



Message from the Office of Primary and Ambulatory Care

By W. Mark Stanton, M.D., MHS

Annual (2002) Ambulatory Care Conference Cancellation: What Happened?

Some practice managers and front-line outpatient staff have asked the same question: What happened to the Ambulatory Care meeting this year? Let me respond to the inquiries and comments regarding the cancellation of this important meeting. In the past, the conference brought together leaders in VHA outpatient healthcare, including primary care, prevention, women's health, and patient education. It has also been a forum for NAVAAM and AVACOM. For 2002, the meeting would also have formally added mental health and geriatrics to the mix. Many involved in outpatient practice management, in the field and in Central Office, were disappointed that this year's meeting was cancelled.

All of us in VHA are aware that demand for VA healthcare is increasing, and that resources are limited. This is particularly relevant when having to decide between funds spent directly on front line healthcare for veterans rather than on face-to-face meetings. The initial decision to cancel the meeting was appealed. After discussions among the Chief Consultants in Primary & Ambulatory Care, Mental Health, Geriatrics & Extended Care, the Women's Program Director, and the Director of the National Center for Health Promotion and Disease Prevention, a modified meeting proposal was presented to both Employee Education System (EES) and the Under Secretary's Office, but was not accepted. The decision to cancel the national conference was confirmed by the Deputy Under Secretary. The higher-level decision to cancel the meeting supported cost savings mandated by the Secretary's Office.

EES allocates its budget among all the program requests it receives, and the requests always are far in excess of the available funds. EES thus must prioritize the requests. Knowing that funding for travel comes from the VISNs and facilities, all of which are carefully scrutinizing expenditures, the Office of Primary and Ambulatory Care and the other program offices involved in the 2002 meeting, planned a very tight agenda covering in depth important topic areas for all practice managers. The 2001 meeting in San Diego had over 600 attendees, and the original predictions for 2002 topped 800 attendees. Even with a reduced attendance expectation of 400 people coming to Washington, DC, the meeting would be one of the larger face-to-face gatherings in VHA.

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One of the decision points in evaluating meetings was whether a contract with the hotel was already signed, and what penalty would result from cancellation. Meetings relatively early in the year, which had progressed further in planning, held an advantage; meetings later in the year were at a disadvantage.

One NAVAMM member commented that an announcement was made about the national VA Rehabilitation Symposium. The implication was that if there could be a national meeting on Rehabilitation then why not a national Ambulatory Care meeting? The planning process (signed contract) was apparently further advanced than the Ambulatory Care Conference at that point in time. Other conferences held later in the year, such as the Information Technology Conference (the ITC) were also cancelled.

Since the proposed agenda was the result of significant effort and the subject matter was considered to be important for the "hands on" staff and front line managers, other avenues to share information were explored. Working with same program offices and EES, the best alternative to deliver the substantive content is the opportunity to develop satellite programs. We hope to prepare two satellite programs that will be broadcast by September 2002. A technical staff has been selected, subjects chosen and consultants contacted as to their availability and fee requirements. Funds have been budgeted by EES in support of the satellite programs.

That's where we stand today. As time and events occur we will do our best to keep everyone informed. If you would like further clarification please contact me, Mark Stanton, Chief Consultant, in the Office of Primary & Ambulatory Care.

Outlook: Optometry Service

By John C. Townsend, O.D.

*National Director of Optometry Service
located at VAMC, Fort Howard, MD*

It is an honor to have been selected as the Director of Optometry Service. There are many challenges and opportunities awaiting us to improve provision of eye care services to veterans. Being part of the Primary and Ambulatory Strategic Healthcare Group, I greatly appreciate their assistance in helping me transition into this new role.

My clinical, academic and administrative career has been dedicated to the Department of Veterans Affairs. I am the product of the foresight of the VA when it established post-graduate residency training programs for optometrists. Having worked at VA Ambulatory Care and Medical Centers as well as a Health Maintenance Organization, I feel that I bring a broad perspective on eye care delivery systems and needs in various practice settings.

Working with James C. Orcutt, M.D., Ph.D., the Chief Consultant Ophthalmology, has been a distinct pleasure. We work closely as a team for eye care strategic planning thereby providing the full spectrum of primary, secondary and tertiary eye care services.

