INDIAN HEALTH SERVICE

Patient and Family Education Protocols and Codes (PEPC)

DENTAL, OPTOMETRY & PHYSICAL THERAPY CODES

11th Edition

January 2005

FOREWORD

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

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

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

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

kholiver@southcentralfoundation.org

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

FOREWORD TO THE 11TH EDITION OF THE PATIENT EDUCATION PROTOCOLS

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

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

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

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

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

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

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

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

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

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

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

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

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

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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)

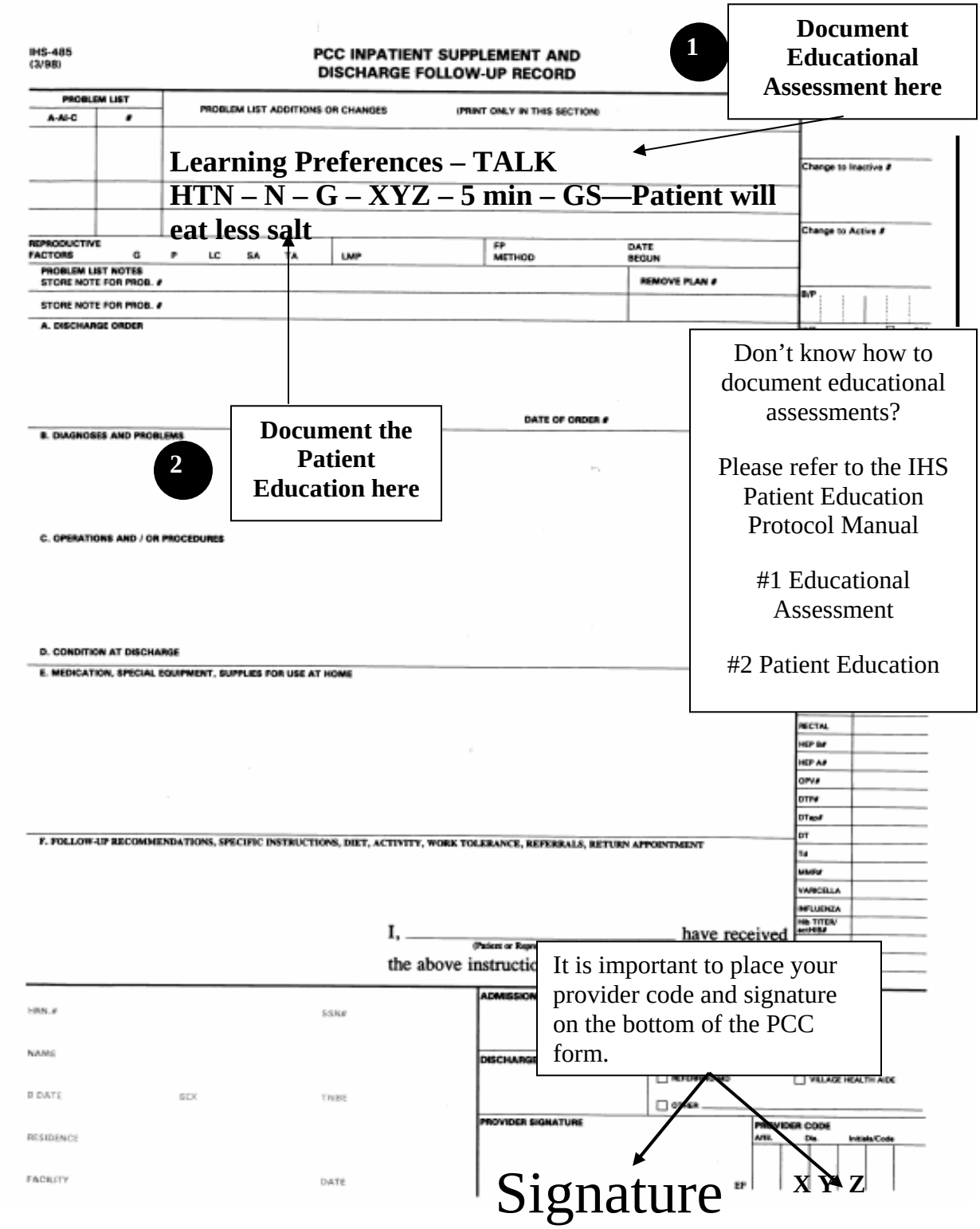


Figure 1: ***Documenting Patient Education on the PCC Inpatient Supplement and Discharge Follow-Up Record form.***

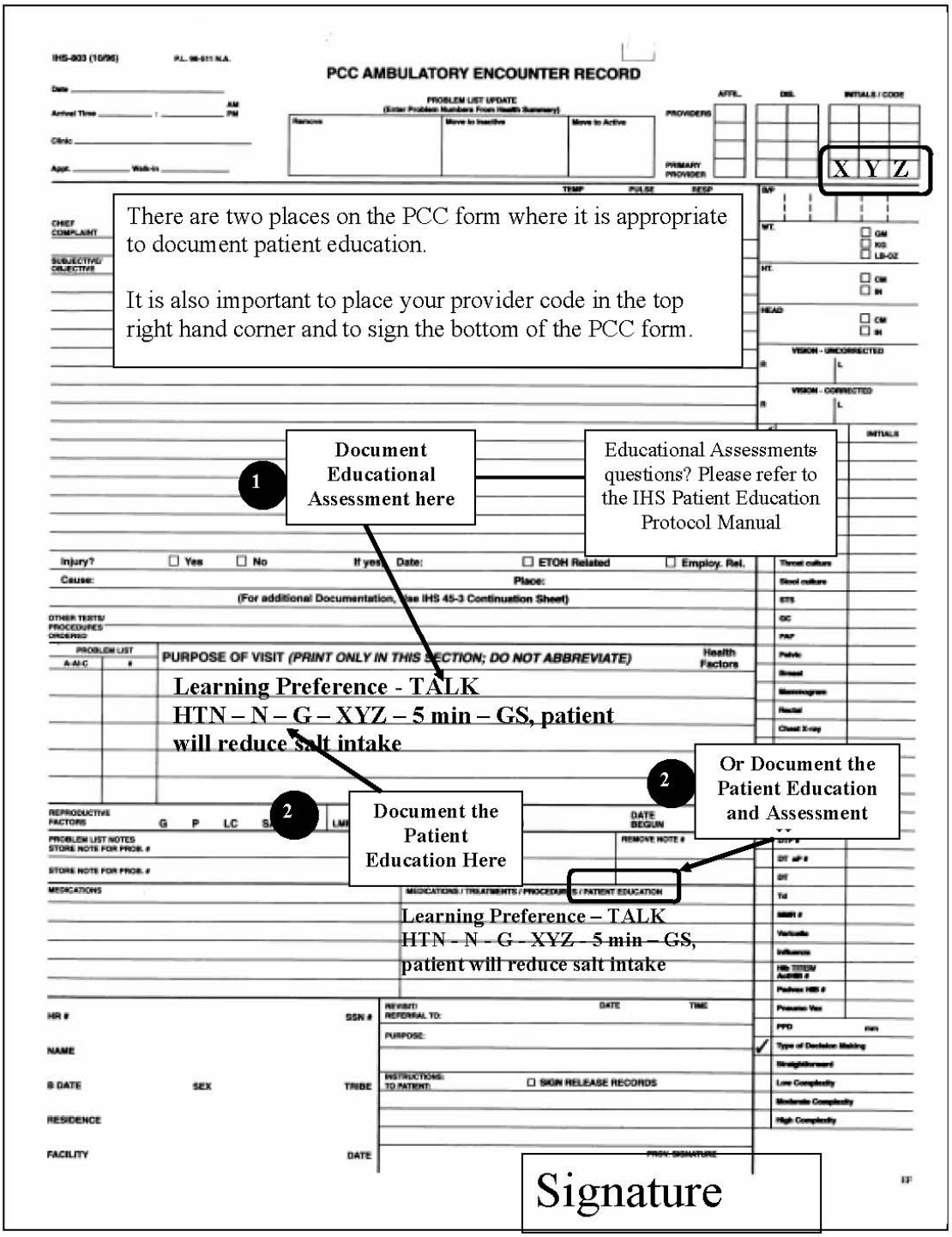


Figure 2: Documenting Patient Education with the PCC Ambulatory Encounter Record form

