INDIAN HEALTH SERVICE

DOCUMENTING PATIENT EDUCATION

Volume I

18th Edition

effective date October 2011

FOREWORD

We begin by expressing our profound sorry at the passing of one of our long-time committee members, Sharon John of Yakama, WA. In 1995, as the idea for this national education committee was discussed, Sharon agreed to serve to represent the nursing profession and continued to serve for 16 years until her death in October of 2011. Sharon's dedication, perseverance and love of Native American people will always be remembered and her legacy of care will live on through the countless lives she touched. We will miss our friend and colleague.

In 1995, the Indian Health Service Health Education program assumed ownership of all Resource Patient Management System (RPMS) documentation and coding of health and patient education provided within our IHS, tribal, and urban facilities. The assumption of this responsibility was to ensure that continuity and consistency in education prevailed throughout the Indian Health Service. In 1998, the Patient Education Protocols and Codes (PEPC) committee began annual meetings to provide oversight to education. The Joint Commission on Accreditation of Healthcare Organizations encouraged all JCAHO accredited facilities to move towards "hospitals without walls." To achieve that goal, the Indian Health Service recognized the need to document educational activities provided in the community, in schools, and in other locations.

The PEPC committee would like to sincerely thank all the members and guests of this committee. As usual, long hours were spent preparing for the committee meeting and even longer hours in committee. This national PEPC committee deserves our appreciation. Without these dedicated committee members this effort 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. Many years ago, nurses in the Tucson Area, led by Elizabeth Dickey, R.N. developed the first brief manual envisioning an easier way to document education in the Indian Health Service. A special thanks to Tricia Price in developing the concept for a booklet and to Shirley Teter, OIT, for her assistance in formatting and ensuring consistency in our documents. We would like to thank all the Indian Health System programs for their dedication to the documentation of patient and family education. Finally, we are indebted to our colleagues in the Indian Health System 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 in Word format. Please try to follow the existing format as much as possible using mnemonics (codes) that are already in existence. The submissions will be reviewed by the committee and may be changed extensively prior to their publication for general use. New submissions should be sent to:

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FOREWARD TO THE 18th EDITION OF THE PATIENT EDUCATION PROTOCOLS

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TABLE OF CONTENTS

About This Document

This document is Volume I for the Patient Education manual. Documenting Patient Education contains the information you need to know when you document Patient Education about a patient.

Because the previous Patient Education manual became so large, we decided to divide the manual into two volumes:

Volume 1 is Documenting Patient Education. You can print this volume as part of your Patient Education manual.

Volume 2 is Patient Education Protocols and Codes. This volume will contain all of the protocols and codes for patient education, what protocols changed, and the index to the protocols. You can print this volume in its entirety; by doing this Volume 1 and Volume 2 would comprise the entire Patient Education manual. However, you could print the protocols and codes by name on the IHS Web site (instead of all of Volume 2).

We have endeavored to get the Patient Education manual into a more manageable document.

Important Changes in the 18th Edition

CONSISTENCY IN WORDING OF STANDARDS: Word consistency was increased across protocols, when specificity was not required. For example, the exercise standards are similar in many protocols.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE: This is a new code on chronic obstructive pulmonary disease which is one of the most common lung diseases. It makes it difficult to breathe.

COGNITIVE DISORDER: This new code was designed to address a cognitive dysfunction that does not meet criteria for dementia, delirium, or other amnestic disorders, but presumed to be due to the effects of a medical condition, such as post-concussional disorder and mild neurocognitive disorder.

CRITICAL CARE: People with life-threatening injuries and illnesses need critical care. Critical care involves close, constant attention by a team of specially-trained health professionals working in an intensive care unit (ICU) and emergency rooms or trauma center. This new code includes services such as the use of monitors, intravenous (IV) tubes, feeding tubes, catheters, ventilators and other equipment.

ENCEPHALITIS: Encephalitis is irritation and swelling (inflammation) of the brain, most often due to infections.

FEEDING DISORDERS OF INFANCY OR EARLY CHILDHOOD: These disorders include persistent, problematic eating behaviors in childhood, including eating nonnutritive substances, the repeated regurgitation and re-chewing of food, or failure to eat adequately.

GENDER DISORDER: Gender Identity Disorder reflects a strong and persistent cross-gender identification or insistence that one is of the other sex, and persistent discomfort about one's assigned sex.

HEMORRHOIDS: This new code addresses hemorrhoids, which are painful, swollen veins in the lower portion of the rectum or anus.

LYMPHOMA: This new code addresses lymphoma, a cancer in the lymphatic cells of the immune system.

MENINGITIS: Meningitis is a bacterial infection of the membranes covering the brain and spinal cord.

MENTAL HEALTH: These codes are used to assist MH providers in documenting common psychological educational topics not found elsewhere in the codes for patients with any diagnosis or for therapeutic groups.

SARCOIDOSIS: Sarcoidosis is a disease in which inflammation occurs in the lymph nodes, lungs, liver, eyes, skin, or other tissues.

TIC DISORDERS: These disorders include a combination of simple or complex motor and verbal tics that occur in varying intervals, depending on the specific disorder, and that cause marked distress or significant impairment in functioning.

URINARY CATHETER AND ASSOCIATED INFECTION: This is a new code to provide education on either or both urinary catheter and the possible urinary tract infection that can develop as a complication.

VENTILATION (MECHANICAL) AND ASSOCIATED PNEUMONIA: This is a new code to provide education on either or both mechanical ventilation and the possible pneumonia that can develop as a complication.

NEW 2012 PROTOCOLS:

COPD: Chronic Obstructive Pulmonary Disease
COG: Cognitive Disorder
CRIT: Critical Care
ENCOP: Encephalitis
FEED: Feeding Disorders Of Infancy Or Early Childhood
GENDR: Gender Disorder
HEM: Hemorrhoids
LOMA: Lymphoma
MNG: Meningitis
MNTL: Mental Health
SARC: Saracoidosis
TICD: Tic Disorders
UCATH: Urinary Catheter And Associated Infection
VENT: Ventilation (Mechanical) And Associated Pneumonia

NEW 2011 PROTOCOLS:

CERP: Cerebral Palsy
DEL: Delirium
DEM: Dementia
ELEC: Electrolyte Imbalance
FACT: Factitious Disorder
IV: Home IV Therapy
STONES: Kidney Stones
MD: Muscular Dystrophy
OCCU: Occupational Health
PYELO: Pyelonephritis
SEX: Sexual Disorders
SLEEP: Sleep Disorders
SYN: Syncope

NEW 2010 PROTOCOLS:

ADJ: Adjustment Disorders
ABXD: Antibiotic Associated Diarrhea
CVC: Central Line Catheter
EAT: Eating Disorders
ENU: Enuresis
GOUT: Gout
IMPLS: Impulse Control Disorders
LD: Learning Disorders/Disabilities
MR: Mental Retardation
MDRO: Multidrug-resistant Organisms
OEX: Otitis Externa
PDD: Pervasive Development Disorders
RH: Reactive Hypoglycemia
SEP: Separation Anxiety Disorder
SOMA: Somtoform Disorders
TPLNT: Organ Donation/Transplant

NEW 2012 SUBTOPIC CODES:

AG -Anger Management
AS - Assertiveness Skills
CD - Cognitive Distortions
COM - Communication Skills
COP - Coping Skills
CR - Conflict Resolution
DEF - Defense/Resistance
FI - Feeling Identification
REL - Interpersonal Relationships

NEW 2011 SUBTOPIC CODES:

ALL: Allergies
ASBI: Alcohol Screening and Brief Intervention
INF: Infant Care
ORAL: Oral Care
PCC: Pre-conception Care

For 2011, the sub-topic DC has been changed from Dental Caries to **Dental Care**.