The major initiatives we intend to accomplish include:

- Improve waiting times and access to eye care services and prosthetic devices at VA facilities
- Prevent unnecessary blindness from diabetic retinopathy by providing eye fundus evaluations to diabetic patients
- Enhance the continuum of care for significantly visually impaired and legally blind veterans through low vision programs, such as VICTORS, with the Blind Rehabilitation Service

- Develop a quick reference guide for monitoring ocular toxicity from selected systemic and topical medications
- Expand information technologies such as telemedicine, automated medical records and eye image acquisition and storage systems
- Develop criteria for "Eye Care Centers of Excellence" for advanced eye diagnostic and treatment procedures, clinical training and research activities
- Provide quality guidelines for contracting out eye care services and eyeglasses to assist field facilities

These are just some of the ongoing projects we are working on to improve access to and quality of eye care services for veterans. By continuing to recruit and retain the most talented and qualified eye care providers, we should be able to accomplish these goals.

Tele-Care Services Update

By Mildred Eichinger, R.N., MPH

VA Headquarters, Wash, DC

The VHA Directive 2000-035 addressed the issue of Tele-Care Services 24 hours a day, 7 days a week. There is a mandate in the directive which requires that an application for Utilization Review Accreditation Commission (URAC) accreditation be submitted by the end of FY 03 and subsequently be accredited. One Call Center in VISN 3 has already received accreditation for two years. Frances Schwartz, Clinical Manager and Laura Genovese, Associate Clinical Manager both at VISN 3-Bronx, VAMC co-coordinated the successful process with URAC. On April 29, 2002, they discussed the accreditation process on a national conference call. They presented the URAC requirements, documentation and their observations.

We suggest that any contracts under negotiation with URAC be put on hold for now. Don't be intimidated by URAC's "buy now, buy cheaper." When we develop the national contract, we should be able to negotiate good prices given the magnitude of the system. Feel free to forward URAC messages to me if they have questions.

URAC has been working on Version 3 Standards, which they anticipate will be published with the next three months. Apparently one of the major differences are the requirements to [pass "core" standards. When we do sign a contract with URAC we would want to base the requirements on the current Version. (Probably Version 3.)

We do not need to develop a national contract with URAC- perhaps, as starters, at the VISN level then later on at the facility level. There is congressional interest in establishing and tracking data.

We continue to discuss the necessary steps we should be taking to "do it right." Right now we are thinking about how to best deal with standardization between daytime and after hours calls and local calls versus call center calls. We need to revise the directive after we sort out some concerns.

A website is available: <http://vaww.va.gov/primary>. There is a VA Telephone Care section that is being administered by Trent.Zorn@med.va.gov. In one section of this web site we will post policies and procedures that meet various criteria so you don't have to reinvent the wheel. Check it out periodically for additional information. If you have examples of good policies or procedures please forward them to Trent so we can include them on the web site.

The MAP Newsletter published quarterly will provide some current information as we make progress with URAC. The VISN Tele-Care Liaisons will be added to the electronic distribution lists. Stay tuned.

Please forward any Tele-Care comments/concerns particularly about daytime clinic calls versus call center calls, administrative notes, etc. to me: mildred.eichinger@mail.va.gov or nicheole.amundsen@mail.va.gov.

Tinea Pedis (Athletes Foot)

By Jeffrey M. Robbins, DPM

National Director, Podiatry Service, located at Cleveland, OH

Fungal infections of the foot are classified as either acute or chronic tinea pedis. In the healthy adult the condition is relatively benign. However for "at risk" patients (e.g., those with diabetes, peripheral vascular disease or immunocompromised) it can be potentially limb threatening if not treated immediately. The causative organism is usually *Trichophyton mentagrophytes*. More severe cases can

exhibit fissures in the web spaces and local erythema/cellulitis. Signs and symptoms of acute tinea pedis may include one or more of the following; macerated web spaces, vesicles, bulla, and pruritis that can be severe at times. When cellulitis is present, secondary bacterial infection must be suspected.

Chronic tinea pedis is characterized by a moccasin type distribution of scaling and dry skin. The web spaces may also be involved. The symptoms are generally not uncomfortable to the patient and may persist untreated for years. The causative organism is usually *Trichophyton rubrum*.

Although this diagnosis is most often made clinically, cultures and potassium hydroxide prep may be used for definitive diagnosis.

