use of heat and cold as appropriate.
4. Refer to Social Services, Behavioral Health, Physical Therapy, Registered Dietician, Rehabilitative Services and/or community resources as appropriate.
5. Review the areas that may require adaptations: diet, physical activity, sexual activity, and bladder/bowel habits.

FMS-M MEDICATIONS

OUTCOME: The patient/family will understand the prescribed medication(s) FMS.

STANDARDS:

1. Review the patient's medication. Reinforce the importance of knowing the medication, dose, and dosing interval of medications.
2. Discuss potentially adverse interactions with other drugs (i.e., OTC medications, traditional/herbal medications) and the adverse effects of this medication when combined with certain foods.
3. Emphasize the importance of checking with a medical provider prior to starting any prescription, OTC, or herbal/traditional treatments.
4. Discuss the importance of taking medications as prescribed. It is important not to increase your dose of medications without first consulting your healthcare provider.

FMS-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand pain management techniques.

STANDARDS

1. Discuss non-pharmacologic pain control measures such as:
   a. Learning techniques that relieve stress and promote relaxation.
   b. Practicing good health habits such as eating a nutritious diet, managing weight, and getting adequate sleep, and avoiding alcohol, highly sugared foods, caffeine drinks, and tobacco.
   c. Understanding the feeling that pain creates.
   d. Becoming more physically active.
   e. Organizing the day and performing daily tasks more efficiently.
   f. Identifying capabilities and not just limitations.
   g. Improving communications with family and friends.
   h. Weight loss, if overweight
   i. Addressing any problems with sleep disturbances
   j. Exploring alternative/complimentary medicine such as massage, acupuncture, chiropractic, yoga, and Tai Chi, traditional healing, and hypnosis.

FMS-SM STRESS MANAGEMENT

OUTCOME: The patient will understand the role of stress management in chronic pain management

STANDARDS:

1. Explain that uncontrolled stress may exacerbate the symptoms of the chronic pain of FMS. This can set up a cycle of pain-stress which becomes self-sustaining and may escalate.
2. Explain that uncontrolled stress can interfere with the treatment of chronic pain.
3. Discuss that in chronic pain, uncontrolled stress may lead to depression or other mood disorders. **Refer to CPM-PSY**.
4. Explain that effective stress management may reduce the severity of symptoms the patient experiences, as well as help improve the health and well-being of the patient.
5. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all which can increase the severity of pain.
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. becoming aware of your own reactions to stress
   b. recognizing and accepting your limits
   c. talking with people you trust about your worries or problems
   d. setting realistic goals
   e. getting enough sleep
   f. maintaining a reasonable diet
   g. exercising regularly
   h. taking vacations
   i. practicing meditation
   j. practicing meditation
   k. self-hypnosis
   l. using positive imagery
   m. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   n. spiritual or cultural activities
7. Provide referrals as appropriate.

FMS-TE TESTS

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

STANDARDS:

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

G

GAD—Generalized Anxiety Disorder

GAD-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the complications associated with generalized anxiety disorder.

STANDARDS:

1. Discuss that GAD can cause major disruptions in family and work relationships. Refer to counseling or behavioral health services as appropriate.
2. Discuss that GAD can cause many physical symptoms such as chest pain, dizziness, abdominal pain, headaches, jaw pain, palpitations, shortness of breath, bruxism, broken teeth, fatigue, sleep disruption and other physical symptoms. Generalized anxiety disorder is frequently misdiagnosed as cardiac or gastrointestinal disease.
3. Explain that untreated GAD may worsen and result in depression and/or suicide.

GAD-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.

GAD-DP DISEASE PROCESS

OUTCOME: The patient/family will understand some of the current information about cause and expected course of generalized anxiety disorder and will make a plan to obtain treatment, when appropriate.

STANDARDS:

1. Explain that GAD is a primary disorder in which the patient has a constant and severe sense of anxiety/fear which is not attributable to a specific stressor and is significant enough to interfere with work, home, or social functioning.
2. Explain that as of May, 2003, it is believed that GAD results from a dysfunction of the GABA neurotransmitter system in the brain. Discuss that GAD is a neurochemical/biological disorder and is not the result of a weak personality or inappropriate parenting.
3. Explain that symptoms of GAD may include difficulty sleeping, difficulty with concentration, unusual sense of fear in ordinary circumstances, stressed relationships, inability to work with others, unusual number of physical complaints for which a source cannot be found.
4. Explain that because the symptoms of GAD are numerous and non-specific, the diagnosis can only be made by a trained healthcare professional. Explain that because GAD has a tendency to run in families, the health care professional will likely request information about other family members.
5. Explain that generalized anxiety disorder is typically a chronic disease which is often progressive and may be associated with other mental/emotional disorders. (For example: agoraphobia, panic disorder, and/or depression.)
6. Explain that the symptoms of GAD may get better or worse at different times; symptoms will often worsen when the patient is more stressed, but symptoms may not be related to outside stressors.
7. Explain that there is a tendency for GAD to worsen over time if it is not treated, but there are effective treatments available. **Refer to GAD-TX.**

GAD-EX EXERCISE

OUTCOME: The patient/family will understand the role of exercise in the treatment of generalized anxiety disorder.

STANDARDS:

1. Explain that it is believed that regular exercise favorably alters the chemistry of the brain by changing the levels of various neurotransmitter chemicals and by degrading (“burning up”) stress hormones.
2. Explain that many physicians believe that exercise can be an important part of the treatment of GAD and other emotional disorders and that the patient’s physician or other provider may prescribe exercise. As appropriate, encourage the patient to ask his/her physician or provider about starting an exercise program.
3. Explain that the optimal level of exercise may vary from patient-to-patient, but that 30 minutes of aerobic exercise (i.e., fast walking, bicycling, running, swimming laps) daily is usually enough to result in improvement in GAD symptoms.
4. Explain that other forms of exercise (i.e., weight-lifting, sit-ups) may very well be helpful, but have not been studied as well as aerobic exercise. Encourage the patient to engage in whatever form of exercise he/she is able and willing to do. This may include increasing daily activities, i.e., gardening, house cleaning, dancing.
5. Explain that most people should be evaluated by a physician or other provider before starting an exercise program. Refer to physician or provider as appropriate. Refer to community-based exercise program(s) as appropriate.
6. Encourage the patient to increase the intensity of the activity as he/she becomes more fit.
7. Assist the patient in developing a personal exercise plan. **Refer to WL-EX.**
8. Discuss obstacles to a personal exercise plan and solutions to those obstacles.
9. Discuss medical clearance issues for physical activity.

GAD-M MEDICATION

OUTCOME: The patient/family will understand the patient's medication regimen and some common or important side effects of medication as well as the possible risks of not using medication as prescribed.

STANDARDS:

1. Explain that medication is often required to improve the GAD patient's level of functioning at home, at work, and in social situations.
2. Explain that because GAD often occurs in conjunction with other emotional disorders, more than one medication may be necessary.
3. Explain (when appropriate, according to the medication prescribed) that some of the medications for GAD have some potential to cause addiction when they are not used as prescribed, but this is very unusual when medications are used properly. Emphasize the importance of adhering strictly to the prescribed regimen and not increasing or decreasing the medication without consulting the physician or provider who prescribed it.
4. Explain (when appropriate, according to the medication prescribed) that some of the medications for GAD are classified by the Drug Enforcement Administration as controlled substances and may be stolen by persons who wish to sell them or use them illicitly. Emphasize the importance of keeping strict control of medications, i.e., the patient may keep most of the medication in a locked cabinet and carry only a small amount in his/her pocket, purse. Refer the patient to the physician or provider who prescribed the medication regarding what to do if medication is lost or stolen.
5. Discuss common or important possible side effects which may be caused by the patient's medication. Discuss signs/symptoms of possible adverse medication effects and actions for the patient/family to take if they believe an adverse effect is occurring or has occurred.
6. Review possible drug/drug and drug/food interactions. Emphasize that it is dangerous to combine psychotropic medications with alcohol or street drugs, and that use of alcohol, street drugs or herbal supplements may make the prescribed medication ineffective.
7. Emphasize the importance of informing the provider of all medications, drugs, herbals and supplements that are used by the patient.
8. As appropriate, provide the patient/family with the phone numbers or other access information for the pharmacy, hospital emergency department, medication/drug hotline, and/or other available resources.

GAD-SM STRESS MANAGEMENT

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

STANDARDS:

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

GAD-TX TREATMENT

OUTCOME: The patient/family will understand what the treatment plan is for this patient, that the treatment plan will usually require some participation by other family and/or household members, and will make a plan to fully participate in the treatment plan.

STANDARDS:

1. Explain that treatment for GAD may vary according to the patient's life circumstances, severity of the condition, and resources available.
2. Explain that GAD usually can be treated successfully, but that the patient's active participation in the treatment plan is critical to a good outcome.
3. Explain that regular exercise will usually contribute significantly to improving the symptoms of GAD and in some cases will eliminate the need for medication. **Refer to GAD-EX.**
4. Explain that some form of counseling or psychotherapy will usually be prescribed initially and in some cases may be continued indefinitely.
5. Explain that medication may be prescribed; medication may be used chronically or intermittently according to circumstances. Explain that the decisions about timing and duration of medication will be made jointly by the physician or provider and the patient. **Refer to GAD-M.**
6. Explain that treatment for GAD will almost always require periodic follow-up with the physician or provider and often will require periodic follow-up with other health care professionals.

H

HA—Headaches

HA-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand the basic the AP of their particular type of headache.

STANDARDS:

1. Explain that headaches are multifactorial and the pathophysiology is dependant on the disease process.
2. Discuss the pathophysiogoly and related anatomy of this patient disease process.

