

## **STEP SIX**

### **Documentation and Coding**

## **STEP SIX—Documentation and Coding of Patient Education**

### **Step Six Documentation and Coding**

#### **Patient Care Component (PCC) of the Resource and Patient Management System (RPMS)**

The Resource and Patient Management System (RPMS) of the Indian Health Service is an integrated group of automated data systems designed to operate on micro- and mini-computers located in any IHS or Tribal health facility. The primary objective of the RPMS is to integrate patient care and cost data in a single automated data processing system that collects and stores a core set of health and management data that cuts across disciplines and facilities. A typical RPMS configuration in a health facility might include these systems: Patient Registration, Pharmacy, Dental, Maternal and Child Health, Contract Health Services, Laboratory and the Patient Care Component.

The Patient Care Component (PCC) provides for the collection, integration, and storage, on local RPMS computers, of a broad range of health data resulting from inpatient, outpatient, and field visits at IHS, tribal, contract and community sites. It is designed to support health care delivery, planning, management, and research.

#### **Purpose Of Effective Patient Education Documentation**

There are two main reasons why documentation needs to be done. The first is to meet complex legal requirements, and the second is to meet the standards of the JCAHO and other accrediting organizations. In addition, effective documentation provides a meaningful way for the team members to communicate with each other, thereby enhancing the team's patient education efforts and collaboration.

The basis for patient education documentation encompasses professional practice acts, standards of practice from professional associations, institutional policies; informed consent, quality and continuity of care issues, and program evaluation considerations.

In today's era of health care, simply having provided the education is not sufficient. In order to get credit for education and certainly to better meet the requirements for possible reimbursement for PFCE, it is necessary that patient and family education be properly documented and coded. However, better patient and family education translates to support for prevention and wellness of the patient and their family.

Each Indian Health Service Hospital, clinic and community health programs are encouraged to build a health and PFCE program using the documentation from the Indian Health Service's *Patient Education Protocols*. Where can the Indian Health Service's *Patient Education Protocols* (and Codes) be found? There are no printed copies available. Due to the prohibitive cost of printing for 500+ Native American and Alaskan Native Hospitals, Clinics, and Community Health programs, these protocols and codes can be found and downloaded from the Indian Health Service's Web Page on the Internet.

#### **Professional Practice Acts**

Virtually all health care providers have language in their professional practice acts that set a legal precedent for them to render adequate and relevant patient education. *Health care providers can be held liable for negligence if a patient does not understand what is necessary for effective management of his or her health condition.* This liability challenges health care professionals to develop accurate and reliable methods to evaluate a patient's understanding and to document their educational efforts.

#### **Standards of Practice from Professional Associations**

Standards of practice delineated by the various professional associations often outline the responsibilities of a particular professional group to teach the patient and family information about their specific health care needs and how to appropriately modify behavior. Again, implicit in providing information to help patients make decisions and choices about promoting, maintaining, and restoring health is documentation of these educational efforts and their results. If patient education is not documented, it is considered not done. These statements and standards for practice from professional organizations provide a basis upon which the professional will be held accountable should there be a question of practice in a court of law.

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### **Institutional Policies**

Most clinics and all hospitals have policies and procedures or standards within the various departments that guide health care providers in delivering care. Often these standards and policies include the professionals' role and responsibilities in providing patient education and documenting the process. These documents are important to discuss with staff to help change the mind-set, so that patient education documentation is seen as an expectation of performance and, therefore, is more likely to be valued.

### **Informed Consent**

Informed consent is the legal duty of disclosure and is primarily a liability issue for physicians. It is based on the principle of self-determination. That is, self-determination is a person's right to decide what should be done to his or her body. It occurs when an individual voluntarily agrees to allow someone else to do something to him or her after information is received. For the individual to exercise this right to decide, appropriate information must be provided about the kind and purpose of the treatment or procedure and its expected outcomes; the benefits and risks or complications of the procedure; any alternatives and their risks and benefits; and the prognosis if treatment is refused. As part of this education process, the physician must determine the patient's ability to understand the explanation.