Management

- Acute tinea pedis involves the use of commonly available topical anti-fungal agents and local skin care consisting of:
- Warm saline soaks (**except in diabetic, peripheral vascular disease and other compromised patients**)
- Proper foot hygiene
- Avoiding trauma that could result in secondary bacterial infection
- With acute vesicular or pustular tinea a short course of an oral anti-fungal agent may be used
- If a secondary bacterial infection is suspected an oral antibiotic directed toward Staphylococcal and Streptococcal organisms may be considered. Diabetic infections should be always suspected of being polymicrobial and antibiotic selection should be so directed
- Chronic tinea pedis is treated similarly, but for longer periods of time
- Following resolution, preventive measures are given to the patient to prevent recurrence. These include proper hygiene, anti-fungal foot powder on a daily basis, and disinfective spray to shoes at least once weekly

For additional information contact: Jeffrey Robbins, DPM, Podiatry Service, VAMC Cleveland, OH, at 216-231-3286.

Drug Interaction Capabilities with VISTA

By Kathy Tortorice, Pharm.D.

Pharmacy Benefits Service, VA MC, Hines IL

The Pharmacy Benefits Management, Strategic Healthcare Group strives to ensure that the pharmacy software provides clinicians with current, useful and adequate information on pharmacologic agents. To accomplish this goal the National Drug File (NDF) Support Group updates and maintains the drug-drug interaction file in VISTA. The Group is also responsible for maintaining the VA Drug Classification

system, which has been adopted by the United States Pharmacopia (USP) and other organizations. VA Drug Class codes are assigned in a manner consistent with the need to provide a logical organization and to provide efficient duplicate drug class checks in VA prescription processing software applications.

As a general rule, only true pharmacokinetic drug interactions are entered in the National Drug File, including alterations in GI absorption, plasma protein binding, enzyme induction, enzyme inhibition, and renal excretion interactions. Allergic cross-reactions and pure pharmacodynamic drug interactions (such as drugs with additive or antagonistic pharmacologic actions) are not routinely entered in the National Drug File.

Drug interactions are classified as critical or significant. To be classified as critical, the interaction must be identified in the manufacturer black box warning, or be well documented in the literature to cause significant sequelae (e.g. death). Drug interactions that do not meet these criteria, but which are still considered to be of substantial clinical importance, are classified as significant interactions. Literally thousands of drug interactions that can be found in the literature and in reference books have been omitted from the National Drug File because the NDF Support Group does not consider them to be sufficiently important for inclusion. It is felt that inclusion of trivial or minor drug interactions adds the risk that users will become so inundated with unimportant warnings that they will begin to overlook the truly important ones. Interactions may be maintained locally (by individual stations), even if the NDF Support Group does not elect to add them to the National Drug File. However, the NDF Support Group is automatically notified of all local changes, so that they can be reviewed for possible inclusion at the national level.

The team of experts meets monthly via teleconference, and annually in person, to review potential new drug interactions and update the National Drug File. The team reviews all drug interactions, which have been newly entered into the drug file by local stations, as well as drug interaction updates from Hansten's Drug Interactions, Drug Interaction Facts, and Evaluations of Drug Interactions (EDI). In addition, if a new drug interaction is identified with one member of a large class of similar drugs (e.g. ACE Inhibitors), the interaction is evaluated for all of the drugs in that class. Information about potential new drug interactions is gathered from EDI, Hanstems, DI Facts, Micromedex, Medline, official FDA labeling changes to drug package inserts, and other sources, by members prior to each meeting. The group determines from this evidence whether the interaction should be added to the National Drug File and how it should be classified.

For additional information contact: Kathy Tortorice, Pharm.D., Pharmacy Benefits Service, VAMC, Hines at 708-786-7873.

Bob Thompson's "Top Ten" Lessons From My Sprint Career

*The following article is quoted. We recognize that grammatically there is room for improvement, however, since it is a quote, we do not feel it is appropriate to make editorial changes.

1. Integrity matters.

Do the right thing every time.
Proverbs 10:9 (He who walks with integrity walks securely, but he who perverts his ways will be discovered.)

2. Work is temporary. Family is forever.

Be there for your family.

3. Be positive and optimistic.

No whining is allowed for the leader, especially in public.

4. Strategy without execution is a pipe dream.

Make a decision and do something. If nobody seems to be in charge, assume you are. Collaborative decision-making is best, but if it's taking too long to get there and you feel you have at least 80% of the information you need, go with your gut and decide. Remember, one of your primary roles are direction.

5. Encourage the hearts of the people you lead - their minds and deeds will quickly follow.

Love 'em and lead 'em.

6. Assume you're in charge and the decision is yours to make unless you've explicitly been told "no."

The old saying: It's better to ask for forgiveness than ask for permission, is true.

7. Create a compelling picture of the desired future. State and describe it to anyone who will listen. A lot.

Once you've figured out the direction, get a "stump speech" and give it every time you see a stump with some of your people standing around it.

