

Division of Diabetes Treatment and Prevention

Diabetes Foot Care

Christine White, DPM

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Christine White:

Sounds good. Thank you Jan for such a wonderful introduction. My name is Chris White and I'm the Chief of Podiatry at Gallup Indian Medical Center in Gallup, New Mexico. I'm also very privileged to be on the National Podiatry Council and helping that get up, get started and spread the correct diabetic foot care across Indian Country and hopefully we can start saving some limbs with our people, which is wonderful and fantastic. We are also working very closely with the Wound Care Consortium trying to spread out a standard wound care protocol across Indian Country as well, so we're very excited.

I have come up with a "Basics of Diabetic Foot Care" presentation that I'm going to present to everyone today. At the end we're going to have a Q&A session, but if you would like throughout, as the questions come to mind, you can type them in the "Enter Your Questions Here" section and we'll go through those at the end. Jan did a wonderful section about how you -- later do the recording and actually get their CMEs that way. So people have the option, they can stay live or they can also look at the recording. So, thank you all for participating today. I try to base my lecture towards the people that are on the front lines, people that are seeing our patients everyday, the people that can make a difference and actually help us save limbs. So, thank you all for participating.

For us, there's -- for any diabetic foot examination, there's four critical areas that you need to cover. You need to do vascular, neurological, muscular skeletal and dermatological examination. Now if I sound like I'm gearing it towards medical, at some point in time when you do a complete diabetic foot examination, a provider needs to sign off. So, I will try to connect all of the dots. But I'm trying to be basic as well, so that the first line providers can actually get in there and know what their part of the puzzle is, so that we're all working together as a team. The key to save limbs and to help our patients with diabetes, make sure that they prevent ulcerations, prevent amputations, actually working as multidisciplinary team, so that's first and foremost.

So, when we're doing a neurological exam, what we like to look at when you're saying, "We're doing a complete diabetic foot examination for our patients," it is including a neurological examination, which is a monofilament examination. For Monofilament Examination, we use the 5.07. We have standards, we have throwaways. You can use it once on that patient and give it to them and they can test on their selves as well.

You can also do a neurological examination other ways. You can do a vibratory sensation, you can do crude touch and you can do cold-hot sensation. So, it doesn't necessarily have to be a monofilament exam if you don't have them at your site. But we would prefer that that be the standard across the Indian Country. There are ways, and later in the lecture, I'll let you know, how you can actually get free monofilament examinations. I mean, free Semmes-Weinstein monofilaments so that you perform your examinations on site.

For a neurological testing for the monofilament exam, you have to do an annual exam. Later in the lecture, I'll show how you can actually document that in EHR. Documentation is key because that's



how they pull it all out when they're doing our dashboards and making sure that we're meeting our standards annually. When you do the testing for a monofilament examination, you're actually testing nerve roots that are coming out of the patient's spine.

Now I have a lot of patients, a lot of people, a lot of providers that get confused because they say, "I give a patient a diagnosis of Diabetic Peripheral Neuropathy, but their monofilament examination is normal." A few things for people, so that that can clear up that misunderstanding. When you're doing a monofilament exam, you're actually testing large nerve fibers. Patients and people all have small nerve fibers. Those are the ones that give you your cold sensation, your sharp shooting pain sensation.

So, if you have a patient that comes in and says, "At night, my feet feel like they're on fire, they're burning or they're really hot or cold, or they have sharp shooting pains going up my legs," that person is actually already experiencing neuropathy, probably associated with their diabetes. You could do monofilament examination and still get a 10/10, so that's why. Remember, you're doing a large fiber testing when you do the monofilament exams.

For neuropathy, as I said, you can do large fiber, that's your touch. Small fibers are sharp shooting pain, your tingling, your numbness, your burning. I've actually had a patient that had a burning hot foot. She literally told me her foot was on fire for five years. So, it's very scary. It limits people's active lifestyle, so it's really something that we need to address early on.

For our monofilament examinations when you're doing the documentation, it's very, very important that we're all documenting the same way, so that we're all comparing apples to apples. So, you always want to document bilaterally and you always want to document amputations. That even includes toe amputations. If you don't know the fancy words, transmetatarsal amputation or Lisfranc, that doesn't matter. You can always say they had a, "Right third toe amputation" or "They had a right midfoot amputation." Then we're all on the same page. And you want to always refer your abnormal examinations for follow-up.