Involvement of staff, other than the physician, in the informed-consent process includes the following three elements:

#### **INFORMED CONSENT**

1. Observing the interaction between the physicians and the patient, thereby witnessing the signatures.
2. Validating that the patient had the capacity to understand and was not coerced to consent.
3. Assessing the patient's understanding and clarifying any misunderstandings.

To validate understanding of the information, staff need to ask the patient to explain in his or her own words what the physician said. If there seems to be a basic misunderstanding about diagnosis or treatment and prognosis, the physicians should be asked to explain all the information once more. Staff should document the results of this process and any actions taken.

### **Quality of Care Issues - Chart Audits**

A foremost method used to monitor the quality of care provided in Tribal clinics and by the IHS is to audit patient charts and patient medical records. Audits of records to identify patient education documentation have shown major deficiencies in the medical records of many clinics and hospitals. *Accrediting agencies list lack of documentation about education for self-care and preparation for discharge as the most common charting deficiencies.* Chart audits help define strengths and weaknesses in all patient education efforts, not only the problems of documentation.

### **Continuity of Care Issues**

Effective documentation provides direction for all interdisciplinary team members so that there is continuity and consistency in their patient education efforts. To achieve this goal, documentation records need to be interdisciplinary in scope. Separate care plan documentation sheets for each discipline can no longer be afforded if continuity of care is achieved. A patient education documentation system must also be developed to communicate the relevant information in an understandable way to those persons responsible for the patient's care after discharge.

### **Program Evaluation Considerations**

Aspects of the patient education process can be studied by using the documentation to help define actual practice against standard criteria. For example, physicians may want to know what assessment data are being collected by nurses to identify a knowledge deficit or what methods are being used by staff to evaluate patient response to teaching. The answers to such questions as these can often be determined by auditing the medical record. Results from this process can be used to help formulate changes in a patient education program and the way it is implemented.

### **JCAHO and Other Accreditation Standards Addressing Patient/Family Education Documentation**

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**Hospitals:** The goal of patient and family\* education function is to improve patient health outcomes by promoting healthy behavior and involving the patient in care and care decisions. While the standards in the JCAHO Standards of Patient and Family Education recommend a systematic approach to education, they do not require any specific structure, such as an education department, a PFCE committee, or the employment of an educator. More important is a philosophy that views the education function as an interactive one in which both parties are learners. These standards help the hospital or clinic focus on how education is consistent with the patient's plan of care, level of care, the educational setting, and continuity of care. The overall focus is on the instructions given for self-care and the patient's understanding of these instructions at discharge. The standards state that specific knowledge and/or skills must be provided to meet the patient's ongoing health care needs including teaching safe and effective use of medication and medical equipment, potential drug-food interactions, diet counseling, rehabilitation techniques, community resources and when and how to obtain further treatment, if needed.

\* Family: The person(s) who plays a significant role in the individual's life. This may include a person(s) not legally related to the individual. This person(s) is often referred to as a surrogate decision-maker if authorized to make care decisions for an individual should the individual lose decision-making capacity.

### Documenting Patient Education as Reflected in JCAHO Standards:

#### 1. Relevant and Adequate Information for Self-Care

Evidence in the medical record needs to indicate that the patient's education needs pertaining to self-care are assessed, identified, and addressed. Relevant and adequate information for self-care includes the following elements:

- Explanation of the condition
- What to do to manage the condition and how to do it
- When the physician should be consulted
- When the treatment regimen should be discontinued
- Special precautions to take
- What to do when the regimen is not followed
- What to do if new symptoms occur
- How to get clarification of instructions

#### 2. How the Teaching was Done

Standard PF.1.1 states that the educational received is given "in ways understandable to the patient and/or his or her significant other." This suggests that how the teaching is done is an important factor. It is not sufficient to simply hand out instructional material or have patients watch audiovisual aids as the sole method of teaching. Evidence needs to be documented that learning differences among patients were considered when giving patient education information. Use of the word *taught* does not enable staff who read the patient's medical record to adequately follow-up using an appropriate teaching method. Words such *explained, discussed, read, demonstrated, reviewed, practice* and *problem-solved* more accurately describe how the teaching was done. Health care professionals must be available to answer questions the patient may have and to give needed explanations.

