DRAFT

CLINICAL MEASURES WORKBOOK
PART II
MIGRANT HEALTH CENTERS
MARCH 20, 1992

The Division of Primary Care Services thanks the Migrant Clinicians Network, the Migrant Workgroup members and other professionals from the United States Public Health Service and public health community who contributed their expertise and time to this project.

Part II. Migrant Health Clinical Measures

I. Introduction

When the issue of clinical measures was first being discussed in 1989, there was a consensus to await the results of an epidemiologic study of farm workers in the midwestern migratory stream before identifying specific migrant measures. The study, conducted by Dr. Alan Dever of the Mercer University School of Medicine, was supported by the National Migrant Resource Program, the Migrant Clinicians Network and the Bureau of Health Care Delivery and Assistance (BHCDA).

Utilizing the results of the deliberations and conclusions of the groups that developed the clinical measures for community health centers as well as the findings of the Dever study, a work group of migrant health center clinicians and BHCDA clinicians developed clinical measures for migrant health centers. These measures are similar to the measures for community health centers and are based on the same assumptions and principles. In addition, these measures are designed to fit into a migrant approach to the delivery of primary care. For example, migrant health center protocols that incorporate these measures should continue to utilize the CLEF approach that emphasizes the cultural, linguistic, environmental, and patient education issues as well as follow-up.

In general, differences between migrant health measures and community health measures are:

* a change in the definition of active user
* elimination of the trimester measure and geriatric life cycle specific measures
* addition of the prenatal data transfer measure in the perinatal life cycle and a TB screening measure in the pediatric life cycle.
* changes in the review criteria for cardiovascular risk

Lastly, the implementation plan for migrant health centers differs. Fiscal year 1991 is devoted to planning and the development of necessary protocols and systems in the migrant health center; fiscal year 1992 is also devoted to planning, development as well as the establishment of baseline information; fiscal year 1993 for continued development and completion of baseline setting; and fiscal year 1994 for reporting of progress in the grant application.

II. Sampling Method

Who

The definition of the life cycle to be sampled, including the age of the user and the definition of an "active user" is in the individual sections on each life cycle measure. The "active user" definition for the purposes of a review does not imply that episodic users of the C/MHC are less important. **In order to build continuity in the practice, BHCDA expects C/MHC to have systems that identify patients who are sporadic users and endeavor to reach them and engage them into becoming "active users."**

329/330 projects: Health centers that receive both Section 329 and 330 funds should attempt to include a representative sample of migrant users in the perinatal, pediatric, adolescent and adult lifecycles. It is understood that many projects may not be able to identify the charts of migrant users, but they should be working toward establishment of a system that will allow them to do this.

329 projects only: For health centers receiving only Section 329 funding, the definition of an active user is different, and described in each lifecycle section. These programs should use the MHC measures exclusively.

329 voucher programs: These projects should use the definition of active user as described in each lifecycle section as for 329 programs, but assess to what extent their contract and referral arrangements allow them to assess these measures. They may chose a subset of appropriate measures, in consultation with the Regional Office, that are appropriate for their practice and for which goals can be set.

When

The clinical measures are designed to be reported annually in the MHC application or progress report.

How

Sampling should be done on a regular basis. This makes data collection easier and provides timely information on progress, enabling the MHC to make mid-course corrections when necessary. In addition, when reviewing medical records for the clinical measures, other information gathering important to the MHC can be accomplished at the same time, e.g. individual provider performance evaluation, or quality assurance audits. **A medical record may be reviewed for more than one measure.** For example, a medical record from a woman aged 17 could be reviewed for family

planning counseling and behavioral risk assessment (see Table __).

MHC with 3000 or fewer users may sample fewer charts than described in the workbook. The MHC must work with the regional office to agree upon a reasonable number of charts to sample for that practice. MHC that are part of networks, consortia or that have satellite practices also need to establish with their regional office a method for sampling an appropriate and representative number of records. MHC that refer its patients for prenatal care are expected to work with their regional office to agree upon methods to obtain perinatal data.