Your stump speech must:

point a clear picture of where you're going,
a plausible path to getting there, and most important -

8. Executive leadership is about two things: Direction and Development.

An executive's role lies in direction & development.
Direction - People need to know where they're going and why they're going there.

Development - Find the right people. Invest in your people. Listen to them. Teach them. Trust them with important stuff. It pays dividends over and over.

9. It's not who you know, it's what you accomplish.

If you want to get ahead, put your head down, do a great job and accomplish great things. People will notice.

10. Take the time to write well.

WRITE WELL. Remember...the **BEST** speech you ever give will be forgotten by most of your audience within seconds of your finishing. But your **WORST** writing will live forever.

Maximizing Outcome in Veterans with Traumatic Brain Injury

William Walker, M.D., and Barbara Sigford, M.D.
VAMC Richmond, VA and VAMC Minneapolis, MN

Introduction

In the Veterans Health Administration, the rehabilitation of traumatic brain injury (TBI) is a special emphasis program. TBI is commonplace in the U.S., with approximately one million new injuries per year admitted to hospitals, and a further 2 to 5 million new injuries not admitted.¹ Owing to an under-reporting of mild TBI cases, the true incidence of TBI is unknown. High-risk age groups are 1) < 3 years, 2) 16-34 years, and 3) > 70 years. Of special relevance to veterans, the incidence and prevalence is increasing in the older adult population.

Overall outcome after TBI is highly variable, ranging from death or permanent vegetative state to total independence (see Table 1)². Since outcome is partly dependent on severity of injury, TBI is usually divided into severity grades (e.g., mild, moderate, and severe (see Table 2). The severity grades are based on loss of consciousness (LOC), CT/MRI findings, and the Glasgow Coma Score (GCS). The GCS is comprised of initial verbal, eye, and motor responsiveness as shown in Table 3.

The VHA has developed a nationwide TBI Network of Care to provide a comprehensive continuum of services to this special emphasis population.

Mild TBI

Approximately 80% of patients who sustain TBIs have had mild TBI.³ The diagnostic criteria for mild TBI are shown in Table 4. Mild TBI is believed to result when injury triggers the pathologic neurochemical cascade, but is insufficient to produce widespread neuronal dysfunction or the axonal disruption that characterizes more severe brain injuries. The

majority of these patients make excellent neurobehavioral recovery, but many have persistent and disabling symptoms. Those with residual symptoms should be referred for specialty care. Common post-concussive symptoms are shown in Table 5. These must be recognized and managed since spontaneous resolution may not occur. Headaches are the most common complaint and usually there is a musculoskeletal component. Other potential sources for post-traumatic headache are shown in Table 6.

Moderate and Severe TBI

All patients with moderate and severe TBI need neurosurgical evaluation and subsequent physiatrist (physical medicine and rehabilitation specialist) evaluation. The nature of deficits usually correlates with the type of injury (see Table 7)². Even with a full physical recovery, the vast majority of moderate to severe TBI survivors do not regain their full premorbid cognitive status and have troubling behavioral issues. Damage to the highly complex brain cell bodies, axons and/or synapses can have far reaching implications for TBI survivors and their families. Specialized treatment and rehabilitation services are needed for TBI survivors to reach their full functional potential.⁴

Acute management of moderate/severe TBI focuses on prevention of secondary injuries. The two usual highest priorities in the ICU are hypoxia management and intracerebral pressure control. The former is addressed via intubation, hydration, hypertension, and/or oxygenation, and the latter via ventriculostomy, sedation/paralysis and/or shunting. Sometimes debridement or hematoma evacuation is necessary. Specialized neurosurgery services are mandatory.

Recovery after severe TBI occurs for at least 18-36 months.² The most rapid and majority (80-85%) of recovery occurs in the first 6 months. Poorer outcome has been associated with the following factors: age > 55, poorer premorbid function, lower socioeconomic status, increased length of coma, presence of brainstem abnormalities, lower motor score on GCS, elevated intracranial pressure (ICP), prolonged post-traumatic amnesia (inability to form new memory), presence of intracranial mass lesion, and low functional abilities on admission to rehabilitation.² Once medically stabilized, the emphasis of care shifts to rehabilitation. Individuals with residual impairments after TBI should receive rehabilitation services in the least restrictive environment and return to prior living environment as soon as feasible.⁴ Rehabilitation level-of-care options are shown in Table 8. Inpatient rehabilitation should occur in dedicated brain injury rehabilitation units, where better outcomes have been shown. Basic criteria for inpatient TBI rehabilitation include: 1) inability to safely function independently in home environment, 2) need for 24 hour per day supervision and or nursing, 3) ability to participate in 3 hour per day of structured therapy, and 4) medical stability. Social factors (family support system, availability of service options) often play a large role in determining if inpatient care is required. Selection of the appropriate service level is best made by a consulting physiatrist. Medical complications

after moderate/severe TBI are common and are also best managed by a psychiatrist (see Table 9).⁴