HA-C COMPLICATIONS

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

STANDARDS

1. Discuss the possible complications, including:
   a. Depression or other mood disorders
   b. Suicidal behaviors
   c. Domestic violence
   d. Substance abuse
   e. Substance use
   f. Employment problems.
   g. Relationship problems
   h. Cognitive difficulties
   i. Appetite change
   j. Sensitivity to light and noise
   k. Alteration in sleep patterns

HA-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the headache pain symptoms, type (migraine, tension, sinus, or cluster) and the causes if known.

STANDARDS:

1. Explain that the patient is the primary source of information about the pain's location, quality, intensity, onset, precipitating, or aggravating factors, frequency of headache pain and the measures that bring relief.
2. Discus the current knowledge of this patient’s type of headache.
3. Emphasize the importance of communicating information about the headache to the provider.
4. Discuss that the patient's presentation of symptoms is a unique combination of the type of pain, individual experiences and sociocultural adaptive responses.
5. Explain that headache pain may act as a warning sign of some problems in the body, including:
   a. Sinus problems
   b. Dehydration
   c. Decayed teeth
   d. Problems with eyes, ears, nose or throat
   e. Infections and fever
   f. Injury to the head
   g. Physical or emotional fatigue
   h. Exposure to toxic chemicals
   i. High blood pressure
   j. Sleep apnea
   k. Mood disorders
   l. Caffeine withdrawal (i.e., coffee, chocolate, tea, soft drinks)
   m. Hangovers
   n. Tumor (extremely rare)
6. Emphasize that influencing factors from internal and external changes are present. Some of these factors include:

Internal Factors:	External Factors:
Hormonal changes	Weather changes
Stress	Alcohol
Change in sleep habit	Bright /flickering light

HA-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of follow-up care.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.
4. Discuss important warning signs that would indicate earlier follow up is needed, including:
   a. If the headache keeps you from your usual activities
   b. If the headache lasts more than one day
   c. If you have fever, stiff neck, nausea, or vomiting
   d. If you feel drowsy or want to go to sleep
   e. If you have had a recent head injury
   f. If you develop eye pain, blurred vision, or trouble seeing
   g. If you suspect the headache was caused by medicines
   h. If you have persistent headaches seen by doctor
   i. If the headache was the result of a head injury
   j. If you have difficulty speaking
   k. If you develop numbness or weakness of the arms or legs
   l. If the headaches increase in intensity or frequency over time
   m. If you experience instantaneous onset of severe headache
   n. If the headaches require the daily use of pain-reliever medications
   o. If the headache is experienced by very young children (preschool age)
   p. If there is new onset headaches in middle-aged people.

HA-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

HA-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle changes necessary to optimize performance of everyday activities and promote well-being.

STANDARDS:

1. Explain that treatment of headache pain is very individualized and may involve lifestyle adaptation, i.e., medication, rest and relaxation, exercise, stress-reduction, and/or internal or external changes.
2. Explain that exercise and social involvement (i.e., familial, traditional, cultural) may decrease the sense of pain and the depression and anger associated with pain.
3. Review lifestyle areas that may require adaptations, i.e., diet, substance use, rest and sleep patterns, physical activity, sexual activity, role changes, communication skills and interpersonal relationships.
4. Discuss lifestyle changes in relation to headache style.
5. Discuss techniques that may reduce stress and depression, such as meditation, maintaining regular sleep patterns, exercise program, hobbies and crafts, acupuncture, spiritual and cultural activities, or biofeedback training.
6. Refer to community resources as appropriate.

HA-M MEDICATION

OUTCOME: The patient/family will understand their medication regimen and the importance of fully participating with the therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Discuss that there are many medications for the treatment or prevention of headaches and that narcotics are usually not indicated.
3. Explain that excess sedation and euphoria are not goals of palliative pharmacotherapy.
4. Emphasize that headache pain is not always completely understood and it is often necessary to take prophylactic medicines to assure optimal comfort levels. It is important to take preventive medication exactly as prescribed to prevent or reduce pain.
5. Discuss patient/family concerns about addiction. Explain the difference between psychological addiction and physical dependence upon prescribed medications. Reinforce that addiction is psychological dependence on a drug and is not equivalent to tolerance or physical dependence.
6. Emphasize the importance of consulting with provider before taking any OTC or herbal/traditional remedies.
7. Discuss the use of adjunct medications, if indicated, to control analgesic side effects, i.e., anti-emetics, laxatives, antacids.

HA-N NUTRITION

OUTCOME: The patient/family will understand the important contribution of healthy food choices and an adequate fluid intake in the treatment of headaches. They will be able to identify some dietary factors that may affect their headaches.

STANDARDS:

1. Assess eating habits.
2. Stress that eating regularly and not skipping meals is important.
3. Emphasize the necessary component – water – in a healthy diet.
4. Explain that constipation is a common side effect of some pain medications. Dietary measures such as increased water, increased fiber, increased fruit and decreased intake of milk products may be helpful.
5. Refer to dietitian or other local resources as indicated.

HA-P PREVENTION

OUTCOME: The patient/family will understand that headaches have varying etiologies and the mechanisms are not known for many headaches. The patient/family will identify the precipitating factors, if known, and develop a plan to maximize prevention strategies.

STANDARDS:

1. Discuss strategies for identifying headache triggers (i.e., journal, activity and food log).
2. Stress the importance of avoiding any known triggers.
3. Discuss that prophylactic medications must be taken as directed to be effective.
4. Emphasize that headaches seem to be more common during stressful times. **Refer to HA-SM.**

HA-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand that grief reactions and mood disorders are common with chronic headaches.

STANDARDS:

1. Discuss symptoms of mood disorders that may need additional professional support, sympathy, time, attention, compassion, and communication for patient/family.
2. Explain that if anti-depressant drugs are prescribed by the provider, full participation with the treatment plan is important to maximize the effectiveness of the treatment.
3. Explain that many mechanisms for dealing with grief and depression are available, i.e., support groups, individual therapy, family counseling, spiritual guidance.
4. Refer to community resources as appropriate.

HA-SM STRESS MANAGEMENT

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

STANDARDS:

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

HA-TE TESTS

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

STANDARDS:

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

HA-TX TREATMENT

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

STANDARDS:

1. Discuss with the patient/family the possible appropriate noninvasive pain relief measures, i.e., massage, heat, cold, rest, over-the-counter medications, books or tapes for relaxation.
2. Discuss with the patient/family the possible alternative pain relief measures, when appropriate, i.e., meditation, imagery, acupuncture, healing touch traditional healer, biofeedback, hypnosis.
3. Discuss with the patient/family the possible appropriate pharmacotherapy. **Refer to HA-M.**
4. Discuss with the patient/family other possible approaches, i.e., lifestyle changes, physical therapy, nutritional changes, stress management, or psychotherapy.
5. Emphasize the importance of the patient/family's active involvement in the development of a treatment plan.

HIV—Human Immunodeficiency Virus

HIV-C COMPLICATIONS

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

STANDARDS:

1. Discuss the common or significant complications associated with HIV/AIDS:
   a. Bacterial infections;
   b. Viral infections;
   c. Fungal infections;
   d. Parasitic infections;
   e. Cancers.
2. Discuss common or significant complications which may be prevented by full participation with the treatment regimen.
3. Discuss common or significant complications that may result from treatment(s).

HIV-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

HIV-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the risk factors, methods of transmission and prevention of HIV (Human Immunodeficiency Virus) and the progression from HIV positive status to AIDS (acquired immunodeficiency syndrome).

STANDARDS:

1. Explain the methods of HIV transmissions, i.e., semen, blood and blood product transfusions, needle sharing, accidental needle sticks, vaginal fluids, mother to infant, and in rare cases, organ or tissue transplants and unsterilized dental or surgical equipment.
2. Explain that HIV is a virus and there is no current vaccine to prevent its occurrence.
3. Explain that the human immunodeficiency virus attacks the immune system resulting in increased susceptibility to infections and cancers.
4. Explain the difference between HIV infection and AIDS. Explain that it is currently believed that all HIV infections will progress to AIDS. Early treatment and strict participation may slow the progression from HIV infection to AIDS.
5. Some symptoms of AIDS may be unusual or more frequent infections that are especially difficult to treat.
6. Explain the current knowledge about the progression of HIV and AIDS.

HIV-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient’s status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

HIV-FU FOLLOW-UP

OUTCOME: The patient/family/caregiver will understand the importance of follow-up and testing as appropriate and will formulate a plan to keep follow-up appointments.

STANDARDS:

1. Discuss the importance of follow-up care with referral resources and assistance from HIV case managers.
2. Discuss the procedure for accessing health care resources for HIV positive patients.
3. Discuss importance of follow-up appointments and follow-up testing as appropriate for this patient if initial or repeat HIV tests are negative.
4. Refer as appropriate to community resources.

HIV-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand how to manage HIV/AIDS at home.

STANDARDS:

1. Discuss the risks and benefits of the use of over the counter medications for symptom relief.
2. Discuss the use of alternative therapies or complementary medicinals that may be useful in symptom relief.
3. Help the patient/family identify appropriate resources for managing HIV/AIDS at home.

HIV-HY HYGIENE

OUTCOME: The patient will recognize good personal hygiene as an important component of preventing complications.

STANDARDS:

1. Discuss hygiene as part of a positive self image.
2. Review bathing and daily dental hygiene habits, i.e., don’t share razors and toothbrushes.
3. Discuss the importance of hand washing in infection control.
4. If using IV drugs, discuss the importance and implications of not sharing needles; discuss the proper disposal of used needles.
5. Discuss the importance and implications of preventing unprotected sexual activity:
   a. Use a new latex or polyurethane condom every time you have vaginal or anal sex. Condoms other than latex or polyurethane are not effective in the prevention of HIV.;
   b. During oral sex use a condom, dental dam or plastic wrap;
   c. If you use sexual devices, don’t share them;
   d. Don’t share razor blades or tooth brushes
6. Discuss any hygiene habits that are specifically pertinent to this disease state or condition.

HIV-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family/caregiver will receive written information about HIV and other sexually transmitted infections (STIs).