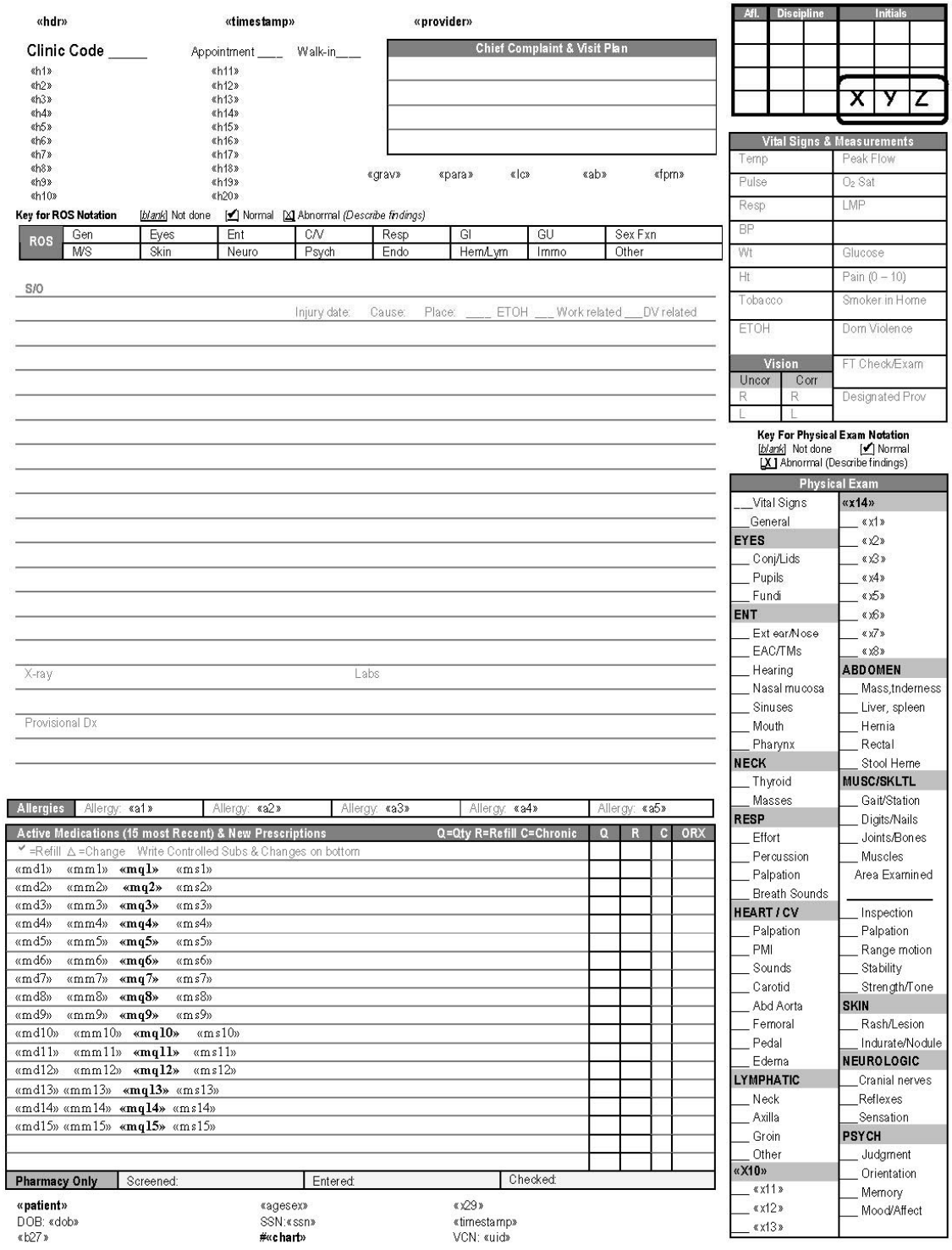


Figure 3: Documenting Patient Education on a PCC+ form, page 1

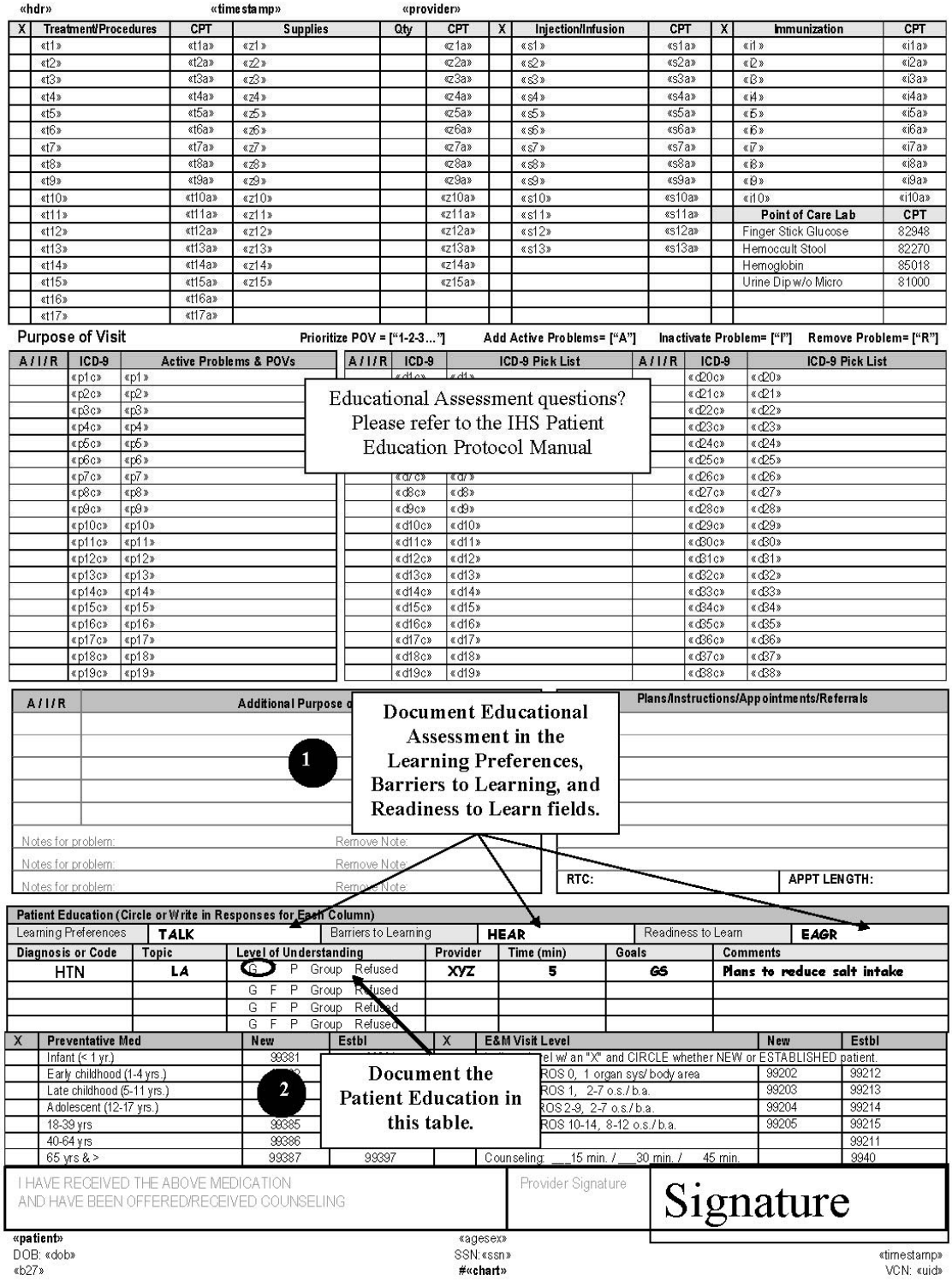
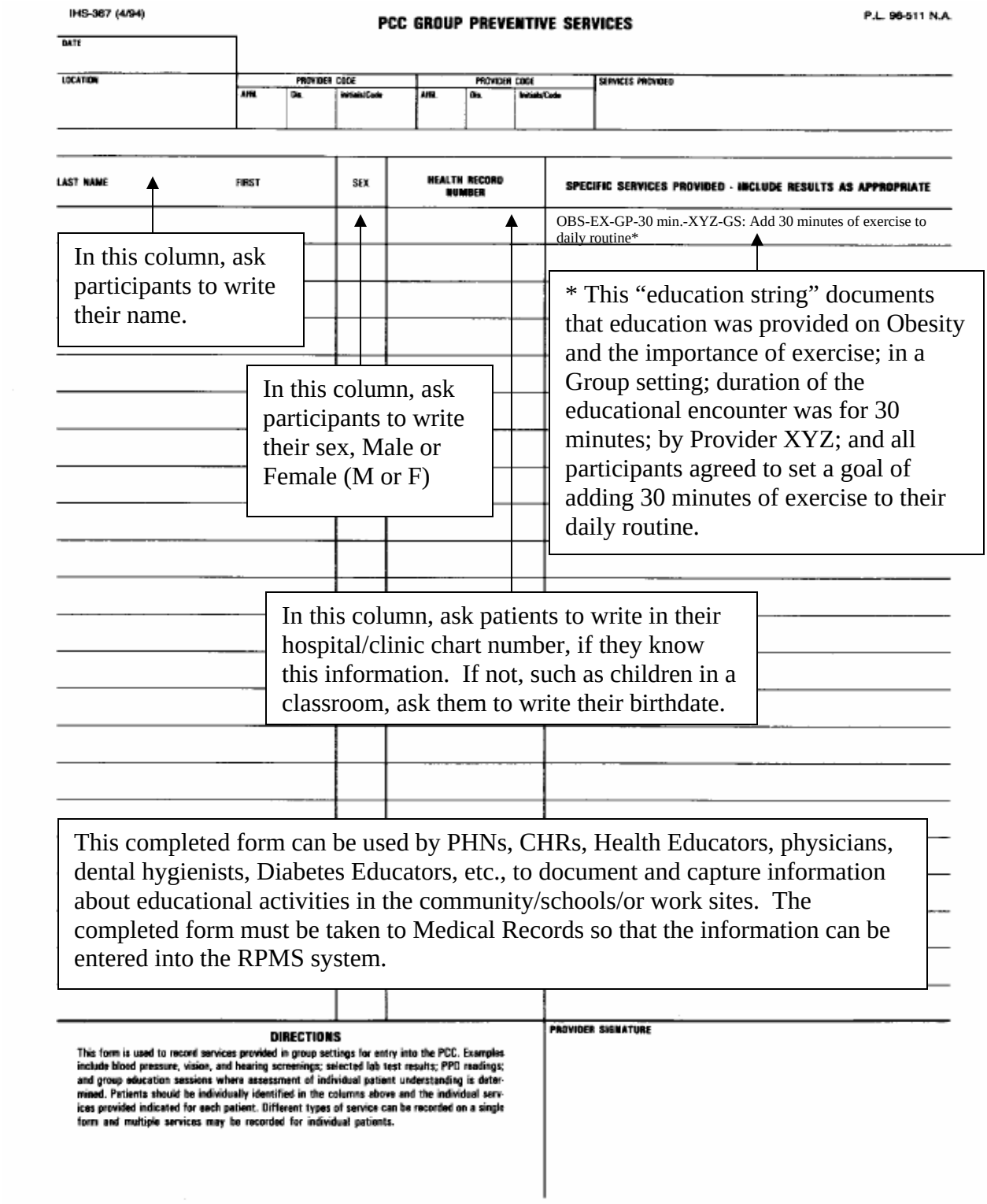


Figure 4: Documenting Patient Education on a PCC+ form, page 2

USE AND DOCUMENTATION OF PATIENT EDUCATION CODES

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



IHS-367 (4/94)

PCC GROUP PREVENTIVE SERVICES

P.L. 86-511 N.A.

DATE

LOCATION

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

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

SERVICES PROVIDED

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

In this column, ask participants to write their name.

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

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

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

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

DIRECTIONS

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

PROVIDER SIGNATURE

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

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

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

List measures taken to address above barriers:

Comments: ____

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

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

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. (Refer to codes 99401-99412 for reporting those counseling/anticipatory

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

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

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

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

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

Documentation Requirements:

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

Coordination of Care

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

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

Important Aspects concerning Reimbursement for PATIENT EDUCATION

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

Documentation of Evaluation and Management (E/M) Services

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

BRIEF Sample - Office Visits, Established Patients

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

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

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

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

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

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

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

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.

B

BELL—Bell's Palsy

BELL-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand the anatomy and physiology as it relates to Bell's palsy.

STANDARDS:

1. Explain that Bell's palsy is a form of facial paralysis resulting from damage or disease of the 7th (facial) cranial nerve.
2. Explain that the mechanism of Bell's palsy involves swelling of the nerve due to immune or viral disease, with ischemia and compression of the nerve in the confines of the temporal bone.

BELL-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of Bell's Palsy.

STANDARDS:

1. Explain that damage to the cornea can occur if the eyelid does not close: blinking is impaired or lacrimation does not occur.
2. Discuss that the frequent use of artificial tears or saline drops in the eyes may be helpful.
3. Explain that a lubricant eye ointment is most effective.
4. Explain that the healthcare provider may recommend the use of tape or an eye patch to help close the eye.

BELL-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the possible causes and disease process of Bell's Palsy.

STANDARDS:

1. Explain that Bell's palsy can strike almost anyone at any age, but it is less common before age 15 and after age 60. Explain that it is more common in persons with diabetes, influenza, a cold or upper respiratory ailment, and pregnancy.
2. Explain that the common cold sore virus, herpes simplex, and other herpes viruses cause many cases of Bell's palsy, but Bell's palsy can also be caused by other infections especially tick fevers.
3. Explain that pain behind the ear may precede facial weakness and that weakness may progress to complete unilateral facial paralysis within hours. This paralysis may cause a drooping eyelid, inability to blink, drooping mouth, drooling, dryness of the eye or mouth, impaired taste, and excessive tearing. Explain that in severe cases the eye may not close and that salivation, taste and lacrimation may be affected.
4. Discuss that the prognosis for Bell's palsy is generally very good. Explain that about 80 % recover completely within 3 months, but that for some the symptoms may last longer and may never completely disappear. Explain that the recovery for complete paralysis takes longer and that there is an increased incidence of residual symptoms.
5. Discuss that during the recovery period regrowth of nerve fibers may result in tearing while eating and unexpected muscle contractions during voluntary facial movements.