At times, the MHC will have offered the needed service, e.g. vaccination, but the patient decides not to accept it, or the patient does not respond to a follow-up call or letter. Since there is always a certain number of "non-compliant" patients, this situation is unavoidable; yet, if the number of such patients appears significant, the reasons for this should be analyzed by the quality assurance committee. Thus, "non-compliant" patients should be counted in a random review. Lastly, in projecting a goal for a measure, the MHC and regional office should take into account the issue of "non-compliance."

MHC should maintain a record for two years of the medical records sampled and those in or out of compliance for follow-up. During the routine site visit, the clinical member of the team may wish to review a sample of these medical records.

Methods suggested for sampling include:

* Select a random number (e.g. every fifth record) of charts from one day's visits. This avoids a separate effort by medical record personnel to pull records.
* Produce a computer or manually generated list of users by lifecyle, and then select every fifth, tenth or twentieth record from the list until an appropriate sample is obtained.
* Use the method that is currently applied for the quality assurance program. This option should be exercised after consultation with the regional office.

Goal Setting

Although different time periods may be used during the implementation phase, the final objective is for goal setting to be done in the last year of the grantees project period, during the midyear assessment, before the competing application is submitted.

The period to reach the goal responds to the grantee's project period. This allows the MHC sufficient time to integrate the goals into the health care plan, to complete necessary education,

training and implementation, and to realize some progress towards the goal.

In projecting future goals, the MHC and the regional office should take into account the resources of the MHC, the patient mix, provider and patient compliance, and both facilitators and barriers to improving clinical systems, protocols, etc. Lastly, since only a small but clinically useful number of medical records are sampled, MHC and regional offices should aim to set goals in increments of at least ten to twenty percent to enhance validity. The critical issue is improvement over time, not the interpretation of single yearly percentages.

Perinatal Life Cycle

I. Risk Assessment

Introduction

Risk assessment, together with planning for pregnancy (interconceptual counseling), family planning and early access to high quality care, is vital to an effective perinatal program. The proper identification, management and tracking of risk depends on strong primary care systems, such as outreach, tracking, medical record and appointment systems, well trained providers, and a holistic approach to risk that includes demographic, psychosocial, nutritional, medical, health education, environmental and behavioral factors.

MHC should have protocols for perinatal care that encompass pre-pregnancy planning, antepartum and postpartum care. It is strongly recommended that MHC take advantage of one of the major systems for identifying risks and maintaining on-going assessment of risk management such as the POPRAS or Holister medical record formats. As will be described, migrants should have a portable OB record.

Behavioral and environmental issues which are especially important for migrants/seasonal farmworkers include: domestic violence; compliance; self-prescribed medicines; pesticide exposure; lay midwives; culturally defined healers; anticipatory guidance, e.g., method of feeding the newborn, family planning; location of hospital; arrangements for birth (depends on stream); how to initiate care in another area; signs of labor; and where to go in case of an emergency.

Special Instructions

Although there are numerous risk factors identified with pregnancy today and a number of evolving concepts of risk, this review will focus on the assessment and management of **medical risks** and **behavioral and environmental risks** for pre-term or low birth weight.

A. Each MHC has its own perinatal protocols that will and should include many issues not covered here. But, **medical risk assessment** for the purpose of this review includes documentation of pre-existing problems such as:

age, parity, low weight for height, previous pregnancy in the last 6 months, pre-existing medical conditions, poor obstetric history (previous low birthweight, multiple spontaneous abortions), significant diseases such as diabetes or hypertension, genitourinary anomalies or surgery, history of parental genetic abnormalities, and lack of immunity to rubella.

The **medical risk assessment** must also include current and developing problems during pregnancy such as:

late access to care, multiple gestation, poor weight gain, significant infections (rubella, sexually transmitted diseases, cytomegalovirus, HIV), first or second trimester bleeding, placental problems, hyperemesis, oligohydramnios/polyhydramnios, anemia/abnormal hemoglobin, isoimmunization, hyper or hypotension, fetal anomalies, incompetent cervix and spontaneous premature rupture of membranes.