I would of course, I'm a podiatrist, so I would prefer that a podiatrist see any of our patients with diabetes that have an abnormal exam. I wish that we can get podiatrists at every site across the Indian Country, but I know that we do not have those. So, I want to make sure that if we have sites that are having nurse-based run clinics, please make sure anybody that has an abnormal exam. Make sure they're getting in to see a provider that can actually either address the neuropathy or if the person has PAD, Peripheral Arterial Disease, get them out to see a vascular doctor. Someone, somewhere that can them out to the people that need to see them to address those abnormalities.

For neurological testing, you can also go a step further. A lot of the sites don't have nerve conduction velocity capability, but I put it in here just to be complete. Also, a lot of people, we need to make sure that we're discerning between, do they actually have diabetic peripheral neuropathy, or do they have just an isolated one-nerve tarsal tunnel syndrome? Versus just like neuritis, like a lateral calcaneal nerve might be compressed and shows symptoms.

There's three types of peripheral neuropathy, a lot of people don't realize this. I put it in to be complete, there's sensory, there's autonomic, and there's motor. So of course sensory, that's when the people are feeling cold or burning foot, they're feeling a sharp shooting pain. Autonomic, you ever look at those patients that have diabetes and they really don't have a lot of skin growth and their skin gets -- I mean hair growth and their skin gets really dry and it looks like -- I always tease my patients that they're chizzy, but they always look like they have dry skin. That's a component of having neuropathy.

And then if you look at your patients and they start to have that appearance of their skin is sunken in between the toes, at the toe bases. That's actually motor. That's atrophy of the muscles. So then it all rotates around the nerve is not functioning the way that they're supposed to.

Also with that we want make sure that when we're looking at our patients that have diabetes for an extended period of time, they also lose their spatial orientation. So that's why they kind of widen their gait and walk like a duck. So, sometimes we want to make sure that if they are doing that, we might want ask them if they need any ambulatory assistance like a walker, or a cane or something like that.

We'll move on to the vascular exam. With the vascular exam, I put DPPT; those are just simple initials for dorsalis pedis and a posterior tibial artery examination. The dorsalis pedis runs along the middle of the dorsum of the foot and the posterior tibial runs behind the medial malleolus.

Very easy to check. Very difficult when you first start learning. You have to make sure you're getting the patient's pulse and not your own. But the more you do it, the better you're going to get at it, and it's wonderful to make sure that our patients actually have enough blood flow going down to their feet.

Other ways that you can tell if they have enough blood flow-- do they have hair growth on their toes? Now one thing to be aware of when you're talking to young ladies who have diabetes, ask them, do they shave their toes? Because I have a lot of young ladies who shave their toes just for -- they think it's prettier without the hair.

You want to check their temperature, we always check from the tibial tuberosity or the front of the leg down to the dorsum of the foot. And that would go anything from warm to warm, or warm to cool, or cool to cold. It just gives people a sensation of, this person is actually starting to lose some blood flow going to their leg, and they're not able to monitor their temperature as well. So that's why were able to put that in.

Varicosity, that's when you ever look at somebody's legs and they have those railroad tracks like those blue or purple. They look tortuous like it's underneath their skin. They look like little worms are crawling underneath their skin. Those are actually varicose veins, and they're very interesting, if a patient has those, that somebody puts it into their chart, because down the line when we get older, and our skin thins, we can have difficulties with those varicose veins. We can also have edema or swelling associated with the varicose veins. And if we do, then we need to make sure that we're treating those patients, whether it's elevation or compression stockings.

Next thing we want to look at when we're doing the vascular testing, when you're putting a DP or PT in, you want to -- here when we work with podiatry, we use numbers, 0/4, 1/4, 2/4, 3/4, or 4/4. 0/4 would be you can't feel it at all. 1/4, it's diminished, 2/4 is normal, 3/4 is normal to bounding like you've just barely touched their skin and you could really feel that pulse boom, boom, booming. 4/4 is literally you walk in the room and you can see their pulse across the room.

