

Disparity in Preventive Eye Examination

by Greer Lauren Geiger, M.D

The disparity in preventive eye examination in Alabama, relative to the nation, likely has many factors. For starters, this is a very rural state with close to 50% having not completed high school. The average statewide family income is \$25,000 a year. There is a high percentage of working poor who are uninsured.

The poor typically underutilize health care in general, fearful of expenses they cannot afford. Few realize that there are non-profit organizations that may help with financing needed care.

For minorities, there is a significant component based in “distrust” of the medical system, hospitals, etc. The history of the Tuskegee Syphilis Study and its abuses of patient trust are still very vivid in the African-American community, particularly in rural areas.

A prime contributor is “denial” on the patient’s part and incomplete information on the physician’s part. This is where we can make our biggest impact. For the physician’s part, primary provider or otherwise, one must impart firmly that having their patient’s eyes checked routinely is essential to prevent unnecessary loss of vision. This commonly is under-emphasized, and there is no formal plan to insure an exam has been undertaken. Early detection allows treatment before vision is affected. It must be stressed that blindness is not inevitable because the patient has diabetes. The routine office visit with the primary care physician is the opportune time to schedule the patient’s appointment with the eye care professional. The eye care professional must also do a better job communicating findings to the patient’s primary doctor as many patients appropriately come in on their own. They need to routinely inquire who their primary care doctor is and forward a report along with recommended treatment and interval of exam. This fosters coordinated care and heightens the patient’s insight into this being important.

For the patient, particularly those with close family or friends with diabetes, they have witnessed blindness or other ravages of diabetes. They are terrified of suffering the same fate and are often in denial when they develop symptoms. They typically do not acknowledge these feelings to their busy doctor and stay away until their symptoms have caused functional impairment. The physician can be a tremendous help in inquiring, as part of follow-up, on how the patient is coping emotionally with their disease and/or complications. The ophthalmologist in particular can volunteer typical fears that patients experience when confronting vision loss which opens the doors to the patient to communicate and perhaps receive help. Confronting fears, educating the patient and letting them know that blindness is not inevitable will go a long way toward improving compliance.



Greer Lauren Geiger, M.D.
Diseases and Surgery of the
Retina and Vitreous
Brookwood Eye Institute

“Come on Alabama - We Can Do Better”

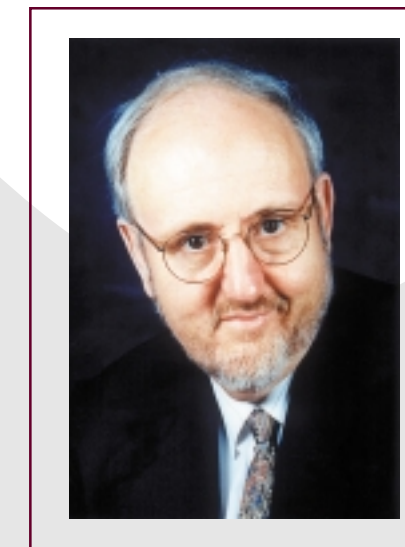
by David S. H. Bell, M.D., F.A.C.E.

An article in *JAMA* on October 4, 2000 concerning quality care in the U.S. showed each state’s ranking in certain areas of care. In all 50 states, Puerto Rico, and Washington D.C., as far as diabetes was concerned, Alabama’s performance ranked near the bottom. With regards to obtaining an annual hemoglobin A1c, Alabama ranked 48th. For obtaining a biennial eye examination, Alabama ranked 45th. Lastly, Alabama ranked 48th in obtaining a biennial lipid profile.

Poor performance on these quality indicators occurred in Alabama, which now has the dubious distinction of having the highest prevalence of diabetes in the United States. With this epidemic in place, our performance in treating diabetes should be a positive rather than a negative example to the rest of the nation. Action in improving our treatment of the patient with diabetes should not be mandated from the legislature in Montgomery or Congress in Washington, but should be voluntarily improved starting at the grass roots level of the primary care physician.

- How can we improve glycemic control if we don’t know how good or bad it is?
Please order an A1c at least twice yearly.
- How can we prevent blindness without an eye examination? **Please get an ophthalmology consult every year.**
- How can we prevent cardiovascular disease if we don’t know the lipid levels? **Please get an annual lipid profile.**
- How can we prevent kidney failure if we do not know that diabetic nephropathy is present? **Please order an annual renal profile and urine albumin.**
- How can we prevent amputations if we don’t at least annually do a comprehensive examination of the feet? **Please examine the feet of your patients with diabetes.**

With these simple interventions we can not only improve performance on quality indicators, but far more importantly, we can improve the longevity and quality of life of our patients with diabetes. **Therefore, recognizing that Alabama is number one in the prevalence of diabetes, our goal should be to become the number one state in the treatment of diabetes.**



David S. H. Bell, M.D., F.A.C.E.
Professor of Medicine
UAB School of Medicine

Let’s Get Alabama Immunized!

by Laurie T. Hall, M.D.