NEW 2010 SUBTOPIC CODES:

ISO: Isolation
RRT: Rapid Response Team
ABST: Abstinence

Please discard old PEP-C Manuals; download the new FY 2012 PEPC Manuals from http:\\www.ihs.gov and ensure that your local Information Technology Department /Computer Department has installed all current patches for RPMS.

Use and Documentation of Patient Education Codes

Why Use the Codes?

Hospital or clinic policies and procedures must clearly indicate that the facility will use the *IHS Patient Education Protocols and Codes (PEPC) Manual*. A copy of the entire PEPC Manual must be located within the hospital/clinic policies and procedures.

Use of the codes helps nurses, physicians, and other healthcare providers to document and track patient education. While it is desirable to spend 15, 30, even 60 minutes making an assessment of educational needs, provide the education and then document 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 entered into RPMS and RPMS transfers that information not only to the National Patient Information Resource System (NIPRS) but the information is also transferred to the individual patient health summary. The information located on the patient's chart informs everyone using the patient's chart that a given patient received education on specific topics. Use of the codes reflects that a minimum of education (i.e., the protocols) were provided to the patient.

The codes are limited in that they do not detail the exact nature of the education – locally developed lesson plans should reflect *exactly* what was taught – but locally developed lesson plans must be built upon the protocols contained in the Manual. Use of the protocols for patient education does not preclude the development and use of lesson plans. Good education requires that lessons plans be developed that are built upon the foundation of the protocols. The codes are merely an abbreviated tool used to document the comprehensive education that was provided. 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:

07/19/05 DM-Nutrition, poor understanding, 10 min. (Provider Initials) GS: Pt. will include 5 veg/fruit/day
10/27/05 DM-Foot care, good understanding, 7 min. (Provider Initials)GM: Pt included 5 veg/fruit/day
11/07/05 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 the patient's diabetes.

Charting and the Codes

Use of the codes *does not* preclude or require writing a 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 the SOAP note and use the codes 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 patient education code string is composed of five mandatory components and four optional components. These components are:

1. Topic - mandatory; identifies the disease state or condition for which you are educating
   - May use patient education mnemonic (e.g., DM for diabetes)
   - May use ICD9 or CPT Code (e.g., 250.04 for diabetes)
2. Subtopic - mandatory; identifies the aspect of the education (example: exercise, nutrition, medications)
3. Readiness to learn - optional

Readiness Status	Code	Definition
Distraction	DSTR	The patient/family has limited readiness to learn because of distractions that cannot be minimized.
Eager	EAGR	The patient/family is exceedingly interested in receiving education.
Intoxicated	INTX	The patient/family has decreased cognition due to intoxication with drugs or alcohol.
Receptive	RCPT	The patient/family is ready or willing to receive education.
Pain	PAIN	The patient/family has a level of pain that limits readiness to learn.
Severity of Illness	SVIL	The patient/family has a severity of illness that limits readiness to learn.
Unreceptive	UNRC	The patient/family is NOT ready or willing to receive education

4. Level of Understand - mandatory

Level of Understanding	Code	Definition
Good	G	Verbalizes understanding Verbalizes decision or desire to change (plan of action indicated) Able to return demonstration correctly
Fair	F	Verbalizes need for more education Undecided about making a decision or a change Return demonstration indicates a need for further teaching

Level of Understanding	Code	Definition
Poor	P	Does not verbalize understanding Refuses to make a decision or needed changes Unable to return demonstration
Refused/declined	R	Refuses or declines patient education
Group	GP	Education provided in group Unable to evaluate individual responses

5. Provider who did the education - mandatory
6. Time spent educating the patient in minutes - mandatory
7. Education comment (free text up to 160 characters) - optional
8. Goal status - optional

Goal Status	Code	Definition
Goal Set	GS	The patient has identified a goal the patient would like to accomplish that is associated with the patient education code
Goal Not Set	GNS	The patient is not interested or able to set a goal that is related to the patient education provided during this visit
Goal Met	GM	The patient has successfully completed a goal that is associated with the patient education code
Goal Not Met	GNM	The patient did not meet the goal set for the patient education code

9. Goal comment (free text up to 160 characters) - optional

Documenting Patient Education (Forms)