When you do your vascular testing, whether it's the pulse or you're looking at capillary fill time or hair growth or they're cool or they're cold to touch. If they have problems, if there are any technical difficulties in doing the exam, have someone else do it for you. But if you find that they're abnormal, please let's get our patients intervention early so that we can save their limbs. We have so many patients that for years, they don't realize they have peripheral arterial disease, and by the time we find out, we're cutting stuff off. We want to get in there earlier.

So, a few things that you can think of. You want to send them off for -- first round is usually non-invasive studies. Some sites are able to do, in the olden days, everybody said, "Let's do ABIs." ABIs were very good. They're very good for patients who don't have diabetes. Here at my site, we don't use ABIs because they're called -- its Arm Brachial Index. Our patients have such calcified vessels, that we do not compress their blood vessels, so the ABIs don't mean anything to us. They're elevated. They're abnormal. So we don't even use that.

Here at our site, our noninvasive tests are actually an SPP, which actually does skin pressure or a PVR waveform. Not all sites again have those, but if you don't have them, please send the patient out to a vascular surgeon to get evaluated. But again, as I've said, those are noninvasive.

Now if the patient goes to a vascular surgeon, they do the noninvasive test and they're abnormal, they'll proceed the patient on to invasive studies. Those include like your angiogram. They're actually going to do an injection in their groin usually, inject a dye and see if they have blood vessels that are running off and down into the feet and toes. And that's what we're talking about when you see the distal runoff and the trifurcation.

When you're doing the invasive testing, I always tell people, "Refer, refer, refer. You will never go wrong if somebody has an abnormal vascular study to refer them to a vascular surgeon." You'll never go wrong because you're going to get there sooner rather than later. If a person has a small decrease or a stenosis, the blood vessels closing down and the doctor can get in there and do what we call an angioplasty. Oh I'm sorry, that first one is angiogram. I guess I can't type.

The angiogram is when you inject the dye to see if the vessels are open. But, say one of the vessels closed down, the doctor will pass like, I tell my patients they're passing like a little wire in there and they open up a balloon to open that vessel back up. If they do that and they think it's going to collapse very quickly then sometimes they'll place a stent. And when I explain stents to my patients, I tell them, imagine putting a small little piece of a straw inside your artery to keep it open so the blood can go through. That's what a stent is. If the patient can't have any of those done, and it is a viable option, then they would do bypasses. But that's all done at the vascular surgeon and at a good 90% of our facilities we're sending those patients out.

For the muscular-skeletal examination, all we really expect is gross deformities. When you look at a patient and they have a bunion, that's when they have the bump on the inside of their big toe area, that's a bunion. Just put down positive bunion on the right. Now, hammertoes, big fancy word for contracted toes. All you have to write down is contracted toes 2, 3, and 4 on the left; 2 and 5 on the right. Everybody will know what that means and you've done a muscular skeletal examination.

So, any of these things that I have put on underneath those would be considered part of a muscular-skeletal exam. A midfoot breach for us, that means a person usually has already have developed Charcot. I'll explain Charcot later next and I have a couple of pictures.

Pes cavus is when somebody has really high arch and pes planus is when people have a really low arch. In Indian Country, about 90% of our patients are flatfooted. I call them pes pancakus. They have flat feet that are just flat as a pancake. But you can always put flatfoot. You can always put high arch. You don't have to know the medical savvy name, that's okay and acceptable.

I talked before the amputations, again, just put down, "5th toe amputation, right foot. Midfoot amputation, left foot," and that's acceptable for everybody. And Charcot is a very devastating problem that we're handling on the reservation and I would love to do another presentation on that down the road, so that we can learn how to isolate and find that and notice it earlier so that we can prevent a lot of the deformities that we're seeing.

Now this picture is actually a patient that has Charcot. If you can the middle of the foot where it's fat and edematous and there's actually a bump on top of the foot, and a bump on the bottom. Inside this foot, the bones are starting to break down. Charcot is called neuropathic osteoarthropathy. Don't get scared, it's a big fancy word for the nerves aren't working right. They're not sending the messages back to the brain the way that they're supposed to. So a neurotypical patient that has full sensation, if they break their bone, they feel that. It's painful. They get off of it. A patient that has Charcot doesn't

feel it, so they continue to walk and they break it down more and more, and subsequently they have other small fractures around this.