BELL-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize that full participation in the treatment plan is the responsibility of the patient.
2. Review the treatment plan with the patient/family, emphasizing the need for keeping appointments, taking medications as prescribed, and fully participating with the physical therapy plan.
3. Review the symptoms that should be reported and measures to take if they occur.
4. Stress the importance of keeping follow-up appointments and continuing the prescribed therapy as long as recommended by the healthcare provider.

BELL-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information regarding Bell's palsy and its treatment.

STANDARDS:

1. Provide the patient/family with written patient information literature regarding Bell's palsy and its treatment.
2. Discuss the content of the patient information literature with the patient/family.

BELL-M MEDICATIONS

OUTCOME: The patient will understand their medications and the importance of taking them as prescribed.

STANDARDS:

1. Explain that medications may reduce inflammation of the nerve and may relieve pain.
2. Discuss the proper use, benefits, common side effects and interactions of the prescribed medication(s). Review signs of possible toxicity and appropriate follow up as indicated.
3. Emphasize the importance of taking medications as prescribed.
4. Discuss the mechanism of action of the medication as needed.
5. Emphasize the importance of consulting with a health care provider prior to initiating any new medications, including over-the-counter or herbal medications.
6. Emphasize the importance of providing a list of all current medications, including non-prescription or traditional remedies to the provider.

BELL-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that usually pain from Bell's palsy is transient and controllable with mild analgesics.
2. Explain that short term use of narcotics may be helpful in pain management as appropriate.
3. Explain the use of heat and cold in the relief of pain as appropriate.
4. Explain that the use of non-pharmacologic measures, such as imagery may be helpful with pain control.

BELL-TE TESTS

OUTCOME: The patient/family will understand the tests that may be performed, including indications and impact on further care.

STANDARDS:

1. Explain that chest and skull x-rays, CT and/or MRI scans may be necessary to rule out other serious causes of facial paralysis.
2. Explain that tests for tick fever may also help diagnose the cause of the palsy and may be necessary to guide appropriate treatment.
3. Explain that nerve conduction studies and electromyography may be ordered to determine the extent of the nerve damage.
4. Explain the specific test ordered.
5. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
6. Explain any necessary preparation for the test ordered.
7. Explain the meaning of the test results, as appropriate.

BELL-TX TREATMENTS

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

STANDARDS:

1. Explain that the patient and medical team will make the treatment plan after reviewing available options.
2. Discuss the treatment plan, including lifestyle adaptations, pharmacologic, and psychosocial aspects.
3. Discuss the importance of fully participating with the treatment plan, including scheduled follow-up.

BURN—Burns

BURN-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with burns.

STANDARDS:

1. Explain that burned tissue is very susceptible to infections.
2. Review the symptoms of a generalized infection, i.e., high fever, swelling or oozing, spreading redness, red streaking, increased tenderness/pain, changes in mental status, decreased urine output.
3. Review the effects of uncontrolled burn or wound infections (i.e., cellulitis) or generalized infection, i.e., loss of limb, need for facsiotomy and skin grafting, multi-organ failure, death.
4. Explain that scarring and/or tissue discoloration is common after healing of a burn.
5. Emphasize the importance of early treatment to prevent complications.
6. Explain that third degree or large body surface area burns are particularly prone to infection dehydration and other metabolic derangement that can be lethal.

BURN-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.

BURN-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology and staging of burns.

STANDARDS:

1. Explain that burns may be the result of various causes such as fire and heat or steam; chemical or electrical burns and sunburns.
2. Explain the first step is to determine the degree and the extent of damage to body tissues:
    a. First-degree burns are those in which only the outer layer of skin (epidermis) is burned. The skin is usually red, with swelling and pain sometimes present. The outer layer of skin hasn't been burned through. Treat a first degree burn as a minor burn unless it involves substantial portions of the hands, feet, face, or other large areas of the body.
    b. Second-degree burns are when the first layer of skin has been burned through and the second layer of skin (dermis) also is burned. Blisters develop and the skin takes on an intensely reddened, splotchy appearance. Second-degree burns produce severe pain and swelling.
    c. Third-degree burns are the most serious and are painless and involve all layers of the skin. Fat, muscle and even bone may be affected. Areas may be charred black or appear dry and white. Difficulty in inhaling and exhaling, carbon monoxide poisoning or other toxic effects may occur if smoke inhalation accompanies the burn.
3. Chemical burns are injuries to the body as a result of chemicals (i.e., cleaning materials, gasoline).
4. Explain that electrical burns are caused by the skin or body coming in contact with electricity and while an electrical burn may appear minor, the damage can extend deep into the tissues beneath the skin. If a strong electrical current passes through the body, internal damage such as heart rhythm disturbance or cardiac arrest can occur. Explain that electrical burns should be evaluated by a healthcare provider.
5. Explain that sunburn is the result of overexposure to the sun's ultraviolet (UV) radiation. Repeated exposure to UV radiation both tans and damages your skin. The signs and symptoms of sunburn usually appear within a few hours of exposure, bringing pain, redness, swelling and occasional blistering. Because sun burn often affects a large area of your skin, sunburn can cause headache, fever, fatigue, and dehydration. **Refer to SUN**.

BURN-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information appropriate to the type and degree of the burn.

STANDARDS:

1. Provide written information about first, second, third-degree burns, chemical or electrical burns or sunburn.
2. Discuss the content of the patient information literature.

BURN-P PREVENTION

OUTCOME: The patient/family will understand the factors associated with an increased risk of burns and how to lower the risk of burns.

STANDARDS:

1. Explain that all homes should have ABC fire extinguishers in several locations throughout the home.
2. Explain the importance of having fire escape ladders in multi-story homes.
3. Discuss safety issues:
   a. To prevent fire burns:
      (1) Install smoke detectors
      (2) Don't smoke in bed
      (3) Practice home fire drills and "stop, drop, and roll"
      (4) Don't let children play with matches, lighters, flames, or fireworks
      (5) Explain that fireworks are extremely dangerous
      (6) Ensure heat lamps and other sources of heat have timers or appropriate safety devices
      (7) Never leave burning candles unattended
      (8) Assure that electrical wiring, outlets, and electrical devices are safe
   b. To prevent chemical burns:
      (1) child-proof cabinets and store chemicals out of the reach of children,
      (2) use caution in storing cleaning materials,
      (3) wear gloves and other protective clothing when using chemicals
   c. To prevent heat/steam burns:
      (1) set your water heater no higher than 120°F
      (2) Test the water temperature before entering or putting children into bathtubs/showers

(3) Use cool water humidifiers not steam vaporizers

(4) Before putting a child into a car seat, touch the seat to check how hot it is. It is a good idea to keep a towel covering the car seat in summer months.

(5) When cooking, turn the handles of pots toward the side or rear of the stove, don't wear loose clothing that can come in contact with the stove. You should always use the back burners first.

(6) Use extreme caution when lifting lids from pots as steam may suddenly be released

(7) Use caution when removing items in a microwave as they may be very hot. Use only microwave approved dishware.

d. To prevent electrical burns:

(1) Put covers on any electrical outlets not currently in use.

(2) Don't use items with frayed or damaged electrical cords.

(3) Don't overload outlets

(4) Keep electrical devices away from water and use ground fault circuit interrupter outlets near water sources

(5) Don't modify electrical cords or plugs

(6) Use power surge protectors

6. Review the dangers inherent in the use of wood-burning stoves, "charcoal pans", kerosene heaters, and other open flames.
7. Encourage the use and proper maintenance of smoke detectors, carbon monoxide detectors, and fire suppression systems.
8. Encourage routine practices of fire escape plans, chimney cleaning, and fireworks safety.
9. Review the safe use of electricity and natural gas.
10. Avoid the use of kerosene or gasoline when burning debris piles.

BURN-TX TREATMENT

OUTCOME: The patient/family will understand the risks and benefits of treatment as well as the possible consequences of not participating with the treatment plan.

STANDARDS:

1. Explain that treatment of burns varies according to the degree, size, and location of the burn. Discuss this individual's specific burn treatment plan.
2. Explain and urge caution:
   a. Don't use butter on a burn as butter may contain salt which can worsen the burn.
   b. Don't use ice, as putting ice on a burn can cause frostbite, further damaging your skin.
   c. Don't break blisters as fluid-filled blisters protect against infection. If blisters break, wash the area with mild soap and water, then apply an antibiotic ointment and a gauze bandage. Clean and change dressings as directed by a healthcare provider. Antibiotic ointments don't make the burn heal faster but they can help prevent infection.
   d. Don't remove any burnt clothing that is "stuck" to the skin as a result of the burn. The victim should be taken immediately to an emergency room. Until arriving at the emergency room, cover the area of the burn with a cool, moist sterile bandage/gauze or clean cloth.
3. **Refer to PM.**

BURN -WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care and infection control measures.

STANDARDS:

1. Explain the reasons to care appropriately for the burn, i.e., decreased infection rate, improved healing.
2. Explain the correct procedure for caring for this patient's burn.
3. Explain signs or symptoms that would prompt immediate follow-up, i.e.; increasing redness, purulent discharge, fever, increasing pain or swelling.
4. Detail the supplies necessary for care of this burn (if any) and how/where they might be obtained and proper methods for disposal of used supplies.
5. As appropriate, have the patient/family demonstrate burn care techniques.
6. Emphasize the importance of follow-up.

D

DC—Dental Caries

DC-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand that different components make up the tooth structure. The patient/family will further understand that the properties of the various components affect the susceptibility for decay.

STANDARDS:

1. Explain that enamel is a protective covering for the tooth. Discuss that the portion of the tooth that is normally seen in the mouth (crown) is covered with enamel.
2. Explain that the root of the tooth is not covered with enamel. The root of the tooth is made of dentin. Explain that dentin is a softer, more easily decayed substance.
3. Explain that the living portion of the tooth (pulp) is a sensitive structure containing the nerve and blood vessels. Decay into this portion of the tooth may cause severe pain and will kill the tooth.

DC-C COMPLICATIONS

OUTCOME: The patient/family will understand some complications/consequences of treated or untreated dental caries.

STANDARDS:

1. Explain that, by necessity, when dental caries are treated, a portion of the healthy tooth structure must also be removed. This results in a weakening of the tooth.
2. Explain that occasionally when dental caries are treated, inflammation of the pulp may occur. This insult may be reversible and result in temporary soreness of the tooth, or may be irreversible and result in infection and/or death of the tooth.
3. Explain that occasionally dental caries may result in abscess of the tooth, which may extend into a sinus or other adjacent tissues.
4. Explain that some dental caries may involve so much of the tooth structure that root canal or removal of the tooth may be necessary.
5. Explain that early tooth loss in children may cause abnormal eruption of permanent teeth. Further explain that early tooth loss of permanent teeth may result in loosening of other teeth and further tooth loss unless restorative measures are taken.

DC-DP DISEASE PROCESS

OUTCOME: The patient/family will be able to explain what dental caries are and summarize some causes as appropriate to this patient.