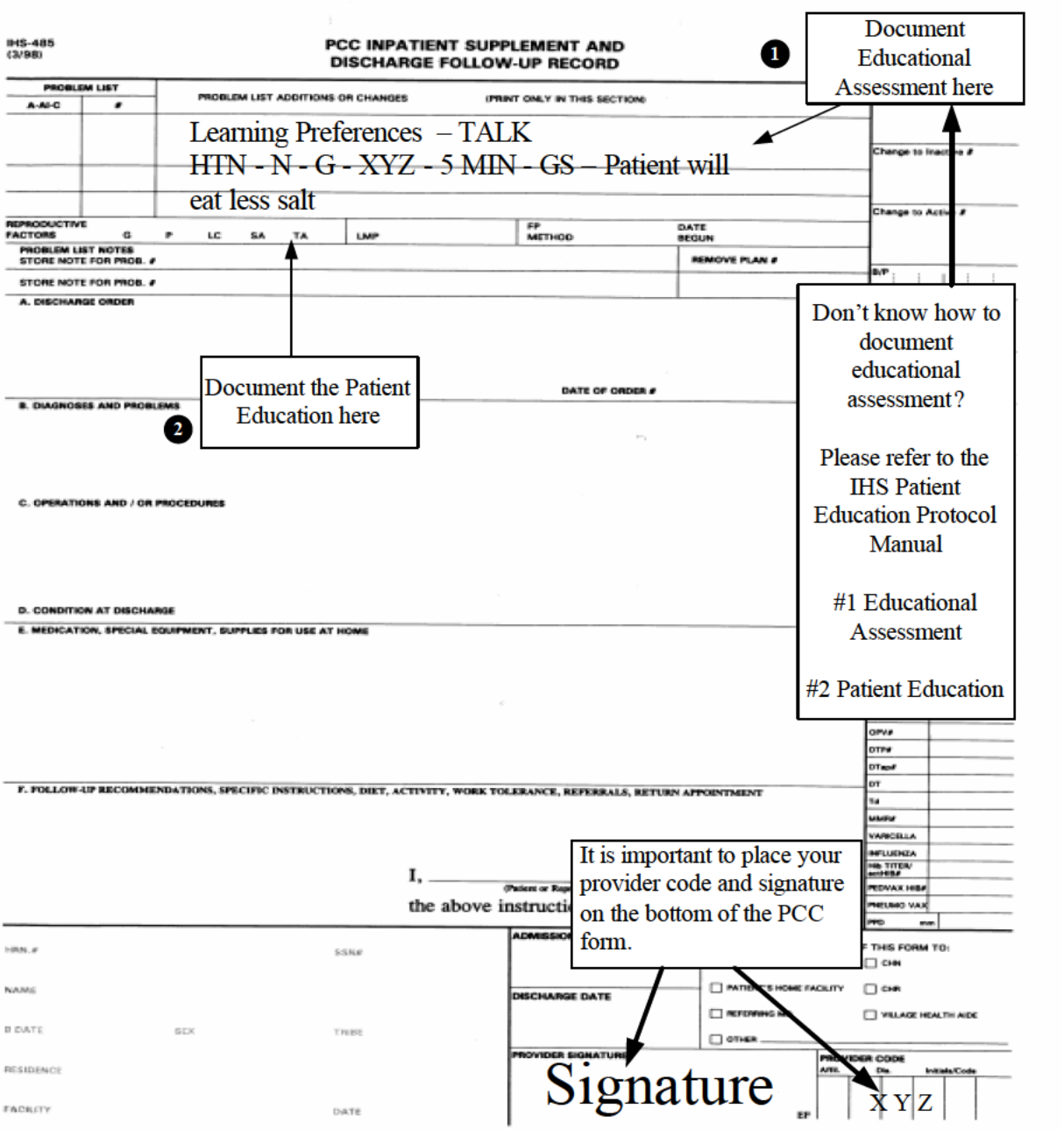


Figure 1: ***Documenting Patient Education on the PCC Inpatient Supplement and Discharge Follow-Up Record form.***

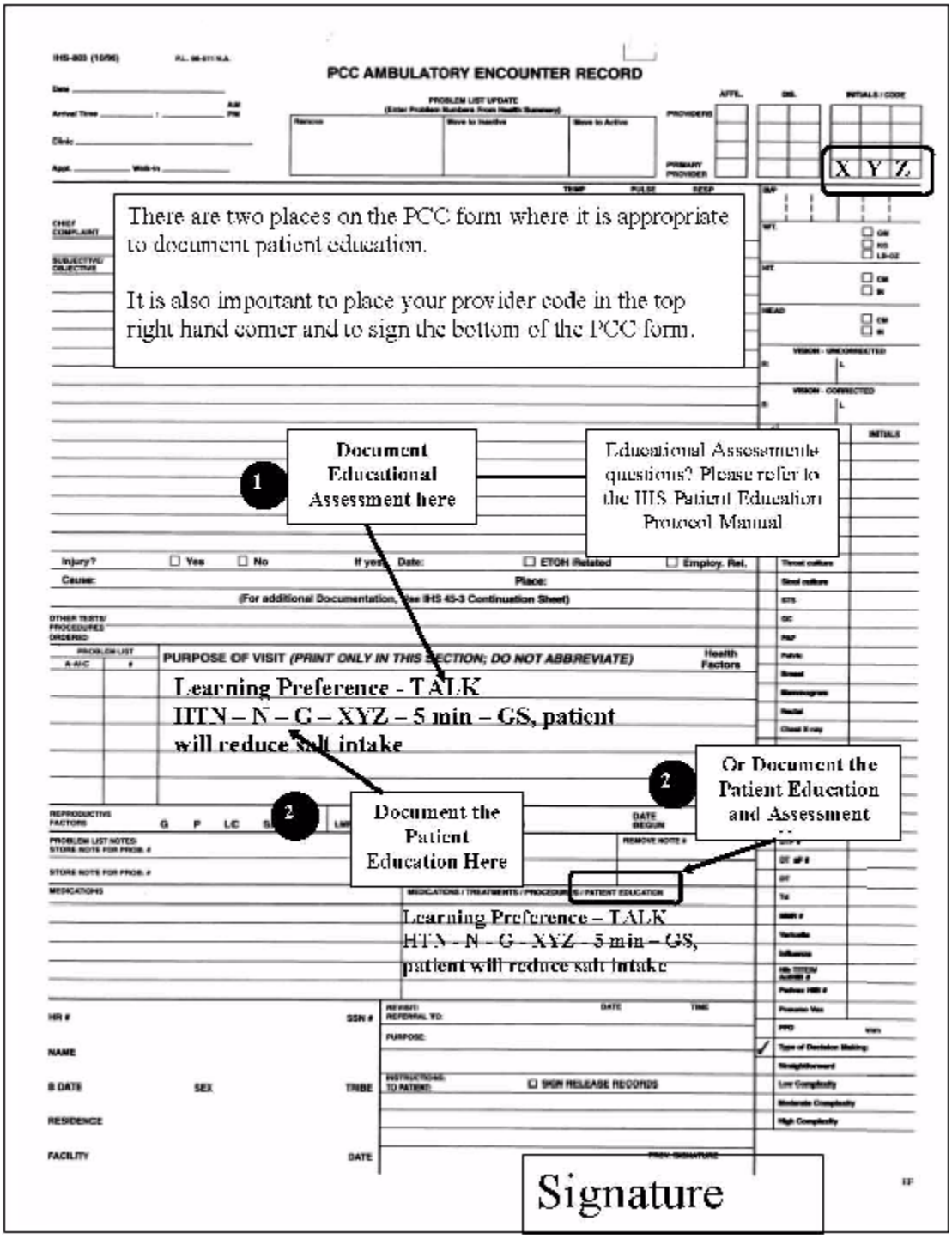
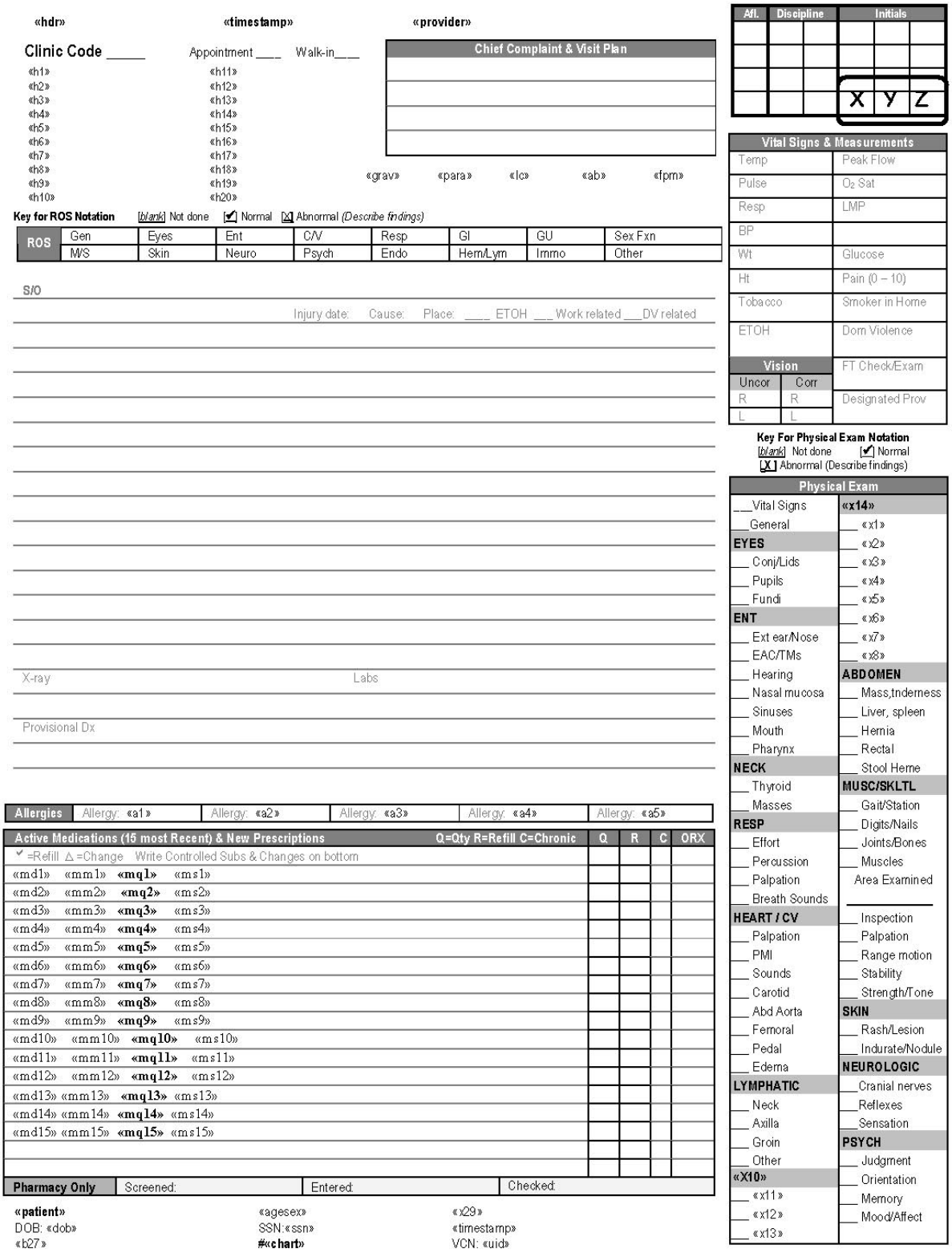