Internal Medicine

The Kirklin Clinic

Thousands of patients in Alabama who should receive annual vaccinations are not getting them! In a year which has been particularly difficult for physicians and caregivers due to a delay in availability of influenza vaccine, Alabama has been highlighted nationally as a state near the bottom in providing quality medical care. Ranking 44th in a national study which collected data from 1997-1999 on all fee-for-service Medicare beneficiaries across 24 care measures, Alabama lagged in pneumococcal and influenza immunizations failing to vaccinate 52% and 37% respectively.

Despite vaccine delays, the CDC is urging caregivers to give the influenza and pneumococcal vaccines to all high-risk patients including anyone over 65.

Pneumonia and influenza grouped together rank as the sixth leading cause of death in the United States across most age, sex and race categories. In Alabama, over **1400** people died from influenza and pneumonia in 1997. *Streptococcus pneumoniae* causes more deaths than any other vaccine preventable disease, yet in Alabama less than half of the Medicare patients are getting vaccinated.

Let’s make a resolution to provide medical care in a state recognized for the highest quality of care!

Let’s make a resolution to provide medical care in a state recognized for the highest quality of care!

- **Make influenza and pneumococcal vaccination a priority in your practice.**
- **Recruit your nurse and office staff by initiating standing orders for vaccination.**
- **Remember, most physicians overestimate how well they are immunizing their patients. Step back and see if your patients have been immunized.**
- **Screen all emergency department and hospitalized patients for immunization status.**
- **Don’t wait - make changes today to save lives!**

Annual Screening Mammogram Still the Best Detection

In the United States, 1 in 8 women will develop breast cancer during her lifetime. The American Cancer Society (ACS) estimated that 2700 new cases of breast cancer would be diagnosed among women in Alabama during 2000. ACS also estimated that 600 women in Alabama would die from breast cancer in 2000.

On January 1, 1998, the Health Care Financing Administration (HCFA) significantly changed its reimbursement policies regarding screening mammography. Medicare covers an annual screening mammogram for all women over the age of 40 who are covered under the program. In addition, the Medicare Part B deductible was waived, leaving only a 20% co-payment for the recipient. In the United States, approximately 44% of the women who were eligible for Medicare Part B **did not** get a mammogram during 1997 and 1998. This means Alabama's **failure rate** was approximately 45%.

We CAN do something to protect all the women in Alabama from suffering needlessly due to late stage breast cancer.

1. Educate all health care professionals on the importance of annual screening mammograms for all women over the age of 40.
2. Remind every female patient over the age of 40 to get her mammogram every year. A number of health insurance and managed care plans follow HCFA policy for coverage of mammography. Schedule the appointment for her.
3. Perform a thorough clinical breast exam, every year, on every female patient over the age of 20.
4. Display and distribute patient education materials to help educate all women on the need for early screening and monthly self breast exams.

Lori Langner of the Mid-South Division of the American Cancer Society reminds us, "An annual screening mammogram is still the most effective method of detecting breast cancer at its earliest stage. When combined with an annual breast exam by a health care professional, breast cancer can be detected at its earliest stages in all age groups. Breast cancer is over 96% curable if found in the early stages. The 5 year survival rate for localized breast cancer is 96%."

Alabama Quality Assurance Foundation (AQAF) is working on a unique directory called **AQAF's Good Health Guide**. The directory includes a brief description and contact information about ongoing health education programs and health support groups throughout the state.

February 15, 2001, is the anticipated date for the first publication with tentative plans for distribution at the AQAF Annual Conference February 22nd and 23rd at the HealthSouth Richard M. Scrushy Conference Center. Entries for next year's issue may be submitted on-line through the AQAF web site www.aqaf.com. Current entries can also be viewed on-line.

All directory participants will receive a free hardcopy for their organization.

Alabama Quality Assurance Foundation / One Perimeter Park South, Suite 200 North / Birmingham, Alabama 35243-2354

(205) 970-1600 • 1(800) 760-4350 • www.aqaf.com

James F DeLong, M. D.
Medical Director

Richard M. Allman, M.D.
HCQIP Director

E. Eugene Marsh, M.D.
Associate HCQIP Director

Patricia A. Burgess, R.N., B.S.N.
VP QIC

Laurie Hall, M.D.
Clinical Coordinator

Jeroan Allison, M. D.
Clinical Coordinator

Penny Pierce, R.N., B.S.N.
Outpatient Project Manager
alpro.pierce@sdps.org

Joan Wimberly, R.N.
Outpatient Project Manager
alpro.jwimberly@sdps.org

Sandra Richardson, R.H.I.A.
Outpatient Project Manager
alpro.srichard@sdps.org

Alison Muncy, M. S. P. H.
Outpatient Project Manager
alpro.amuncy@sdps.org

Kimberly Henderson
Editor / Writer

Kenny Glover
Layout / Design

Birmingham City Council Issues Resolution to Pratt City Community Health Advisors