Now, I think I have an X-ray, yes. Right here is an X-ray and if you look at the midfoot, remember on the one slide, I said a midfoot breach. This patient actually has a midfoot breach. If you look at the bottom of their foot, it actually looks like a rocker bottom, so whenever you've seen notes that say rocker bottom deformities; this is what we're talking about. The person's midfoot has completely collapsed down and they're walking on bones that they shouldn't. This is the deformity that we want to try to prevent. We want to get there earlier rather than later.

So for a dermatological exam, if you can just do the basics, that's all we need. We just need to know, does the patient have normal skin? Does it feel normal? Are the nails normal? Are the nails thick? Are they ingrown on the corners? If they're ingrown or are they a little red? If they're ingrown with red, they need to be referred out because they probably need the ingrown taken out.

When I put down texture and turgor, I always tell people, pinch the skin. If it goes right down, real gentle and easy, beautiful. If it stays tented up, that means that usually means that person a few things, either they're getting older and they don't have fat underneath their skin like they used to or they could be getting dehydrated. But those are things you want to look for.

When I put in tinea pedis, that is, think athlete's foot. Think that rash between the toes or you look at the bottom of the foot and they have that dry kind of scaly peeling, either between the toes or even on a moccasin distribution, a low moccasin, not a high moccasin. Those on the Indian Country would definitely appreciate and laugh at that one.

So, what you're looking at is actually a fungal infection. We have had patients that have had tinea pedis or athlete's foot that has not been addressed, that they go on to a secondary bacterial infection and they end up getting admitted for IV antibiotics. So it's really important if you see this tinea pedis, actually treat it. You can put them on topical antifungal. If people are interested, we actually have handouts. We have people change their socks twice a day. Alternate their shoes because it takes a full day for their shoes to dry out. Put a little powder on their feet before they put their socks on in the morning, get tinactin and spray their feet and their shoes twice a day. If anybody wants those, we can always get a copy of the handout attached and people can use it wherever they would like. But that's really critical and crucial. We see so many hospital bed stays attributed to a cellulitis associated from a tinea pedis. So, if we can get there quick and solve the problem early, we can help our patients have a much better life.

And then of course with wounds, wounds is an entire category onto itself. But I just want it to touch it very gently, just to give people an idea. At the end of the day, if we do no harm, we're all on the right path. So, for wounds I wanted to go over just really quickly the grades and the types as well. When you look at this picture, this person, slightly on the inside of their -- at the base of their big toe, you see that little bump developing, they have the beginning of a bunion. If you look at the fourth and fifth toes how they're curling just a little bit. Well, actually it's the third, fourth, and fifth, those are contracted digits or hammertoes. Did you notice all the nails? They look thick. They look yellow. They have, like crumbles underneath the nails. That's a fungal nail infection. And those are all what you want to take into consideration when you're doing a dermatological exam.

We got a lot just from five seconds looking at a picture huh? The next picture, this one I just wanted to show people because a lot of people don't realize two things. Number one, we get a lot of people that get contact dermatitis. This is actually a guy that was working on, he works on the highways and he was mixing cement and he didn't realize that the fumes from the powder when he was mixing the cement was getting down in his sock. This is a contact dermatitis.

Also we want to make sure that people, while I look at this, this always makes me think of like scalded skin and patients that soak their feet. I always tell my patients who have diabetes to not soak their feet. Again I say, do not soak their feet for several reasons. Number one, if they have that small nerve fiber neuropathy, they can't feel if the temperature of the water is too hot. And we've actually had people come in with horrific burns on their feet because they put their foot in scalding water and didn't know it. And then number two, there's also bacteria in water that people aren't aware of.

On the bottom of this foot, you're actually looking at a diabetic ulcer. This is a neuropathic ulcer. Usually neuropathic ulcers are on weight bearing surfaces. As you can see that this person has two, there's 1.1 and 1.2, three areas. Patients can't feel pressure. Usually you get callus formation. Usually, it feels like it's painful. You kind of let up off of it, your body throws up off your body weight. When you're diabetic and you have neuropathy, you don't feel that, you keep on walking until you walk that callus straight through to an ulcer which is on the bottom. Again, this is the same neuropathic ulcers after they've been debrided.