Figure 2: Documenting Patient Education with the PCC Ambulatory Encounter Record form

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



«hdr» «timestamp» «provider»

Clinic Code _____ Appointment ___ Walk-in___

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

Chief Complaint & Visit Plan

«grav» «para» «lc» «ab» «fpm»

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

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

S/O

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

X-ray Labs

Provisional Dx

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

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

Pharmacy Only	Screened:	Entered:	Checked:

«patient»
DOB: «dob»
«b27»

«agesex»
SSN: «ssn»
#«chart»

«x29»
«timestamp»
VCN: «uid»

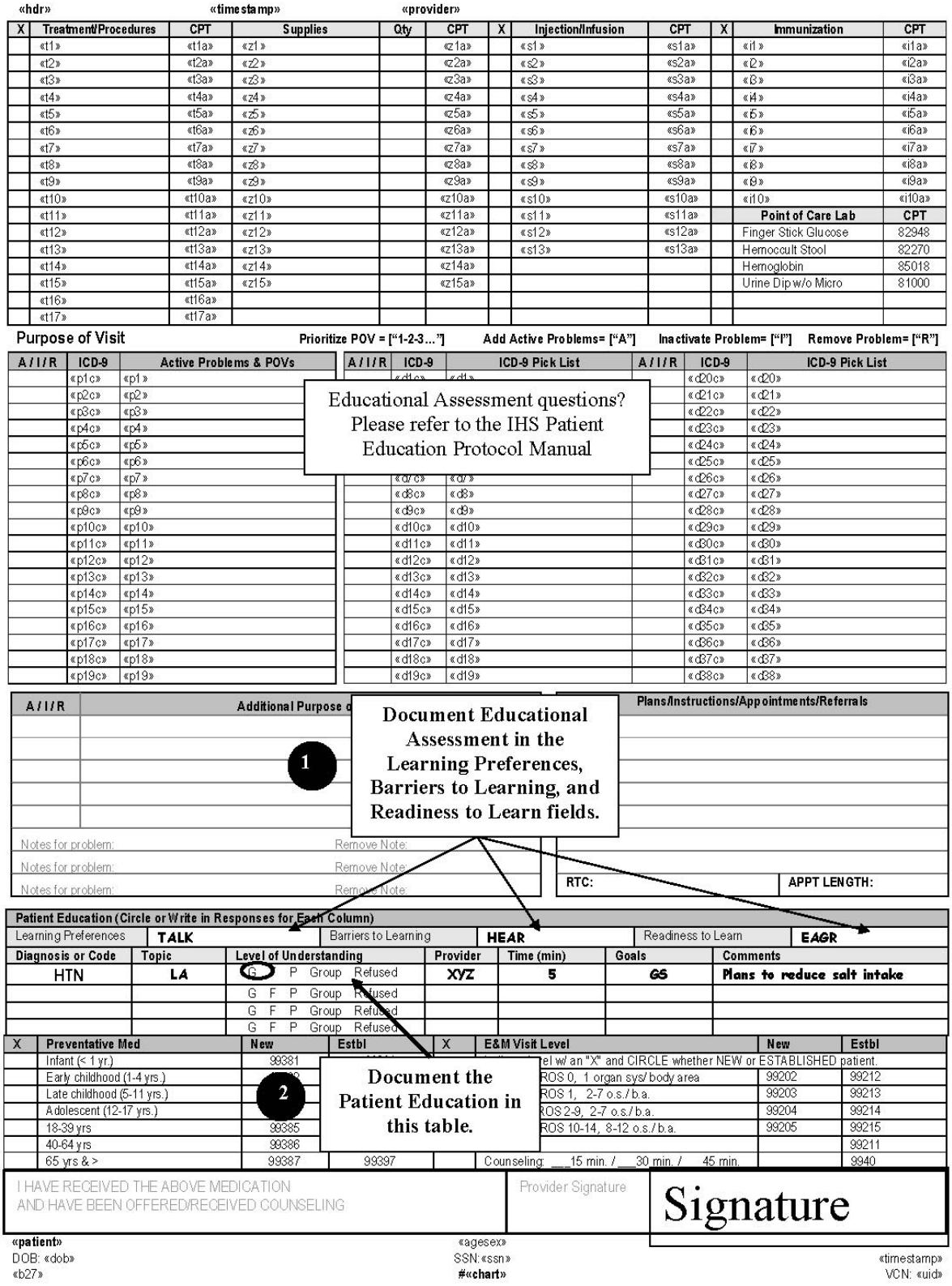
Atl.	Discipline	Initials		
		X	Y	Z

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

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

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

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



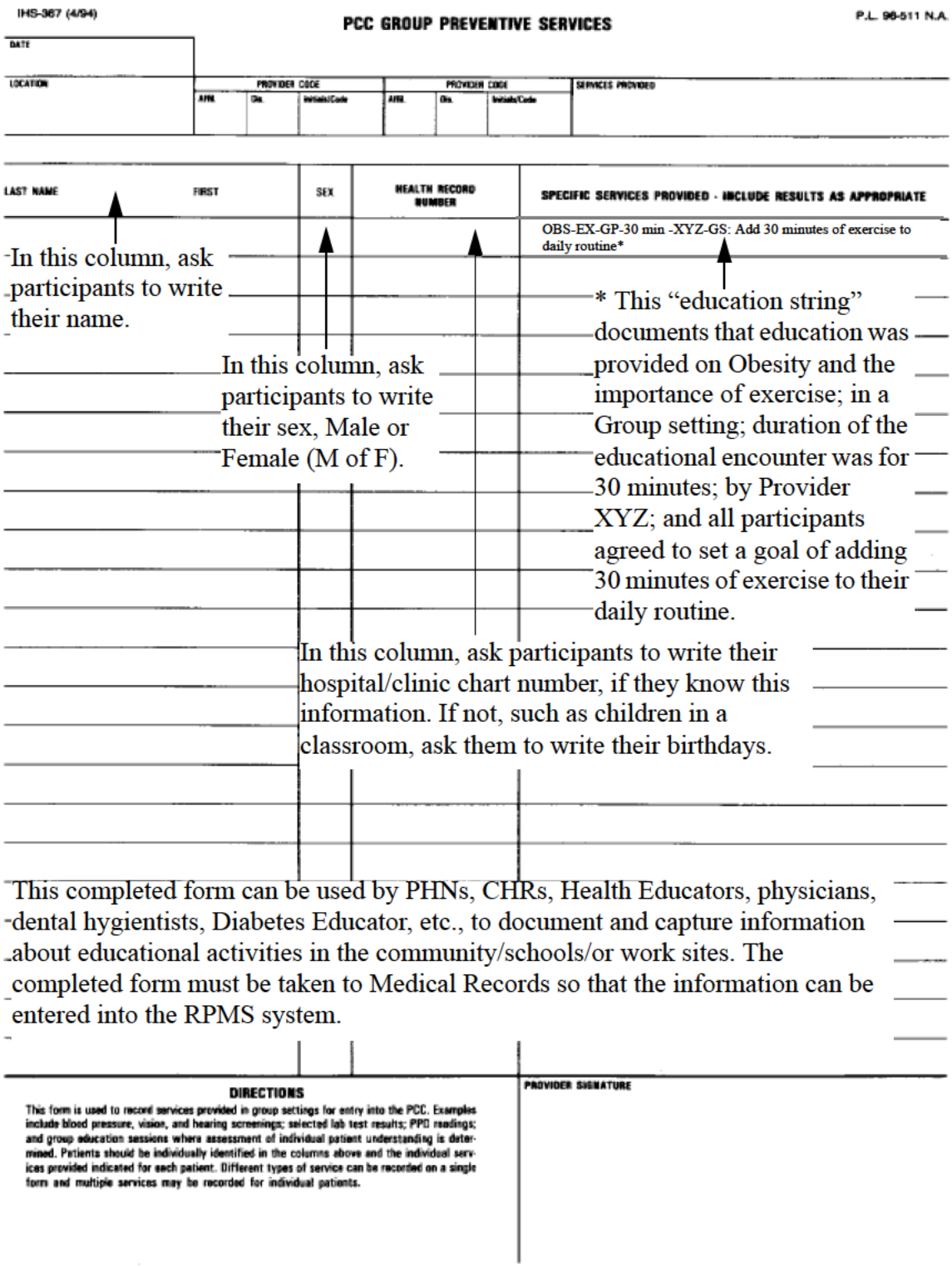


Figure 5:Form used by all healthcare workers providing education in the community, schools, work sites, etc.

Recording Goals

OBJECTIVE	DEFINITION	ACTION	MNEMONIC
Goal Set	The preparation phase defined as "patient ready to change" (patient is active)	State a plan • State a plan how to maintain at least one _____ • Write a plan of management • Plan to change _____ • State 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 Not Set	The pre-contemplation phase defined as "patient is not thinking about change"	Goal Not Set	GNS
Goal Met	The action phase defined as "patient activity making the change" or maintenance phase defined as "patient is sustaining the behavior change"	Behavior Goal Met • Patient maintains goal	GM
Goal Not Met	The contemplation phase defined as "patient is unsure about the change" or relapse when the patient started making the change and did not succeed due to ambivalence or other	Behavior Goal Not Met • Patient set a goal but is ambivalent about change • Relapse • Patient set a goal but is unable to meet the goal	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.

1. READINESS TO LEARN (RL Code)	2. PATIENT'S RESPONSE TO EDUCATION (LEVEL OF UNDERSTANDING)
Eager to Learn RL-EAGER Receptive RL-RCPT Unreceptive RL-UNCR Pain RL-PAIN Severity of Illness RL-SVIL Intoxication RL-INTX 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 need changes. Unable to return demonstration. • Refused (R) Refuses education. • Group (GP) Group taught.

3. LEARNING PREFERENCES (LP Code)				
DO/Practice LP - DOIT	Group LP - GP	Read LP - Read	Talk (one on one) LP - Talk	Video LP - Video

BARRIERS TO LEARNING (BAR) (Check those that apply)						DATE ASSESSED (If assessed today):
