Quality and Meaningful Use in Migrant Care

Session 7: Orientation to Migration Health

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Disclosure Statement

- **Faculty:** Ed Zuroweste, MD
- **Disclosure:** I have no real or perceived vested interests that relate to this presentation nor do I have any relationships with pharmaceutical companies, biomedical device manufacturers, and/or other corporations whose products or services are related to pertinent therapeutic areas.
Objectives

• Why is Quality important in M/CHCs?
• Why is it important to know “Migrant Specific” Quality Data?
• How to “think out of the box” to create QI program objectives for mobile patients
• Know and understand our patient population and “reach out” to the community to tap all resources.

Quality Improvement Best Practice #1

Retinal exams for DM patients...

Scarce ophthalmology + Expensive & inconvenient for patients = Poor Outcomes
Bring technology in-house

1. Retinal camera via grant
2. Trained staff to take retinal pictures
3. CMO trained to do "preliminary screening"
4. Ophthalmology agreed to review all abnormal exam
Results Measure

\[ \approx 10\% \rightarrow \approx 90\% \]

What is Quality Improvement?

“However beautiful the strategy, you should occasionally look at the results.”

Winston Churchill
What do we need in QI Program?

- Patient Satisfaction Surveys
- Credentialing/Privileging
- Performance improvement projects
- BPHC Clinical Performance Measures
- Peer Review/Chart Audits
- Risk Evaluation
- High risk, poor performing or bad outcomes

Data

Data

Data
Meaningful Data

• Accurate
• User friendly
• Rapid
• Consistent
• Retrievable with multiple variables
• Able to search for migrant patients and other subgroups of patients
Use Data to Promote Change/Improvement

Accurate Data is your friend!

- Good analysis is key
- When you see areas that need improvement DO SOMETHING!
- Decide on intervention
- If intervention improves outcome—institutionalize
- If interventions do not improve outcome—try again
- Should be aggregate but also clinician/team specific
- Display the data for all staff, BOD and community
Quality Improvement Best Practice #2

Cervical cancer screening...

- Provider male non-Spanish speaker
- No extended hours
- Co-pay
- Low rates of cervical cancer screening
Root causes of poor outcomes

Pap results were not being sent from Health Dept. and when they were they were “scanned into EHR” and not retrievable

Female Spanish speaking NP reassigned to site

Policy and procedure for “outside lab results” developed and implemented

Community awareness campaign begun by bilingual community health workers
Results Measure

\(~20\%\) \rightarrow \sim \(50\%\) ...in one year

16 Required Clinical Performance Measures

See HRSA NAP website and UDS Manual for measure details, exclusions, and sampling methodology
Health Outcomes and Disparities

Percentage of diabetic patients whose HbA1c levels are < 7 percent, < 8 percent, ≤ 9 percent, or > 9 percent

Percentage of adult patients with diagnosed hypertension whose most recent blood pressure was less than 140/90

Percentage of births less than 2,500 grams to health center patients

Outreach/Quality of Care Indicators

Percentage of pregnant women beginning prenatal care in first trimester

Percentage of children who have received age appropriate vaccines on or before their 3rd birthday

Percentage of women age 21-64 who received one or more tests to screen for cervical cancer

Percentage of patients age 2-17 who had a visit during the current year and who had Body Mass Index (BMI) documentation, counseling for nutrition, and counseling for physical activity during the measurement year
Outreach/Quality of Care Indicators

- Percentage of patients age 18 years or older who had their Body Mass Index (BMI) calculated at the last visit or within the last six months and, if they were overweight or underweight, had a follow-up plan documented.

- Percentage of patients age 18 years and older who were queried about tobacco use one or more times within 24 months.

- Percentage of patients age 18 years and older who are users of tobacco and who received (charted) advice to quit smoking or tobacco use.

Outreach/Quality of Care Indicators

- Percentage of patients age 5 to 40 years with a diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed either the preferred long term control medication or an acceptable alternative pharmacological therapy during the current year.

- Percentage of patients age 18 years and older with a diagnosis of Coronary Artery Disease prescribed a lipid lowering therapy (based on current ACC/AHA guidelines) during the measurement year.
Outreach/Quality of Care Indicators

Percentage of patients age 18 years and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG), or percutaneous transluminal coronary angioplasty (PTCA), or who had a diagnosis of Ischemic Vascular Disease (IVD), and who had documentation of use of aspirin or another antithrombotic during the measurement year.