Neuropathic ulcers are really easy to spot, they're on weight-bearing surfaces and they usually have calluses on them. Because again patients can't feel, so they continue to walk on them. And it's also a good way to see if your patients are paying attention to you. Because anytime a patient of mine that has a wound on the bottom of the foot, they're either partial weight-bearing or non-weight bearing, and they come in weekly every other week if they're stable. And when I look at them and they have a large callus formation, I know they've been walking without their crutches or walkers. So, sometimes patients' feet will tell on them.

Okay, so again, of course for me, I'm just really big on no soaking. I've seen so many problems with it on our site, and our patients just don't need these problems especially if they have diabetes that's out of control.

So, remember, you know there's pseudomonas in water. It's polymicrobial. They can get burns if they have an associated neuropathy. So, just try to keep that in the back of your head. This patient actually, this is one of our patients that got that burn because he put his foot down in scalding water.

So, it's a very big concern and people don't realize it. When they tell people, "Oh, just go ahead and soak." There are some products out there that if they need to cleanse the area or even if we use saline, that's better than telling a person to soak that has neuropathy that might get a burn. Okay, I'll get off my soapbox now, I'm sorry everybody. So again, that was the same person that had a burn after they had the debridement.

Again, this is the patient with neuropathic ulcers. Again, for me, bottom line, "Do no harm." If you're doing wound care or if you're even just doing the entry level wound care, two things I always tell people to keep in the forefront of their head. Number one, if it's too wet, if it's soupy, dry it up. If it's too dry, moisten it. Wounds usually heal better in a moist environment, but there is one thing to always keep and it's a cardinal sin in my book if you do this. If a person has nice, dry, stable eschar or we call it dry gangrene, please do not wet it. If you wet it, it becomes a wet gangrene; it's a surgical emergency.

I'll try to repeat that again because I know I'm on a soap box but, if you have a nice, stable, dry gangrene like some of those our older grandmas and grandpas that get those heel ulcers, those eschars on the heels, take the pressure off but please don't moisten those up. If you moisten those up, sometimes underneath, it goes straight down because at that point, you have a pressure ulcer, you don't know what stage it is underneath that eschar, you don't know how deep it went and if you moisten it, it goes down to bone and we're in a big, big puddle of problems.

Risk-appropriate education is crucial. A lot of our patients that come in, they tell me, when I ask them if they have diabetes, they say that's what they told me. So, with that type of patient, I just do standard

general education. I will look at their A1C; if their A1C is high I also will try to sneak in a little bit about diet. And then of course, if patients immediately say, "Well I don't eat candy". Then I actually try to slide in a little bit of information about like, carbohydrates actually will affect your sugars and then if your sugars are too high for a long period of time, you know your eyes could be affected, your kidneys could be affected.

If they're in the denial stage, I try to gently sneak all that stuff in, hoping some of it will absorb in when they get home. But I always make sure that we go over the daily examination. Check their feet every single day, take ten seconds, top, bottom and between their toes. I tell them, "You're looking for anything abnormal." They know their feet better than anybody else. If they have corns, calluses, ingrown toe nails, anything that they see that is different, a discoloration. A lot of people drop stuff on their toenails and they started to get that black or blue underneath their toe, I tell them, "Get in to see a doctor right away. It's better to be safe than sorry." I'd rather them come to the hospital and us tell them it's nothing, then to not come in, when they show up, we're cutting off toes.

Another thing that we always try to cover with our diabetic patient population at least once a year is shoe gear. Shoe gear for me, if you just tell the patient to check their shoes, make sure that they are alternating their shoes and make sure when the tread breaks down, that they're getting new shoes, that's awesome. For us, we do a little bit more but if you can at least do the standards for them, and a lot of patients don't realize what tread is. So I always turn the shoes over, show them those little bumps on the bottom of the shoes which is tread, and show them where they're wearing it off and tell them when you wear it down, then that shoes outlived its usefulness.

I always tell patients, if they are going to cut their toenails at home, because we have a lot of patients that have diabetes, their A1Cs are six or seven even. They can bend over, they don't have limitations in their back, they don't have dementia, they're very able to take care of their own health and they're aware and they can take on the responsibility. We will train them to cut their nails straight across. I tell them straight across because if they can't see the corners and they cut down into the corners and leave a nail spicule behind, then they're setting themselves up for an ingrown. But we have a lot of patients that cut their own nails.