B. **Behavioral and environmental risk assessment** includes: documentation of low educational level and low socioeconomic status, unmarried status, poor nutritional and oral health status, smoking, alcohol and other substance abuse, toxic/pesticide exposure and occupational hazards, and domestic violence.

Sample: Twenty-five charts of women who attended the MHC for prenatal care at least **once** in the past 6 months.

Compliance is defined as a medical record that documents with notations in the medical record of the presence or absence of the major risks for pre-term or low birth weight as outlined above and, for risks identified, have a management plan consistent with the MHC protocols. The MHC may identify additional risks and review the charts for these additional issues. However, for consistency and for the purposes of this review, limit the report to the items noted above.

Reporting of Data: See exhibit __. Divide the number of charts in compliance by the number sampled and multiply by 100 to obtain percent in compliance.

II. Data Transfer System

To assure continuity of care, it is essential that a data transfer system (portable OB record) be instituted: This is defined as providing the pregnant woman with an up-to-date record of her pregnancy. This is one of two migrant-specific issues identified by the Work Group. A portable obstetrical record is available from the Migrant Clinician's Network. A copy is attached.

Reporting of Data: To assess for presence of a data transfer system/portable OB record: Divide the number of women with documentation of an up-to-date portable record by the number of charts sampled and multiply by 100 to obtain the percent of women who have a data transfer system. Charts reviewed for risk assessment can also be used for the data transfer review.

Compliance is defined as a medical record that documents in the medical record that the patient has a current portable OB record.

III. Postpartum Visit

The postpartum visit is important for an assessment of the mother, child, family, and social resources and relationships. The visit should include an assessment for medical problems and family planning. This encounter is also an opportunity for education about parenting, nutrition, breast feeding, etc.

Of particular importance for migrants is the documentation of counseling regarding the method of feeding the newborn, whether by breast or bottle, and also the documentation of family planning counseling, including the methods offered and the method chosen.

It is understood that migrants often leave the area after delivery and therefore the postpartum (PP) visit may occur at a later date and/or site distant from delivery site. However, the standard of care should be maintained (PP visit within six to eight weeks of delivery). Like the portable OB record, this is a migrant stream issue. Ideally, the portable record will include the name of a provider up- or down-stream where she can be seen. Patient education should reinforce the importance of this visit, if the family is leaving the area prior to her post partum check up.

Specific Instructions:

A postpartum visit is defined as a documented encounter with a provider for the purpose of providing postpartum care, as outlined in the MHC's postpartum protocol.

Compliance is defined as a postpartum visit that occurs within six to eight weeks of delivery.

Reporting of data. Number of PP visits that occur within 6-8 weeks of delivery/the number of PP visits x 100 = percent of visits occurring within 6-8 weeks.

IV. Newborn Follow up

Like the postpartum visit, the newborn visit is crucial for the assessment of parental interaction with the infant, the medical and behavioral examination, review of metabolic screening, immunization, and anticipatory guidance. Again, it is understood that migrants often leave the area after delivery and therefore the first visit may occur at a site different from delivery and/or at a later date. This, however, should not change the

standard of care. Like the OB record, this is a stream issue. Ideally, a portable perinatal record will document that the parent(s) or caretaker was given the name of a provider up- or down-stream where the baby can have the visit. Patient education should reinforce the importance of this visit, if the family is leaving the area prior to the baby's first check-up.

Specific Instructions:

A first newborn visit is defined as a documented visit with the MHC provider that conforms to the MHC's protocol for a newborn first visit. The visit must occur within the first four weeks after delivery.

Reporting of data: The number of newborns seen within 4 weeks of delivery/the number of newborn visits x 100 = the percent of newborn follow up visits within 4 weeks.

V. First and Third Trimester Enrollment

Access to early prenatal care is one of the most important factors that determines the outcome of pregnancy. The factors that influence early access to care are multiple, and include patient characteristics, socio-economic and cultural factors, and the capacity and resources for the MHC to design effective appointment and outreach programs.

