Veterans Health Care
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1: Am J Manag Care 2002 Dec;8(12):1105-15
Profiling resource use: do different outcomes affect assessments of provider efficiency?
Rosen AK, Rakovski CC, Loveland SA, Anderson JJ, Berlowitz DR.
OBJECTIVES: To examine whether 2 outcome measures result in different assessments of efficiency across 22 service networks within the Department of Veterans Affairs (VA). STUDY DESIGN: A retrospective analysis using VA inpatient and outpatient administrative databases. METHODS: A 60% random sample of veterans who used healthcare services during fiscal year 1997 was split into a 40% sample (n = 1,046,803) for development and a 20% sample (n = 524,461) for validation. Weighted concurrent case-mix models using adjusted clinical groups were developed to explain variation in 2 outcomes: "days of care"--the sum of a patient's inpatient and outpatient annual visit days, and "average accounting costs"--the sum of the average service costs multiplied by the units of service for each patient. Two profiling indicators were calculated for each outcome: an unadjusted efficiency index and an adjusted efficiency index. These indices were compared to examine network efficiency. RESULTS: Although about half the networks were identified as "efficient" before and after case-mix adjustment, assessments of individual network efficiency were affected by the adjustment. The 2 outcomes differed on which networks were efficient. For example, 4 networks that appeared as efficient based on days of care appeared as inefficient based on average costs. CONCLUSIONS: Assessments of provider efficiency across the 22 networks depended on the outcome measure used. Knowledge about the extent to which assessments of provider efficiency depend on the outcome measure used is an important step toward improved and more equitable comparisons across providers.
PMID: 12500886

2: Am J Nurs 2002 Nov;102(11):11
War is unhealthy.
O'Neill S.
PMID: 12436068 [PubMed - indexed for MEDLINE]

3: Am J Psychiatry 2002 Dec;159(12):2081-6
Medical service utilization by veterans seeking help for posttraumatic stress disorder.
Calhoun PS, Bosworth HB, Grambow SC, Dudley TK, Beckham JC.
OBJECTIVE: Posttraumatic stress disorder (PTSD) has been associated with higher rates of health complaints and medical conditions diagnosed by physicians, yet

research examining the relationship between PTSD and health care utilization has been limited. This study compared the health service use of veterans with PTSD to that of help-seeking veterans without PTSD. The relationship between severity of PTSD and service utilization was also examined. METHOD: Data were collected from 996 veterans seeking an evaluation at a Veterans Affairs (VA) Medical Center specialty PTSD clinic in the southeastern United States between March 1992 and September 1998. Data included sociodemographic characteristics, severity of PTSD, and disability status. The outcome variable, VA health service utilization, was prospectively assessed 1 year from the date of the initial PTSD assessment. RESULTS: Although the use of VA mental health services by patients with PTSD was substantial (a median of seven clinic stops), these patients used more services in general physical health clinics that provided predominantly nonmental health services (a median of 18 clinic stops). Negative binomial regression models revealed that younger veterans with PTSD had greater health care utilization than those without PTSD who also sought services. Greater severity of PTSD was related to higher rates of mental and physical health service use among veterans without a service-connected disability. CONCLUSIONS: PTSD is associated with substantial health service use. The results highlight the importance of increased collaboration between primary care and mental health specialists, given that patients with PTSD are more likely to receive treatment in nonmental health clinics.
PMID: 12450960]