STANDARDS:

1. Provide the patient/family with written patient information literature on HIV and/or other sexually transmitted infections.
2. Discuss the content of patient information literature with the patient/family.
3. Caution the patient that information found on the Internet is not necessarily screened for accuracy and may not be correct. Emphasize the importance of using reliable sources of information.

HIV-LA LIFESTYLE ADAPTATIONS

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

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over - diet, exercise, safety and injury prevention, avoidance of high risk behaviors, and full participation with treatment plan:
   a. Follow safer sex practices
   b. Tell your sexual partner(s) that you have HIV
   c. If your partner is pregnant, tell her you have HIV
   d. Tell others who need to know, i.e., family, friends, health providers
   e. Don't share needles or syringes
   f. Don't donate blood or organs
   g. If you are pregnant, get medical care right away
2. Emphasize that an important component in the prevention or treatment of disease is the patient's adaptation to a healthier, lower risk lifestyle.
3. Emphasize the importance of not smoking, using illegal drugs, or alcohol as these further weaken your body.
4. Review the community resources available to assist the patient in making lifestyle changes. Refer as appropriate.

HIV-M MEDICATIONS

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

STANDARDS:

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

HIV-N NUTRITION

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

STANDARDS:

1. Discuss the fact that wasting syndrome is a serious, yet common, complication that can be prevented or minimized by maximizing nutrition.
2. Review nutritional needs for optimal health when living with HIV/AIDS. The patient/family will understand that fighting an infection (HIV) requires maximizing dietary intake.
3. Discuss current nutritional habits. Assist the patient in identifying health promoting nutritional habits.
4. Discuss nutritional modifications as related to the specific disease state/condition, especially in regards to fluid, protein and calories.
5. Emphasize the importance of fully participating in the prescribed nutritional plan.
6. Emphasize the importance of food safety.
7. Discuss nutrition supplements, i.e., vitamin and mineral supplements, antioxidants, complementary supplements.

HIV-P PREVENTION

OUTCOME: The patient will develop a healthy behavior plan, which will prevent/reduce exposure to HIV infections.

STANDARDS:

1. List circumstances/behaviors that increase the risk of HIV infection:
   a. IV drug use and sharing needles.
   b. Multiple sexual partners.
   c. Unprotected sex, i.e., sex without latex or polyurethane condoms or other protective agents, dental dams, plastic wrap.
   d. Anal intercourse
   e. Breastfeeding by an HIV infected mother
   f. Being born to an HIV infected mother
   g. Presence or history of another sexually transmitted infections
   h. Victims of rape
   i. Involvement in a abusive relationship.
2. Describe behavior changes which prevent/reduce transmission of HIV virus.
3. Discuss/demonstrate proper application of condom with model if available. Discuss proper lubricant type. (No oil based lubricants.)
4. Describe how alcohol/substance use can impair judgment and reduce ability to use protective measures.
5. Explain ways to reduce exposure to infected persons.
6. Explain that the best way to prevent exposure to HIV is to abstain from risky sexual behavior and from recreational drug use.

HIV-PN PRENATAL

OUTCOME: The patient/family will understand risk factors for HIV (mother and child) and offer referral for testing.

STANDARDS:

1. Discuss risk factors for HIV (mother and child).
2. Offer referral for HIV testing.
3. Explain that early detection, early treatment and full participation with the medication regimen as well as maintaining a healthy lifestyle will often result in a better quality of life and slower progression of the disease and may have beneficial effects upon the delivery and longevity of the child.

HIV-S SAFETY

OUTCOME - The patient/family/caregiver will understand principles of planning and living within a safe environment.

STANDARDS:

1. Explain that opportunistic infections are a major cause of death.
2. Discuss the need to prevent opportunistic infections through creating and living within a safe environment.
3. Assist the patient/family/caregiver in identifying ways to adapt the home to improve safety and prevent injury, illness and disease transmission appropriate to the patient's age, disease state and condition.
4. Identify which community resources promote a safe living environment.

HIV-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in HIV/AIDS.

STANDARDS:

1. Explain that uncontrolled stress can contribute to a suppressed immune response and increased complications from HIV/AIDS.
2. Explain that effective stress management may help to reduce the adverse consequences of HIV/AIDS, as well as improve the patient's health and well-being.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance abuse, all which can increase the risk of morbidity and mortality from HIV/AIDS.
4. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. becoming aware of your own reactions to stress
   b. recognizing and accepting your limits
   c. talking with people you trust about your worries or problems
   d. setting realistic goals
   e. getting enough sleep
   f. maintaining a reasonable diet
   g. exercising regularly
   h. taking vacations
   i. practicing meditation
   j. self-hypnosis
   k. using positive imagery
   l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   m. spiritual or cultural activities
5. Discuss suggestions for dealing with the emotional toll of living with HIV/AIDS:
   a. Learn all you can about HIV/AIDS;
   b. Be proactive, take an active role in your treatment;
   c. Maintain a strong support system;
   d. Take time to make important decisions concerning your future;
   e. Come to terms with your illness.
6. Provide referrals as appropriate.

HIV-TE TESTS

OUTCOME: The patient/family will understand the reason for testing, the expected outcome and whether the test will be confidential or anonymous.

STANDARDS:

1. Explain that early detection, early treatment and full participation with the medication regimen as well as maintaining a healthy lifestyle will often result in a better quality of life and slower progression of the disease.
2. Explain that identification of all partners is necessary to facilitate the treatment of those persons and limit further spread of the infection.
3. Explain that if you receive a diagnosis of HIV/AIDS, your doctor will use a test to help predict the probable progression of your disease. This test measures the amount of virus in your blood and aids in determining your course of treatment.
4. Emphasize the importance of using only approved test kits for HIV (as of November 2004 is the Home Access HIV test marketed by Home Access Health).

HIV-TX TREATMENT

OUTCOME: The patient/family will understand the importance of a comprehensive treatment plan.

STANDARDS:

1. Explain that according to current guidelines, treatment should focus on achieving the maximum suppression of symptoms for as long as possible. This aggressive approach is known as high active antiretroviral therapy (HAART). The aim of HAART is to reduce the amount of virus in your blood to very low levels, although this doesn't mean the virus is gone.
2. Emphasize and discuss the importance of a comprehensive treatment plan, which includes health and risk assessment, common lab tests, disease staging, prophylaxis therapy, immunizations, social and insurance needs, plus follow up.
3. Discuss the process for developing a comprehensive treatment plan.
4. Help the patient/family identify the appropriate resources for developing a comprehensive treatment plan.
5. Explain that identification of all partners is necessary to facilitate the treatment of those persons and limit further spread of the infection.

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

DEP—Major Depression

DEP-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.

DEP-DP DISEASE PROCESS

OUTCOME: The patient and/or family will understand the psychological and physiological causes of major depression.

STANDARDS:

1. Discuss the common symptoms of major depression with the patient and/or family:
   a. Persistent sadness lasting longer than two weeks
   b. Loss of interest in usual activities
   c. Weight loss or gain
   d. Sleep disturbances
   e. Energy loss
   f. Fatigue
   g. Hyperactive or slowed behavior
   h. Decreased or slowed sexual drive
   i. Feelings of worthlessness
   j. Difficulty concentrating or making decisions
   k. Recurrent suicidal thoughts. **Refer to SB**.
   l. Memory loss
2. Assure the patient and/or family that prognosis is usually good, with appropriate treatment.
3. Stress that many episodes of depression are not preventable. Treatment, including medications and psychiatric intervention, may prevent recurrences.
4. Discuss that antidepressant drug therapy combined with psychotherapy appears to have better results than either therapy alone.

DEP-EX EXERCISE

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

STANDARDS:

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

DEP-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the patient's responsibility in managing major depression.
2. Review the treatment plan with the patient/family, emphasizing the need for keeping appointments and adhering to medication regimens.
3. Instruct the patient/family to contact a mental health professional or other medical personnel if persistent thoughts of suicide occur.
4. Explain the process for making follow-up appointments.

DEP-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

1. Provide the patient/family with written patient education literature on major depression.
2. Discuss the content of the patient education literature with the patient/family.

DEP-M MEDICATIONS

OUTCOME: The patient/family will understand the proper use of antidepressant medication.

STANDARDS:

1. Review the mechanism of action of the prescribed medication.
2. Discuss proper use, benefits and common side effects of prescribed medications.
3. Explain that some medications may have long-term effects that require regular monitoring and follow-up.
4. Discourage the use of alcohol and recreational drugs.
5. Explain that it may be six weeks before the antidepressant medication takes effect.
6. Explain that drug therapy may include one or a combination of tricyclic antidepressants, monoamine oxidase inhibitors and serotonin re-take uptake blockers or psychotropic medications that work by other mechanisms.
7. Discuss the risks associated with the medications especially in overdoseage. All medications should be stored in a safe place in child-resistant containers.
8. Discuss drug/drug and drug/food interactions as applicable.

DEP-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand the goals and process of psychotherapy.

STANDARDS:

1. Emphasize that for the process of psychotherapy to be effective the patient must keep all appointments.
2. Emphasize the importance of openness and honesty with the therapist.
3. Explain to the patient that the therapist and the patient will establish goals, ground rules, and duration of therapy.

DEP-SCR SCREENING

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

STANDARDS

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

DEP-SM STRESS MANAGEMENT

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

STANDARDS:

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

DEP-WL WELLNESS

OUTCOME: The patient/family will understand some of the factors which contribute to a balanced and healthy lifestyle.

STANDARDS:

1. Explain that a healthy diet is an important component of emotional health.
2. Emphasize the importance of stress reduction and exercise in emotional health.
3. Refer the patient/family to support groups as appropriate.

O

OBS—Obesity

OBS-C COMPLICATIONS

OUTCOME: The patient will be able to name at least 2 complications of obesity.