Specific Instructions:

Enrollment is defined as the date the woman had her first prenatal visit. Using a data transfer system allows for the assessment of when this occurred, regardless of where it occurred, and this data will continue to be collected on the perinatal data sheet. However, it is recognized that it may be difficult and unrewarding to set goals around trimester in a mobile population, and therefore trimester data will not be part of migrant measures or goal setting.

Pediatric Life Cycle

I. Immunizations

The vaccination of children against infectious diseases is critical to a quality primary care program. A successful immunization program stresses parent education, especially during the prenatal period, continuing education of clinicians, and an effective tracking and appointment system.

An effective parent education program provides information on the major benefits of vaccination for children and the community as well as the risks of vaccination. Providers need also to be current on recommendations for vaccinations as well as the importance of taking advantage of the clinical visit, whenever possible, for immunizations. This means a thorough knowledge of the importance of simultaneous vaccination with multiple vaccines and the use of routine vaccination in minor illnesses, as well as the use of immunizations in immunocompromised children.

An appointment and tracking system that provides for easy access for vaccinations as well as aggressive follow up of children with lapsed immunizations is vital. The medical record should also clearly document the child's immunization status. Although not a vaccine, the medical record should also clearly document the date and result of PPD screening as outlined in the MHC protocol.

Finally, the National Childhood Vaccine Injury Act (PL 99-660; amended by PL 100-203) which became effective in 1988, requires informed consent, the recording in the patient's permanent medical record, the date the vaccine was given, manufacturer and lot number, and the name, address, and title of the person who gave the vaccine. The Act also mandates the reporting of selected adverse reactions that might occur after vaccination. Although not required, the expiration date of the vaccine and the site and route of administration should also be recorded in the patient's record.

As of April 15, 1992, all providers of immunizations must provide additional specific information regarding MMR, DPT and OPV. The pamphlets containing this information are available through your State immunization coordinator at the State Health Department. There is a specific form which must be signed by a parent or legal guardian before any of the three vaccines are given. As of April 1992, this is not a requirement for other vaccines.

Specific Instructions For Immunization Indicator:

Definition of Immunized: A child **immunized on schedule** has received immunizations following the schedule recommended by the American Academy of Pediatrics (AAP) or the CDC's Immunization Practices Advisory Committee (ACIP). This includes DPT, OPV, MMR, and HIB vaccines given according to the standard schedule for children who start immunizations at age 2 months, or the AAP modified schedule for children who start immunizations later.

The **chart** is defined as in **compliance** when all the appropriate immunizations have been entered and include both the month and year the vaccines were given.

Sample of active users to be reviewed: Because of the highly mobile nature of the migrant population, the definition of an **active user** is a migrant child age 18-24 months at the time of the review and who has had at least **one** well child visit to the MHC.

Number of charts to be reviewed: At least 25 charts of the pediatric life cycle chart review should be from this age group.

Reporting: Enter the data on exhibit B. Calculate the percent in compliance by dividing the number of charts in compliance by the number of charts sampled and multiply by 100.

II. PPD Testing in Children

Because of the high and rising incidence of TB in the migrant population, **PPD testing** in children is a critical migrant-specific issue. Therefore, for migrant children, the presence of PPD testing is an additional measure.

The definition of an **active user** is a migrant child who has had at least **one** well child visit.

Sample: Using the 25 charts pulled for children aged 18-24 months **or** the 25 charts pulled for 6 year olds, the medical record should be reviewed for documented PPD testing. As recommended by the American Academy of Pediatrics (AAP) for high risk populations, PPD testing should be done annually.

Reporting: Number of charts in compliance/number of charts sampled x 100 = percent in compliance.

III. Growth and Development

Growth and development issues are fundamental to providing primary care to children. The foundation of the assessment of growth and development rests on routine and appropriate spaced visits over time, an understanding of the particular child and family in a cultural and socio-economic context, a strong relationship between the health care team, child and family, and skills and knowledge of child development, growth, and behavioral issues.

