Tool 16. Assess patient education needs

Health Factors are important medical concerns that are not addressed by other forms of documentation. Patient education needs, along with other types of data are documented using the health factors.

Barriers to Learning

Barriers to learning are patient specific. They usually are not visit specific, but rather relate to the patient's overall health status. Barriers are assessed by observation and interview, and then documented to alert other health care providers that may provide education. It is important to accommodate and overcome barriers to enhance patient learning. Barriers should be assessed annually or any time the situation warrants assessment.

Using the Barriers to Learning health factor

1. Observe and question the patient for any barriers to learning.

2. Document the health factor screening results using the values in the table.

HEALTH FACTOR	DEFINITION	ASSESSMENT
No Barriers (NONE)	The patient has no apparent barriers to learning	
Visually Impaired (VISI)	The patient has difficulty seeing even with best corrected vision. The difficulty can be compensated with the use of other measures, devices, or both to improve vision (large print, better lighting, magnifying glasses).	The patient may divert the eyes, squint, or state his or her difficulty seeing.
Blind (BLND)	The patient is blind and cannot compensate with low vision devices.	The patient may divert the eyes, wear sunglasses inside, state his or her inability to see, or is diagnosed with blindness (best corrected vision is ≤ 20/200 or ≤20 degrees of visual field in the better eye).
Hard of Hearing (HEAR)	The patient has a problem hearing that can be compensated with increased volume or hearing devices.	The patient may not respond to questions initially and may ask for things to be repeated, may speak loudly, bend ear or lean toward the speaker, or wear a hearing device.

HEALTH FACTOR	DEFINITION	ASSESSMENT
Deaf (DEAF)	The patient is deaf and CANNOT compensate with increased volume or hearing devices.	The patient may not respond to questions, may look intently at your lips as you speak, may motion to communicate by writing, may use sign language to indicate deafness, or may have a diagnosis of deafness.
Does Not Read English (DNRE)	The patient is unable to read English.	Ask the patient or the patient's family about his or her ability to read English. The patient may be embarrassed to admit he or she 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 the patient how he or she interprets the sentence. If the patient is unable, state that reading English can be hard for people who learned another language first and ask if this applies to him or her.
Speaks English as a second language (ESLA)	The patient's primary language is not English.	The patient speaks English fluently, but may have minor barriers due to differences in primary language.
Interpreter needed (INTN)	The patient does not readily understand spoken English.	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.

HEALTH FACTOR	DEFINITION	ASSESSMENT
FineMotorSkills Deficit (FIMS)	The patient has fine motor skills impairment which can interfere with tasks requiring manual dexterity.	The patient may have difficulty or lack the physical control to direct or manage body movement, such as paralysis, arthritis, amputation, unable to handle testing supplies (for example checking blood sugars or measuring medications).
Dementia (DEMN)	The patient may have difficulty learning because of impaired thought processes.	The patient may answer questions inappropriately, behave inappropriately, or display symptoms of confusion or forgetfulness. The patient may have a documented diagnosis of dementia.
Values or Beliefs (VALU)	The patient has values or beliefs that may impact learning; this may also include traditional Native American/Alaska Native values or beliefs that may impact the medical or clinical aspects of heath care.	The patient may comment or be asked about values or beliefs in relation to health information or medical or clinical aspects of health care.
Stressors (STRS)	The patient's ability to learn is limited due to social stressors from current personal difficulties or ongoing mental or behavioral health issues.	The patient may appear distraught, avoid eye contact, or show anger. The stressors may be acute or ongoing, as in the case of conflict, mental disorders, disease, death, alcohol or substance abuse, or domestic violence. Social stressors are external while emotional stressors are internal.
Low Health Literacy (LOHL)	The patient does not demonstrate the ability to obtain, process, and understand basic health information.	Assessment is made by a low score on a health literacy screening tool or observation.
Cognitive Impairment (COGI)	The patient demonstrates cognitive impairment	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.

Learning Preferences

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 educational encounter. Learning preference can be evaluated when the provider deems it necessary.

To use the Learning Preferences health factor:

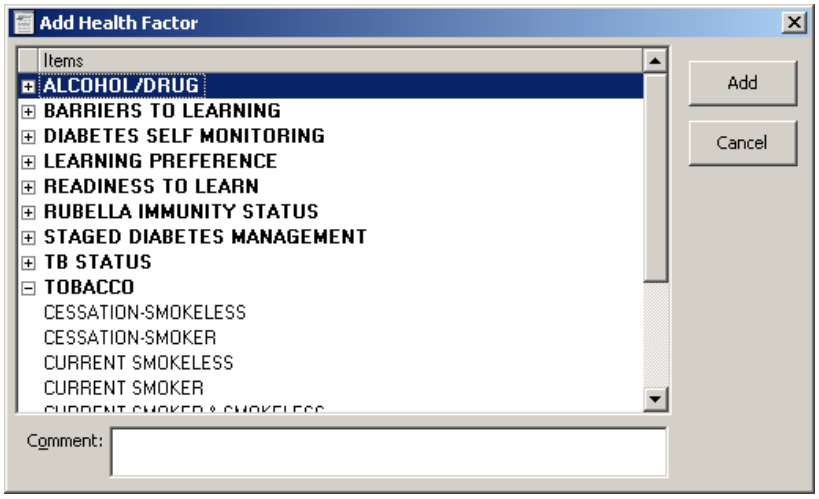
1. Review the most common styles of adult learning (talking and asking questions, group discussion, videos, reading).
2. Explain that every individual is unique and has his or her own preference(s) in how they receive new information.
3. Ask the patient, or the patient's family, "How do you learn best?"
4. Document the health factor screening results using the values in the table.

HEALTH FACTOR	DEFINITION
Do or Practice	The patient states that doing or practicing a new skill is the preferred style of learning new information.
Read	The patient, or the patient's family, states that reading is a preferred style of learning.
Small Group	The patient, or the patient's family, states that participating in small groups is a preferred style of learning.
Talk	The patient, or the patient's family, states that talking and asking questions is a preferred style of learning.
Media	The patient, or the patient's family, states that media (kiosk, videos, interactive displays) is a preferred style of learning.

Adding a Health Factor

Make sure a patient and visit are selected. Follow these steps to add health factor information:

1. Click Add (or select Add Health Factor on the right-click menu) to display the Add Health Factor dialog.



2. Highlight the Health Factor you want to add. To expand a Health Factor category, click on the plus sign (⊞) next to the Health Factor Category.
3. You can add a comment about the selected health factor in the Comment field for clarification about the documented health factor. This has a right-click menu to aid in editing the text.
4. Click Add to have the selected Health Factor display in the Health Factors panel. Notice that it displays in blue lettering; this indicates that this health factor is associated with the current visit as well as added to the patient's medical record. (Otherwise, click Cancel.)