☐ No Barriers BAR-NONE	☐ Cognitive Impairment BAR-COGI	☐ Doesn't Read English BAR-DNRE	☐ Fine Motor Skills BAR-FIMS	☐ Interpreter Needed BAR-INTN	☐ Low Health Literacy BAR-LOWLIT	☐ Values/Beliefs BAR-VALU
☐ Blind BAR-BLND	☐ Deaf BAR-DEAF	☐ Dementia BAR-DEMN	☐ Hard of Hearing BAR-HEAR	☐ Social/ Emotional Stress BAR-STRESS	☐ English as a Second Language BAR-ESLA	☐ Visually Impaired BAR-VISI

List Measures taken to address above barriers

Comments: _____

DATE	ICD-9 Code Disease State, Illness or Condition	EDUCATION SUBTOPIC Check box to refer to Progress Notes	PROVIDER INITIALS OR PROVIDER CODE	READINESS TO LEARN CODE (RL)	LEVEL OF UNDERSTANDING CODE	PERSON TAUGHT (Mark appropriate checkbox)	TIME	Goal Not Set (GNS) Goal Set (GS) Goal Met (GM) Goal Not Met (GNM)	CPT CODE
	ADM			EAGR RCPT UNRE PAIN SVIL DSTR INTX	Good Fair Poor Refused	☐ Patient ☐ Other			
	NPSG-13 MSAF			EAGR RCPT UNRE PAIN SVIL DSTR INTX	Good Fair Poor Refused	☐ Patient ☐ Other			
	NPSG-7-MDRO			EAGR RCPT UNRE PAIN SVIL DSTR INTX	Good Fair Poor Refused	☐ Patient ☐ Other			
	NPSG-7-SPE			EAGR RCPT UNRE PAIN SVIL DSTR INTX	Good Fair Poor Refused	☐ Patient ☐ Other			
	NPSG-7-CVC			EAGR RCPT UNRE PAIN SVIL DSTR INTX	Good Fair Poor Refused	☐ Patient ☐ Other			

Figure 1: Page 1 of Inpatient Form

Patient Identification

Providers please sign on back of form

DATE	ICD-9 Code Disease State, Illness or Condition	EDUCATION SUBTOPIC Check box to refer to Progress Notes	PROVIDER INITIALS OR PROVIDER CODE	READINESS TO LEARN CODE (RL)	LEVEL OF UNDERSTANDING CODE	PERSON TAUGHT (Mark appropriate checkbox)	TIME	Goal Not Set (GNS) Goal Set (GS) Goal Met (GM) Goal Not Met (GNM)	CPT CODE
				EAGR RCPT UNRE PAIN SVIL DSTR INTX	Good Fair Poor Refused	☐ Patient ☐ Other			
				EAGR RCPT UNRE PAIN SVIL DSTR INTX	Good Fair Poor Refused	☐ Patient ☐ Other			
				EAGR RCPT UNRE PAIN SVIL DSTR INTX	Good Fair Poor Refused	☐ Patient ☐ Other			
				EAGR RCPT UNRE PAIN SVIL DSTR INTX	Good Fair Poor Refused	☐ Patient ☐ Other			
				EAGR RCPT UNRE PAIN SVIL DSTR INTX	Good Fair Poor Refused	☐ Patient ☐ Other			
				EAGR RCPT UNRE PAIN SVIL DSTR INTX	Good Fair Poor Refused	Patient Other			

SIGNATURE	INITIALS	PROVIDER CODE

Figure 2: Page 2 of Inpatient Form

PSYCHOSOCIAL

You have the right to refuse to answer any of these questions

Depression Screen (Exam Code 36 Depression Screening Wellness tab)

Screening for pt ≤ 14 y/o: N/A ☐

Do you cry a lot? No ☐ Yes ☐

Do you cry for no apparent reason? No ☐ Yes ☐

Do you feel lonely even when other people are around No ☐ Yes ☐ **Refused:**_____

"Yes" to any question above OR if depression suspected in parent/caregiver & interfering with child's care, further evaluation indicated

In the last two weeks, how often have you been bothered by:

Little interest or pleasure in doing things?