STANDARDS:

1. Explain that natural bacteria live in the mouth. Some bacteria are healthy and are protective. Explain that a sticky film called plaque forms on teeth and that bacteria live in the plaque.
2. Explain that some bacteria in the presence of carbohydrates will produce acids that attack the tooth structure. The acids dissolve and demineralize the tooth weakening the tooth structure. Progressive acid attacks on the tooth surface may lead to decay or dental caries.
3. Explain the various factors which may predispose a person to dental caries:
    a. Poor oral hygiene
    b. High carbohydrate diet, especially frequent consumption
    c. Children whose parents have active tooth decay
    d. Lack of fluoride
    e. Gingival recession
    f. Persons having undergone radiation therapy
    g. Genetic predisposition

DC-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of regular dental follow-up.

STANDARDS:

1. Explain the current recommendation for regular dental examination and professional tooth cleaning.
2. Emphasize the importance of a dental visit if any problems occur between routine dental visits.

DC-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about dental caries, their treatment and/or the oral care necessary after treatment.

STANDARDS:

1. Provide patient/family with written patient information literature on dental caries, treatment and/or the oral care necessary after treatment.
2. Discuss the content of the patient information literature with the patient/family.

DC-N NUTRITION

OUTCOME: The patient/family will understand the importance of a balanced diet, low in carbohydrates, especially simple sugars, and with adequate calcium and fluoride.

STANDARDS:

1. Discuss the relationship between a diet high in carbohydrates, especially simple sugars, to the development of dental caries. Give examples of foods high in simple sugars, i.e., crackers, potato chips, candy, pre-sweetened cereals.
2. Discuss the importance of calcium and fluoride intake as it relates to tooth development/mineralization.
3. Refer to a registered dietician as appropriate.

DC-P PREVENTION

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

STANDARDS:

1. Explain that early entry into dental care (infancy and prenatal) is important in the prevention of dental caries.
2. Explain that an important factor in the prevention of cavities is the removal of plaque by brushing the teeth and flossing between them daily. Discuss and/or demonstrate the current recommendations and appropriate method for brushing and flossing.
3. Explain that the frequency of carbohydrate consumption increases the rate of acid attacks, thereby increasing the risk of dental decay. **Refer to DC-N.**
4. Explain that pathogenic oral bacteria may be transmitted from one person to another; therefore, it is especially important that families with small children (ages 6 months to 8 years) control active tooth decay in all family members.
5. Explain that the use of fluoride strengthens teeth and may rebuild the early damage caused by bacteria/acid attacks. The most common source of fluoride is drinking water. It is also available in toothpastes and rinses, varnishes or fluoride drops/tablets. Consult with a dentist/physician to determine if the drinking water contains adequate fluoride and if supplementation is needed. Explain that the use of topical fluoride is important in the prevention of decay in persons exposed to radiation therapy, as applicable.
6. As appropriate, discuss sealants as an intervention to prevent dental caries.
7. Explain that the recession of gingival tissue (gums) exposes the softer dentin portion of the tooth (root). This portion of the tooth does not have an enamel covering, therefore, it is more susceptible to decay. Gingival recession may have a variety of causes:
    a. Natural aging process
    b. Loss of attached tissue associated with periodontal disease **Refer to PD.**
    c. Improper brushing methods
    d. Genetic predisposition (frenulum/frenum attachment)

DC-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM**.
2. Explain that short-term use of Tylenol, NSAIDS, desensitizers, and/or narcotics may be helpful in pain management as appropriate.
3. Explain that antibiotics may be helpful in pain relief in the case of abscess.
4. Explain non-pharmacologic measures that may be helpful with pain control, i.e., avoid hot and cold foods.
5. Explain that dental anxiety may be controlled or relieved by the use of anxiolytics or antihistamines as appropriate.
6. Explain that local anesthetics and/or nitrous oxide may be used to control pain during dental procedures.

DC-TE TESTS

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

STANDARDS:

1. Discuss the test(s) to be performed, i.e., x-ray, pulp vitality.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks of non-performance of the testing.

DC-TX TREATMENT

OUTCOME: The patient will understand the necessary treatment (filling, root canal, extraction) and the proper oral care after treatment.

STANDARDS:

1. Explain the basic procedure to be used (filling, root canal, extraction) and the indication, common complications and alternatives as well as the risks of non-treatment.
2. Review the specific elements of oral care after treatment. **Refer to DC-P.**
3. Discuss the indications for returning to the provider, i.e., bleeding, persistent or increasing pain and fever.

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

ECC—Early Childhood Caries

ECC-C COMPLICATIONS

OUTCOME: The parent and/or family will understand the effects and consequences of ECC on their child.

STANDARDS:

1. Review the consequences of severe tooth decay, i.e., infection, tooth loss, speech problems, aesthetics.
2. Review treatment modalities (tooth restoration, behavior management).
3. Review the health risks of general anesthesia.
4. Review the costs of extensive treatment.

ECC-DP DISEASE PROCESS

OUTCOME: The parent and/or family will understand the causes, identification, and prevention of Early Childhood Caries (ECC).

STANDARDS:

1. Review the current factual information regarding the causes of ECC.
2. Discuss how dental disease germs can be passed from parent to infant.
3. Discuss the role of sugar.
4. Review how to identify early signs of ECC.

ECC-FU FOLLOW-UP

OUTCOME: The parent and/or family will understand the importance of infant and early childhood oral health care including dental well checks.

STANDARDS:

1. Discuss dental well child visits.
2. Review recommendations for early childhood dental care.
3. Discuss the importance of follow up in patients who have developed dental disease.

ECC-GD GROWTH AND DEVELOPMENT

OUTCOME: The parent and/or family will understand that primary dentition begins to develop during fetal life and that primary teeth serve several purposes.

STANDARDS:

1. Review primary tooth development.
2. Discuss the role of primary teeth in the growth and development of the mandible, maxilla, and permanent teeth.

ECC-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ECC-LA LIFESTYLE ADAPTATIONS

OUTCOME: The parent and/or family will understand how to avoid the disease, adopt good feeding practices, avoid falling prey to old habits and develop positive oral hygiene habits.

STANDARDS:

1. Discuss attitudes toward feeding habits.
2. Review breastfeeding and bottle feeding practices.
3. Provide information on alternatives to misuse of baby bottles, i.e., no bottles in the bed, no propping of bottles, weaning at 12 months of age.

ECC-N NUTRITION

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

STANDARDS:

1. Review normal nutritional needs for optimal general and dental health.
2. Discuss current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
3. Discuss nutritional modifications as related to Early Childhood Caries.
4. Emphasize the importance of fully participating in the prescribed nutritional plan.

ECC-P PREVENTION

OUTCOME: The parent and/or family will understand how to prevent ECC.

STANDARDS:

1. Review adult oral hygiene with the parent.
2. Review infant/child oral hygiene, i.e., the use of a soft washcloth to clean the gums of infants.
3. Discuss methods of prevention, including fluoride supplementation and limitation of sugar in diet.
4. Explain to parents the methods of early identification of dental disease in infants and small children. Explain the importance of early treatment.
5. Review proper use of and alternatives to misuse of the bottle or nipple, i.e., no bottles in bed, no propping of bottles, and weaning at 12 months of age.
6. Emphasize that nothing should be given from a bottle except formula, breastmilk, water, or electrolyte solution, i.e., no juice or soda pop.

ECC-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM**.
2. Explain that short-term use of NSAIDS may be helpful in pain management as appropriate.
3. Explain non-pharmacologic measures that may be helpful with pain control, i.e., avoid hot and cold foods.

ECC-PRO PROCEDURES

OUTCOME: The patient/family will understand procedure(s) to be performed to treat ECC and the risk of not treating ECC.

STANDARDS:

1. Explain the procedures proposed as well as alternatives and/or the risk of doing nothing.
2. Discuss common and important complications of treatment or non-treatment.

ECC-TE TESTS

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

STANDARDS:

1. Discuss the test(s) to be performed, i.e., x-ray.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks of non-performance of the testing.

ECC-TX TREATMENT

OUTCOME: The patient will understand the necessary treatment (i.e., filling, capping) and the proper oral care after treatment.

STANDARDS:

1. Explain the basic procedure to be used (i.e., filling, capping) and the indication, common complications and alternatives as well as the risks of non-treatment.
2. Review the specific elements of oral care after treatment. **Refer to DC and ECC-P.**
3. Discuss the indications for returning to the provider, i.e., bleeding, persistent or increasing pain, and fever.

EYE—Eye Conditions

EYE-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient and/or family will have a basic understanding of the anatomy and physiology of the eye and surrounding tissues as it relates to the specific eye condition.

STANDARDS:

1. Explain the normal anatomy and physiology of the eye.
2. Discuss the changes to the anatomy and physiology as a result of the specific eye condition.
3. Discuss the impact of these changes on the patient's vision and health.

EYE-C COMPLICATIONS

OUTCOME: The patient/family will understand the potential complications of their ocular condition.

STANDARDS:

1. Review the effects that this condition has on the patient's ocular status. Emphasize the short/long-term effects and the degree of control that the patient has over the progression of the condition.
2. Discuss symptoms which may indicate progression of the condition.

EYE-DP DISEASE PROCESS

OUTCOME: The patient/family will understand their ocular condition.

STANDARDS:

1. Review the current information about the patient's specific condition.

EYE-FU FOLLOW-UP

OUTCOME: The patient/family will understand the need and process for obtaining and fully participating with follow-up for their condition.

STANDARDS:

1. Discuss the patient's responsibility in the management of his/her condition.
2. Emphasize the importance of making and keeping appropriate follow-up appointments.

EYE-HM HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of their specific eye condition 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.

EYE-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about his/her ocular condition.

STANDARDS:

1. Give the patient/family written information about his/her ocular condition.
2. Discuss the information with the patient/family.

EYE-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will strive to make the lifestyle adaptations necessary to prevent complications of the specific eye condition and improve overall health.

STANDARDS:

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

EYE-M MEDICATIONS

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

STANDARDS:

1. Discuss, and demonstrate as appropriate, the proper use, benefits, common side effects, and common interactions of the prescribed medications. Review the signs of possible toxicity and appropriate follow-up as indicated.
2. Emphasize the importance of full participation with the 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 nonprescription or traditional remedies, to the provider.

EYE-P PREVENTION

OUTCOME: The patient/family will understand that healthy lifestyle behaviors can reduce the risk of developing some eye conditions and complications.

STANDARDS:

1. List lifestyle habits that increase the risk for the onset or progression of the specific eye condition.
2. Identify behaviors that reduce the risk for the onset or progression of a specific eye condition, i.e., proper nutrition, safety and infection control practices.
3. Assist the patient in developing a plan for prevention of the specific eye condition.

EYE-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the pain management techniques for this particular eye condition.

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient and may be multifaceted. **Refer to PM.**
2. Discuss pharmacologic pain management strategies as appropriate, i.e., eye drops, oral pain medicine.
3. Explain that short term use of narcotics may be helpful in pain management as appropriate.
4. Discuss non-pharmacologic measures that may be helpful with pain control, i.e., warm or cool packs.

EYE-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.

EYE-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 specific test ordered.
2. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
3. Explain any necessary preparation for the test.
4. Explain the meaning of the test results, as appropriate.

EYE-TX TREATMENT

OUTCOME: The patient/family will understand the common and important risks, anticipated benefits, and anticipated progress of the condition.