STANDARDS:

1. Emphasize that obesity is the single most important risk factor in Diabetes Mellitus Type 2.
2. Explain how obesity increases the risk for heart disease, infertility, cholelithiasis, musculoskeletal problems, and surgical complications.

OBS-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

OBS-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the process underlying obesity and will be able to relate this process to changes necessary to attain improved health.

STANDARDS:

1. Relate obesity to health outcomes.
2. Emphasize the relationship among obesity, caloric intake, and exercise.
3. Explain that some people have a genetic predisposition to obesity which will require increased persistence to maintain health.

OBS-EX EXERCISE

OUTCOME: The patient will understand the relationship of physical activity in maintaining a healthy body weight, and will strive to increase regular activity by an agreed-upon amount.

STANDARDS:

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

OBS-FU FOLLOW-UP

OUTCOME: The patient will understand that improved health requires a lifelong commitment to lifestyle adaptations which will assist with control of obesity.

STANDARDS:

1. Discuss the individual's responsibility in the management of obesity.
2. Review the patient's plan for lifestyle modification, emphasizing the need for keeping appointments, adhering to dietary modifications and increasing activity levels.
3. Encourage regular weight and blood pressure checks.
4. Reassess exercise and activity levels every 3-6 months.

OBS-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

OBS-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the importance of making lifestyle adaptations to attain a healthier body habitus.

STANDARDS:

1. Review dietary modifications and restrictions. Refer to the standards for **OBS-N**.
2. Emphasize the benefits of regular exercise. **Refer to WL-EX.**
3. Discuss the importance of good hygiene since additional body fat increases perspiration.
4. Discuss the pros and cons of alternate weight loss options, i.e., fad diets, surgery, medications.

OBS-M MEDICATION

OUTCOME: The patient/family will understand that weight loss medications can have side effects or drug interactions and the importance of discussing any over-the-counter or prescription weight loss medications with the health care provider prior to initiating said medication(s).

STANDARDS:

1. Explain the potentially serious adverse effects of the specific interactions of the medication with other drugs (including OTC medications and traditional or herbal medicines).
2. Specifically discuss adverse effects of this medication when combined with specific foods.
3. Emphasize the importance of informing the provider (i.e., physician, pharmacist, nurse) of any drug interaction(s) that have occurred in the past.
4. Discuss the risk/benefit ratio of the medication(s) that are being considered.

OBS-N NUTRITION

OUTCOME: The patient will identify dysfunctional eating patterns and plan adaptations in eating which will promote weight loss and improved health.

STANDARDS:

1. Assess current eating patterns. Identify helpful and harmful components of the patient's diet.
2. Emphasize the importance of regular meal times and of eliminating snack foods, fatty foods, fatty red meats, reducing sodium consumption and adding more fresh fruits, fresh vegetables and fiber to the diet.
3. Emphasize the necessary component — water — in a healthy diet. Reduce the use of colas, coffee, and alcohol.
4. Review which community resources exist to assist with diet modification and weight control. Refer to dietitian as appropriate.
5. Anticipate psychological or social stressors which may lead to over-consumption. Teach the patient to splurge by plan, not by impulse.
6. Teach person(s) responsible for food purchase and preparation techniques for avoiding fats and simple carbohydrates in meal plans.

OBS-P PREVENTION

OUTCOME: The patient/family will understand the importance of attaining and maintaining a healthy body weight throughout the life span.

STANDARDS:

1. Emphasize that obesity often begins at conception. Discuss the roles of maternal obesity, gestational diabetes, and overfeeding of infants.
2. Encourage a physically active lifestyle. **Refer to WL-EX**.
3. **Refer to WL-N and OBS-C.**
4. Identify cultural, familial, and personal perceptions of body image and their relationship to obesity and health.

OBS-SM STRESS MANAGEMENT

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

STANDARDS:

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

OBS-TE TESTS

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

STANDARDS:

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

P

PM—Pain Management

PM-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand that the perception of pain is highly complex and individualized.

STANDARDS:

1. Explain that pain normally acts as the body's warning signal of tissue injury. This warning signal notifies the body to withdraw from the stimulus.
2. Discuss the difference between the body's physiological response to pain and the person's perception of the event.
3. Explain that tissue damage causes the release of chemicals which result in the sensation of pain. Most pain medications work by blocking these chemicals.
4. Explain that touch type signals (i.e., rubbing, stroking, touching) may block the brain's reception of pain signals.

PM-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

PM-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pain symptoms, type (i.e., chronic, acute, malignant) and the causes of the patient's pain if known.

STANDARDS:

1. Explain that the patient is the primary source of information about the pain's location, quality, intensity, onset, precipitating or aggravating factors and the measures that bring relief.
2. Emphasize the importance of communicating information about the pain to the provider.
3. Discuss that the patient's presentation of symptoms is a unique combination of the type of pain, individual experiences and sociocultural adaptive responses.
4. Explain that pain tolerance varies greatly from person to person and in the same individual under different circumstances.
5. Explain that it is very rare for patients to become addicted to drugs administered for the relief of acute pain.

PM-EQ EQUIPMENT

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

STANDARDS:

1. Discuss the indications for and benefits of the prescribed medical equipment.
2. Discuss types and features of the medical equipment as appropriate.
3. Discuss and/or demonstrate proper use, care, and cleaning of medical equipment.
4. Participate in a return demonstration by the patient/family.
5. Discuss signs of equipment malfunction and proper action in case of malfunction as appropriate.
6. Discuss proper disposal of associated medical supplies.
7. For inpatients, explain that the various alarms are to alert the medical personnel of the patient’s status and/or the function of the equipment.
8. Emphasize the importance of not tampering with any medical device.

PM-EX EXERCISE

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

STANDARDS:

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

PM-FU FOLLOW-UP

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

STANDARDS:

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

PM-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the patient's specific disease process, pain management issues, support groups or community resources as appropriate.

STANDARDS:

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

PM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle changes necessary to optimize performance of everyday activities and promote healing.

STANDARDS:

1. Explain that treatment of pain is very individualized, i.e., medication, rest, exercise, and disease-specific treatment modalities.
2. Explain that exercise and social involvement (i.e., familial, traditional, cultural) may decrease the subjective sense of pain and the depression and anger often associated with pain.
3. Review lifestyle areas that may require adaptations (i.e., diet, physical activity, sexual activity, bladder/bowel habits, role changes, communication skills and interpersonal relationships). Discuss lifestyle changes in relation to disease progression. Review activity limitation as appropriate.
4. Discuss techniques that may reduce stress and depression such as meditation and biofeedback as appropriate.
5. Refer to community resources as appropriate**. Refer to WL**.

PM-M MEDICATION

OUTCOME: The patient/family will verbally summarize the medication regimen and the importance of full participation with therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of prescribed medications.
2. Emphasize that excess sedation and euphoria are not goals of palliative pharmacologic therapy.
3. Explain that chronic pain is usually irreversible and often progressive.
4. Discuss patient/family concerns about addiction. Explain the difference between psychological addiction and physical dependence upon prescribed pain medications. Reinforce that addiction is psychological dependence on a drug; and is not equivalent to tolerance or physical dependence.
5. Explain that insomnia and depression are often significant problems for chronic pain patients. Emphasize the importance of developing a plan with the provider to address these issues as appropriate.
6. Explain that spiritual pain is a reality and cannot be relieved with medications.
7. Discuss the importance of full participation with the medication regimen in order to assure optimal comfort levels. For example, round-the-clock dosing of pain medication is more effective in the treatment of chronic pain than medications that are taken after the pain recurs.
8. Discuss the use of adjunctive medication, if indicated, to control analgesic side effects, i.e., anti-emetics, laxatives, antacids.
9. **Refer to M.**

PM-N NUTRITION

OUTCOME: The patient/family will understand the importance of a nutritionally balanced diet in the treatment of their pain and specific disease process. They will be able to identify foods and meal plans that will promote the healing process if applicable.

STANDARDS:

1. Assess current nutritional habits and needs.
2. Emphasize the necessary component - WATER - in a healthy diet.
3. Explain that constipation is a common side-effect of opiates. Dietary measures such as increased water, increased fiber, increased fruit juices and decreased intake of milk products may be helpful. Other control measures should be discussed with the provider prior to initiation.
4. Review the patient's prescribed diet, if applicable. Refer to dietitian or other local resources as indicated.

PM-P PREVENTION

OUTCOME: The patient and/or family will understand the source of pain in relation to the appropriate disease process. They will make a plan to avoid the precipitating factors, minimize disease progression, promote healing; and/or maximize coping strategies.

STANDARDS:

1. Discuss importance of fully participating in treatment plan for an acute injury to reduce the risk of residual chronic pain.
2. Discuss good body mechanics in order to reduce risk of musculoskeletal injuries.

PM-PSY PSYCHOTHERAPY

OUTCOME: The patient/family will understand that grief reactions are common with chronic pain and that depression may be seen and that treatments are available for these problems.

STANDARDS:

1. Discuss symptoms of grief reaction, i.e., vigilance, trouble concentrating, hyperattentiveness, insomnia, distractibility.
2. Explain that the patient/family may need additional support, sympathy, time, attention, compassion and communication.
3. Explain that if anti-depressant drugs are prescribed by the provider, full participation with the treatment regimen is important to maximize the effectiveness of the treatment.
4. Refer to community resources as appropriate, i.e., bio-feedback, yoga, healing touch, herbal medicine, laughter, humor, traditional healer, guided imagery, massage, acupuncture, acupressure.
5. Explain that many mechanisms for dealing with grief and depression are available, i.e., support groups, individual therapy, family counseling, spiritual counseling. Refer as appropriate.

PM-TE TESTS

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

STANDARDS:

1. Explain the test ordered, i.e., EMG, CT scan, ultrasound.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Discuss any necessary preparation for the test(s).