4: Am J Surg 2002 Nov;184(5):452-9
Cholecystectomy in patients with previous spinal cord injury.
Ahmed HU, Smith JB, Rudderow DJ, Longo WE, Virgo KS, Johnson FE.
BACKGROUND: The number of people in the United States with spinal cord injury (SCI) is estimated at about 200,000. The prevalence of gallbladder disease in this population is about three times as high as in neurally intact people, but the results of surgical treatment have received little attention. METHODS: A retrospective, population-based study of patients with SCI who later received cholecystectomy for benign gallbladder disease was performed. National computer data sets of all patients receiving medical care in all Department of Veterans Affairs (DVA) medical centers for fiscal years 1994 to 1998 were used. Computer-based data were augmented with chart-based resources. RESULTS: During the period of interest, there were 21,849 patients with ICD-9-CM codes for SCI in the DVA computer system, among whom 367 had codes for cholecystectomy. After retrieval and review of data from individual charts, 118 were deemed evaluable. There were 68 who had successful laparoscopic cholecystectomy and 14 who required conversion to open cholecystectomy after laparoscopic efforts failed (conversion rate 14 of 82=17%). There were 36 who received planned open cholecystectomy. Patients under the age of 60 years were more likely to have a laparoscopic approach ($P < 0.05$). Emergency cholecystectomies were more likely to be performed via the open route ($P < 0.01$). The morbidity rate was 8 of 68 (12%) for successful laparoscopic cholecystectomy, 4 of 14 (29%) for failed laparoscopic surgery completed by conventional open technique, and 11 of 36 (31%) for planned open surgery. The mortality rate in the traditional surgery group was 1 of 36 (3%). There were no deaths in the other groups. CONCLUSIONS: We believe this series is the largest so far reported. The mortality rate of cholecystectomy in SCI patients is comparable to that in neurally intact individuals, but the morbidity rate is high. Contractures, stomas, heterotopic ossification, and other sequelae of SCI do not generally cause technical difficulties with surgery. If complications of cholecystectomy are indeed SCI-related, attention to perioperative SCI care could improve outcomes of cholecystectomy. Future research should continue to explore this important research topic.
PMID: 12433613

5: Arch Intern Med 2002 Dec 9-23;162(22):2597-604
Diabetes, plasma insulin, and cardiovascular disease: subgroup analysis from the Department of Veterans Affairs high-density lipoprotein intervention trial (VA-HIT).
Rubins HB, Robins SJ, Collins D, Nelson DB, Elam MB, Schaefer EJ, Faas FH, Anderson JW.
BACKGROUND: Diabetes mellitus, impaired fasting glucose level, or insulin resistance are associated with increased risk of cardiovascular disease.OBJECTIVES: To determine the efficacy of gemfibrozil in subjects with varying levels of glucose tolerance or hyperinsulinemia and to examine the association between diabetes status and glucose and insulin levels and risk of cardiovascular outcomes. METHODS: Subgroup analyses from the Department of Veterans Affairs High-Density Lipoprotein Intervention Trial, a randomized controlled trial that enrolled 2531 men with coronary heart disease (CHD), a high-density lipoprotein cholesterol level of 40 mg/dL or less (</=1.04 mmol/L), and a low-density lipoprotein cholesterol level of 140 mg/dL or less (</=3.63 mmol/L). Subjects received either gemfibrozil (1200 mg/d) or matching placebo and were followed up for an average of 5.1 years. In this article, we report the composite end point (CHD death, stroke, or myocardial infarction). RESULTS: Compared with those with a normal fasting glucose level, risk was increased in subjects with known diabetes (hazard ratio [HR], 1.87; 95% confidence interval [CI], 1.44-2.43; P =.001) and those with newly diagnosed diabetes (HR, 1.72; 95% CI, 1.10-2.68; P =.02). In persons without diabetes, a fasting plasma insulin level of 39 micro U/mL or greater (>/=271 pmol/L) was associated with a 31% increased risk of events (P =.03). Gemfibrozil was effective in persons with diabetes (risk reduction for composite end point, 32%; P =.004). The reduction in CHD death was 41% (HR, 0.59; 95% CI, 0.39-0.91; P =.02). Among individuals without diabetes, gemfibrozil was most efficacious for those in the highest fasting plasma insulin level quartile (risk reduction, 35%; P =.04). CONCLUSION: In men with CHD and a low high-density lipoprotein cholesterol level, gemfibrozil use was associated with a reduction in major cardiovascular events in persons with diabetes and in nondiabetic subjects with a high fasting plasma insulin level.
PMID: 12456232