I again go over no soaking and then I always tell people if they have ingrowns to make sure that they come in. We have a lot of patients that have ingrowns, not for any fault of their own, it's just genetic. It runs in families. So, it's nothing that they did. I just try to make them aware of it. Let them know come in, if we cut the nail properly, sometimes we can keep them out of trouble. But sometimes they actually need surgical intervention for those ingrown so that they don't run into problems down the road.

I just wanted to let everybody know that when we're looking down the road, when we're all on the same page and we're all talking the same language, I would love for us to be able to use the International Work Group on the Diabetic Foot.

And so that anybody, anywhere, whether you're on Cherokee land or in Seminole Country. If somebody sends a stage 1 from the International Work Group on Diabetic Foot, we all know that that patient has diabetes, but they have no peripheral neuropathy and no peripheral arterial disease. So, we're all on the same page.

This is actually tells us what the risk is of our patients to develop ulcers, infections, amputations, and hospitalizations. It's very true. It's very real. This actually converts into real life dollars. This actually converts into a real life daily quality of life for our patients. So, if they're stage 1 and they have, PN means peripheral neuropathy, but they don't have any PAD, which is peripheral arterial disease, and they don't have any deformities. They don't have those hammertoes. They don't have the bunions. Then they are 2.5% -- 2.4% risk of getting an ulcer, 1.9% to get an infection, 0% for amputation, thank God. But, they probably have the 10% chance of getting a hospitalization of some sort.

And then in 2A -- I won't read them down. I know everybody can read those, but I would love for us all to be able to get to the stage where we're using this terminology and we're always comparing apples to apples.

Now, one thing I did want to draw to everybody's attention, stage 3B; a person with the description of an amputation. Risk of complications by odds: 52% chance of getting an ulcer, 62% chance of infection, 567% of getting an additional amputation, 650% to go into hospitalization. Those are staggering numbers. Those are numbers that scare me and make me want to just be so proactive that none of our patients end up with amputations.

So, for us shoes are a real big deal. They have shown across the board in the literature in at least the last ten years, but over the last 20 years, that getting a patient in a good diabetic shoe every year can decrease the chances of ulcerations and amputations. It's real life, it's in the literature, it's out there. I know not everybody can afford to send our patients or to give our patients diabetic shoes, but if your patients have insurance, you can actually refer them out and they are eligible for one pair of shoes every single year with three heat-molded inserts. I'm sorry; I just wanted to get that out to everybody.

But we have options. You can do a standard diabetic shoe. We actually have a shoe source here. Thankfully our diabetic grant money has helped us be able to provide shoes to our patients that don't have insurance. So, we actually do dispense shoes from here in our clinic, but we can always do the annual DM foot shoe referral and if anybody needs that, we actually have a therapeutic shoe referral form that we can just use. We fill it out, the patient has their primary care provider sign it and they can take it out to any DME provider that does diabetic shoes.

Always refer to a pedorthist for the diabetic shoes. We do have some places that -- the places that sell like maybe TED Hose or Jobst Stockings and Port-O-Potties and walkers. They're fantastic and we need them. If our patients have just standard diabetes with not a lot of deformities, no PAD or peripheral arterial disease, their neuropathy is limited, I have no problems with them getting their shoes from that place, because a lot of places just carry diabetic shoes on the shelf. If your patient has deformities, please refer them up to a pedorthist. It's the safest for our patients across the board.

Now, one thing of course, if you are already tied in, you already know very well about the IHS DDTP program. I think they're fantastic. They have a site, if you're interested, you can go there. They actually have, "How to do a diabetic examination?" They actually have videos on how to perform the examinations and you can get CMEs for them as well. So, I just wanted to include that for totality's sake.

For us, what we would love to spread across Indian Country is that everybody can at least do standard limited wound care. I wanted, a lot of places have been getting in contact with me saying, hey how do we do this? There's actually a certified foot care nurse program out there. I prefer the ones through WOCN, which is Wound, Ostomy and Continence Nursing certification. They're fantastic. I'm actually - I guess a little prejudiced because my nurse here at my site is WOCN. There are others out there but this is the one that I'm familiar with and it seems to be the gold standard for wounds across the board. So I just included that if there are any sites that are interested in knowing how to do that.