Percentage of patients age 50 to 75 years who had appropriate screening for colorectal cancer (includes colonoscopy ≤ 10 years, flexible sigmoidoscopy ≤ 5 years, or annual fecal occult blood test).

Migrant Specific Clinical Measures
Migrant Specific Clinical Measures

Percent of migrant patients ≥ 18 years of age with blood pressure ≥ 140/90 who are successfully referred for care.

Calculation: Farmworker patients seen outside of the clinic setting with documented BP of ≥140/90 who are 1) referred for care and 2) are seen by a provider/Total farmworker patients seen outside of the clinic setting with documented BP of ≥140/90.

Migrant Specific Clinical Measures

Percent of registered farmworker patients who receive pesticide prevention education

Calculation: Farmworker patients with documented pesticide prevention education/Total registered farmworker patients.
Migrant Specific Clinical Measures

Percent of migrant women who have documented screening for sexual violence during the measurement year

Migrant Specific Clinical Measures

Percent of migrant patients ≥12 years who have documented tobacco use status during the measurement year (This is now one of the 16 required core clinical measures)
Clinicians with equal privileges can review each other despite training
Objective measures is preferred method of review
Builds teamwork and consistency of quality care
Should review high risk; high volume, adverse outcomes; poor performance measures
Use results to improve care
Use results as component of clinician yearly evaluation
Peer Review Audit Form  
Quarter 2013-03  Audit Date 8/7/10  Clinician Reviewed E Zuwoweste Topic  Diabetes Mellitus  
Reviewer C Kugel Pt Name  ID  Visit Date  

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Were there an appropriate number of visits in the past year (2 if well controlled A1C &lt;7.0 or 4 if A1C &gt;7.0)?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>2. Were there an appropriate number of HbA1c measurements in the past year (2 A1c per year if A1c &lt;7.0 &amp; no treatment changes, or at least 3-4 A1c in past year if A1c &gt;7)?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>3. Was there an assessment for nephropathy in the past year with appropriate follow-up including:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3a. Was urine albumin/creatinine measured in the past year?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>3b. Was an eGFR measured in the past year?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>3c. Was there appropriate treatment plan (e.g. blood pressure, glycemic control, and ACE or ARB addressed) if ACR&gt;300 or eGFR &lt;60?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>4. Was a lipid profile performed in past year?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>4a. If LDL &gt;100, was it addressed (i.e. considered med change) &amp; followed up?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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<tr>
<td>5. Was hypertension managed appropriately (e.g. If SBP&gt;130 or DBP&gt;80 was it addressed, medication change considered, and follow-up given)?</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
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**Productivity vs Quality**

- Clinician productivity should always be evaluated within the larger context of clinical and financial quality outcomes
- Future trends toward payment based on quality not quantity of care

Productivity vs Quality
Retention & Recruitment

Quality clinicians look for health centers that demonstrate quality care.

A CHC that embodies a “culture of quality” will attract quality clinicians.

Clinicians are very interested in quality outcomes of their patients.

Social Determinants of Health

Photo: E Zuroweste
• Most of what determines a “good outcome” lies outside the health center
• Work with community leaders/organizations
• Needs assessments; patient surveys; outreach
• Identify barriers/develop multipronged approach to resolve

Enrolled in Health Network 8/02
“Fernando” is a 56 year old migrant farmworker diagnosed with diabetes at age 49. He traveled each year from South Texas to Minnesota or “wherever I can find work.”

Over the ten years Fernando was close out of Health Network 2013 because he said that he no longer had medical records transferred. He was no longer going to different clinics.

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Fernando’s HBA1c While Enrolled in Health Network

Health Network

Ongoing communication
Care coordination services
Store & transfer medical records
Healthy education
Toll-free access
Expert, bilingual, culturally-competent staff

Bridge Case Management
Health Network

- Helps to assure continuity of care
- Outcome treatments equal to that among geographically stable populations
- Clinicians have access to data from other health centers
- Model for management of diseases in mobile populations

Contact

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