__(0) Not at all __(1) Several days __(2) More than half the days __(3) Nearly every day

Feeling down, depressed or hopeless: TOTAL SCORE_____

__(0) Not at all __(1) Several days __(2) More than half the days __(3) Nearly every day

Normal/Negative ≤2 Abnormal ≥3 need further evaluation (using PHQ-9 or other diagnostic tool)

Tobacco (Health Factor Tobacco Wellness tab)

Do you (patient) currently use any Tobacco Products? (age ≥5yo) N/A ☐ **Refused:**_____

Any tobacco (cigarette/chewing) use in the last year? No ☐ Yes ☐ (Type_____ Amount_____How long_____)

No ☐ Non-Tobacco user

Yes ☐ Current smoker Current smokeless Current Smoker and Smokeless Ceremonial Use

Type_____ Amount_____ How long_____

If yes, educate about cessation options & document education

Have you ever used any Tobacco Products?

No ☐ Non-user

Yes ☐ Previous Smoker Previous Smokeless (Previous – no tobacco use for > 6 months)

Cessation Smoker Cessation Smokeless (Cessation – no tobacco use for < 6 months)

Any Exposure to Tobacco Smoke?

No ☐ Smoke free home

Yes ☐ Smoker in Home, Exposure to environmental Smoke (outside of home)

Alcohol/Drugs (Health Factor Alcohol/Drugs or Exam Code 35 Wellness tab)

Pt ≤ y/o: Do you (patient) or anyone in house use alcohol or drugs? No ☐ Self ☐ Other ☐ Comments _____

If yes for self, further evaluation indicated, document as exam code 35 – abnormal/positive **Refused** _____

If no for self, document as exam code 35 – normal/negative

If suspected in parent/caregiver & interfering with child's care, further evaluation indicated.

Do you use? Alcohol ☐ Marijuana ☐ Cocaine ☐ Meth ☐ Other Drugs ☐ How Often_____How Long_____NonUser____

Was last drink within the past 72 hours? No ☐ Yes ☐ (If yes, consider CIWA)

Pt ≥ 21 y/o that has answered yes to alcohol - administer CAGE questionnaire:

C – Have you ever felt you should CUT down on your drinking? No ☐ Yes ☐

A – Have people ANNOYED you by criticizing your drinking? No ☐ Yes ☐

G – Have you ever felt bad or GUILTY about your drinking? No ☐ Yes ☐ CAGE Score____

E – Have you ever had a drink (or used drugs) first thing in the morning to steady your nerves, get rid of hangover or get the day started (EYEOPENER)? No ☐ Yes ☐ *total yes 0/4 1/4 2/4 3/4 4/4*

*if at least one yes further evaluation indicated

IPV/DV-Intimate Partner /Domestic Violence (Exam 34 Intimate Partner Violence, Wellness tab)

Ask of patient when no family/visitors are present. Peds, ask of parent/caregiver to determine if existence for patient. **Refused** _____

Do you feel safe with the people you live with or spend time with? No ☐ Yes ☐ Past ☐ **Unable** _____

Are you afraid to go home? No ☐ Yes ☐ Past ☐

Has anyone forced you to have sexual activities recently? No ☐ Yes ☐ Past ☐ Want Help: Yes ☐ No ☐

General Education Subtopics

(using IDC-9 diagnosis instead of PEPC to document education)

Guidelines For Use

The following subtopic can be used in conjunction with any ECD-9 diagnosis to document patient/family education. The general subtopics should not be used with standard patient education codes. Standard codes can be found in the IHS Patient Education Protocols and Codes Manual (PEPC). As with PEPC, covering 50% of the standards under a subtopic justifies use of the education coding system. The list below is NOT exhaustive, nor is it intended to be.
The provider will write out the following: 1) ICD-9 code or diagnosis, 2) education subtopic, 3) level of understanding (G, F, P, R, Gp), 4) Provider Code or Initials, 5) Time spent providing the education, and 6) GS for Goal set, GM for Goal Met, and GNM for Goal Not Met if the patient set a goal; use GNS for Goal Not Set if the patient did not set a goal. For example:

(132.9) Pediculosis – TX – F <provider initials> 10min. – GS: Pt. will wash linens

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

(132.9) Pediculosis – treatment – fair understanding, 10 minutes, Goal Set: Pt. will wash linens

The General Education Subtopics used with ICD-9 diagnoses are:

AP - Anatomy & Physiology
C - Complications
DP - Disease Process
EQ - Equipment
EX - Exercise
FU - Follow-up
HM - Home Management
HY - Hygiene
L - Literature
LA - Lifestyle Adaptations
M - Medications
MNT - Medical Nutrition Therapy (Reg. Dietitian use only)
N - Nutrition
P - Prevention
PRO - Procedures
S - Safety
TE - Tests
TX - Treatment

General Education Subtopics Listing

AP - ANATOMY AND PHYSIOLOGY

OUTCOME: The patient/family will understand the anatomy and physiology as it relates to the disease state or condition.

STANDARDS:

1. Explain normal anatomy and physiology of the systems 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/family will understand the effects and consequences as a result of this disease state/condition, the failure to manage this disease state/condition, or those that are a result of treatment.

STANDARDS:

1. Discuss the common or significant complications associated with the disease state/ condition.
2. Describe the signs/symptoms of common complications of this disease state/ condition.
3. Discuss common or significant complications that may result from treatments.

DP - DISEASE PROCESS

OUTCOME: The patient/family will understand the condition/disease.

STANDARDS:

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

EQ - EQUIPMENT

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

STANDARDS:

1. Discuss the following as appropriate regarding the prescribed equipment:
   a. indication for the equipment
   b. benefits of using the equipment
   c. types and features of the equipment
   d. proper function of the equipment
   e. signs of equipment malfunction and proper action in case of malfunction
   f. infection control principles, including proper disposal of associated medical supplies
   g. importance of not tampering with any medical device
2. Demonstrate the safe and proper use, care and cleaning of the equipment as appropriate. Participate in a return demonstration as appropriate.
3. 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.

EX - EXERCISE

OUTCOME: The patient/family will understand the role of physical activity in the patient's disease process or condition.

STANDARDS:

1. Discuss the medical clearance issues for physical activity.
2. Discuss the benefits of any exercise, such as improvement in well being, stress reduction, sleep, bowel regulation, and self image.
3. Discuss obstacles to a personal physical activity plan and solutions to those obstacles. Assist the patient in developing a personal physical activity plan.
4. Discuss the appropriate frequency, intensity, time, and type of activity.
5. Refer to community resources as appropriate.