Table 1 Glasgow Outcome Scale

Death
Persistent Vegetative State
Severe
Moderate
Good

Table 2 Severity Grades of TBI

Mild (Grade 1)	Moderate (Grade 2)
Altered or LOC < 30 min	LOC < 6 hours
Normal CT &/or MRI	Abnormal CT &/or MRI
GCS 13-15	GCS 9-12
	Severe (Grade 3 &4)
	LOC > 6 hours
	GCS <9

Table 3 Glasgow Coma Scale

	Score
Motor Responses:	
Obeys commands	6
Localizing responses to pain	5
Generalized withdrawal to pain	4
Flexor posturing to pain	3
Extensor posturing to pain	2
No motor response to pain	1

Table 4 Diagnostic Criteria for Mild Traumatic Brain Injury

I.	Traumatically induces physiologic disruption of brain function as indicated by at least one of the following:
A.	Any period of loss of consciousness
B.	Any loss of memory for events immediately before or after the accident
C.	Any alteration in mental state at the time of the accident
D.	Focal neurologic deficits that may or may not be transient
II.	Severity of the injury does not exceed:
A.	Loss of consciousness of 30 min
B.	GCS score of 13-15 after 30 min
C.	Posttraumatic amnesia of 24 hr

Table 5 Mild TBI symptomatology based on injury sites

Surface lesions	Amnesia Impaired short term memory Impaired attention Transient neurologic dysfunction
Medullary	Nausea/vomiting Cardiac or respiratory abnormalities
Pontine and mesencephalic	Classic concussion Loss of consciousness
Cranium, Cervical Spine and musculature	Neck pain Headaches
Adnexa	Dizziness Vertigo

Table 6 Post Traumatic Headaches Sources

Musculoskeletal Vascular Neuritic Sinus Sympathetics Basilar artery syndrome

Table 7

<u>Injury Type</u>	<u>Usual Cause</u>	<u>Deficits seen</u>
Focal Cortical Contusion	Ground level fall (GLF) Assault Gunshot Wound	Hemiparesis, Aphasia Seizures Visuoperceptual
Diffuse Axonal Injury	Motor Vehicle Accident Non-ground level fall Geriatric GLF	Confused language Amnesia Apraxia Hypoarousal
Hypoxic/Ischemic	Anoxia Cardiac Arrest Prolonged elevated ICP	Quadraparesis Spasticity Confusion Amnesia Hypoarousal

Table 8 Rehabilitation Level-of-Care Options

Home health services Outpatient services Day rehabilitation services Subacute (or transitional) rehabilitation services Inpatient (or acute) rehabilitation services
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Table 9 Common Medical Complications after Moderate/Severe TBI

Spasticity/hypertonicity	Dysphagia/Aspiration pneumonia
Flexor or extensor synergy	DVT/PE
Dependent edema	Insomnia
Shoulder subluxation	Depression
Reflex sympathetic dystrophy	Hypoarousal/Hypoattention
Heterotopic ossification	Seizures
Bladder incontinence	Hydrocephalus
Decubitus Ulcer	Agitation

Resources in the VA TBI Network of Care

By utilizing the Network of Care professionals can assist the veteran with brain injury in obtaining the specialized care needed to maximize return to the community at the highest possible level of functioning. This may also help minimize the development of secondary conditions and decrease costs. Utilizing VA Centers reduces the need to outsource costly specialized rehabilitation and facilitates maximizing resources instead of waiting until other resources, e.g., private insurance, state, and community, are depleted.

There are four Lead VA facilities for TBI care (Richmond, Tampa, Minneapolis and Palo Alto). The VA Lead Centers provide care not only to veterans eligible for VA services but also to active duty service members, and eligible TRICARE beneficiaries. The TBI Lead Centers have dedicated staff specifically trained and experienced in brain injury rehabilitation and are VA's main resource for specialty care for this population. The Lead Centers offer several services including acute rehabilitation and comprehensive evaluation of difficult cases or for patients who have shown a change in function that may require new types of care. Candidates for acute rehabilitation are usually newly injured while candidates for comprehensive evaluations are typically survivors who are a year or more post injury and who have new needs for rehabilitation services such as a change in function. These evaluations are meant to provide the client, family, and the referring VA with recommendations to appropriately care for the client once they return to their local area. The Lead Centers also provide evaluation of coma or minimally conscious patients. This evaluation helps determine the current and suggested future needs of the patient including nutritional needs, possible ongoing therapy needs at the sub-acute level, and follow up needs.