So, the certified wound care nurse, WOCN, you can go to this site. It shows you how to do it, how many hours you have to have and passing the examination. There's also a certified wound care nurse, WCEI. I included that because I didn't want people to say I was being -- showing preference to WOCN even though I do, I'm sorry. But there is nothing wrong with WCEI so I included that as well.

On top of that, Diabetic Foot Exam Competency, I do a, basically, whenever I'm teaching somebody new on how to do a monofilament exam, I go through and I give them a lecture. And for my people, they have to have an annual competency in order to do a Semmes-Weinstein monofilament

examination here at our site. We've trained them here in podiatry clinic. I've trained them in the family medicine clinic and the internal medicine clinic. This can really be a nurse-driven program, so that more of our patients can get their annual examinations completed and I feel for this. I really want to get this across that if you don't have any providers, any-- nurses are providers, I want to say that first and foremost, but if you don't have a provider that can bill for a visit, your nurses can still do the standard examination and we have to get this done at point of care contact. So, I'll get off my soapbox but that's what I usually do.

Along with that competency, they actually have to pass the exam, a test. So, these are questions that I ask for them to pass their examination for their annual exam. So, I included it so that you could have it at your site if you would like it. Here is the competency quiz. Out of the ten questions; they have to be higher than 70% to show that they are competent. And along with that, they also have to show back to me a certain amount whether you choose three or five examinations, that they're able to do it and document it correctly. So, that's for our site.

Documentation in EHR, you need to go to the Visit Elements tab. I know everybody has slightly different setups for their EHR so I'm telling you how it's setup on ours and then I have some screenshots to show you what it should look like on yours. So visit your Elements tab, your Visit Elements tab, go under Screening Factors, under Exams, you're going to add, that's usually also the right hand side and what you're looking for is the Diabetic Foot Exam Complete. It's the number 28. I always say the DME X28 at my site and everybody laughs. They're like, "What are you talking about?" This is what I'm talking about, you just need to choose or select the 28 and then in that way, it dumps it into your RPMS system. Remember, EHR is just a big candy wrapper around RPMS. So, it dumps it in and anybody can draw that data out of there.

So, this is a screenshot of what it would look like and then when your monofilament examination documentation in EHR for nursing technicians, it had come to my attention that there were some sites that nurse assistants and technicians fall under nurses. And if they would put in, this screenshot is small but when you look at it on your site, there is an area where it says, Resolved. And it says Normal or Abnormal. Some people were concerned that that was being taken that the nurse aides or the technicians were actually making a medical diagnosis. So, what we do at our site, there is actually a comment box, and in that comment box, your nurse aide or your technician can write in nine out of ten on the right, seven out of ten on the left, and put Add. They've completed the examination but they are not making a diagnosis.

So, for those sites that do not have their nurses doing the exam, they actually have their technicians and nurse aides, they do it in the comment section. For the nursing staff and for nurse practitioners, and physician assistants and all the regular MDs, DOs, podiatry, dental, everybody else out there, we can go underneath and do the results, abnormal or normal.

For the diabetic foot care documentation, like I said in the comment section, for proper charting, you got to remember, you have to say what did they feel. Here at our site, I teach the ten sites. It was the standard, it's been the standard for probably 50-60 years and I know the American Diabetes Association just recently has gone to the four spot checks. Because I've been here at my site for ten years and I've taught everybody the ten, we still follow through with the ten so that's why I have the numbers here over ten

If you are at a site and you are following the new ADA standards, that's fine. Your number would be over four. So, you would put monofilament examination, 10/10 on the right, 10/10 on the left or 2/10 on the right, et cetera. If the patient feels less than ten areas, then place that number over ten for example, 6/10 or 4/10. For here at our site, what I have just tried to make it easy for everybody, if the patient has a 10/10, it's normal. If it's 9/10 or lower, it's abnormal, give them a podiatry referral, because we're here on site. So, that's how we do it here at our site.

For your diabetic foot care education, that is a little bit different. For you to be able to capture it, make sure you go to the foot care education documentation in EHR under the Visit Elements tab, put patient education and for us how we are tracking it here in Navajo Area, we're typing in diabetes and we're using the diabetes mellitus foot care and exam. That's the education that we're tracking, so that we're all comparing whether we're here at Gallup or you're over at Tuba City. We're all comparing the same information.

And that's it from my side of the world. Thank you all for attending and participating.