Back row (left to right) - Ruth Henderson, Tina Steele and Francine Huckaby
Front row (left to right) - Sandra Montgomery, Claudia Hardy, Deborah Drake, Marie Ray and Margaret Perry

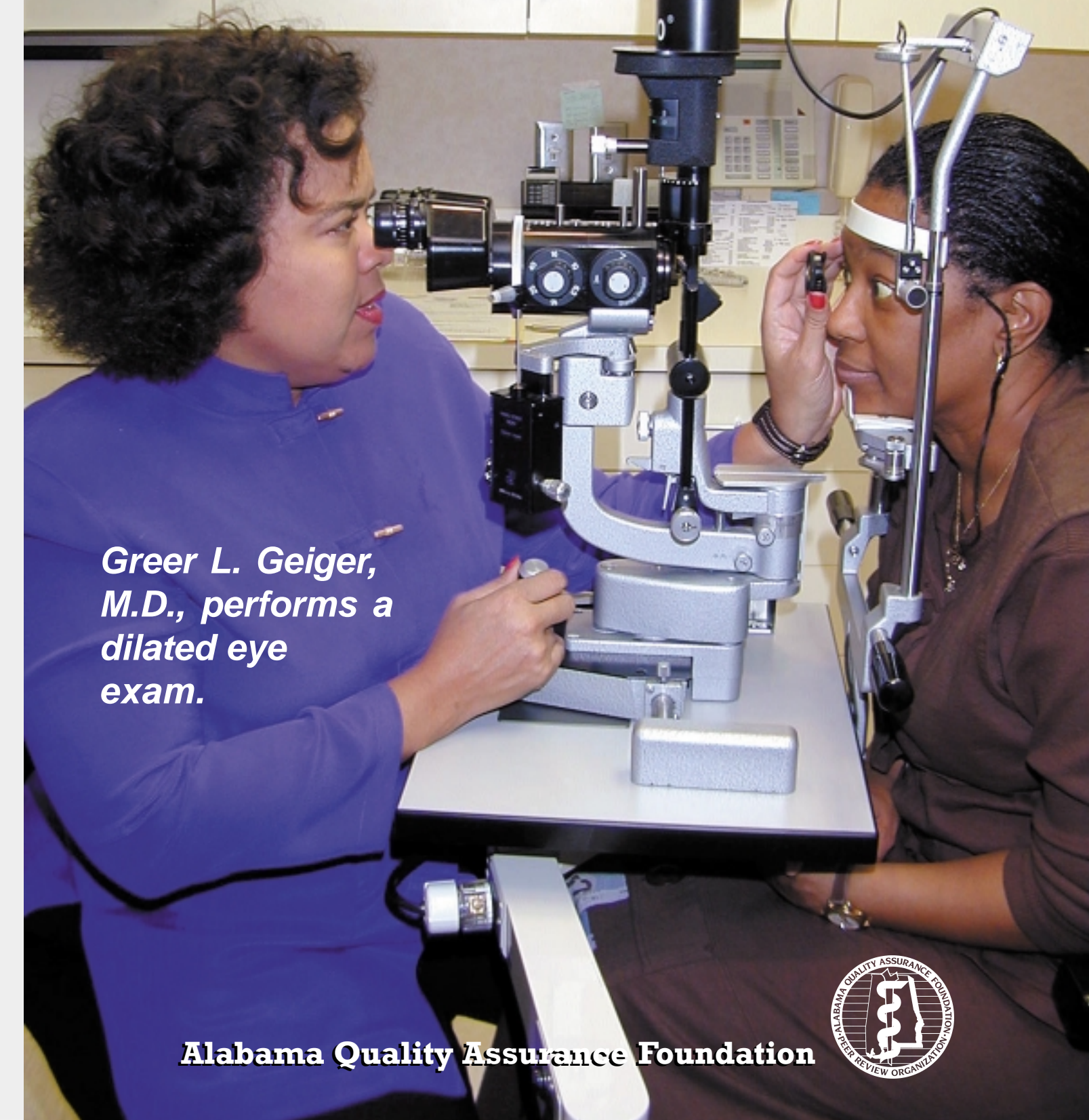
The Pratt City Community Health Advisors trained as Research Partners (CHARPs) were presented with a resolution from the City of Birmingham on January 9, 2001. The CHARPs are a part of the Deep South Network for Cancer Control, a National Cancer Institute funded program of the UAB Comprehensive Cancer Center. The goal of the program is to eliminate the disparity in cancer death rates between African-Americans and Caucasians in the Deep South. AQAF is proud to be partnering with the CHARPs to help increase mammography use among African-American women.

Quality Perspective is not copyrighted; please feel free to copy and distribute as you wish. If you choose to reproduce portions of this newsletter, please credit AQAF.

Quality Perspective

"Come on Alabama -
We Can Do Better"

February 2001
Outpatient



Greer L. Geiger, M.D., performs a dilated eye exam.

Alabama Quality Assurance Foundation