6: Arch Phys Med Rehabil 2002 Dec;83(12):1736-8
The prevalence of postural asymmetry in people with and without chronic low back pain.
Fann AV.
OBJECTIVE: To determine the extent of pelvic obliquity and lateral sacral base angle in subjects with and without chronic low back pain (LBP) by using postural radiographs. DESIGN: Cross-sectional, controlled. SETTING: A Veterans Administration hospital. PARTICIPANTS: Veterans and employees with (n=93) and without (n=76) chronic LBP. INTERVENTION: Postural radiographs. MAIN OUTCOME MEASURE: Differences between the mean extent of pelvic obliquity and the lateral sacral base angle in subjects with and without chronic LBP. RESULTS: The z scores showed no significant statistical differences in the extent of pelvic obliquity or lateral sacral angle in subjects with and without chronic LBP. CONCLUSION: Correction of pelvic obliquity by the use of heel lifts has been used as a modality of treatment for patients with chronic LBP. The majority of
the patients in our clinics for whom this modality is used report at least some improvement in their pain symptoms. Because the extent of pelvic obliquity is similar in the subjects with and without chronic LBP, other factors must account for those who benefit from correction of their pelvic obliquity. Copyright 2002 by the American

Congress of Rehabilitation Medicine and the American Academy of Physical Medicine and Rehabilitation.
PMID: 12474179

7: Comput Inform Nurs 2002 Nov-Dec;20(6):251-60
Creating an interactive interdisciplinary electronic assessment.
Wenzel GR.
The transition from the paper medical record to a fully computerized patient record has not been without pain or dissatisfaction from clinical staff. An often-heard question is, "Are we working for the computer or is the computer working for us?" Documenting patient care activities is a driving force in care planning, treatment, and reimbursement. Patient assessments are traditionally detailed and at least partially documented during the face-to-face interaction between the clinical staff and the patients. Historically, overprinted forms have been developed to guide the documentation of the patient responses to the assessment and care planning. The overprinted forms are lengthy, cumbersome, and available only in hard copy and, therefore, not part of a computerized patient record. Tools enabling these overprinted assessments to be part of the computerized patient record are now available in the Computerized Patient Record System of the Department of Veterans Affairs. This article describes the method used by the Butler, PA, Veterans Affairs Medical Center Clinical Information Systems Coordinator to transform an existing assessment document into an interactive interdisciplinary assessment.
PMID: 12464740

8: Health Manag Technol 2002 Dec;23(12):32-4
The impact of clinical reminders and alerts on health screenings: The VA Pittsburgh Healthcare System achieves notable results by enhancing an automated clinical reminder system within its CPR--and has the data to prove it.
Calabrisi RR, Czarnecki T, Blank C.
PMID: 12467262

9: Health Serv Res 2002 Oct;37(5):1159-80
Comment in: Health Serv Res. 2002 Oct;37(5):1125-7.
Whom should we profile? Examining diabetes care practice variation among primary care providers, provider groups, and health care facilities.
Krein SL, Hofer TP, Kerr EA, Hayward RA.
OBJECTIVE: To evaluate the amount of variation in diabetes practice patterns at the primary care provider (PCP), provider group, and facility level, and to examine the reliability of diabetes care profiles constructed using electronic databases. DATA SOURCES/STUDY SETTING: Clinical and administrative data obtained from the electronic information systems at all facilities in a Department of Veterans Affairs' (VA) integrated service network for a study period of October 1997 through September 1998. STUDY DESIGN: This is a cohort study. The key variables of interest are different types of diabetes quality indicators, including measures of technical process, intermediate outcomes, and resource use. DATA COLLECTION/EXTRACTION METHODS: A coordinated registry of patients with diabetes was constructed by integrating laboratory, pharmacy, utilization, and primary care provider data extracted from the local clinical information system used at all VA medical centers. The study sample consisted of 12,110 patients with diabetes, 258 PCPs, 42 provider groups, and 13 facilities. PRINCIPAL FINDINGS: There were large differences in the amount of practice variation across levels of care and for different types of diabetes care indicators. The greatest amount of variance