The assessment of growth and development is a broad topic. The MHC needs to develop its own protocol, given its particular resources and needs. Issues that need to be considered include growth and nutrition, developmental milestones, hearing/vision, and age appropriate anticipatory guidance and counseling. Also, when providing growth and development evaluations, clinicians should educate parents that PL 99-457 enables them to request and receive an educational evaluation from the child's school to help diagnose and manage developmental delay. Important resources to develop growth and development protocols are listed in the references.

The assessment of growth and development as part of this review will concentrate on two topics. A MHC protocol will, of course, be more extensive and should be; this is only a review of two selected, but crucial, topics: growth and nutrition and developmental milestones.

Specific Instructions:

Definitions:

Growth and Nutrition: Medical records must have an up to date growth chart that includes head circumference, and a screening for anemia. Growth charts are considered up to date if height, weight and, for infants during the first year of life, head circumference are recorded for each scheduled well child visit. The periodicity for anemia screening should be based on the MHC protocol. Charts are considered in compliance only if they conform to the MHC's protocol for anemia screening and have complete growth charts.

Developmental Milestones: Charts must have documented assessment of developmental milestones that are both age appropriate and that conform to the MHC protocol. Developmental milestone protocols must include an assessment of gross motor, fine motor, language and social development. MHC may use accepted short screening forms or may develop their own.

Compliance with Growth and Development: A chart is considered in compliance if it conforms to the MHC protocols for growth and nutrition, and developmental milestone assessment. To be in compliance, the medical chart must satisfy criteria in both subjects and, for children with identified abnormalities or risks, have a management plan consistent with the MHC's protocols.

Sample: Twenty-five active patients as defined above who are six years old at the time of the review.

Reporting: Enter the data on exhibit B. Calculate the percent in compliance by dividing the number of charts in compliance by the number of charts sampled and multiply by 100.

IV. Oral Health Measures

The prevention of oral diseases is a responsibility for all our health providers. The health care team plays a vital role in this endeavor since most of our users will be seeking medical care on a more regular basis than dental care. The two preventive oral health strategies which are easily incorporated into a regular visit are dietary fluoride supplementation and preventive guidance to avoid Baby Bottle Tooth Decay (BBTD).

The recommendation for fluoride supplementation are found in the references. The fluoride measure will apply **only** when the fluoride content of the water supply is known. If the area has a Head Start program, it will know the fluoride status of the water supply and will share this information with the MHC. BBTD preventive counseling should begin for the parent in the prenatal period and continue for the first three years of life. It is recommended that the provider of care inquire about the feeding habits at each visit and encourage only water in the bottle at bedtime if the child has to have a bottle at that time. These inquiries and preventive guidance should be documented in the chart. Each center will set up their protocols for complying with these recommendations.

Compliance with Oral Health Measure: A chart is considered in compliance if it conforms to the MHC protocols for the oral health measure.

Collection of Data: Using the twenty-five charts pulled for children between the ages of 18-24 months check for BBTD counseling and guidance. Using the twenty-five charts of children who are six years of age check for compliance with fluoride supplementation (only for MHC with unfluoridated water supply).

Reporting of Data: Divide the number of charts in compliance for BBTD counseling by the number of charts sampled and multiply by 100. Enter this percentage on exhibit __.

Divide the number of charts in compliance to fluoride supplementation by the number of charts sampled and multiply by 100. Enter this percentage on exhibit __.

Adolescent Life Cycle

I. Behavioral Risk Assessment

The major primary care issues in adolescence revolve around environmental and behavioral factors. Eighty per cent of deaths in adolescents are due to suicide, homicide, or injury. Substance abuse and smoking statistics are also dramatically high; about 8 percent of all 15 to 19 year old girls become pregnant each year.