#### 3. Evaluation of Learning

Even if the information given is relevant and communicated well, the patient's understanding and ability to apply the information for effective self-care needs to be documented. Specific measurable evidence of learning outcomes or the attempted evaluation of learning must be documented. Examples of terms used to indicate measurable, behavioral outcomes includes *states, identifies, applies, independently performs, chooses, verbalizes, and returns demonstration*. If the patient is unable to answer question or perform a skill, a statement that there was no evidence of learning and a proposed reason as to why needs to be written.

#### 4. Characteristics of Educational Process

Throughout the standards, the identification of specific learning needs is stressed. Measurable goals or expected outcomes, stated in behavioral terms, are formulated from this assessment. The educational plan

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needs to be individualized, and reflect patient and family involvement in the development and implementation of the plan.

### Use and Documentation of Patient Education Codes. Using the PCC. 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 realities of our busy clinics and hospitals often require us to do this in a more abbreviated fashion. The codes allow the educator a quick method of documenting the fact 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 has had a certain amount of education. 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 on a diabetic patient might show the following history of patient education:

07/19/90:	DM: Diet, poor understanding
10/27/90:	DM: Foot Care, good understanding
02/07/91:	DM: Exercise, good understanding
05/10/91:	DM; Diet, Fair understanding

A reasonable interpretation of this summary tells you that this patient is trying to understand dietary management of their diabetes but does not yet fully grasp the concepts. It should lead subsequent providers to spend more time reinforcing dietary guidelines.

### SOAP Charting and the Codes

Use of the codes *does not* preclude 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 education 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 does 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 educator should document the education using the following steps:

- Step 1. Log onto the PCC form using the sign-in box in the upper right-hand corner. Circle "Patient Education" in the section marked "Medications/Treatments/Procedures/Patient Education" (Some sites prefer to use the POV section of the PCC Form.)
- Step 2. Relevant and Adequate Information for Self-Care:
  - Using the four parameters of documentation, select the most appropriate code and enter it, e.g., DM-C (Diabetes-Complications), followed by a comma (.). If you discuss more than one topic, separate each of the topic codes with a comma. In do so you will have documented correctly by writing down the disease state, condition or system being addressed; (DM, HTN, etc.)
- Step 3. Document by using the specific education topic. (Exercise, diet, complications, etc.)
- Step 4. Evaluation: Document the level of understanding of the patient and/or their family of the education provided; (Good (G), Fair (F), Poor (P), Refused (R), or Group Education (G). Specific measurable evidence of learning outcomes or the attempted evaluation of learning must be documented. Examples of terms used to indicate measurable, behavioral outcomes includes *states, identifies, applies, independently performs, chooses, verbalizes, and returns demonstration*. If the patient is unable to answer question or perform a skill, a statement that there was no evidence of learning and a proposed reason as to why needs to be written.
  - Initial your entry.

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It is *very important to remember* that the level of understanding does not reflect how well you taught the information. Rather, it indicates how well *you believe* the patient understood it. Obviously, this will vary with patients and with circumstances.

The PCC coders can only select "good, fair, or poor" for level of understanding. Remember, this section is meant for speedy documentation of brief education 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.

### 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 demonstration of understanding 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 demonstration
- Refuse (R):      Refuses education
- Group (GP):     Education provided in a group.

### Documenting Patient Education Using General Codes and Specific Codes

There are two methods for documenting PFCE using PCC PFCE codes. Providers are encouraged to select the method of documentation that best meets their time and needs while ensuring that the education is adequately documented. This documentation may be using the General Codes or the Specific Codes. The first method, or the General Coding method, has the advantage of being quick and easy, but it is not as specific and does not provide as much information as the second, Specific Codes.