tended to be attributable to the facility level. For process measures, such as whether a hemoglobin A1c was measured, the facility and PCP effects were generally comparable. However, for three resource use measures the facility effect was at least six times the size of the PCP effect, and for inter-mediate outcome indicators, such as hyperlipidemia, facility effects ranged from two to sixty times the size of the PCP level effect. A somewhat larger PCP effect was found (5 percent of the variation) when we examined a "linked" process-outcome measure linking hyperlipidemia and treatment with statins). When the PCP effect is small (i.e., 2 percent), a panel of two hundred diabetes patients is needed to construct profiles with 80 percent reliability. CONCLUSIONS: little of the variation in many currently measured diabetes care practices is attributable to PCPs and, unless panel sizes are large, PCP profiling will be inaccurate. If profiling is to improve quality, it may be best to focus on examining facility-level performance variations and on developing indicators that promote specific, high-priority clinical actions.
PMID: 12479491

10: Int J Health Care Qual Assur Inc Leadersh Health Serv 2002;15(6-7):238-48
Quality control circles in the Veterans Administration hospital.
Canel C, Kadipasaoglu S.
In response to residents' reports of inefficiencies in the Veterans Administration (VA) system, a temporary task force of quality control circles was implemented at a VA hospital. A total of 25 internal medicine residents, on rotation at the VA, were subdivided into four groups. Each group was presented with a different problem, given the components and constraints of the problem, and asked to identify possible solutions. Program results were submitted to the hospital administration. Efforts are now being made to improve the working environment for medical residents.
PMID: 12500649

11: J Am Coll Cardiol 2002 Nov 20;40(10):1786-93
The impact of ethnicity on outcomes following coronary artery bypass graft surgery in the Veterans Health Administration.
Rumsfeld JS, Plomondon ME, Peterson ED, Shlipak MG, Maynard C, Grunwald GK, Grover FL, Shroyer AL.
OBJECTIVES: We evaluated the effect of African American (AA) and Hispanic American (HA) ethnicity on mortality and complications following coronary artery bypass graft (CABG) surgery in the Veterans Health Administration (VHA).BACKGROUND: Few studies have examined the impact of ethnicity on outcomes following cardiovascular procedures. METHODS: This study included all 29,333 Caucasian, 2,570 AA, and 1,525 HA patients who underwent CABG surgery at any one of the 43 VHA cardiac surgery centers from January 1995 through March 2001. We evaluated the relationship between ethnicity (AA vs. Caucasian and HA vs. Caucasian) and 30-day mortality, 6-month mortality, and 30-day complications, adjusting for a wide array of demographic, cardiac, and noncardiac variables. RESULTS: After adjustment for baseline characteristics, AA and Caucasian patients had similar 30-day (AA/Caucasian odds ratio [OR] 1.07; 95% confidence interval [CI] 0.84 to 1.35; $p = 0.59$) and 6-month mortality risk (AA/Caucasian OR 1.10; 95% CI 0.91 to 1.34; $p = 0.31$). However, among patients with low surgical risk, AA ethnicity was associated with higher mortality (OR 1.52, CI 1.10 to 2.11, $p = 0.01$), and AA patients were more likely to experience complications following surgery (OR 1.28; 95% CI 1.14 to 1.45; $p < 0.01$). In contrast, HA patients had lower 30-day (HA/Caucasian OR 0.70; 95% CI 0.49 to 0.98; $p = 0.04$) and 6-month mortality risk (HA/Caucasian OR 0.66; 95% CI 0.50 to 0.88; $p < 0.01$) than Caucasian patients. CONCLUSIONS: Ethnicity does not appear to be a strong risk factor for adverse

outcomes following CABG surgery in the VHA. Future studies are needed to determine why AA patients have more complications, but ethnicity should not affect the decision to offer the operation.
PMID: 12446062