Specific Instructions:

Well-adolescent assessment includes medical, psychosocial, and developmental evaluation as well as anticipatory guidance. Issues of particular importance in adolescent behavioral risk assessment include substance abuse, sexual history, school performance, depression, and risk for physical injury. When taking a history, some providers find it useful to ask female adolescents their last menstrual period at each encounter, regardless of the reason for the visit. Of particular importance for migrants is assessment for 1) current school attendance, and 2) sexual activity and the need for family planning. This review focuses on:

***Substance Abuse:** This includes a substance abuse history in both the adolescent, sexual partner(s), and family for alcohol, tobacco, and other abused substances such as cocaine. Adolescents who are abusing drugs, alcohol or tobacco should have a management plan as outlined in the MHC protocols.

Sample of active users to be reviewed: Fifteen charts of active users from the age of 12 through 19 plus ten of the records obtained for the family planning review, for a total of 25 medical records. The definition of an **active user** is a migrant teenager (from the ages of 12 through 19) who has had at least one visit within the year.

Compliance to behavioral risk assessment is defined as documenting adherence to the MHC's protocol on behavioral risk assessment for substance abuse. The protocol should address at least the use of alcohol, tobacco, and other abused substances such as cocaine. To be in compliance, identified risks should be accompanied by a management plan consistent with MHC protocols.

Reporting of data: Divide the number of charts with completed assessments and management plans by the number of charts sampled

and then multiple by 100 to calculate the percent in compliance. Record on exhibit __.

II. Family Planning Counseling

Family Planning is an essential part of preventing the increased infant mortality rate associated with teenage pregnancy and of providing the sexually active teenager with the means to complete his or her psychosocial development and plan a future that includes children and a family, if desired.

Specific Instructions:

Family planning counseling refers to documentation in the medical record of counseling done before, or at the time of, receiving any family planning method.

A chart in **compliance** is defined as a record that includes the following documentation:

* method selected by the patient
* discussion of efficacy, use, and side effects of the method
* discussion of full range of alternative methods
* discussion of prevention of HIV and STD infection, with counseling/testing for HIV as appropriate
* return visit schedule

Sample: At least twenty-five of the medical records pulled for the adolescent life cycle should be of adolescents who have documented use of a family planning method.

Reporting of data: Divide the number of medical records in compliance by the number of charts sampled and multiply by 100 to calculate the percent in compliance. Record this information on exhibit __.

Adult Life Cycle

Introduction

Health risk assessment in the adult lifecycle involves a spectrum of complex issues. These include cardiovascular and cancer prevention and screening; occupational health, life style assessment that includes assessment for risk of HIV infection, substance abuse and smoking; nutrition and oral health; injury prevention; and specific community health issues such as violence, or housing. Moreover, psychosocial issues and risks will change as the person ages from one decade to the next.

Although a MHC's protocols for the adult period involve many clinical issues for the adult lifecycle, this review will focus on cardiovascular risk assessment and cancer screening and follow up.

Definition of **active users:** all adults served by the migrant program who have had at least one visit in the past two years.

I. Cardiovascular Risk Assessment

Specific Instructions

For purposes of Migrant Health Center assessment, the **cardiovascular risk assessment** focuses on screening by history and/or laboratory assessment for diabetes mellitus, hypertension, and smoking. Cardiovascular risk assessment should be part of an overall health risk assessment and include relevant history, physical examination, and laboratory measurements.

Diabetes mellitus is a common metabolic disorder found in migrants, and presence of this disease is a risk factor for cardiovascular disease. It is defined by history or laboratory measurement.

Smoking, for the purposes of this review, is defined as a person who currently smokes, regardless of the number of cigarettes smoked per day or the number of years the person smoked.

Hypertension is defined as a diastolic blood pressure of over 90 mm Hg on two or more occasions, or as a person on treatment for hypertension.

A medical record is in compliance for CV assessment if there is documented assessment for the three risks noted, and a management plan, consistent with MHC protocols, that addresses any of the identified risks which are present.

Sample: Twenty-five medical records of active users.

Reporting: Record the information on exhibit D and calculate the percent in compliance by dividing the number of medical records in compliance by the total number of charts sampled, multiplied by 100.

II. Cancer Risk Screening

There are five cancers with strong evidence for effective screening tests. These include cancer of the breast, cervix, and colorectal, oral and skin cancer. This review will concentrate on two cancers: cervical and breast. MHCs may review for either cervical or breast cancer. A MHC also may review for both cervical and breast cancer but is not required to do so.