FU - FOLLOW-UP

OUTCOME: The patient/family will understand the importance of follow-up in the treatment of the patient's disease or condition.

STANDARDS:

1. Emphasize the importance of follow-up care.
2. Discuss the procedure and process for obtaining follow-up appointments.

3. Emphasize that full participation of the treatment plan is the responsibility of the patient/family.
4. Discuss signs/symptoms that should prompt immediate follow-up.
5. Discuss the availability of community resources and support services and refer as appropriate.

HM - HOME MANAGEMENT

OUTCOME: The patient/family will understand the home management of the disease process/condition.

STANDARDS:

1. Explain the home management techniques.
2. Discuss the implementation of hygiene and infection control measures.
3. Refer to community resources, hospice, or support groups, as appropriate.

HY - HYGIENE

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

STANDARDS:

1. Discuss the importance of hand-hygiene in infection prevention.
    a. Explain the importance of hand washing especially during food preparation and eating, diaper changing, toilet use, and wound management.
    b. Explain that this can be accomplished with soap and water or alcohol-based hand cleaners.
    c. Explain that the patient/family has the right to request staff members to wash their hands if the staff member does not do so in plain sight.
2. Review the importance of bathing, paying special attention to face, pubic hair area, and feet. Discuss hygiene as part of a positive self image.
3. Review the importance of daily dental hygiene, with attention to brushing and flossing.
4. Discuss the importance of covering the mouth preferably with the arm when coughing or sneezing.
5. Review the risks of exposing immunocompromised and high-risk persons (infants and elderly) to communicable diseases.

L - LITERATURE

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

STANDARDS:

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

LA - LIFESTYLE ADAPTATIONS

OUTCOME: The patient/family will understand lifestyle adaptations necessary for the patient's disease state/condition or to improve mental or physical health.

STANDARDS:

3. Discuss lifestyle adaptations specific to the patient's disease state/condition.
4. Discuss that the family may also require lifestyle adaptations to care for the patient.
5. Discuss ways to optimize quality of life.
6. Refer to community services, resources, or support groups, as available.

M - MEDICATIONS

OUTCOME: The patient/family will understand the purpose, proper use, and expected outcomes of prescribed drug therapy.

STANDARDS:

1. Describe the name, strength, purpose, dosing directions, and storage of the medication.
2. Discuss the benefits and common or important side effects of the medication and follow up as appropriate.
3. Discuss any significant drug/drug, drug/food, and alcohol interactions, as appropriate.
4. Discuss the importance of full participation with the medication plan and that this is the patient's responsibility. Discuss any barriers to full participation.
5. Discuss the importance of keeping a list of all current prescriptions and over-the-counter medicines, vitamins, herbs, traditional remedies, and supplements. Encourage the patient to bring this list and pill bottles to appointments for medication reconciliation.

MNT - MEDICAL NUTRITION THERAPY

(* FOR USE BY REGISTERED DIETITIANS ONLY ***)**

OUTCOME: The patient/family will understand the specific nutritional intervention(s) needed in the disease state/condition.

STANDARDS:

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

N - NUTRITION

OUTCOME: The patient/family will understand nutrition, as it relates to the patient's disease or condition.

STANDARDS:

1. Emphasize that nutritional management includes meal planning, careful shopping, appropriate food preparation, and eating.
2. Describe healthy food preparation methods. Emphasize the importance of appropriate serving sizes and reading food labels.
3. Discuss the current nutritional habits. Assist the patient in identifying unhealthy nutritional habits.
4. Explain that oral supplements are beneficial to boost calories if oral intake is less than optimal.
5. Refer to registered dietitian for MNT or other local resources as appropriate.

P - PREVENTION

OUTCOME: The patient/family will understand ways to reduce risk of developing diseases, conditions, or complications.

STANDARDS:

1. Discuss lifestyle behaviors that increase the risk for the onset, progression, or spread of a specific disease/condition.
2. Discuss the behaviors that reduce the risk for the onset, progression, or spread of a specific disease/condition.

PRO - PROCEDURES

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

STANDARDS:

1. Discuss the indications, risks, and benefits of the proposed procedure as well as the alternatives and the risk of non-treatment.
2. Explain the process and what is expected after the procedure.
3. Explain the necessary preparation for the procedure.
4. Explain the safety processes that will be applied to prevent errors and encourage reporting of concerns regarding safety, such as:
    a. informed consent
    b. patient identification
    c. marking the surgical site
    d. time out for patient identification and procedure review
    e. measures to prevent surgical site infections
5. Discuss pain management as appropriate.

S - SAFETY

OUTCOME: The patient/family will understand safety as it relates to the patient's disease or condition.

STANDARDS:

1. Explain that injuries are a major cause of death/disability.
2. Discuss injury prevention adaptations appropriate to the patient's age, disease state, or condition (home safety, car safety, work safety, recreation safety).

TE - TESTS

OUTCOME: The patient/family will understand the test(s) to be performed, the potential risks, the expected benefits, and the risks of non-testing.

STANDARDS:

1. Explain test(s) that have been ordered (explain as appropriate):
    a. method of testing
    b. necessity, benefits, and risks of test(s) to be performed
    c. any potential risk of refusal of recommended test(s)
    d. any advance preparation and instructions required for the test(s)
    e. how the results will be used for future medical decision-making
    f. how to obtain the results of the test
2. Explain test results:
    a. meaning of the test results
    b. follow-up tests may be ordered based on the results
    c. how results will impact or effect the treatment plan
    d. recommendations based on the test results

TX - TREATMENT

OUTCOME: The patient/family will understand the treatment plan.

STANDARDS:

1. Explain the treatment plan. Emphasize the importance of active participation by the patient/family in the development of and participation in the treatment plan.
2. Discuss therapies that may be utilized.
3. Explain that various treatments have their own inherent risks, side effects, and expected benefits. Explain the risk/benefit of treatment and non-treatment.
4. Discuss the importance of maintaining a positive mental attitude.

MNT - Medical Nutrition Therapy

****For Use By Registered Dietitians Only****

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

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

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

Education Needs Assessment Codes

INDIAN HEALTH SERVICE
EDUCATION NEEDS ASSESSMENT CODES

LP - Learning Preference	**Mnemonics**
1. Do	LP-DOIT
2. Group	LP-GP
3. Read	LP-READ
4. Media	LP-MEDIA
5. Talk	LP-TALK

RL - Readiness to Learn	
1. Distraction	RL-DSTR
2. Eager	RL-EAGR
3. Intoxication	RL-INTX
4. Receptive	RL-RCPT
5. Pain	RL-PAIN
6. Severity of Illness	RL-SVIL
7. Unreceptive	RL-UNRC

BAR - Barriers to Learning	
1. Blind	BAR-BLND
2. Cognitive Impairment	BAR-COGI
3. Deaf	BAR-DEAF
4. Dementia	BAR-DEMN
5. Does Not Read English	BAR-DNRE
6. Speaks English as Second Language	BAR-ESLA
7. Fine Motor Skills Deficit	BAR-FIMS
8. Hard of Hearing	BAR-HEAR
9. Interpreter Needed	BAR-INTN
10. Low Health Literacy	BAR-LOWLIT
11. No Barriers	BAR-NONE
12. Social/Emotional Stress	BAR-STRESS
13. Values/Belief	BAR-VALU
14. Visually Impaired	BAR-VISI

BAR - Barriers to Learning

Barriers to learning are PATIENT specific and documented as a Health Factor in the medical record. They usually are not visit specific, but rather relate to the patient's overall health status/ educational or developmental level.