12: J Fam Pract 2002 Nov;51(11):938-42
Validating an instrument for selecting interventions to change physician practice patterns: a Michigan Consortium for Family Practice Research study.
Green LA, Gorenflo DW, Wyszewianski L; Michigan Consortium for Family Practice Research.
OBJECTIVES: The goal of this study was to develop a psychometric instrument that classified physiciansamprsquo response styles to new information as seekers, receptives, traditionalists, or pragmatists. This classification was based on specific combinations of 3 scales: (a) belief in evidence vs experience as the basis of knowledge, (b) willingness to diverge from common or previous practice, and (c) sensitivity to pragmatic concerns of practice. The instrument will help focus efforts to change practice more accurately. STUDY DESIGN: This was a cross-sectional study of physician responses to a psychometric instrument. Paper-and-pencil survey forms were distributed to 3 waves of physicians, with revision for improved internal consistency at each iteration. POPULATION: Participants were 1393 primary care physicians at continuing education events in the Midwest or at primary care clinic sites in the Veteransamprsquo Health Administration system. OUTCOMES MEASURED: Internal consistency was measured by factor analysis with orthogonal rotation and Cronbachamprsquos alpha. RESULTS: A total of 1287 usable instruments were returned (106, 1120, and 61 in the 3 iterations, respectively), representing approximately three fourths of distributed forms. Final scale internal consistencies were a = 0.79, b = 0.74, and c = 0.68. The patterns of scores on the 3 scales were consistent with the predictions of the theoretical scheme of physician types. The "seeker" type was the rarest, at fewer than 3%. CONCLUSIONS: It is possible to reliably classify physicians into categories that a theoretical framework predicts will respond differently to different interventions for implementing guidelines and translating research findings into practice. The next step is to demonstrate that the classification predicts physician practice behavior.
PMID: 12485547

13: J Nerv Ment Dis 2002 Dec;190(12):807-15
Posttraumatic stress disorder symptoms influence health status of deployed peacekeepers and nondeployed military personnel.
Asmundson GJ, Stein MB, McCreary DR.
Posttraumatic stress disorder (PTSD) is associated with depression and alcohol abuse. PTSD symptoms also contribute to poor health among military veterans. The aim of the present study was to test models pertaining to the direct and indirect influences of PTSD symptoms on the health status of deployed and sociodemographically comparable nondeployed military personnel. Participants were 1,187 deployed male peacekeepers and 669 nondeployed male military personnel who completed a battery of questionnaires, including measures of PTSD symptoms, depression, alcohol use, and general health status. Structural equation modeling was used to test predictions regarding the direct and indirect influences of PTSD symptoms on health status. Results indicate that PTSD symptoms have a direct influence on health, regardless of deployment status. PTSD symptoms also indirectly promote poorer health through influence on depression, but not alcohol use, in deployed and nondeployed peacekeepers. Increased alcohol use did not contribute

to poorer health beyond the contribution of PTSD symptoms alone. Future research directions are discussed.
PMID: 12486368

14: J Nerv Ment Dis 2002 Nov;190(11):789-92
Cause of death in veterans receiving general medical and mental health care.
Thompson R, Katz IR, Kane VR, Sayers SL.
PMID: 12436023

15: Jt Comm J Qual Improv 2002 Dec;28(12):646-50
John M. Eisenberg Patient Safety Awards. Advocacy: the Lexington Veterans Affairs Medical Center.
Kraman SS, Cranfill L, Hamm G, Woodard T.
BACKGROUND: After the Veterans Affairs Medical Center (VAMC) in Lexington, Kentucky, lost two major malpractice cases in the mid-1980s, leaders started taking a more proactive approach to identifying and investigating incidents that could result in litigation. An informal risk management team met regularly to discuss litigation-prone incidents. During one in-depth review, the team learned that a medication error had caused the patient's death. Although the family would probably never have found out, the team decided to honestly inform the family of exactly what had happened and assist in filing for any financial settlement that might be appropriate. This decision evolved into an organization wide full disclosure policy and procedure. DISCLOSURE POLICY AND PROCEDURE: The Lexington VAMC's policy on full disclosure includes informing patients and/or their families of adverse events known to have caused harm or injury to the patient as a result of medical error or negligence. The disclosure includes discussions of liability and also includes apology and discussion of remedy and compensation. RESULTS: Full disclosure is the right thing to do and the moral and ethical thing to do. Moreover, doing the right thing actually seems to have mitigated the financial repercussions of inevitable adverse events that result in injury to patients. As reported in 1999, Lexington VAMC was in the top quarter of medical centers for number of tort claims filed but was in the lowest quarter for malpractice payouts resulting from these torts.
PMID: 12481598 [PubMed - indexed for MEDLINE]