STANDARDS:

1. Review the current information regarding the treatment of the condition with the patient/family.
2. Explain indications, benefits, and common or important risks of the proposed treatment.
3. Help the patient/family develop a treatment plan which will achieve the goal(s) of treatment.

G

GL—Glaucoma

GL-DP DISEASE PROCESS

OUTCOME: The patient will understand the complications and progression of glaucoma.

STANDARDS:

1. Explain that glaucoma is characterized by an increase in intraocular pressure.
2. Explain that untreated glaucoma will result in permanent loss of vision due to optic nerve damage.
3. Explain that in early glaucoma there are usually no symptoms.
4. Explain that the acute-angle closure form of glaucoma may occur at any age and may include eye pain, light sensitivity, blurred vision, halos, or nausea and vomiting.

GL-FU FOLLOW-UP

OUTCOME: The patient will verbally summarize their knowledge of their present glaucoma status and understand the importance of regular follow-up in the control of glaucoma.

STANDARDS:

1. Discuss that frequent examinations are required to monitor for side effects of treatment or disease progression.
2. Discuss the status of the ocular condition and the potential to maintain, lose or regain the quality of ocular health and visual capabilities.

GL-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

GL-LT LASER THERAPY

OUTCOME: The patient will understand how laser therapy prevents progression of the disease.

STANDARDS:

1. Explain the preparation for the laser procedure.
2. Explain how the laser prevents worsening of the condition.
3. Discuss the common side effects and major complications of the procedure.

GL-M MEDICATIONS

OUTCOME: The patient will understand the importance of treatment and make a plan to fully participate with the treatment regimen.

STANDARDS:

1. Discuss the medication options for glaucoma treatment.
2. Explain that glaucoma may progress slowly and asymptomatically and that full participation with treatment will halt progression of disease and preserve vision.
3. Discuss the use, benefits, and common side effects of the patient's prescribed medications.
4. Have the patient demonstrate proper use of eye drops.
5. Assist with development of a plan for full participation as appropriate.

GL-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.

I

IM—Immunizations

IM-DEF DEFICIENCY

OUTCOME: The patient/family will understand the importance of fully participating with schedule of prescribed immunizations for protection from vaccine preventable disease.

STANDARDS:

1. Identify reasons for deficiency and provide education as indicated.
2. Explain that deficiency of immunization(s) may cause serious health problems.
3. Discuss diseases that have been eradicated due to immunizations.
4. Discuss the patient's particular immunization deficiency.
5. Review complications that could occur if infection develops.

IM-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 receiving immunizations on schedule.
2. Discuss the procedure for obtaining follow-up appointments.
3. Emphasize that appointments should be kept.

IM-I IMMUNIZATION INFORMATION

OUTCOME: Patient/family will understand the indication for and benefit of immunization, common and important side effects of vaccination, and post immunization care.

STANDARDS:

1. Explain the indication for immunization including the disease which is to be prevented by immunization.
2. Explain the contraindications of administering the vaccine.
3. Discuss appropriate vaccine sites.
4. Explain the important and common side effects of immunizations to be administered.
5. Explain post-immunization care including dose of antipyretics if needed and what to do if serious side effects are observed.
6. Explain how family members can assist with comforting immunized persons during and after vaccine administration, as culturally appropriate.

IM-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

IM-P PREVENTION

OUTCOME: The patient/family will understand communicability and measures to control vaccine preventable disease for children and adults.

STANDARDS:

1. Explain that vaccines are available against certain infections or diseases.
2. Explain that certain infections can be eliminated or avoided through immunizations.
3. Provide information on types of vaccines available for children and adults.
4. Explain that good hand hygiene, use of tissues and waste receptacles and avoiding touching eyes, nose, and mouth are also important measures in the control of some disease transmission.

IM-SCH SCHEDULE

OUTCOME: The patient/family will understand the importance of fully participating with a schedule of prescribed immunizations for protection from vaccine preventable diseases.

STANDARDS:

1. Explain that some vaccines are prescribed to be given in series, within certain time frames and may not be counted if given too early and may need to be repeated.
2. Explain that some vaccines are required by law.
3. Provide schedules on types of vaccines for children and adults.

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

MSX—Metabolic Syndrome

MSX-C COMPLICATIONS

OUTCOME: The patient will understand the complications associated with metabolic syndrome.

STANDARDS:

1. Explain that metabolic syndrome is a precursor to cardiovascular disease and diabetes.
2. Explain that arteriosclerosis and atherosclerosis impede blood flow through the circulatory system.
3. Explain that heart attacks may result from the heart having to work harder to pump blood through congested and hardened arteries.
4. Explain that good control of blood sugar can reverse or prevent progression of pre-diabetes.
5. Explain that strokes may result due to injured blood vessels in the neck or brain.
6. Explain that blindness may result from injured blood vessels in the eye.
7. Explain that leg pain may result due to injured blood vessels in the legs.

MSX-CUL CULTURAL/SPIRITUAL ASPECTS OF HEALTH

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

STANDARDS:

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

MSX-DP DISEASE PROCESS

OUTCOME: The patient will have a basic understanding of the pathophysiology of the metabolic syndrome.

STANDARDS

1. Explain that metabolic syndrome is a combination of dyslipidemia, hypertension and pre-diabetes (insulin resistance).
2. Review the risk factors and causative factors of dyslipidemia, hypertension and pre-diabetes.
3. .Discuss HDL, non-HDL, LDL and triglycerides. Define normal ranges.
4. Explain the difference between systolic and diastolic pressure. Define normal ranges.
5. Discuss the role of insulin resistance**.** Define normal ranges.

MSX –EQ EQUIPMENT

OUTCOME: The patient will receive information on the use of home blood pressure monitors and pedometers.

STANDARDS:

1. Provide the patient with information on the use of specific home blood pressure monitors and pedometers.
2. Discuss the use of blood pressure monitoring equipment in public places, i.e., such as stores.
3. Discuss correct way to record blood pressure and pedometer activity in a logbook and bring to clinic visits.
4. Discuss when to contact a healthcare provider for a blood pressure value which is outside the patient's personal guidelines.
5. Discuss the proper use and care of medical equipment.
6. Discuss signs of equipment malfunction and proper action in case of malfunction.

MSX-EX EXERCISE

OUTCOMES: The patient will understand the relationship of exercise to normal lipids, blood pressure and blood sugar. The patient will develop a physical activity plan.

STANDARDS:

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

MSX-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the patient's responsibility in developing and following a treatment plan and keeping follow-up appointments.
2. Discuss the procedure for making appointments.
3. Discuss any necessary preparation for lab test(s).

MSX-L PATIENT INFORMATION LITERATURE

OUTCOMES: The patient will receive written information about metabolic syndrome.

STANDARDS:

1. Provide the patient with written information about metabolic syndrome.
2. Discuss the content of the patient information literature with the patient.

MSX-LA LIFESTYLE ADAPTATIONS

OUTCOMES: The patient will understand the lifestyle adaptations necessary to prevent or delay the progression of metabolic syndrome and develop a realistic plan to accomplish this.

STANDARDS:

1. Emphasize that healthy food choices and regular physical activity are the critical components in improving metabolic syndrome and preventing the progression to diabetes and cardiovascular disease.
2. Discuss the importance of tobacco cessation. Make referral to tobacco cessation programs if available.
3. Discuss the relationship of stress to metabolic syndrome and suggest ways to reduce stress. Refer to stress reduction program as appropriate.
4. Assist the patient to develop a self care plan.

MSX-M MEDICATIONS

OUTCOMES: The patient/family will understand their medication(s), regimen and the importance of fully participating in therapy.

STANDARDS:

1. Review proper use, benefits and common side effects of the prescribed medications.
2. Discuss any drug-drug or drug-food interactions with this medication as appropriate.
3. Review clinical effects and onset of action expected with these medications.
4. Review recommended monitoring laboratory tests which may be ordered.
5. Explain importance of avoiding over-the-counter medications without checking with a physician and/or pharmacist.
6. Discuss common and important signs of toxicity and/or adverse reactions and what to do if the patient/family suspects a reaction.

MSX-N NUTRITION

OUTCOMES: The patient will understand the importance of nutritional management in the improvement of metabolic syndrome.

STANDARDS:

1. Refer to registered dietician as appropriate.
2. Emphasize that nutritional management includes meal planning, making healthy food choices, appropriate serving sizes and food preparation.
3. Review the food pyramid and its role in meal planning.
4. Explain how to read nutrition information labels. Emphasize the importance of noting the serving size – the serving size may not be the same as the container size.
5. Discuss the merits of various food preparation methods.
6. Describe appropriate portion size and emphasize its importance.
7. Discuss the importance of decreasing total fat intake and using healthier fats sparingly.
8. Explain that excessive salt intake may play a role in hypertension and discuss ways to decrease salt intake.

MSX-P PREVENTION

OUTCOME: The patient will understand ways to prevent cardiovascular disease and diabetes.

STANDARDS:

1. Explain that consuming a diet low in fat and cholesterol, controlling weight and exercising may help prevent complications from metabolic syndrome or progression to cardiovascular disease and diabetes.
2. Emphasize the importance of regular blood sugar, blood pressure, and lipid screening. Discuss current recommendations for screening and/or monitoring.
3. Explain that the metabolic syndrome tends to run in families and that the patient's family members should be evaluated by a physician or other health care provider.

MSX-SM STRESS MANAGEMENT

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

STANDARDS:

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

MSX-TE TESTS

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

STANDARDS:

1. Explain the test(s) ordered, i.e., FBS , A1C, Lipids.
2. Explain any necessary preparation prior to the test(s).
3. Explain the indications, risks and benefits of the test(s), including risks of not having the test(s) performed.
4. Explain the meaning of the test results in relation to what “normal” results are, as appropriate.
5. Explain the test as it relates to planning the course of treatment.

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.

ODM—Ocular Diabetes

ODM-C COMPLICATIONS

OUTCOME: The patient will understand the ocular complications of diabetes.

STANDARDS:

1. Explain the long-term ocular effects of the condition. Emphasize that the outcome depends upon the patient's control of diabetes.
2. Discuss the symptoms indicative of progression of ocular diabetes.

ODM-DP DISEASE PROCESS

OUTCOME: The patient will understand and verbally summarize how diabetes can affect the health of their eyes and their vision.

STANDARDS:

1. Review the current information regarding ocular diabetes. Explain that diabetic retinopathy is a result of retinal ischemia and edema which can result in visual loss or total blindness.
2. Explain that the ocular complications of DM result from high blood sugar and that good control of blood sugar helps prevent loss of vision.
3. Explain that high blood sugar levels can cause swelling of the lens of the eye which can result in blurred vision which may resolve when the blood sugar is under good control.
4. Help the patient develop a plan to achieve diabetes control. Refer to other departments or agencies as appropriate.

ODM-FU FOLLOW-UP

OUTCOME: The patient will understand his/her responsibility to make and keep follow-up appointments in order to maintain optimal ocular health.

STANDARDS:

1. Discuss the status of the ocular condition and the potential to maintain, lose, or regain visual capabilities.
2. Discuss available interventions to help the patient maintain visual capability as much as possible.
3. Discuss the importance of annual dilated eye exams in detecting diabetic retinopathy at an early stage where treatment is most likely to be effective.