In addition to the Lead Centers there are 22 VA TBI Network Sites. Rehabilitation services at the Network Sites vary from acute rehabilitation on a general rehabilitation inpatient unit

References:

1. Elovic E, Antoinett T. Epidemiology and primary prevention of traumatic brain injury. In Hor LJ, Zasler ND, editors. Medical rehabilitation of traumatic brain injury. Philadelphia: Hanley and Belfus, 1996:1-28.
2. Sandel ME, Bell KR, Michaud LJ. Brain injury rehabilitation. 1. Traumatic brain injury: prevention, pathophysiology, and outcome prediction. Arch Phys Med Rehabil 1998;79 Suppl 1:S3-S9.
3. O'Dell MW, Bell KR, Sandel ME. Brain injury rehabilitation. 3. Specific disorders. Arch Phys Med Rehabil 1998;79 Suppl 1:S16-S20.

to sub-acute rehabilitation and case management to facilitate coordination of care. Some Network sites without an inpatient rehab bed service have developed programs within the framework of existing resources and offer special programming for specific problems.

Making a Referral

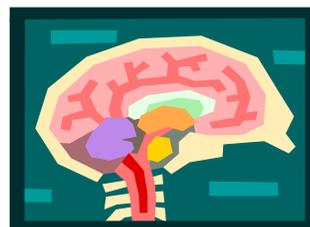
Depending on the services needed, you may seek assistance through either a Lead Center case manager for your region or your local network case manager (See http://vaww.va.gov/health/rehab/TBI_Case_Managers.html). Patients with a recent brain injury in need of acute inpatient services and those needing comprehensive specialty evaluation should be referred to a Lead Center. Patients with a remote history of brain injury who may not require all the specialty services provided at a Lead Center should be referred to the local Network case manager.

VA designated Traumatic Brain Injury (TBI) as both a Special Emphasis and Special Disability Population. Providing access to specialized care, maintaining capacity, and monitoring outcomes are a high priority.

Conclusion

TBI is common and has a wide spectrum of severity and outcome. Every effort should be made to maximize the outcome in each individual with TBI. Even mild injuries with benign physical exams can have debilitating residual symptoms. These symptoms should be recognized, addressed, and referred for specialty care when available. More severe injuries need inpatient neurosurgical evaluation, referral for physiatrist consultation of residual impairments, and consideration for inpatient rehabilitation. Inpatient rehabilitation should occur in dedicated TBI units with knowledgeable staff.

4. O'Dell MW, Bell KR, Sandel ME, Brain injury rehabilitation. 2. Medical rehabilitation of brain injury. Arch Phys Med Rehabil 1998;79 Suppl 1:S10-S15.



VHA Podiatry Leaves its Mark on the ADA Annual Meeting

By Jeffrey M. Robbins

National Director, Podiatric Service, located at VAMC, Cleveland, OH

The VHA podiatry service made several important contributions to the American Diabetes Association 61st Annual Scientific Session Foot Care Council Symposium.

David G. Armstrong, DPM (Tucson VAMC), chairman of the ADA Foot Care Council's Scientific Program report on the first ever randomized controlled trial of offloading modalities for the treatment of diabetic foot wounds and novel means of assessing risk for ulceration with a forefoot to rearfoot pressure ratio. James Wrobel, DPM (White River Junction VAMC) Field Advisor for Research, presented data describing regional variations in amputations in the United States. Leonard Pogach, M.D. (Diabetes Program Director VHA Central Office, Chief of Endocrinology, East Orange VAMC) and Jeffrey M. Robbins; DPM (Director, VHA Central Office, Podiatry Services, Chief Podiatry, Louis Stokes Cleveland VAMC) presented data describing marked reduction in diabetes related lower extremity amputations 1998 – 1999. Dr. Robbins also held a workshop on foot screening and risk assessment. Stephen Albert, DPM (Chief podiatry Denver VAMC) and Robert Pearson, DPM described outcomes associated with modern surgical versus non-surgical treatment of osteomyelitis. Gayle Reiber, PhD. (Seattle VAMC) presented data on the outcomes of shoe-gear in the diabetic foot.