16: Jt Comm J Qual Improv 2002 Dec;28(12):660-5
John M. Eisenberg Patient Safety Awards. System innovation: Veterans Health Administration National Center for Patient Safety.
Heget JR, Bagian JP, Lee CZ, Gosbee JW.
BACKGROUND: In 1998 the Veterans Health Administration (VHA) created the National Center for Patient Safety (NCPS) to lead the effort to reduce adverse events and close calls systemwide. NCPS's aim is to foster a culture of safety in the Department of Veterans Affairs (VA) by developing and providing patient safety programs and delivering standardized tools, methods, and initiatives to the 163 VA facilities. A NOVEL APPROACH: To create a system-oriented approach to patient safety, NCPS looked for models in fields such as aviation, nuclear power, human factors, and safety engineering. Core concepts included a non-punitive approach to patient safety activities that emphasizes systems-based learning, the active seeking out of close calls, which are viewed as opportunities for learning and investigation, and the use of interdisciplinary teams to investigate close calls and adverse events through a root cause analysis (RCA) process. Participation by VA facilities and networks was voluntary. NCPS has always aimed to develop a program that would be

applicable both within the VA and beyond. KEY ACTION ITEMS AND RESULTS RELATED TO RCA: NCPS's full patient safety program was tested and implemented throughout the VA system from November 1999 to August 2000. Program components included an RCA system for use by caregivers at the front line, a system for the aggregate review of RCA results, information systems software, alerts and advisories, and cognitive acids. Following program implementation, NCPS saw a 900-fold increase in reporting of close calls of high-priority events, reflecting the level of commitment to the program by VHA leaders and staff. PMID: 12481600

17: Med Care 2002 Dec;40(12):1161-71
Improving recognition of drug interactions: benefits and barriers to using automated drug alerts.
Glassman PA, Simon B, Belperio P, Lanto A.
BACKGROUND: Clinicians' perceptions about decision support systems may impact the effectiveness of these technologies. OBJECTIVE: To explore clinicians' baseline knowledge of common drug interactions and experiences with automated drug alerts within a provider order entry system as a means to better understand the potential benefits and barriers to using this technology. RESEARCH DESIGN: Cross-sectional survey. SUBJECTS: The study population comprised 263 clinicians practicing within a Southern California Veterans Affairs health care system that used VA's Computerized Patient Record System (CPRS). Response rate was 64%. MEASURES: A 67-item survey (19 questions) was developed to elicit information including: (1) computer use for patient-related activities; (2) recognition of drug interactions; and (3) benefits and barriers to using automated drug alerts. RESULTS: Clinicians correctly categorized 44% (range 11-64%) of all drug-drug pairs, 53% of interacting combinations, and 54% of contraindicated pairs. Providers also correctly categorized 55% (range 24-87%) of 11 drug-disease pairs and 62% of interacting combinations, and 53% of contraindicated pairs. Nearly 90% of clinicians thought drug alerts would be helpful to identify interactions yet 55% of clinicians perceived that the most significant barrier to utilizing existing alerts was poor signal to noise ratio, meaning too many nonrelevant warnings. CONCLUSIONS: Automated drug interaction alerts have the potential to dramatically increase clinicians' recognition of selected drug interactions. However, perceived poor specificity of drug alerts may be an important obstacle to efficient utilization of information and may impede the ability of such alerts to improve patient safety.
PMID: 12458299