ODM-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ODM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the relationship between elevated blood sugar and loss of vision and will develop a plan to achieve and maintain good blood sugar control.

STANDARDS:

1. Emphasize the importance of diet and weight-control guidelines as they relate to blood sugar control and ocular health. **Refer to DM-LA.**
2. Explain that use of tobacco products can exacerbate the disease process and lead to increased loss of vision.
3. Help the patient develop a plan to control blood sugar. Refer to local resources as appropriate.

ODM-LT LASER THERAPY

OUTCOME: The patient will understand the procedure, benefits, and common risks of laser therapy.

STANDARDS:

1. Explain the proposed procedure and indications for the procedure as it relates to the patient's condition.
2. Discuss the common and/or important risks and the potential benefits of the proposed procedure. Explain that the therapy prevents worsening of the condition but probably will not restore any lost vision.
3. Explain the preparation for the procedure.

ODM-M MEDICATIONS

OUTCOME: The patient will understand the type of medication being prescribed, dosage and administration of the medication. They will also be aware of the proper storage of the medication and possible side effects of the drugs.

STANDARDS:

1. Review proper use, benefits, and common side effects of the medication.
2. Emphasize the importance of maintaining full participation in the medication regimen and monitoring schedule.
3. Instruct patient on proper administration and storage of the drug.

ODM-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand that pain relief may be available.

STANDARDS:

1. Discuss the pain management options which are available.
2. Help the patient develop a plan to monitor and manage pain.
3. Discuss symptoms which should prompt an evaluation such as increasing pain unresponsive to the usual measures.

ODM-TE TESTS

OUTCOME: The patient/family will understand the planned tests that may be performed, including indications and impact on further care.

STANDARDS:

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

ODM-TX TREATMENTS

OUTCOME: The patient/family will understand the treatment options that may be used to treat the specific condition or injury.

STANDARDS:

1. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
2. Discuss the treatment plan, including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
3. Discuss the importance of fully participating in the treatment plan, including scheduled follow-up and physical therapy.

ORTH—Orthopedics

ORTH-AP ANATOMY AND PHYSIOLOGY

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

STANDARDS:

1. Explain the normal anatomy and physiology of the body part affected.
2. Discuss the changes to the anatomy and physiology as a result of this condition and/or injury as applicable.
3. Discuss the impact of these changes on the patient's health, well-being and/or mobility.

ORTH-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications of orthopedic conditions and/or procedures.

STANDARDS:

1. Explain that failure to fully participate in the prescribed therapy may result in a deficit in function of the limb or body part involved.
2. Discuss common and important complications associated with this illness, injury or condition.

ORTH-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the current knowledge regarding the patient's orthopedic condition and symptoms.

STANDARDS:

1. Explain that an orthopedic condition involves the bones and/or joints. Describe the specific condition.
2. Discuss the current information regarding causative factors and pathophysiology of this disease state/condition.
3. Discuss the signs/symptoms and usual progression of this disease state/condition.
4. Discuss the signs/symptoms of exacerbation/worsening of this disease state/condition.

ORTH-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate, when appropriate, the proper use and care of orthopedic equipment.

STANDARDS:

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

ORTH-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize that fully participating in the treatment plan is the responsibility of the patient.
2. Review the treatment plan with the patient/family, emphasizing the need for keeping appointments, fully participating with the medication and physical therapy plan.
3. Review the symptoms which should be reported and measures to take if they occur.
4. Stress the importance of keeping follow-up appointments and continuing the therapy for its prescribed duration.

ORTH-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

ORTH-M MEDICATIONS

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

STANDARDS:

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

ORTH-N NUTRITION

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

STANDARDS:

1. Explain that diet can be a contributing factor in the disease process.
2. Explain that diet alone cannot usually treat orthopedic conditions.
3. Encourage the patient to include foods rich in calcium, such as dairy products.
4. Refer to registered dietician as appropriate.

ORTH-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the plan for pain management and the importance of fully participating in the plan.

STANDARDS:

1. Explain that pain management is specific to the disease process/injury of this particular diagnosis and management may be multifaceted.
2. Explain the role of narcotics and other medications in pain management as appropriate.
3. Explain the use of heat and/or cold in the relief of pain as appropriate.
4. Explain that the use of non-pharmacologic measures (i.e., such as physical therapy, imagery, TENS units) in the control of pain.
5. Discuss the importance of restricting the use of the affected body part as recommended by the provider as a pain management tool.

ORTH-PT PHYSICAL THERAPY

OUTCOME: The patient/family will understand the importance of regular physical therapy and will develop a plan to keep physical therapy appointments and fully participate in the physical therapy plan.

STANDARDS:

1. Review the current information regarding the physical therapy indicated for this condition/injury.
2. Explain the benefits, risks and alternatives to the physical therapy plan.
3. Assist the patient/family with a physical therapy plan indicated for this condition/injury. Explain that this may include visits with the physical therapist as well as home exercises.
4. Emphasize that it is the responsibility of the patient to follow the plan.

ORTH-P PREVENTION

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

STANDARDS:

1. List lifestyle habits that increase the risk for the onset, progression, or spread of the specific orthopedic condition or predispose to injury.
2. Identify behaviors that reduce the risk for the onset, progression, or spread of the specific orthopedic condition or predispose to injury.
3. Assist the patient in developing a plan for prevention of orthopedic conditions and/or injuries.

ORTH-PRO PROCEDURES

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

STANDARDS:

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

ORTH-S SAFETY AND INJURY PREVENTION

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

STANDARDS:

1. Explain that injuries are a major cause of death.
2. Discuss the regular use of seat belts and children's car seats and obeying the speed limit.
3. Explain that the use of alcohol and/or drugs increases the risk of injury or death, especially when used by someone operating a motor vehicle or other equipment.
4. Assist the family in identifying ways to adapt the home to improve safety and prevent injuries, as appropriate.
5. Discuss injury prevention adaptations appropriate to the patient's age, disease state, or condition.
6. Identify which community resources promote safety and injury prevention and refer as appropriate.

ORTH-TE TESTS

OUTCOME: The patient/family will understand the planned tests that may be performed, including indications and impact on further care.

STANDARDS:

5. Explain the specific test ordered.
6. Explain the necessity, benefits and risks of the test to be performed and how it relates to the course of treatment.
7. Explain any necessary preparation for the test ordered.
8. Explain the meaning of the test results, as appropriate.

ORTH-TX TREATMENTS

OUTCOME: The patient/family will understand the treatment options that may be used to treat the specific condition or injury.

STANDARDS:

4. Explain that the treatment plan will be made by the patient and medical team after reviewing available options.
5. Discuss the treatment plan, including lifestyle adaptations, pharmacologic, surgical, and psychosocial aspects of the treatment plan.
6. Discuss the importance of fully participating in the treatment plan, including scheduled follow-up and physical therapy.

ORTH-WC WOUND CARE

OUTCOME: The patient/family will understand the importance of wound care and demonstrate how to perform appropriate wound care as applicable.

STANDARDS:

1. Explain the risks and benefits of appropriate wound care and how it relates to the specific condition.
2. Explain step by step how wound care is to be performed. Observe return demonstration as appropriate.
3. Discuss the importance of aseptic technique and appropriate wound care in preventing infection.
4. As appropriate, discuss the proper disposal of soiled wound care items.

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.

PD—Periodontal Disease

PD-AP ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will have a basic understanding of the supportive structures of the tooth.

STANDARDS:

1. Discuss the importance of the supportive structures of the tooth which are composed of attached tissue, periodontal ligaments and alveolar bone.

PD-C COMPLICATIONS

OUTCOME: The patient/family will understand some of the complications of periodontal disease.

STANDARDS:

1. Discuss that periodontal disease may cause seeding of the blood with bacteria. Some of the complications of this may be:
   a. Valvular heart disease
   b. Myocardial infarction
   c. Stroke
   d. Low birth-weight infants
   e. Pre-term delivery
2. Discuss that periodontal disease often results in loss of alveolar bone and loosening of teeth. This may eventually result in tooth loss.
3. Discuss that periodontal disease almost always results in bad breath.
4. Discuss that periodontal disease may result in dental caries. **Refer to DC.**

PD-DP DISEASE PROCESS

OUTCOME: The patient/family will be able to understand the periodontal disease process and list some of the causes.

STANDARDS:

1. Explain that bacterial plaque release toxins that irritate and damage the gums. Over time this infectious process may progress to involve the supporting structures of the tooth leading to bone loss and eventual loss of the tooth/teeth.
2. Explain that genetics and lifestyle choices play a role in the development of periodontal disease, i.e., diseases of the immune system, uncontrolled diabetes, and tobacco and/or alcohol use.
3. Explain that early seeding of the mouth with pathologic bacteria may predispose to the development of periodontal disease.

PD-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of regular dental follow-up.

STANDARDS:

1. Explain the course of treatment for the current disease process, including the schedule for treatments and follow-up.
2. Emphasize the importance of following the current recommendations for routine dental examination and periodontal maintenance appointments.
3. Emphasize the importance of a dental visit if any problems occur between scheduled dental visits.
4. Assist the patient in making follow-up appointments and refer to outside providers as appropriate.

PD-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about periodontal disease, its treatment and/or the oral care necessary for prevention/maintenance of disease.

STANDARDS:

1. Provide patient/family with written patient information literature on periodontal disease, treatment and/or the oral care necessary for prevention/maintenance of disease.
2. Discuss the content of the patient information literature with the patient/family.

PD-M MEDICATIONS

OUTCOME: The patient/family will understand the importance of medication in the treatment of the periodontal disease and make a plan to fully participate with therapy.

STANDARDS:

1. Discuss the proper use, benefits, common side-effects, and food or drug interactions of the prescribed medication. Include procedure for follow-up if problems occur.
2. Discuss the use of chlorhexidine as appropriate. Discuss the common and important side-effects, common or important drug interactions (i.e., fluoride) and indications for immediate follow-up.
3. Explain the importance of completing the course of therapy and its role in eradicating the infection and/or decreasing the infectiousness of the periodontal disease.
4. Explain, as appropriate, that failure to complete the course of antibiotics may cause the development of resistant organisms.
5. Discuss, as appropriate, the concomitant use of antipyretics or NSAIDS.

PD-N NUTRITION

OUTCOME: The patient/family will understand the importance of a balanced diet, low in carbohydrates, especially simple sugars, and with adequate calcium and fluoride.

STANDARDS:

1. Discuss the relationship between a diet high in carbohydrates, especially simple sugars, and the development of dental caries. Give examples of foods high in simple sugars, i.e., crackers, potato chips, candy, pre-sweetened cereals.
2. Discuss the importance of calcium and fluoride intake as it relates to tooth development/mineralization.
3. Discuss foods that may be contraindicated secondary to instability of the teeth, i.e., apples, corn on the cob.
4. Refer to a registered dietician as appropriate.

PD-P PREVENTION

OUTCOME: The patient will be able to identify some ways to help prevent periodontal disease.

STANDARDS:

1. Early entry (prenatal and infancy) into dental care is important in the prevention of periodontal disease.
2. Emphasize the importance of treating all family members with periodontal disease, especially if the family includes children ages 6 months to 8 years.
3. Explain that the best preventive measures are daily plaque removal, primarily by brushing and flossing.
4. Emphasize the importance of regular and timely dental examination and professional cleaning in the prevention of periodontal disease.