PM-TX TREATMENT

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

STANDARDS:

1. Discuss with the patient/family the possible appropriate noninvasive pain relief measures, i.e., TENS units, heat, cold, massage.
2. Discuss with the patient/family the possible alternative pain relief measures, when appropriate, i.e., meditation, imagery, acupuncture, healing touch, traditional healer, hypnosis.
3. Discuss with the patient/family the possible appropriate pharmacologic pain relief measures. **Refer to PM-M**.
4. Discuss with the patient/family the possible appropriate procedural or operative pain management techniques, i.e., nerve block, intrathecal narcotics, local anesthesia.
5. Emphasize the importance of the patient/family's active involvement in the development of a treatment plan.

PNL—Perinatal Loss

PNL-C COMPLICATIONS

OUTCOME: Patients will know that the most serious complications of perinatal loss are infection, hemorrhage, and possible decrease in fertility.

STANDARDS:

1. Instruct patient on the signs and symptoms of postpartum complications, i.e., hemorrhage, infections, and the possibility of decreased fertility.
2. Explain that a common complication of perinatal loss is depression and that this is usually treatable.
3. Explain that marital difficulties are common after perinatal loss. Encourage open discussion and family counseling or support groups as appropriate.

PNL-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

PNL-DP DISEASE PROCESS

OUTCOME: The patient and significant others(s) will understand the type of perinatal loss they had, i.e., miscarriage, ectopic pregnancy, intrauterine death or stillbirth.

STANDARDS:

1. Explain that perinatal loss is common and is most often not a result of actions or lack of actions of the mother.
2. Explain to the patient and significant others what type of perinatal loss the patient had, i.e., miscarriage, stillbirth.
3. Explain to the patient and significant others what the course of the medical treatment will be, i.e., incomplete miscarriage, dilation and curettage, stillbirth induction of labor and vaginal delivery.
4. If appropriate, explain the cause for perinatal loss if one can be identified.
5. If possible explain the implications of this loss on future pregnancies.

PNL-FU FOLLOW UP

OUTCOME: Patient/family will understand the treatment plan and the importance of making and keeping follow-up appointments.

STANDARDS:

1. Instruct patient/family when to return for follow up visits.
2. Instruct patient/family to call or return immediately to the hospital or clinic for any signs of complication.
3. Refer for family planning as appropriate.

PNL-GP GRIEVING PROCESS

OUTCOME: The patient and significant other(s) will understand the grieving process, signs, and symptoms as it pertains to miscarriage, ectopic pregnancy, stillbirth or neonatal death.

STANDARDS:

1. Discuss that culture plays an important role in the grieving process. (Before any teaching/counseling is initiated a discussion with the patient and significant other(s) will be done to ascertain any cultural beliefs and or taboos associated with death and the grieving process. Cultural preferences should be honored.)
2. Explain that grief is a personal process and patients and significant others(s) may have different reactions to the loss. Offer grief information and different options to assist their grieving process.
3. Discuss the grieving process as it relates to perinatal loss.
4. Explain that it is normal to grieve over the loss of the baby, and that everyone may grieve differently, and that different reactions are normal.
5. Explain that anniversary reactions, increased grief during trigger events (i.e., pregnancy of a friend or family member, holidays) are normal.
6. Discuss the various options available to help with the grieving process.
7. As appropriate, encourage viewing of the infant/fetus, picture taking and naming of the infant/fetus.

PNL-L LITERATURE

OUTCOME: The patient/family will receive written patient information literature on perinatal loss and/or related issues.

STANDARDS:

1. Provide the patient/family with written patient information literature on perinatal loss and/or related issues.
2. Discuss the content of the patient information literature with the patient/family.

PNL-M MEDICATIONS

OUTCOME: Patient/family will understand her medication regimen.

STANDARDS:

1. Instruct patient on her discharge medication(s) and the indications and length of therapy for the medication(s).
2. Review the proper use, benefits and common side effects of the medication(s).
3. Emphasize the importance of maintaining full participation in the medication regimen.
4. Discuss common and important drug interactions with foods, drugs and over the counter medications.
5. Encourage continued use of prenatal vitamins as appropriate.

PNL-N NUTRITION

OUTCOME: Patient will understand the need for a balanced diet or special diet as indicated by her medical condition.

STANDARDS:

1. Instruct patient on diet prior to discharge.
2. Encourage patient to continue taking prenatal vitamins or multi vitamin with folic acid.
3. Refer as appropriate to registered dietician or other resources as available.

PNL-PM PAIN MANAGEMENT

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

STANDARDS:

1. Discuss pain relieving and/or pain management techniques.
2. Patient will be instructed on pain medication available to her and encourage to ask for the medication as needed to relieve her pain.
3. Discuss that pain associated with perinatal loss can be physical, emotional and spiritual. Different techniques may be required to address each type of pain.
4. Discuss non-pharmacologic, traditional or spiritual techniques to address emotional and spiritual needs.

PNL-SM STRESS MANAGEMENT

OUTCOMES: The family member will understand the role of stress management in perinatal loss.

STANDARDS:

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

PNL-TX TREATMENT

OUTCOME: The patient/family will understand the treatment necessary as a result of the perinatal loss if any.

STANDARDS:

1. Explain to the patient and significant others the course of the medical treatment, i.e., dilation and curettage, induction of labor and vaginal delivery, laparoscopy or open abdominal surgery.
2. Discuss issues related to sexual activity and family planning, as appropriate.

POI—Poisoning

POI-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of the treatment plan and the importance of making and keeping follow-up appointments.

STANDARDS:

1. Explain the recommended schedule for follow-up.
2. Explain the procedure for obtaining follow-up appointments
3. Explain the importance of keeping follow-up appointments.
4. Explain that failure to keep follow-up appointments may have devastating consequences.

POI-I INFORMATION

OUTCOME: The patient/family will understand the steps to take when an incident of poisoning has been identified.

STANDARDS:

1. Discuss the importance of calling the Poison Control Center immediately.
2. Emphasize that immediate treatment increases the probability of a positive outcome.
3. Explain the importance of having the substance causing the poisoning available. Explain how this will assist medical personnel in making a correct diagnosis and treatment plan.
4. Discuss the use of syrup of ipecac. Explain that ipecac should only be used on the advice of the poison control center or medical personnel.

POI-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

POI-P PREVENTION

OUTCOME: The parent/family will understand necessary steps to poison prevention.

STANDARDS:

1. Discuss ways to poison proof the home by keeping poisons and medications stored safely and out of reach of children, keep medicines and poisons in their original containers, and lock up cabinets containing poisons that are within reach of children.
2. Explain to parents the necessity of discussing poison control with their children. Emphasize to parents to impress upon their children that medication is not candy.
3. Emphasize that child-locks, child-resistant medication containers and other child safety devises are not truly child proof.
4. Explain that poisonous chemicals should not be stored in food or drink containers. Poisonous chemical should be kept in original, properly labeled containers.

POI-TE TESTS

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

STANDARDS:

1. Explain that tests may be necessary for diagnosis and treatment of poisoning and for follow-up of treatment. Discuss the procedure for collecting the sample, the benefit expected and any associated risks.
2. Explain the alternatives to the proposed test(s) and the risk(s) and benefits(s) of the alternatives including the risk of non-testing.

POI-TX TREATMENT

OUTCOME: The patient/family will understand the components of the treatment plan as well as common and important side-effects, risks and benefits and the probability of success of the treatment. The patient/family will further understand the risk of non-treatment.

STANDARDS:

1. Emphasize that immediate treatment increases the probability of a positive outcome.
2. Explain the importance of having the substance causing the poisoning available. Explain how this will assist medical personnel in making a correct diagnosis and treatment plan.
3. Discuss the use of syrup of ipecac. Explain that ipecac should only be used on the advice of the poison control center or medical personnel.
4. Discuss the treatment plan for this specific poisoning. Discuss suicide precautions if this was a non-accidental poisoning. **Refer to SB.**

PDEP—Postpartum Depression

PDEP-DP DISEASE PROCESS

OUTCOME: The patient/family will understand postpartum depression and its symptoms.

STANDARDS:

1. Explain that postpartum depression is a type of mood disorder, a biological illness caused by changes in brain chemistry, and is not the mother's fault or the result of a weak or unstable personality. It is a medical illness which professional treatment can help.
2. Explain that postpartum depression occurs in up to 80% of women who give birth, and that it is treatable.
3. Review some of the biological, psychological/social factors related to the development of postpartum depression:
   a. Biological: Sudden drop in hormones after birth and/or changes in prolactin levels.
   b. Psychological/social: Stressful life events such as financial problems, housing problems, lack of family interaction and support, new mothers facing new roles, lack of sleep, increased responsibility, single mothering, and/or marital problems.
   c. Family or personal history of depression or mood disorders with or without pregnancy.
4. Discuss that postpartum depression is often not recognized by the mother or family. Emphasize the importance of discussing mood/behavior changes with a health care provider.
5. Describe the varying degrees of postpartum depression that may occur-Postpartum Blues, Postpartum Depression, and Postpartum Psychosis:
   a. **PP Blues**: Occurs first three days after birth lasting to a few weeks - tearfulness, irritability, mood swings, nervousness, feelings of vulnerability, trouble sleeping, loss of appetite, lack of confidence, and feeling overwhelmed.
   b. **PP Depression**: Occurs within first 3-6 months up to a year after birth - sadness, loss of interest in normal activities, inappropriate guilt, anxiety, fatigue, impaired concentration/ memory, over concern for baby or non at all, inability to cope, despondency/despair, thoughts of suicide, hopelessness, panic attacks (numbness, tingling in limbs, chest pain, hyperventilation, heart palpitations), feeling "like I'm going crazy", bizarre or strange thoughts.

c. **PP Psychosis:** Rarest and most severe form occurring in only 0.1% of women who have given birth – Extreme confusion, incoherence, rapid speech or mania, refusal to eat, suspiciousness, irrational statements, agitation, hallucinations, or inability to stop an activity.