18: Med Care 2002 Dec;40(12):1172-85
Organizational predictors of adherence to ambulatory care screening guidelines.
Vaughn TE, McCoy KD, BootsMiller BJ, Woolson RF, Sorofman B, Tripp-Reimer T, Perlin J, Doebbeling BN.
OBJECTIVE: The purpose of this study was to identify hospital organizational characteristics consistently associated with adherence to multiple clinical practice guidelines (CPGs). We examined the relationship between organizational and patient population characteristics and adherence to three screening CPGs implemented throughout the Veterans Health Administration (VHA). MATERIALS AND METHODS: The study included 114 acute care facilities. Three sources of data were used: 1998 American Hospital Association data, VHA External Peer Review Program data for 1998 and 1999, and the 1999 Veterans Satisfaction Survey. Organizational characteristics likely to affect adherence with the CPGs were classified into five conceptual domains (clinical emphasis, operational capacity, patient population, professionalism, and urbanicity). Organizational characteristics were ranked, based

on their standardized beta coefficients in bivariate logistic regressions predicting the likelihood of adherence.
Within-domain multivariable logistic analyses assessed the robustness of individual predictors of CPG adherence, controlling for other organizational factors within the same domain. RESULTS: Overall, 46 of 48 relationships in the bivariate logistic analyses were significant, and 43 of these remained significant in the within-domain multivariate analyses. The relative rankings of the variables as predictors of CPG adherence within conceptual domains were also quite consistent. CONCLUSIONS: Strong evidence was found for the importance of specific organizational factors, including mission, capacity, professionalism, and patient population characteristics that influence CPG adherence in a large multi-institutional sample involving multiple provider practices. Research and programs to improve adherence to CPGs and other quality improvement activities in hospitals should incorporate these organizational factors.
PMID: 12458300

19: Mil Med 2002 Nov;167(11):ii
Comment on:
Mil Med. 2002 Jun;167(6):483-8.
The Millennium Cohort Study.
Ryan MA, Amoroso P, Boyko EJ, Gackstetter GD, Gary GC, Hooper TI, Riddle JR.
PMID: 12448607

20: Neurology 2002 Nov 26;59(10):1518-25
Comment in: Neurology. 2002 Nov 26;59(10):1484-5.
Neurophysiologic analysis of neuromuscular symptoms in UK Gulf War veterans: a controlled study.
Sharief MK, Priddin J, Delamont RS, Unwin C, Rose MR, David A, Wessely S.
BACKGROUND: UK veterans who were deployed to the Gulf in 1990 to 1991 reported higher prevalence of neuromuscular symptoms. OBJECTIVE: To investigate whether these Gulf War-related symptoms were associated with objective evidence of neuromuscular dysfunction. METHODS: Forty-nine Gulf War veterans with more than four neuromuscular symptoms (Gulf-ill), 26 Gulf-well veterans, 13 symptomatic Bosnian veterans (Bosnia-ill), and 22 symptomatic veterans who were not deployed to the Gulf (Era-ill) underwent detailed neurophysiologic assessment: nerve conduction studies, quantitative sensory and autonomic testing, and concentric needle and single-fiber electromyography (EMG). RESULTS: Nerve conduction studies detected carpal tunnel syndrome in two Gulf-ill, two Gulf-well, one Bosnia-ill, and three Era-ill veterans. Ulnar neuropathy was detected in one Gulf-ill and two Era-ill veterans. However, results of detailed nerve conduction studies of the Gulf-ill veterans were comparable with results observed in the other three groups. Quantitative sensory and autonomic assessments also failed to show any specific abnormalities in the Gulf-ill group. Similarly, quantitative assessment of concentric needle and single-fiber EMG detected no chronic denervation or myopathic changes or any abnormalities of neuromuscular transmission in the Gulf-ill veterans. CONCLUSION: Gulf War-related neuromuscular symptoms are not associated with specific impairments of peripheral nerves, neuromuscular junctions, or skeletal muscles.
PMID: 12451190