PD-PM PAIN MANAGEMENT

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

STANDARDS:

1. Explain that pain management is specific to the disease process of this particular diagnosis and patient; and may be multifaceted. **Refer to PM**.
2. Explain that short-term use of Tylenol, NSAIDS, and/or narcotics may be helpful in pain management as appropriate.
3. Explain that antibiotics may be helpful in pain relief.
4. Explain non-pharmacologic measures that may be helpful with pain control, i.e., avoid firm foods.
5. Explain that dental anxiety may be controlled or relieved by the use of anxiolytics or antihistamines as appropriate.
6. Explain that local anesthetics and/or nitrous oxide may be used to control pain during dental procedures.

PD-TE TESTS

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

STANDARDS:

1. Discuss the test(s) to be performed, i.e., x-ray, bacteriological testing, periodontal probing.
2. Explain the necessity, benefits, and risks of the test to be performed and how it relates to the course of treatment. Discuss the risks of non-performance of the testing.

PD-TX TREATMENT

OUTCOME: The patient will understand the necessary treatment (i.e., scaling and root planning, chemotherapeutics, surgical treatment) and the proper oral care after treatment.

STANDARDS:

1. Explain the proposed procedure including indications, risks, benefits, alternatives and the consequences of non-treatment.
2. Review the specific elements of periodontal maintenance after treatment, i.e., daily plaque removal, use of oral rinses, and keeping scheduled appointments.

PT—Physical Therapy

PT-EQ EQUIPMENT

OUTCOME: The patient/family will understand and demonstrate as appropriate proper use of equipment.

STANDARDS:

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

PT-EX EXERCISE

OUTCOME: The patient/family will relate exercise program to optimal health and plan to follow the customized exercise program developed with the Physical Therapist.

STANDARDS:

1. Review the benefits of regular exercise.
2. Discuss the three types of exercise: aerobic, flexibility, and endurance, as appropriate.
3. Review the recommendations of an exercise program:
   a. Start out slowly.
   b. Modification of exercises to accommodate specific health problems.
   c. Exercise according to the specific plan developed for the individual.
4. Discuss the exercise(s) in the customized program.
5. As appropriate, demonstrate and assist in practicing the exercise(s) in the program.
6. Emphasize the importance of following the customized exercise plan developed with the Physical Therapist to achieve optimal benefit.
7. Review the exercise programs available in the community.

PT-FU FOLLOW-UP

OUTCOME: The patient/family will understand the importance of fully participating with the treatment plan and the process for obtaining follow-up appointments.

STANDARDS:

1. Discuss the patient's responsibility in the management of his/her condition.
2. Emphasize the importance of making and keeping appropriate follow-up appointments.
3. Discuss the process for obtaining follow-up appointments.

PT-GT GAIT TRAINING

OUTCOME: The patient will understand the importance of improved gait and plan to practice.

STANDARDS:

1. Discuss the components necessary for optimal gait:
   a. Normal range of motion
   b. Proper cadence or rhythm
   c. Appropriate stride length
   d. Heel-to-toe pattern to step
2. Discuss the importance of normal range of motion as appropriate. Demonstrate and assist in return demonstrations of specific exercises to increase the range of motion of the affected joint(s) or extremity(s).
3. Discuss the value of cadence or rhythm in walking as appropriate. Demonstrate and assist to accomplish an improved cadence.
4. Discuss stride length as appropriate. Demonstrate appropriate stride length and assist in improving stride.
5. Discuss and demonstrate the usual heel-to-toe pattern of a normal step as appropriate. Assist the patient to learn modification techniques.
6. Emphasize the importance of intentionally practicing improved gait.

PT-I INFORMATION

OUTCOME: The patient/family will understand their physical condition as it relates to their disease process and the rehabilitative process.

STANDARDS:

1. Review the current information about the patient's specific diagnosis.
2. Review the effects that this condition has on the patient's physical status. Emphasize the short/long term effects and the degree of control that the patient has over the condition.
3. Discuss the symptoms which may indicate progression of the condition.

PT-L PATIENT INFORMATION LITERATURE

OUTCOME: The patient/family will receive written information about the physical therapy plan.

STANDARDS:

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

PT-N NUTRITION

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

STANDARDS:

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

PT-TX TREATMENT

OUTCOME: The patient/family will understand the common and important risks, anticipated benefits and anticipated progress of the patient's rehabilitation process.

STANDARDS:

1. Review the current information regarding the treatment of the condition.
2. Explain the benefits of the proposed treatment.
3. Assist the patient/family in development of a treatment plan which will achieve treatment goals.
4. Refer to other departments or community resources as appropriate.

PT-WC WOUND CARE

OUTCOME: The patient/family will understand the necessity and procedure for proper wound care. As appropriate they will demonstrate the necessary wound care techniques.

STANDARDS:

1. Explain the reasons to care appropriately for the wound, i.e., decreased infection rate, improved healing.
2. Explain the correct procedure for caring for this patient's wound.
3. Explain signs or symptoms that should prompt immediate follow-up, i.e., increasing redness, purulent discharge, fever, increased swelling/pain.
4. Detail the supplies necessary for the care of this wound (if any) and how/where they might be obtained.
5. Emphasize the importance of follow-up.

PDM—Prediabetes

PDM-C COMPLICATIONS

OUTCOME: The patient/family/caregiver will understand common or serious complications of abnormal fasting blood glucose level.

STANDARDS:

1. Explain that fasting blood glucose levels above 100 mg/dL but less than 126 mg/dL and 2 hour post prandial between 140-200 mg/dL are diagnostic of prediabetes and that prediabetes may progress to Type 2 Diabetes.
2. Emphasize that optimal control of blood sugar can reverse or prevent progression of PDM.
3. Emphasize that optimal control of blood sugar can reduce the risk of complications.
4. State that PDM is a disease that needs to be monitored for progression and complications. Routine examinations are essential.
5. Discuss higher risk factors of PDM, i.e., heart attack, stroke. **Refer to CVA, CAD, DM and PVD.**
6. Discuss complications that can occur if PDM develops into Diabetes, i.e., heart disease, stroke, eye problems, kidney damage.

PDM-DP DISEASE PROCESS

OUTCOME: The patient/family will have a basic understanding of the pathophysiology and symptoms of PDM.

STANDARDS:

1. Briefly describe the pathophysiology of PDM.
2. Discuss the role of insulin resistance in PDM and Type 2 DM.
3. Describe risk factors for development and progression of PDM, i.e., including: family history, obesity, sedentary lifestyle, previous history of gestational diabetes, history of high blood pressure, high triglycerides.
4. Emphasize that PDM is a reversible, controllable condition, which requires permanent lifestyle alterations and continuous attention and medical care. **Refer to PDM-LA**.

PDM-EX EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in reducing insulin resistance and will make a plan to increase regular activity by an agreed-upon amount.

STANDARDS:

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

PDM-FU FOLLOW-UP

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

STANDARDS:

1. Emphasize the importance of early intervention to prevent the progression of PDM to Type 2 Diabetes.
2. Discuss the procedure for making appointments.
3. Discuss any necessary preparation for lab test(s). **Refer to PDM-TE**.

PDM-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

PDM-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family/caregiver will understand the lifestyle adaptations necessary to prevent or delay the progression of PDM and develop a realistic plan to accomplish this.

STANDARDS:

1. Emphasize that nutrition and exercise are the critical components in improving impaired glucose tolerance.
2. Emphasize that the complications (i.e., heart attack, stroke) result from the higher than normal blood sugar levels and that the goal of management is to keep blood sugar as near to normal as possible.

PDM-N NUTRITION

OUTCOME: The patient/family will understand the importance of nutritional management in the control of PDM and develop a plan to meet nutritional goals.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation and intake.
2. Review the food pyramid and its role in meal planning. Refer to registered dietician or to other local resources as appropriate.
3. Emphasize the importance of reading food labels. Instruct the patient/family as necessary.
4. Discuss the merits of various food preparation methods, i.e., broiling or baking is preferred over frying, avoid gravies and sauces, rinsing or blotting excess grease.
5. Emphasize the importance of portion control (appropriate serving sizes).
6. Emphasize that extra caution or planning is required when eating out, using USDA commodities, or going to special events since these foods are usually high in fat and sugar and serving sizes are often inappropriately large.
7. Emphasize that carbohydrates (such as whole grains) and low-fat proteins are preferred and that sugars and fats should be limited.
8. Emphasize the importance of family involvement and early intervention.

PDM-P PREVENTION

OUTCOME: The patient/family will understand major risk factors for development of PDM and will develop a plan for risk reduction.

STANDARDS:

1. Discuss the risk factors for PDM and Type 2 DM, i.e., obesity, sedentary lifestyle.
2. Explain that following an appropriate meal plan and increasing activity levels will reduce the risk of progression of PDM to Type 2 Diabetes.
3. Emphasize the importance of regular screening. Discuss current recommendations for screening.

PDM-TE TESTS

OUTCOME: The patient/family will understand the test to be performed and the reasons for the testing.

STANDARDS:

1. Explain the test(s) ordered, i.e., FBS, $HgbA_{1C}$, Fasting Lipid Profile.
2. Explain any necessary preparation prior to the test(s).
3. Explain the indications, risks and benefits of the test(s).
4. Explain the meaning of test results in relation to what "normal" results are.
5. Explain the test as it relates to planning the course of treatment.

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.

RD—Rheumatic Disease

RD-C COMPLICATIONS

OUTCOME: The patient will understand how to lessen complications of rheumatic disease.

STANDARDS:

1. Review the common complications associated with the patient's disease.
2. Review the treatment plan with the patient. Explain that complications are worsened by not participating with the treatment plan.

RD-DP DISEASE PROCESS

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

STANDARDS:

1. Review the disease process of the patient's rheumatic disease.
2. Review the physical limitation that may be imposed by the patient's disease.
3. Explain that treatments are highly individualized and may vary over the course of the disease.
4. Refer to the Arthritis Foundation or community resources as appropriate.

RD-EQ EQUIPMENT

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

STANDARDS:

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

RD-EX EXERCISE

OUTCOME: The patient will maintain an optimal level of mobility with minimal discomfort.

STANDARDS:

1. Emphasize that exercise is an important component of the treatment plan. Stress the importance of balancing rest and exercise.
2. Explain that exercise, when done correctly, can help reduce rheumatic disease symptoms, including the following:
    a. Preventing joint stiffness
    b. Keeping muscles strong around the joints
    c. Improving joint flexibility
    d. Reducing pain
    e. Maintaining strong and healthy bone and cartilage tissue
    f. Improving joint alignment
    g. Improving overall fitness
3. Emphasize that exercise can also help with weight reduction and contributes to an improved sense of well-being, enhance sleep, and reduce stress and depression.
4. Review the different types of exercises including active and passive range of motion, muscle strengthening and endurance exercises.
5. If applicable, review and demonstrate the prescribed exercise plan.
6. Emphasize the importance of "warm-ups and cool-downs". Explain how the application of heat or cold prior to beginning exercise may reduce joint discomfort. Explain that people who have poor circulation should talk to their healthcare provider before using hot or ice packs.
7. Caution the patient not to overexert. Stress the importance of taking a break when experiencing pain or fatigue.