6. Explain that sometimes only a professional, through test interpretation, obtaining an appropriate history, and physical examination may be able to differentiate the degree of depression. Discuss the current knowledge of postpartum depression.
7. Emphasize that postpartum depression is reversible with early intervention and appropriate treatment. Refer as appropriate.

PDEP-FU FOLLOW-UP

OUTCOME: The patient/family will participate in the treatment plan and understand the importance of full participation with medications and observations.

STANDARDS:

1. Emphasize the importance of keeping appointments for postpartum, well child and postpartum depression care.
2. Review treatment plan with the patient/family. Discuss the procedure for obtaining follow-up care, the importance of taking medications as prescribed, and how to recognize any functional impairments (as evidenced by the avoidance of family or friends, an inability to attend to hygiene, or an inability to care adequately for the infant). Explain that patients with coexisting with substance abuse may need more rapid referral.
3. Explain that if the patient has considered a plan to act on suicidal thoughts or has thoughts about harming her infant, this is a medical emergency and hospitalization may be necessary. Discuss the procedure for obtaining urgent and rapid referrals.

PDEP-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

PDEP-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the lifestyle adaptations necessary to decrease the risk for postpartum depression and maintain optimal health.

STANDARDS:

1. Advise that the patient may be able to decrease the risk for postpartum depression by preparing during the pregnancy for the changes in lifestyle that motherhood will bring.
2. Emphasize lifestyle adaptations that will help speed recovery from postpartum depression:
   a. Over-sleeping may be a symptom of depression but has also been shown to increase depressed feelings. Discourage remaining in bed or sleeping more than 8-hours a day.
   b. Advise that natural light and exercise have an antidepressant effect. Encourage the patient to exercise, for example take a walk out of doors for at least ½-hour between 11 AM and 2 PM to take care of the need for bright light and exercise.
   c. Emphasize the importance of TOTALLY abstaining from alcohol and recreational drugs. Alcohol and street drugs both induce depression and prevent antidepressants from working effectively. Advise your provider of all medications, drugs herbals and supplements you are taking to minimize this effect.
   a. Encourage the patient/family to accept the recommended help and assistance of others. There is no shame in asking for or accepting help.

PDEP-M MEDICATIONS

OUTCOME: The patient/family will understand the goal of medication therapy and plan to follow the prescribed medication regimen.

STANDARDS:

1. Review the patient's medications. Reinforce the importance of knowing the drug, dose and the time interval of medications.
2. Review common side effects, signs of toxicity. Discuss what actions to take if a significant side effect or signs of toxicity occurs.
3. Emphasize the importance fully participating in the medication regimen. Explain that many medications for postpartum depression do not exert an immediate effect and must be used regularly to be effective.
4. Briefly explain the mechanism of action of the patient's medication as appropriate.
5. Discuss any significant drug/drug or food/drug interactions, including interaction with alcohol.
6. Explain that the patient's wish to breast-feed can be respected. The transfer of medication to the baby can be minimized by the mother breastfeeding before she takes her pills. Although many depression medications are excreted in breastmilk, no cases of deleterious effects have been noted in infants to date. Refer the patient to a physician or pharmacist who is knowledgeable in the use of medications during breastfeeding for more specific information.

PDEP-N NUTRITION

OUTCOME: The patient/family will understand how diet relates to postpartum depression.

STANDARDS:

1. Assess current nutritional habits.
2. Review the relationship between diet and depression.
3. Explain that even marginal deficiencies in the diet will negatively affect the nervous system, mood and breastfeeding. A daily multivitamin and mineral supplement may be recommended to help ensure an adequate intake.
4. Assist in developing an appropriate diet plan. Refer to dietitian or other local resources as available. Stress the importance of eating on a regular schedule and eating a variety of foods.

PDEP-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress is attributed to an increase in severity of the symptoms of postpartum depression.
2. Explain that uncontrolled stress can interfere with the treatment of postpartum depression.
3. Explain that effective stress management may help reduce the severity of the symptoms of depression, as well as help improve the health and well-being of the patient.
4. Emphasize the importance of seeking professional help as needed to reduce stress.
5. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use as well as overeating, all of which can increase the severity of the depression or the risk of suicidal/homicidal behaviors.
6. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. becoming aware of your own reactions to stress
   b. recognizing and accepting your limits
   c. recruiting other family members or friends to help with child care
   d. talking with people you trust about your worries or problems
   e. setting realistic goals
   f. getting enough sleep (e.g., sleeping when the baby sleeps if possible)
   g. maintaining a reasonable diet
   h. exercising regularly
   i. taking vacations
   j. practicing meditation
   k. self-hypnosis
   l. using positive imagery
   m. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   n. spiritual or cultural activities
7. Provide referrals as appropriate.

PDEP-TX TREATMENT

OUTCOME: The patient/family will understand the possible treatments that may be available based on the specific disease process, test results, severity of symptoms, the preferences of the patient, and the response to treatment during previous episodes.

STANDARDS:

1. Assist the patient/family in understanding that postpartum depression may require long-term intervention which may include psychotherapy, medication, support groups or electro-convulsive therapy.
2. Review the nature of postpartum depression as a treatable condition.
3. Explain that both the patient AND family may need to participate in the treatment to help understand the symptoms and cope with the increased stress on the family.
4. Assist the family in the realization that left untreated, postpartum depression can have significant negative effects on the baby that can persist into adulthood. It is therefore very important to identify and treat postpartum depression as early as possible.
5. Urge the family/patient to find someone to stay with and assist the patient at all times. Family and friends may offer support, reassurance, hope, and validation of the new mother's abilities.
6. Explain that treatment may begin at any point, even prior to pregnancy depending on the circumstance.

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.

S

SZ—Seizure Disorder

SZ-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of the patient's seizure disorder.

STANDARDS:

1. Explain some of the complications that may occur during a seizure, i.e., anoxia from airway occlusion by the tongue or by vomitus, traumatic injury, potential for automobile accident.
2. Explain that uncontrolled seizures may result in progressive brain injury.

SZ-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.

SZ-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of seizure disorders.

STANDARDS:

1. Explain that seizures are usually paroxysmal events associated with abnormal electrical discharges of the neurons of the brain.
2. Explain that at least 50% of seizure disorders are idiopathic. No cause can be found and the patient has no other neurologic abnormalities.
3. Discuss the patient's specific type of seizure disorder if known.
4. Explain that following a seizure it is usual for a patient to have a period of increased sleepiness (postictal phase).

SZ-FU FOLLOW-UP

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

STANDARDS:

1. Discuss the importance of regular follow-up care in the prevention of complications and adjustment of medications.
2. Encourage full participation in the treatment plan. Discuss the patient/family responsibility in the management of seizure disorder.
3. Discuss the mechanism for obtaining follow-up appointments.

SZ-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

SZ-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand the impact of a seizure disorder on the patient/family's lifestyle and make a plan for needed adaptations.

STANDARDS:

1. Explain the importance of full participation with therapy to reduce seizure risk.
2. A normal lifestyle should be encouraged. Explain the particular risks of driving and participation in sports or other potentially hazardous activities if the seizure disorder is poorly controlled.
3. Emphasize a common sense attitude toward the patient's illness. Emphasis should be placed on independence and preventing invalidism.
4. Teach the patient's family how to care for the patient during a seizure, i.e.:
   a. Avoid restraining the patient during a seizure
   b. Help the patient to a lying position, loosen any tight clothing, and place something flat and soft such as a pillow under his/her head
   c. Clear the area of hard objects
   d. Avoid forcing anything into the patient's mouth
   e. Avoid using tongue blades or spoons as this may lacerate the patient's mouth, lips or tongue or displace teeth, and may precipitate respiratory distress.
   f. Turn the patient's head to the side to provide an open airway
   g. Reassure the patient after the seizure subsides, orienting him/her to time and place and informing him/her about the seizure.
5. Encourage the patient to get enough sleep as excessive fatigue may precipitate a seizure.
6. Discourage use of alcohol and street drugs as these may precipitate seizures.
7. Encourage the patient to learn to control stress, i.e., relaxation techniques.
8. Discuss the need to avoid photic stimulation such as strobe lights, emergency vehicle lights, light from some ceiling fans or any intermittent repeating light source.
9. Instruct that pregnancy or hormone replacement therapy may lower a person's seizure threshold.
10. Inform the family to keep track of duration, frequency and quality of seizure. Bring this log to the health care provider on follow-up.
11. Refer to community resources as appropriate.

SZ-M MEDICATIONS

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

STANDARDS:

1. Explain the importance of full participation with the prescribed medication schedule. Review the patient's medications. Reinforce the importance of knowing the drug dose and dosing intervals.
2. Review common and important side effects, signs of toxicity, and drug/drug, and drug/food interactions. Review signs of toxicity that should prompt immediate evaluation. Of note there is an interaction between most seizure medications and birth control pills that may make the contraceptive less reliable.
3. Explain the importance of having anticonvulsant blood levels checked at regular intervals even if seizures are under control as applicable.
4. Explain how consistent use of anticonvulsant medications as prescribed can facilitate a more active lifestyle by improved seizure control.
5. Emphasize the importance of notifying the health care provider if the patient is not taking the medication as prescribed.
6. Advise women of childbearing age to inform their health care provider prior to becoming pregnant or as soon as pregnancy is expected as many anticonvulsant medications may be teratogenic.

SZ-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient/family will understand the necessary measures to undertake to avoid injury of the patient or others.

STANDARDS:

1. Teach the patient's family how to care for the patient during a seizure, i.e.:
   a. Avoid restraining the patient during a seizure
   b. Help the patient to a lying position, loosen any tight clothing, and place something flat and soft such as a pillow under his/her head.
   c. Clear the area of hard objects
   d. Avoid forcing anything into the patient's mouth
   e. Avoid using tongue blades or spoons as this may lacerate the patient's mouth, lips or tongue or displace teeth, and may precipitate respiratory distress.
   f. Turn the patient's head to the side to provide an open airway
   g. Reassure the patient after the seizure subsides, orienting him/her to time and place and informing him/her about the seizure.
2. Explain the particular risks of driving and participation in sports or other potentially hazardous activities if the seizure disorder is poorly controlled.