21: Neurology 2002 Nov 26;59(10):1484-5
Comment on:

Neurology. 2002 Nov 26;59(10):1518-25.
Neurology and Gulf War veterans.
Barohn RJ, Rowland LP.
PMID: 12451187

22: SCI Nurs 2001 Winter;18(4):191-3
Hurricane: evacuating an SCI unit.
Holmes R, Zapata T.
PMID: 12481614

23: Stroke 2002 Dec;33(12):2944-9
To what extent should quality of care decisions be based on health outcomes data? Application to carotid endarterectomy.
Samsa G, Oddone EZ, Horner R, Daley J, Henderson W, Matchar DB.
BACKGROUND AND PURPOSE: Most quality improvement methods implicitly assume that facilities with high complication rates are likely to have substandard processes of care, a stable characteristic that, in the absence of intervention, will persist over time. We assessed the extent to which this holds true for carotid endarterectomy. METHODS: Using data from the Department of Veterans Affairs National Surgical Quality Improvement Project, we classified facilities on the basis of 30-day complications of carotid endarterectomy (stroke, myocardial infarction, death) during 1994 to 1995 (period 1, n=3389) and then compared these groups of facilities for complication rates during 1996 to 1997 (period 2, n=4453). RESULTS: Despite wide variation in facility-specific complication rates, the correlation between rates in periods 1 and 2 was low (Spearman correlation coefficient, 0.04; P=0.01) Facility-specific rates did not show greater correlation when we examined only facilities with higher volumes patients in different clinical categories (asymptomatic, transient ischemic attack, stroke). Comorbid illness profiles were similar between the 2 time periods. CONCLUSIONS: Most of the facility-specific differences in complication rates in period 1 were not maintained into period 2. Many apparent quality improvement problems may not be as large as they first appear, especially when based on few complications per facility. The inability, in practice, to estimate complication rates at a high degree of precision is a fundamental difficulty for clinical policy making regarding procedures with complication rates such as carotid endarterectomy.
PMID: 12468795

24: Stroke 2002 Dec;33(12):2936-43
Carotid endarterectomy and race: do clinical indications and patient preferences account for differences?
Oddone EZ, Horner RD, Johnston DC, Stechuchak K, McIntyre L, Ward A, Alley LG, Whittle J, Kroupa L, Taylor J.
BACKGROUND AND PURPOSE: Carotid endarterectomy (CE) has been proved to reduce the risk of stroke for certain patients, but black patients are less likely than whites to receive CE. The purpose of this work was to determine the importance of clinical indications and patient preferences in predicting the use of carotid angiography and CE in a racially stratified sample of patients. METHODS: Between 1997 and 1999, 708 patients with at least 1 carotid artery containing a >/=50% stenosis were enrolled (617 whites, 91 blacks) from 5 Veteran Affairs Medical Centers. Patient interviews were conducted at the time of the index carotid ultrasound, and each patient was followed up for 6 months to determine clinical events and receipt of carotid angiography or CE. RESULTS: Black and white patients were similar in terms of age, sex, education level, and social support. More black

than white patients received ultrasound for a completed stroke (36% versus 13%), and fewer black patients were classified as asymptomatic (56% versus 70%) or as having had a TIA (8% versus 17%; P<0.001). Health-related quality of life scores, trust in physician, and medical comorbidity scores were similar for black and white patients. Black patients expressed higher aversion to CE than white patients (31% versus 15% in the highest aversion quartile for blacks and whites, respectively; P=0.01). During follow-up, 20% of white patients and 14% of black patients received CE (P=0.19). In adjusted analyses, only patient clinical status as it relates to the indication for CE and site were associated with receipt of CE. CONCLUSIONS: Contrary to prior research, patient's race was not associated with receipt of invasive carotid imaging or CE for older male veterans. These findings persist after controlling for patient preferences, comorbid illness, and quality of life. For patients enrolled in an equal-access health care system, clinical status was the primary determinant of the receipt of CE.
PMID: 12468794