RD-FU FOLLOW-UP

OUTCOME: The patient will understand the importance of fully participating in the treatment plan and regular follow-up.

STANDARDS:

1. Discuss the patient's responsibility in managing rheumatic disease.
2. Review treatment plan with the patient/family, emphasizing the need for keeping appointments and adhering to medications regimens.

RD-L PATIENT INFORMATION LITERATURE

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

STANDARDS:

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

RD-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle changes necessary to optimize performance of everyday activities.

STANDARDS:

1. Discuss that treatment for arthritis is usually a combination of rest and relaxation, exercise, proper diet, medication, joint protection and ways to conserve energy. Discuss way to pain management. **Refer to RD-PM**.
2. Review activity limitation and the importance of avoiding fatigue.
3. Discuss ADL aids. Make a referral to social services for assistance in procuring such devices.
4. Explain how exercise and social involvement may decrease the depression and anger often associated with rheumatoid disease.
5. Discuss how self-image, pain, fatigue, inflammation, limited joint mobility, and medications can alter sexual desire and sexual activity.
6. Assess level of acceptance and offer support and referral to social services and community resources as appropriate.
7. Discuss the importance of relaxation to minimize stress, thus minimizing symptoms. A relaxed body means the muscles are relaxed, relieving some of the pain associated with rheumatic disease.
8. Discuss the techniques that may reduce stress and depression such as meditation, imagery, prayer, hypnosis, and biofeedback.
9. **Refer to WL**.

RD-M MEDICATIONS

OUTCOME: The patient/family will understand the proper use of anti-rheumatic medications.

STANDARDS:

1. Review the mechanism of action of the prescribed medication.
2. Discuss proper use, benefits and common side effects of prescribed medications.
3. Explain that some medications may have long-term effects which require regular monitoring and follow-up.
4. Explain the importance of consulting with a health care provider prior to using OTC medications, or other non-prescribed or illicit drugs. **Refer to CPM and PM.**
5. Discourage the use of alcohol, since it worsens most rheumatic diseases in the long term.
6. Explain that many rheumatic diseases are chronic, making long-term management of pain and symptoms of the disease very important.

RD-N NUTRITION

OUTCOME: The patient will strive to achieve and maintain a safe weight level through a nutritionally balanced diet.

STANDARDS:

1. Assess the patient's current nutritional patterns and review improvements which can be made. **Refer to WL-N.**
2. Explain that a well-balanced diet helps to manage body weight and provides the body with the nutrients it needs to stay healthy.
3. Refer to a Registered Dietitian.

RD-PM PAIN MANAGEMENT

OUTCOME: The patient/family will understand the patient's pain management program.

STANDARDS:

1. Stress the need to fully participate with the prescribed treatment plan.
2. Emphasize the importance of rest and avoidance of fatigue.
3. Discuss the use of heat and cold.
4. Discuss the techniques that may reduce stress and depression such as meditation and bio-feedback.
5. Emphasize the role of exercise in reducing pain, maximizing mobility, and reducing stress/anxiety.
6. Refer to physical therapy as appropriate.

RD-TE TESTS

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

STANDARDS:

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

S

SUN—Sun Exposure

SUN-C COMPLICATIONS

OUTCOME: The patient/family will understand the complications associated with excessive sun exposure.

STANDARDS

1. Explain that UVB causes sunburn and plays a significant role in superficial skin cancers called basal cell carcinomas and squamous cell carcinomas.
2. Discuss the 4 ABCD warning signs of malignant melanoma:
    a. Asymmetry – one half of the mole or lesion differs from the other half
    b. Border – The border of the mole or lesion is irregular, scalloped or underlined
    c. Color – Color varies from one area to another within the mole or lesion
    d. Diameter – The mole or lesion is larger than 6mm across – about the size of a pencil eraser
3. Explain that sunburns before the age of 18 are more likely to cause skin cancers later on in life.
4. Explain that excessive sun exposure causes premature aging of the skin.
5. Explain that dehydration and pain are common complications of sunburn.
6. Explain that secondary infections may result from sunburns that blister and peel.

SUN-DP DISEASE PROCESS

OUTCOME: The patient/family will understand the pathophysiology of overexposure to the sun or other UV radiation/light.

STANDARDS:

1. Explain that the two types of ultraviolet radiation – ultraviolet A (UVA) and ultraviolet B (UVB) – have an effect on your skin and can impair your skin's DNA repair system which may contribute to cancer.
2. Explain that UVA usually causes the leathery, sagging, brown-spotted skin of those who spend a lot of time in the sun. UVA can also penetrate window glass, including car windows. Tanning beds are a source of high doses of UVA.
3. Explain that sunburn is the result of overexposure to the sun's ultraviolet (UV) radiation. Repeated exposure to UV radiation both tans and damages your skin. The signs and symptoms of sunburn usually appear within a few hours of exposure, bringing pain, redness, swelling and occasional blistering. Because sun burn often affects a large area of your skin, sunburn can cause headache, fever and fatigue.
4. Explain that the first step is to determine the degree and the extent of damage to body tissues. Damage from the sun is usually limited to first and second degree burns:
    a. First-degree burns are those in which only the outer layer of skin (epidermis) is burned. The skin is usually red, with swelling and pain sometimes present. The outer layer of skin hasn't been burned through. Treat a first degree burn as a minor burn unless it involves substantial portions of the hands, feet, face, or other large areas of the body.
    b. Second-degree burns are when the first layer of skin has been burned through and the second layer of skin (dermis) also is burned. Blisters develop and the skin takes on an intensely reddened, splotchy appearance. Second-degree burns produce severe pain and swelling.

SUN-I INFORMATION

OUTCOME: Parents/Family will understand sunburns; and the factors that are associated with increased risk of sunburn.

STANDARDS:

1. Explain that the UV content of sunlight varies. It's greater at higher elevations because it is unfiltered by clouds or haze. But reflected UV light also comes from snow, sand, water and other highly reflective surfaces and can burn as severely as direct sunlight. You can also get sunburn on a cloudy day
2. Explain that protection from the sun is very important in the prevention of skin cancer. Protective steps should begin in early childhood. Regular, proper use of broad-spectrum sunscreens such as those that offer protection from both UVA and UVB radiation is the key in preventing sunburn, sun damage and skin cancer.
3. Explain that regardless of skin pigmentation, all people are at risk for sun damage to their skin and should wear sunscreen.

SUN-L PATIENT INFORMATION LITERATURE

OUTCOME: The parent(s) and family will receive written information appropriate to the type and degree of the sunburn.

STANDARDS:

1. Provide written information about first and second-degree burns that are the result of over-exposure to the sun.
2. Discuss the content of the patient information literature.

SUN-LA LIFESTYLE ADAPTATIONS

OUTCOME: The patient will understand the lifestyle adaptations necessary to prevent complications of sunburn.

STANDARDS:

1. Review lifestyle aspects/changes that the patient has control over, such as:
    a. Consistent use of a sunscreen each and every day
    b. Discuss the importance of infants, children and youth using a sunscreen. Explain that sunburns before the age of 18 are more likely to cause skin cancers later on in life.
    c. Avoid the use of tanning beds
    d. Limit outdoor exposure to early morning or late afternoon. Sunlight is strongest from 11am-2pm.
    e. Wear appropriate clothing to cover the body, i.e., long sleeved shirts and wide brimmed hats.

SUN-P PREVENTION

OUTCOME: The patient/family will understand the factors associated with an increased risk of sunburns and how to lower the risk of sunburn and prevent complications.

STANDARDS

1. Explain that protection from the sun is very important in the prevention of skin cancer. Protective steps should begin in early childhood. Regular, proper use of broad-spectrum sunscreens such as those that offer protection from both UVA and UVB radiation is the key in preventing sunburn, sun damage and skin cancer.
2. Explain that when purchasing sunscreens, it is important to check the label to ensure that the product is a broad spectrum sunscreen offering both UVA and UVB protection. Sunscreen advertisements such as total sunblock, waterproof, all-day protection and deep-tanning are mis-leading as they do not necessarily offer both UVA and UVB protection. Read sunscreen labels carefully for UVA and UVB protection.
3. Explain that the Sun Protection Factor (SPF) ratings are based on how much longer someone may be protected from sunburn than he or she is if no sunscreen were applied. For example, if you normally burn in 20 minutes, a product with SPF 15 may allow you to stay out in the sun 15 times longer, if properly applied. The minimum level of SPF purchased should be SPF 15.
4. Explain that most people use sunscreens too sparingly. A liberal application is 1 ounce – two tablespoons full – to cover exposed parts of the body.
5. Explain that the timing of sunscreen application is also important. To have the best effect, sunscreens need to be applied 30 minutes before any outdoor activities– not after you go out.
6. Explain that because of sweating, swimming and toweling off, sunscreen should be reapplied throughout the day. Even water-resistant sunscreens need to be reapplied every 90 minutes.
7. Discuss the need to avoid using tanning beds. There is no such thing as a safe tan. Tanning beds aren't safe, and they may cause skin cancer. While tanning salons may advertise that they use only UVA light, research doesn't support VUA being "good" and UVB – as being "bad." Both UVA and UVB may increase the risk of skin cancer or melanoma.
8. Explain that if a tan is desired, consider use of one of the many "bronzers" available at cosmetic counters. Patients using "bronzers" must be reminded that they must still use a sunscreen over their "bronzer" as bronzers usually do not contain sunscreens.
9. Discuss ways in which the patient can protect themselves from the sun regardless of whether you are in the sun for work or play.
10. Explain that regardless of skin pigmentation, all people are at risk for sun damage to their skin and should wear sunscreen.

SUN-S SAFETY AND INJURY PREVENTION

OUTCOME: The patient will understand that precautions should be taken every day to avoid over exposure to UVA and UVB sunlight.

STANDARDS:

1. Discuss the consistent use of a sunscreen each and every day.
2. Discuss the added importance of infants, children and youth using a sunscreen.
3. Remind patient/family to avoid the use of tanning beds.
4. Emphasize outdoor exposure during the 11am-2pm time period should be limited.

SUN-TX TREATMENT

OUTCOME: The patient/family will understand the importance of treating the discomforts of sunburn and when to seek appropriate medical care.

STANDARDS:

1. Explain that exposure to large areas of the skin can result in headache, fever, fatigue, and dehydration.
2. Explain that if you have a sunburn:
   a. Take a cool bath or shower
   b. Apply an aloe vera lotion several times a day
   c. Leave blisters intact to speed healing and avoid infection. If they burst, apply an antibacterial ointment on the open areas and cover with a sterile gauze bandage.
3. Explain, if needed, for discomfort take a mild over-the-counter analgesic.
4. Encourage consumption of water or other non-caffeinated beverages.
5. Explain that severe sunburn may require and benefit from medical attention.
6. Encourage the patient to be smart about sun exposure:
   a. wear a broad-brimmed hat and light-colored clothing that covers your exposed skin
   b. use a broad-spectrum sunscreen
   c. limit outdoor sports and other activities to the early morning or late afternoon whenever possible.
   d. wear UVA and UVB rated sunglasses
7. Explain that the use of alcohol and other drugs may impair sound judgment when participating in outdoor activities. Caution should be exercised in combining the use of alcohol and other drugs with outdoor activities.
8. Refer to **BURN**.

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.