Providers should document barriers to learning when they are observed. However, some barriers may need to be documented more often. Barriers are assessed by observation and interview, and then documented to alert other healthcare providers that may provide education. It is important to accommodate and overcome barriers in order to enhance patient learning.

Examples of how to overcome barriers to learning may include:

- Involve a family member or care taker in the education
- Minimize education to "need to know" information
- Speak loudly and clearly
- Communicate in writing
- Provide written materials that are low-literacy and have demonstrative pictures
- Refer to mental health, social services, or community resources as appropriate
- Assist the patient in identifying adaptive techniques or equipment that could accommodate the impairment
- Utilize a translator or sign interpreter
- Use different size medication bottles or a medication box
- Use medical assisted devices
- Ask the patient: "Do you feel ready for this education session or is there too much going on right now? When would be a better time for you?"

BAR-BLND BLIND

DEFINITION: The patient is blind and cannot compensate with low-vision devices.

ASSESSMENT: The patient may divert the eyes, wear sunglasses inside, state an inability to see or is diagnosed with blindness (best corrected vision is not better than 20/ 200 or 20 degrees of visual field in the better eye).

BAR-COGI COGNITIVE IMPAIRMENT

DEFINITION: The patient demonstrates cognitive impairment.

ASSESSMENT: The patient may be unable to give return demonstration, fails to understand simple information despite multiple attempts to teach, or has a diagnosis of cognitive impairment.

BAR-DEAF DEAF

DEFINITION: The patient is deaf and can NOT compensate with increased volume or hearing devices.

ASSESSMENT: The patient may not respond to questions, may be looking intently at your lips as you speak, may motion to communicate by writing, use sign language to indicate deafness, or may have a diagnosis of deafness.

BAR-DEMN DEMENTIA

DEFINITION: The patient may have difficulty learning because of impaired thought processes.

ASSESSMENT: The patient may answer questions inappropriately, behave inappropriately, or display symptoms of confusion or forgetfulness. The patient may have a documented diagnosis of dementia.

BAR-DNRE DOES NOT READ ENGLISH

DEFINITION: The patient is unable to read English.

ASSESSMENT: Ask the patient/family about the ability to read English. Patients may be embarrassed admitting they cannot read English or may make excuses such as "I forgot my glasses." This is a sensitive subject and must be treated accordingly. Stress "English" in this evaluation and acknowledge that the patient's primary language may be unwritten. Another technique is to have the patient read a sentence that could be interpreted in different ways and ask them how they interpret the sentence. If the patient is unable, state that reading English can be hard for people that learned another language first and ask if this is applicable.

BAR-ESLA SPEAKS ENGLISH AS SECOND LANGUAGE

DEFINITION: The patient's primary language is not English.

ASSESSMENT: The patient speaks English, but may have barriers due to differences in primary language.

BAR-FIMS FINE MOTOR SKILLS DEFICIT

DEFINITION: The patient has fine motor skills impairment that can interfere with tasks requiring manual dexterity.

ASSESSMENT: The patient may have difficulty or lack the physical control to direct/ manage body movement, e.g., paralysis, arthritis, amputation, unable to handle testing supplies (for example, checking blood sugars or measuring medications).

BAR-HEAR HARD OF HEARING

DEFINITION: The patient has a problem hearing that can be compensated with increased volume or hearing devices.

ASSESSMENT: The patient may not respond to questions initially and may ask for things to be repeated, may speak loudly, may bend ear/lean toward the speaker, or wears a hearing device.

BAR-INTN INTERPRETER NEEDED

DEFINITION: The patient does not readily understand spoken English.

ASSESSMENT: The patient may verbalize the need for an interpreter, answer questions inappropriately, or answer or nod "yes" to all questions. These actions could also imply hearing difficulty and may require further assessment.

BAR-LOWLIT LOW HEALTH LITERACY

DEFINITION: The patient reads and understands below the 6th grade reading level.

ASSESSMENT: The patient is unable to read and understand basic health information.

BAR-NONE NO BARRIERS

DEFINITION: The patient has no apparent barriers to learning.

BAR-STRESS SOCIAL/EMOTIONAL STRESS

DEFINITION: The patient's ability to learn is limited due to social and emotional stressors from current personal difficulties or on-going mental/behavioral health issues

ASSESSMENT: The patient may appear distraught, avoid eye contact, or show anger. The stress may be acute or ongoing. e.g., martial/relationship problems, unemployment/ financial stress, lack of housing, problems with children/family members, disease, death, alcohol/substance abuse, domestic violence.

BAR-VALU VALUES/BELIEF

DEFINITION: The patient has values or beliefs that may impact learning; this may also include traditional Native American/Alaska Native values/beliefs that might impact the medical/clinical aspects of healthcare.

ASSESSMENT: The patient may comment or be asked about values/beliefs in relation to health information or medical/clinical aspects of healthcare.

BAR-VISI VISUALLY IMPAIRED

DEFINITION: The patient has difficulty seeing even with best corrected vision. The difficulty can be compensated with the use of other measures/devices to improve vision (large print, better lighting, magnifying glasses).

ASSESSMENT: The patient may divert the eyes, squint, or state having difficulty seeing.

LP - Learning Preference

Learning Preference is listed in the medical record as a Health Factor. Although a patient may have a predominant way of learning, it is important to use a variety of teaching methods to optimize an education encounter. Learning preference should be documented.

The procedure for Evaluating Learning Preference is as follows:

1. Review the most common styles of adult learning (talking & asking questions, group discussion, videos, reading)
2. Explain that every individual is unique and will have their own preference(s) in how they receive new information.
3. Ask the patient/family, "How do you learn best?"

LP-DOIT DO

DEFINITION: The patient/family states that doing and participating a new skill is the preferred style of learning new information.

LP-GP GROUP

DEFINITION: The patient/family states that participating in small groups is the preferred style of learning. A group is more than one person being educated.

LP-READ READ

DEFINITION: The patient/family states that reading is the preferred style of learning.

LP-MEDIA MEDIA

DEFINITION: The patient/family states that media (kiosk, videos, interactive displays, demonstrations, or pictorial teaching) is the preferred style of learning.

LP-TALK Talk

DEFINITION: The patient/family states that talking and asking questions is the preferred style of learning.

RL - Readiness to Learn

Readiness to Learn can be assessed through both observation and interview. Readiness to Learn is sub-topic specific while Barriers apply to the overall health status of the patient. Readiness to learn is documented in EHR within the education sub-topic window.

RL-DSTR DISTRACTION

DEFINITION: The patient/family has limited readiness to learn because of distractions that cannot be minimized, e.g., children in room, cell phones, noise.

RL-EAGR EAGER

DEFINITION: The patient/family is exceedingly interested in receiving education.

RL-INTX INTOXICATION

DEFINITION: The patient/family has decreased cognition due to intoxication with drugs or alcohol.

RL-RCPT RECEPTIVE

DEFINITION: The patient/family is ready or willing to receive education.

RL-PAIN PAIN

DEFINITION: The patient/family has a level of pain that limits readiness to learn.

RL-SVIL SEVERITY OF ILLNESS

DEFINITION: The patient/family has a severity of illness that limits readiness to learn.

RL-UNRC UNRECEPTIVE

DEFINITION: The patient/family is NOT ready or willing to receive education.