Lawrence B. Harkless, DPM (Podiatry representative to Special Medical Advisor Group, University of Texas A health Science Center, San Antonio VAMC) was awarded the Diabetes Educator of the Year Award.

Lee Sanders, DPM (Chief of Podiatry, Lebanon VAMC) completed his tenure as American Diabetes Association President of Healthcare and Education. He was the first podiatrist to ever hold this position. Additionally Dr. Sanders published a book titled "A Philatelic History of Diabetes" and has donated all of the proceeds to the ADA.



Podiatry

National Template/Encounter Form Task Force Primary Care Sub-Group

By Kathryn C. Corrigan

Introduction

Over the last few years, there has been an increasing focus on the importance that documentation plays in supporting VHA's mission to provide high quality health care for our nation's veterans. Quality medical record documentation is important when caring for the health care needs of the individual veteran but it is equally important on a much broader level. Documentation is integral to the revenue cycle; to assuring that financial resources are available to VA facilities to meet the health care needs of the veteran population. Appropriate and accurate documentation of the medical care rendered is critical for assigning CPT E&M coding and ICD-9 diagnostic coding for third party billing as well as for accurate internal workload capture. These codes determine if an encounter will be reimbursed and the rate at which the VA will be reimbursed.

Vital Role Of Documentation To The Revenue Cycle

The VHA Revenue Cycle Improvement Plan (September 2001) recognized medical record documentation as a vital part of the revenue cycle and recommended development and implementation of nationally standardized documentation templates and electronic encounter forms for use in VHA facilities. The VHA National Template/Encounter Form Task Force was chartered in September 2001 to develop standardized documentation templates and encounter forms. The Task Force members selected Primary Care and Mental Health as the top two priority areas for development.

Rationale For Standard Templates/Encounter Forms

- Standardized templates prompt the provider to document essential elements of the patient encounter (e.g. chief complaint, review of systems, physical examination, etc) in primary care clinics. When these elements are performed but not documented, either a non-billable service or a lower valued service results
- Standardized electronic encounter forms will improve quality and accuracy of data capture in primary care. The ability to use the electronic encounter form as a pick list for the problem list will enhance the accuracy of the problem list

Primary Care Subgroup Purpose And Process

Purpose of the Primary Care Sub Group:

- Develop a national documentation template for use in primary care.
 - Incorporate essential elements of a patient encounter to support E&M coding
 - Incorporate instructional text to avoid omission of appropriate information
 - Take advantage of the newest CPRS GUI templating functionality (dialog templates and template fields) for improved end product
 - Design templates to avoid “cloning” of documentation
 - Eliminate the duplication of manpower required to create template fields and dialog templates at each facility
- Develop a national electronic encounter form (EF) for use in primary care
 - Incorporate features to improve coding accuracy
 - Structure the EF to facilitate use as a “pick list” for the problem list tab
 - Eliminate the duplication of manpower required to create updated electronic EF’s at each facility

Primary Care Sub Group members include: Linda Nugent, HIM Support Staff, Information Assurance, OI; James Wilson, MD, Compliance Officer, Jackson VA; Charles Haskell, MD, Compliance Officer, Greater Los Angeles VA; Barbara Sieperinski, MD –ACOS Geriatrics, Detroit VA; Laura Kroupa, MD, Chief Primary Care, St. Louis VA; Kathy Corrigan, MD, Outpatient Coordinator CPRS & Primary Care physician, Tampa VA; Mauri Miner, CAC, Puget Sound VA; Marty Sibley, CAC, Orlando OPC; Jack Westfall, CAC, Bay Pines VA; Beth Acker, Chief of HIMS, Bay Pines VA; Donna Harris, Computer Specialist, Albany CIOFO; Joy Pasternak, Computer Specialist, Hines CIOFO.

The primary care sub-group met in a face-to-face work session from October 30 - November 2, 2001. Examples of encounter forms from several sites were obtained.

Considerable time was spent in developing and testing dialog templates with various structures. Early templates were too complex and took too long to “expand.” Since it was clear that that this would be unacceptable to primary care providers, refinements were made to the templates. Testing involved both the usability of the dialog as well as the content of the resulting note. Additional time was needed to test a software patch that fixed a problem affecting template exchange. Early in the template development, the workgroup identified several barriers to use of template dialogs in the clinical setting. The primary care sub-group working with national HIMS Office has submitted a New Service Request for software enhancements to correct these barriers.