A. Cervical Cancer

The MHC protocol for cervical cancer should address appropriate history, physical examination, technique for Papanicolaou testing, systems for follow up and tracking of laboratory results, and relevant health education. The MHC protocol should outline the schedule for regular PAP tests. The test should begin at the age the woman begins sexual intercourse; the periodicity for testing should be based on one or more of the recommendations by national professional organizations. But, the final decision on the schedule is the MHC's. It is important to remember that women who have never been screened for cervical cancer are at high risk.

All PAP tests showing dysplasias or more severe lesions must be followed-up within six weeks from when the PAP test was done. Dysplasias or more severe lesions correspond to Class II, III and IV under the Papanicolaou system, or low-grade squamous intraepithelial lesion (SIL), high-grade SIL, and squamous cancer under the Bethesda system.

A medical record is defined as being in compliance when the PAP test was performed according to the MHC protocol and schedule, the result promptly posted and reviewed, with appropriate follow-up documented within six weeks of the test according to MHC protocol for abnormal PAPs that are Class II or higher.

Sample: Twenty-five medical records of women who are active users of the MHC as defined above and are, or have been, sexually active.

Reporting: Record the data on exhibit __. Calculate the percent compliance by dividing the number of records in compliance by the total number of charts sampled and multiply by 100.

B. Breast Cancer

As with cervical cancer, MHC protocols for breast cancer screening should consist of the appropriate history, physical examination and health education that includes teaching breast self-examination.

For purposes of the review, a medical record is in **compliance** if a breast examination and/or mammography was performed according to the schedule outlined in the MHC protocol, and breast self examination education was provided. Although the MHC should select the appropriate screening method given local resources, MHC should strive to work with other relevant agencies and persons to make mammography available to women in their community at an affordable cost.

Sample: Twenty-five medical records of women above the age of 40 who are active users as defined above.

Reporting: Record the data on exhibit __. Calculate the percent in compliance by dividing the number of records in compliance by the total number of charts sampled and multiply by 100.

Geriatric Lifecycle

Migrant programs see few if any persons over the age of 65. Therefore, the adult measures will be extended to include this age group, and the present geriatric measures will be eliminated for the migrant health centers.

SUMMARY OF PREVIOUS PREGNANCIES

Total # _____ Full Term _____ Prematures _____

Abortion/Miscarriages _____ Now Alive _____

	Mo/Yr	Gest	Labor	Wt	Hosp	Complications*
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

*Explain Maternal/Child Complications: _____

PAST MEDICAL/SURGICAL HISTORY:

Medications:

Allergies: Transfusions:

Childhood Illnesses: TB Exposure:

Smoke: Alcohol:

Other Drugs:

Field Work in Past 6 Months: ☐ Yes ☐ No

FAMILY HISTORY:

Twins: Diabetes:

Congenital Anomalies: Other:

GYN HISTORY:

Menarche: Freq:

Duration: Birth Control:

PID: GC:

Herpes: UTI's

Syphilis

LIST OF CLINICS VISITED/LISTA DE CLINICAS VISITADAS:

Address, Telephone Number/Dirección, Número de teléfono

En caso de emergencia, avisele a:/In case of emergency call:

PLAN FOR DELIVERY:

Distributed By:

MCN

MIGRANT CLINICIANS NETWORK

2512 SOUTH IH-35, SUITE 220 AUSTIN, TEXAS 78704 (512) 447-0770 (800) 531-5120

Please send results of pregnancy outcome to MCN.

Date of Birth _____ Wt: _____ Sex: _____

Apgars 1 min 5 min

Gestation _____ Complications: _____

MIGRANT PORTABLE OB/PRENATAL RECORD

RECORD PRENATAL DE: _____
(Prenatal Record)

Este documento contiene información importante acerca de su salud y la del bebé que viene. Por eso, debe llevarlo con Ud. cada vez que vaya a una visita prenatal.