#### General Codes:

- 17 topic areas, which are applicable to most disease states or condition which, will be encountered in a health care setting.
- In order for these general codes to be captured by the computer, the first element must be associated with or used in conjunction with a valid ICD-9 diagnosis
- General Codes:
 

1. AP	Anatomy and Physiology	9. M	Medication
2. C	Complications	10. N	Nutrition
3. DP	Disease Process	11. P	Prevention
4. EQ	Equipment	12. PRO	Procedures
5. EX	Exercise	13. S	Safety
6. FU	Follow-up	14. TE	Testing
7. HM	Home Management	15. TX	Treatment
8. HY	Hygiene	16. L	Literature
- General Code Documentation:
  - 1<sup>st</sup> Part = diagnosis (written out)
  - 2<sup>nd</sup> Part = education topic
  - 3<sup>rd</sup> Part = level of understanding
  - 4<sup>th</sup> Part = Provider initials

#### Specific Codes:

- The Specific Codes are found in the Indian Health Service *Patient Education Protocols*.

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- No fixed number of codes
- Can cover any topic for which protocols are written
- General Code Documentation:
  - 1<sup>st</sup> Part = Disease state, condition or system being addressed
  - 2<sup>nd</sup> Part = education topic
  - 3<sup>rd</sup> Part = level of understanding
  - 4<sup>th</sup> Part = Provider initials

Why bother to learn anything more than the general codes if the provider can use the general codes for everything?

The Specific Codes are found in the *Patient Education Protocols* and these Specific Codes contain more information available through the protocols, which were written specifically for that subject. Also some topics do not have an associated ICD-9 diagnosis and cannot be recorded with general codes; e.g. nutrition or wellness. If the education encounter is consistently entered into the patient's Health Summary, the education improves both from provider to provider and from one visit to another. Furthermore, this method of documentation meets JCAHO requirements for documentation of patient and family education.

### **What Happens to this Information?**

Providers enter the codes on the PCC at the time of the education encounter. Data Entry inputs the codes on RPMS. This translates as an entry on the PCC Health Summary. Using Q-Man, data can be retrieved for performance improvement, JCAHO Surveys, ORYX Indicators or any other purpose. Since the codes are entered by providers at the time of the patient visit, data retrieved should be an accurate reflection of the education happening at a given facility.

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**STEP 6  
CHECK LIST  
DOCUMENTATION AND CODING**

\_\_\_ All staff providing PFCE have received information concerning the legal requirements concerning Patient

Education Documentation:

\_\_\_ Professional Practice Acts

\_\_\_ Standards of Practice from Professional Associations

\_\_\_ Institutional Policies

\_\_\_ All staff providing PFCE have received information concerning the accreditation requirements concerning Patient Education Documentation

\_\_\_ Staff has received education on Informed Consent

\_\_\_ Staff has participated in patient education chart audits to help define strengths and weaknesses in all patient education efforts, including documentation.

\_\_\_ Continuity of Care Issues are resolved through care plans that involve each discipline to communicate the relevant information in an understandable way to those persons responsible for the patient's care after discharge.

\_\_\_ Aspects of the patient education process have been studied by using the documentation of patient education to help define actual practice against standard criteria.

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- \_\_\_ When the treatment regimen should be discontinued
- \_\_\_ Special precautions to take
- \_\_\_ What to do when the regimen is not followed
- \_\_\_ What to do if new symptoms occur
- \_\_\_ How to get clarification of instructions

\_\_\_ How the teaching was completed is evidenced by the documentation that learning differences among patients were considered when giving patient education information

\_\_\_ The evaluation of learning, or the attempted evaluation of learning, is documented through specific measurable evidence of learning .

\_\_\_ Measurable goals or expected outcomes, stated in behavioral terms, are formulated from the facilities' accepted assessment method.

\_\_\_ Educational plan and the patient's needs are individualized, and reflect patient and family involvement in the development and implementation of the plan.

\_\_\_ In-Service Education has been provided that encompasses all aspects of accountability such as logging in correctly on the PCC, documenting correctly on the PCC, and initialing all patient education provided.

\_\_\_ In-Service Education has been provided that encompasses all aspects of documentation such as the use of education protocols, codes, and evaluation.

\_\_\_ In-Service Education on how to documenting Patient Education using the General Codes has been provided.

\_\_\_ In-Service Education on how to documenting Patient Education using the Specific Codes has been provided.