SZ-SM STRESS MANAGEMENT

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

STANDARDS:

1. Explain that uncontrolled stress is linked with an increased frequency of seizures.
2. Explain that effective stress management may reduce the occurrence of seizures, as well as help improve the patient's health and well-being.
3. Discuss that stress may exacerbate adverse health behaviors such as increased tobacco, alcohol or other substance use, all of which can increase the risk of morbidity and mortality of seizure disorders.
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.

SZ-TE TESTS

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

STANDARDS:

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

STD—Sexually Transmitted Disease

Refer to **STI—Sexually Transmitted Infections**.

STI—Sexually Transmitted Infections

STI-C COMPLICATIONS

OUTCOME: The patient/family/partner will understand the common and important complications of sexually transmitted infections.

STANDARDS:

1. Explain that the most common complication of untreated or progressed STI is pelvic inflammatory disease, infertility, and/or sterility.
2. Explain that some STIs if left untreated can progress to disability, disfigurement, and/or death.
3. Discuss that having one sexually transmitted infection greatly increases a person's risk of having a second sexually transmitted infection.
4. Explain the importance of HIV testing.
5. Discuss that some sexually transmitted infection can be life-long or fatal.
6. Discuss the potential for harm to a fetus from the sexually transmitted infection or its treatment.

STI-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.

STI-FU FOLLOW-UP

OUTCOME: The patient/family/partner 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.

STI-I INFORMATION

OUTCOME: The patient/family/partner will understand risk factors, transmission, symptoms and complications of causative agent(s).

STANDARDS

1. Discuss specific STI.
2. Explain the importance of partner(s) notification in the treatment and prevention of the spread of infection.
3. Explain how STIs are transmitted, i.e., semen, vaginal fluids, blood, mother to infant during pregnancy, child birth, breastfeeding, skin-to-skin contact.
4. Explain how STIs cannot be transmitted, i.e., casual contact, toilet seats, eating utensils, coughing.
5. Explain that there are no vaccines against STIs and that there is no immunity to STIs. List curable and incurable STIs. Stress the importance of early treatment.
6. Explain that infection is dependent upon behavior, not on race, age, or social status.
7. Describe how the body is affected.
8. List symptoms of infection and how long it may take for symptoms to appear.
9. List complications that may result if infection is not treated.
10. Review the actions to take when exposed to an STI.

STI-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family/partner will receive written information about sexually transmitted infections.

STANDARDS:

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

STI-M MEDICATION

OUTCOME: The patient/family/partner 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. Explain that medications may cure bacterial STIs but typically provide only symptomatic relief for viral STIs.
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. Emphasize the importance of informing the provider of any allergies or the potential for pregnancy.
5. Emphasize the importance of providing a list of all current medications, including non-prescription, complementary medicine or traditional remedies, to the provider.
6. Explain that in most cases, the patient's partner(s) will need to be treated. Describe the treatment regimen as appropriate.

STI-P PREVENTION

OUTCOME: The patient/family/partner will plan behavior patterns which will prevent STI infections.

STANDARDS:

1. List behaviors that eliminate or decrease risk of infection, i.e., use of latex condoms, use of spermicide with condom, monogamy, abstinence, not injecting drugs. Non-latex condoms, while not as effective as latex, are recommended when latex sensitivity is an issue.
2. Describe behavior changes which prevent transmission of STIs.
3. Discuss proper application of a condom.
4. Describe type of lubricant to use with condom, i.e., water-based gels, such as K-Y, Astroglide, Foreplay.
5. Describe how alcohol/substance use and/or abuse can affect ability to use preventive measures.

STI-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in sexually transmitted infections.

STANDARDS:

1. Explain that uncontrolled stress is linked with an increased recurrence of symptomatic outbreaks with many sexually transmitted infections, such as genital herpes and human papilloma virus.
2. Explain that effective stress management may help reduce the frequency of outbreaks, as well as help improve the patient's health and well-being.
3. Discuss various stress management strategies which may help maintain a healthy lifestyle. Examples may include:
   a. becoming aware of your own reactions to stress
   b. recognizing and accepting your limits
   c. talking with people you trust about your worries or problems
   d. setting realistic goals in small attainable increments
   e. getting enough sleep
   f. maintaining a reasonable diet
   g. exercising regularly
   h. taking vacations
   i. practicing meditation or prayer
   j. self-hypnosis
   k. using positive imagery
   l. practicing physical relaxation methods such as deep breathing or progressive muscular relaxation
   m. spiritual or cultural activities
4. Provide referrals as appropriate.

STI-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 and any special preparatory information, such as first morning void versus not voiding prior to test.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Explain the meaning of test results.

STI-TX TREATMENT

OUTCOME: Patient and partner will understand their treatment plan.

STANDARDS:

1. Emphasize the importance of early detection and treatment.
2. Stress the importance of treatment of the partner to prevent re-infection and spread of the infection.
3. Discuss the patient's specific treatment plan.
4. Discuss the importance of routine follow-up and testing as appropriate.

SIDS—Sudden Infant Death Syndrome

SIDS-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.

SIDS-I INFORMATION

OUTCOME: Parents/Family will understand what SIDS is and factors that are associated with increased risk of SIDS.

STANDARDS:

1. Explain that SIDS stands for Sudden Infant Death Syndrome. It is the sudden and unexplained death of a baby under 1 year of age. Most SIDS deaths happen between 2 and 4 months of age, occur during colder months, and more likely to be boys than girls.
2. Explain that because many SIDS babies are found in their cribs, some people call SIDS "crib death." But, cribs do not cause SIDS.
3. Explain that the cause of SIDS remains unknown. SIDS is unique, because, by definition its major presenting symptom is unexplained death. The diagnosis is based entirely on what is not found. SIDS is, in other words, a diagnosis of exclusion.
4. Emphasize that although the incidence of SIDS is on the decline in the US, the rate of SIDS highest among Native Americans and Alaska Natives.
5. Explain that several important factors are associated with an increased risk of SIDS. These factors are prone (stomach) and side infant sleeping positions, exposure of infants to cigarette smoke and potentially hazardous sleeping environments.

SIDS-L PATIENT INFORMATION LITERATURE

OUTCOME: The parent(s) and family will receive written information about Sudden Infant Death Syndrome.

STANDARDS:

1. Provide the parent(s) and family with written information about SIDS.
2. Discuss the content of the patient information literature with the parent(s) and family.

SIDS-P PREVENTION

OUTCOME: The parents and/or family will understand the factors associated with an increased risk of SIDS and how to lower the risk of SIDS and prevent problems.

STANDARDS

1. Explain that placing your baby on his or her back to sleep, even for naps, is the safest sleep position for a healthy baby and has been proven to reduce the risk of SIDS. "Back is best" from a SIDS risk-reduction point of view. There is no evidence of increased risk of choking or other problems associated with healthy infants sleeping on their backs.
2. Explain that the stomach sleeping position is associated with the highest risk of SIDS. Side lying position falls in between and babies who sleep on their sides can roll onto their stomach and have an increased risk of SIDS.
3. Explain that when a baby sleeps only in the back position, some flattening of the back of the head may occur. Flat spots on the back of the head are not harmful or associated with any permanent effects on head size and go away a few months after the baby learns to sit up.
4. Discuss that specialists recommend changing the baby's head position during sleep to minimize the effects on head shape. One way to do this is to alternate the head of the bed to the foot of the bed on alternate nights. That is, place the baby's head on different ends of the bed on different nights with the face always facing the inside of the room.
5. Explain that "tummy time" is important. An infant can safely be placed on his or her tummy when he/she is awake and someone is watching. This is important for infant development and will help make neck and shoulder muscles stronger.
6. Explain that there is no evidence that infant home monitoring can prevent SIDS. Physicians may recommend monitors in some special circumstances.
7. Discuss that the greatest majority of infants dying of SIDS are apparently healthy infants who do not meet the criteria for home monitoring.
8. Discuss that other sleep behaviors are associated with a higher than average rate of SIDS deaths; (co-sleeping, fluffy materials in the bed with the infant, waterbed sleeping, sleeping in the same bed with other persons, overheating during sleep.
9. Discuss that alcohol use in the first trimester of pregnancy is associated with increased risk of SIDS death.
10. Explain that infants who sleep in homes where smoking occurs inside the home are at a greatly increased risk of dying of SIDS compared to infants who sleep in homes where no one ever smokes in the home.
11. Encourage the client to be receptive to home visits by public health nurses as this has been associated with a lower risk of SIDS deaths.

SIDS-S SAFETY AND INJURY PREVENTION

OUTCOME: The parents/family will understand that even though there is no way to know which babies might die of SIDS, there are some measures that can be taken to make their baby safer.

STANDARDS:

1. Discuss that placing a baby to sleep on soft mattresses, sofa cushions, waterbeds, sheepskins, or other soft surfaces can increase the risk of SIDS, possibly by increasing the risk of carbon dioxide rebreathing (asphyxiation).
2. Emphasize firm bedding, Discourage the use of pillows, loose bedding, crib bumpers, fluffy blankets and stuffed toys in the baby's sleep area. Make sure baby's face and head stays uncovered during sleep.
3. Discuss potential hazards of overheating. Don't let baby get too warm during sleep. Babies should be lightly dressed and covered with a sheet or thin blanket, and the room temperature should be comfortable. The current recommendation is for no more than two layers of clothing during sleep.
4. Discuss that there are hidden hazards in letting babies sleep on adult beds, including falls, suffocation, and getting trapped between the bed and wall, the head board, and foot board. Beds are not designed to meet safety standards for infants and carry risk of accidental entrapment and suffocation.
5. Explain that it is currently believed that the safest place for an infant to sleep is in a crib with a firm mattress. Sleeping alone, with no other person in the bed is recommended. Infants sleeping in adult beds are at increase risk of suffocation.