Al revés de esta tarjeta se encuentra una lista de citas para Ud. El asistir a cada una de ellas es importante para asegurar la buena salud de Ud. y del bebé.

Como el crecimiento y desarrollo saludable del bebé depende de las actividades diarias y costumbres suyas, todo lo que Ud. come y bebe lleva mucha importancia. El fumar, el beber alcohol y el uso de medicinas le pueden hacer daño al bebé antes de nacer. Así es que debe consultar con su médico o enfermera antes de tomar alguna medicina.

Si se presentan cualquiera de los siguientes síntomas llámele a su médico o enfermera inmediatamente, no lo deje para la próxima cita:

1) Empezar a vomitar demasiado.
2) Sangrado por la vagina.
3) Fuerte dolor de cabeza, vista nublada o se le hinchan demasiado las manos y la cara.
4) Rompimiento de la bolsa del agua.
5) No puede sentir ningunos movimientos del bebé.
6) El bebé casi nunca se mueve.
7) Los dolores vienen regularmente cada quince minutos.

This document contains important information about your health and your baby-to-be. That is why you should take it with you each time you go for a prenatal visit.

On the back of this card is a list of your appointments. Attending each one of them is important in order to assure your good health and that of your baby.

Since the healthy growth and development of your baby depends on your daily activities and lifestyle, everything that you eat and drink carries a great deal of importance. Smoking, drinking alcohol, and taking medicines can harm your baby before birth. That is why you should consult your doctor or nurse before taking any medicine.

If any of the following occur, do not wait for your next appointment—contact your health care provider immediately:

1) Excessive vomiting.
2) Vaginal bleeding.
3) Develop severe headaches, blurred vision, and/or excessive swelling of the hands or face.
4) Bag of water breaks.
5) Cannot feel fetal movement or markedly reduced fetal movements.
6) Regular contractions at 15-minute intervals.

PERMISO PARA PEDIR Y OBTENER INFORMACION MEDICA:
Entiendo que las direcciones y números de teléfono de todas las clinicas que he visitado para cuidado prenatal están escritos en este documento. Si es necesario que esta clinica pida información de alguna otra clínica que está en la lista, aquí firmo que doy permiso a cualesquiera de estas clinicas de dar la información pedida.

PERMISSION TO REQUEST AND OBTAIN MEDICAL INFORMATION:
I understand that the addresses and telephone numbers of all the clinics I have visited for prenatal care are written on this document. If it is necessary that a clinic request information from another clinic on this list, I hereby, with my signature, give permission to any of these clinics to release the information requested.

Firma _____ Fecha _____
Signature Date

DATE	Estimated Gestational Age	Weight	Blood Pressure	Urine: Sugar/Albumin	Fundal Height	Fetal Heart Tones	Position	Edema	Cervix: Dilation/ Station/Effacement

PATIENT EDUCATION (Fill in date discussed)

Nutrition	Drugs/Alcohol	Danger Signs	Exercise	Hygiene	Labor Preparation	Fetal Growth	Child Care	Car Seat	Job Hazards	Infant Feeding	Family Planning	Tooth Decay	Periodontal Problems	Post Partum Depression

PROBLEM LIST

1

2

3

4

5

TREATMENT AND REMARKS

INITIALS

NAME: Birthdate

LMP EDC: Revised EDC:

Preg Test Type: Quickening:

Sonograms 1.

2.

PHYSICAL EXAM:

Date: Height: Weight:

BP Heent: Thyroid:

Breasts Lungs: Heart:

Fundal Height Extremities:

PELVIC EXAM:

Vulva Vagina: Perineum:

Cervix Uterus: Adnexa:

Pelvis Adequate: ☐ Yes ☐ No

LAB DATA:

Blood Type Rh:

Antibody Screen 1 2.

VDRL Rubella:

HCT/Hb 1 Date

2 Date

3. Date

PAP Smear: TB:

GC Culture. Urine Culture:

1 Hr. Blood Glucose: Date

AFP: RHOGAM

HIV: Other:

MEDICATIONS:

DATE Rx DIAGNOSIS