Developing primary care templates that meet coding and compliance guidelines that are also acceptable to the end user is not as easy and straightforward as it sounds. Multi-disciplinary expertise and collaboration are essential. Here is a brief outline of the resources needed for a project of this scope:

- Content expertise: Compliance experts, HIMS staff, Coders, Primary Care Providers
- Consensus on clinical content, code selection and compliance issues
- Technical expertise: CAC, EF builder, Primary Care providers with hands-on template experience
- National Informatics support: Clin II support staff, TIU software developer, CIO support for a CPRS test account to use for building the templates and EF’s
- Time to create, format, review and re-format the templates and EF
- Frequent virtual meetings through conference calls and E-mail
- Agreement/consensus on naming conventions for templates and template fields
- Ongoing commitment to log onto the test account, use the templates and give timely feedback
- Communication with CPRS developers and Clin II support staff to create and test TIU patch to fix technical issues with exchange of template dialogs
- Support of national HIMS office: New Service Request for enhancements to existing template functionality and for exchange patch for the EF

Current Status Of PC Templates And Encounter Forms

After 7-8 months of work the primary care sub-group has two templates currently completing alpha testing by front-line primary care providers: VA*PC New Patient and VA*PC Established Patient. Each template incorporates the essential elements of a patient encounter needed to support E&M coding with instructional text. A quick coding guide is included at the end of each dialog. The dialogs take full advantage of the latest CPRS GUI templating functions.

As expected, the modifications to the templates will be made prior to beta testing. The users who have been involved in alpha testing have been positive in their feedback and at the same time very generous in their suggestions for further improvements. Modifications to the templates will be made based on user feedback. Additional input was obtained when the templates were presented at Camp CPRS at the end of April. The improved version of the templates is targeted for beta testing by the end of May 2002.

The primary care electronic encounter form began alpha testing in mid April 2002. This “multi-page” EF greatly expands the choices and specificity of diagnoses available for selection. Choices are broken down by organ system. Expanded sections are included for personal history of

illnesses, family history of illnesses, women's health, symptoms (such as pain) and abnormal findings. Features such as the ability to select the site of cellulitis or ulcer should diminish the number of write-in diagnoses. Initial feedback on the encounter forms has been positive. It is expected that only minor changes will be needed prior to beta testing.

Conclusion

Two Primary Care templates and one Primary Care encounter form will be exported this summer along with 5 Mental Health templates and 3 Mental Health encounter forms. The national workgroup has committed to develop future templates for: Attending note, inpatient H&P, ER, and outpatient notes for Cardiology, Rehabilitation and Eye. The availability of these national products will assist all VA sites to meet the challenges for full implementation of the electronic record as well as the challenges of improving each site's revenue cycle.

Future Endeavors

In addition to Primary Care and Mental Health, encounter forms are being planned/developed for Pulmonary, GI,

Cardiology, Eye, Podiatry, Rehabilitation, Hematology/Oncology, Orthopedics, Urology, Rheumatology, SCI, and Dematology. The Encounter forms will be distributed via 4 separate patches over the next several months. The patches will be considered an update to the original ACIS toolkit. Additionally, the visit block is being modified to accept modifiers and the ability to be updated with annual code changes for the current diagnosis and procedures blocks. It is expected that the encounter forms will be out by the end of August, 2002.

New Primary and Ambulatory Care Websites

By Alex Kutner

*Office of Primary and Ambulatory Care
VA Headquarters, Wash, DC*

Primary and Ambulatory Care has newly designated intranet and Internet websites. Each Program in our Strategic Healthcare Group has a page on the intranet site that can be added to or revised with the approval of the Chief Consultant. The internet site is a listing of our Programs and key officials. The URL's for the new sites are <http://vaww.va.gov/primary/> and <http://www.va.gov/primary>.



Schedule for MAP articles

FLOW	3 rd Q/2002			4 th Q/2002			1 st Q/2003			2 nd Q/2003		
	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Articles Submitted	19			19			18			17		
Dist. to Board Members		17			16			15			21	
Comments to OPAC		31			30			29				
Final Presentation to 112			14			13			13			7
Electronic Distribution			17			16			16			21
Hard Copies Delivered			17			16			16			24

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**It is clearly my intent to continue with the significant contributions made through the newsletter.
Please feel free to contact me electronically if you have any ideas or recommendations for future newsletters.*

Articles may be submitted electronically at any time to Mildred Eichinger and/or Renee Hodges.

Website <http://vaww.va.gov/primary>



We welcome your articles related to any current Issues in the area of healthcare in general or specifically in the field of ambulatory and primary care. Contact Mildred Eichinger at 202-273-8552 if you have any questions.