SIDS-SHS SECOND-HAND SMOKE

OUTCOME: The patient and/or family will understand the adverse health consequences associated with exposure to second-hand tobacco smoke, and discuss methods for limiting babies' exposure 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. Discuss that tobacco smoke increases the risk of SIDS and it appears to be related to the "dose" of passive-smoke exposure - - the greater the exposure to smoke both before and after birth, the higher the risk of SIDS.
4. Explain that smoking anywhere in the home may increase the risk, so just going into another room to smoke is not sufficient. Smoke gets trapped in carpets, upholstery, and clothing. Parents should keep the baby in a smoke-free environment.
5. Discuss factors that increase level of exposure to second-hand smoke and preventive methods for minimizing this exposure.
6. Encourage and offer smoking cessation or at least never smoking in the home or car.
7. **Refer to TO**.

SB—Suicidal Behavior

SB-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.

SB-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.

SB-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

SB-PSY PSYCHOTHERAPY

OUTCOME: The patient will understand the goals and process of such therapy.

STANDARDS:

1. Emphasize that for the process of psychotherapy to be effective the patient must keep all appointments. Emphasize the importance of openness and honesty with the therapist.
2. Explain to the patient/family that the therapist and the patient will jointly establish goals, ground rules, and duration of therapy.

SB-SCR SCREENING

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

STANDARDS

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

SB-SM STRESS MANAGEMENT

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

STANDARDS:

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

SB-TX TREATMENT

OUTCOME: The patient/family will have a basic understanding of the short and long term goals and expected result of treatment.

STANDARDS:

1. Reassure the patient. Reinforce the fact that the patient is not alone and that he/she can be helped.
2. Discuss options for treatment, both short-term and long-term.
3. Discuss that there may be an initial crisis stabilization period followed by a longer period of psychotherapy and lifestyle adjustments.

SB-WL WELLNESS

OUTCOME: The patient/family will understand some of the factors which contribute to a balanced and healthy lifestyle.

STANDARDS:

1. Explain that a healthy diet is an important component of behavioral and emotional health. **Refer to WL-N.**
2. Emphasize the importance of stress reduction and exercise in behavioral and emotional health.
3. Explain that behavior and emotional problems often result from unhealthy patterns of social interaction. Help to identify supportive social networks.
4. Emphasize that use of alcohol and/or other drugs of abuse can be extremely harmful to behavioral and emotional health. **Refer to AOD.**
5. Emphasize that behavioral and emotional problems often co-exist with domestic violence. Encourage the patient to use local resources as appropriate. **Refer to DV.**
6. Explain other ways the patient can help him/herself feel better:
   a. Talk to someone you trust.
   b. Try to figure out the cause of your worries.
   c. Understanding your feelings will help you see other ways for dealing with your anger or depression.
   d. Write down a list of good things you have done. Remember them and even read the list out loud to yourself when you feel bad.
   e. Do not keep to yourself; being with other people that support and encourage you as much as possible.
   f. **In an emergency or during a crisis call 9-1-1** or other emergency access numbers or crisis hotlines.

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.

W

WL—Wellness

WL-ADL ACTIVITIES OF DAILY LIVING

OUTCOME: The patient/family will understand how the patient's ability to perform activities of daily living (ADLs) impact the care plan including in-home and out-of-home care.

STANDARDS:

1. Define activities of daily living (ADLs) (i.e., the everyday activities involved in personal care such as feeding, dressing, bathing, moving from a bed to a chair (also called transferring), toileting and walking) and discuss how the patient's ability to perform ADLs affects their ability to live independently
2. Assist the patient/family in assessing the patient's ability to perform activities of daily living.
3. Provide the appropriate information and referrals for services needed to increase, maintain, and/or assist with activities of daily living.

WL-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

WL-EX EXERCISE

OUTCOME: The patient will relate exercise and/or physical fitness to health promotion and disease prevention.

STANDARDS:

1. Review the benefits of regular exercise.
2. Discuss the three types of exercise: aerobic, flexibility, and endurance.
3. Review the basic recommendations of any exercise program:
4. If any chronic health problems exist, consult with a health care provider.
5. Start out slowly.
6. Exercise a minimum of three times a week.
7. Review the exercise programs available in the community.

WL-FU FOLLOW-UP

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

STANDARDS:

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

WL-HY HYGIENE

OUTCOME: The patient will recognize personal routine hygiene as an important part of wellness.

STANDARDS:

1. Review bathing habits, paying special attention to face, pubic hair area and feet. Discuss hygiene as part of a positive self image.
2. Review the importance of daily dental hygiene, with attention to brushing and flossing.
3. Discuss the importance of hand-washing in infection control especially in relationship to food preparation/consumption, child care and toilet use.
4. Discuss the importance of covering the mouth when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

WL-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

1. Provide the patient/family written information about wellness.
2. Discuss the content of the written information with the patient/family.

WL-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will be able to explain at least one lifestyle change necessary to improve mental or physical health.

STANDARDS:

1. Review the concept that health or wellness refers to the whole person (mind, body and spirit) and is a positive state of health which results from appropriate habits and lifestyle.
2. Review lifestyle aspects/changes that the patient has control over - diet, exercise, safety and injury prevention, and avoidance of high risk behaviors (e.g. smoking, alcohol and substance abuse, sex with multiple partners).
3. Discuss wellness as an individual responsibility to:
   a. Learn how to be healthy.
   b. Be willing to change.
   c. Practice new knowledge.
   d. Get help when necessary.
4. Review the community resources available for help in achieving behavior changes.

WL-N NUTRITION

OUTCOME: The patient will relate diet to health promotion and disease prevention.

STANDARDS:

1. Assess current nutritional habits.
2. Discuss the importance of the food pyramid.
3. Review the relationship of calories to energy balance and body weight.
4. Emphasize the importance of limiting snack foods, fatty foods, red meats, reducing sodium consumption and adding more fresh fruits, fresh vegetables, and fiber to the diet.
5. Emphasize the necessary component —WATER— in a healthy diet. Reduce the use of colas, coffee and alcohol.
6. Review which community resources exist to assist with diet modification and weight control.
7. Stress the importance of being a smart shopper.

WL-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient will be able to identify at least one way to reduce injury risk.

STANDARDS:

1. Discuss the importance of vehicle safety:
   a. regular use of seat belts and children's car seats, obeying the speed limit, and avoiding the use of alcohol while in a vehicle.
   b. wear personal protective equipment when operating recreational vehicles (i.e., boats, snow mobiles, sea dos, ATVs, skateboards, bicycles.), and horses.
   c. **never** leave children unattended in a vehicle.
   d. never ride on the hood, bumper, or in the cargo compartment of any vehicle.
2. Discuss the importance of poisoning prevention:
   a. Discuss poison prevention: i.e., proper storage and safe use of medicines, cleaners, auto products, paints.
   b. Discuss current recommendations for use of ipecac syrup.
   c. Discuss common poisonous plants.
3. Discuss the importance of fire safety and burn prevention:
   a. Review the dangers inherent in the use of wood-burning stoves, "charcoal pans", kerosene heaters, and other open flames.
   b. Encourage the use and proper maintenance of smoke detectors, carbon monoxide detectors, and fire suppression systems.
   c. Encourage routine practices of fire escape plans, chimney cleaning, and fireworks safety.
   d. Review the safe use of electricity and natural gas.
   e. Encourage hot water heater no hotter than 120 degrees Fahrenheit to avoid scalding.
   f. Cook on the backburners of the stove and turn panhandles toward the back of the stove.
   g. Avoid the use of kerosene or gasoline when burning debris piles.
4. Discuss the proper handling, storage, and disposal of hazardous items and materials:
   a. firearms and other potentially hazardous tools.
   b. waste, including sharps and hazardous materials.
   c. Chemicals, including antifreeze

d. lead based materials, i.e., pre-1970 paint, pottery, smelting, pre-1993 window blinds, solder, old plumbing

e. never store hazardous chemicals in food containers

5. Discuss the importance of water safety:
   a. Never swim alone
   b. Never leave a child unattended in a bathtub, swimming pool, lake, river, or other water source.
   c. Always close toilets, mop buckets, and other water containers to avoid toddler drowning.
6. Discuss the importance of food and drinking water safety:
   a. proper handling, storage, and preparation of food, i.e., original preparation, reheating to a proper temperature (165°F).
   b. importance of uncontaminated water sources. Discuss the importance of purifying any suspect water by boiling or chemical purification.
   c. prevention of botulism, salmonella, shigella, giardia, listeria, E-coli, etc.
7. Identify which community resources promote safety and injury prevention. Provide information regarding key contacts for emergencies, e.g., 911, Poison Control, hospital ER, police.

WL-SCR SCREENING

OUTCOME: The patient/family will understand the proposed screening test including indications.

STANDARDS:

1. Discuss the indication, risks, and benefits for the proposed screening test, i.e., guaiac, blood pressure, hearing, vision, development, mental health.
2. Explain the process and what to expect after the test.
3. Emphasize the importance of follow-up care.

WL-SM STRESS MANAGEMENT

OUTCOMES: The patient will understand the role of stress management in overall health and well-being.

STANDARDS:

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

WL-SX SEXUALITY

OUTCOME: The patient will understand how sexuality relates to wellness.

STANDARDS:

1. Review sexuality as an integral part of emotional and physical health.
2. Discuss how sexual feelings play a part in each person's personal identity.
3. Discuss sexual feelings as an important part of interpersonal relationships.
4. Discuss how sexuality varies with gender, age, life-stage, and relationship status.
5. Explain the preventive measures for STIs (**refer to STI-P**), including abstinence and monogamy.
6. Review the community resources available for sexual counseling or examination.

WL-TE TESTS

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

STANDARDS:

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