QIDA 2020

What Counts as a Yes
Teens and Asthma
Announcements

• All 2017, 2018, and 2019 (except 2019 3-6 year olds) will be “hidden” from the home page as of February 1.
  • See Laura for directions for downloading your old raw data.

• Everyone will be doing both 2020 Asthma and 2020 Teens
  • Please answer every question, we have mostly eliminated “not a practice priority” to give us the most accurate state average
  • Your practice is to select a focus area for your QI work, this is where we will focus our discussion when we come for site visits.
Asthma 2020 (age 5 – 18)

• Is there documentation in the medical record that the patient has been seen for a scheduled asthma visit in the past 6 months?
  • Documentation in the medical record that the patient had and attended a prescheduled asthma visit in the past 6 months.

• Is there documentation in the medical record of the level of asthma severity?
  • Classifying Asthma severity helps in treatment and follow ups. The levels of severity are Intermittent (J4.20/21), Mild Persistent (J45.30/31), Moderate Persistent (J45.40/41) and Severe Persistent (J45.50/51).
• Is the patient prescribed an appropriate medication based on the level of severity?
  • A rescue inhaler (Albuterol) for Intermittent Asthma and any persistent asthmatic should be on a controller medication (usually a steroid inhaler or a combination steroid inhaler)

• Is there documentation in the medical record indicating that functional status was checked in the past 12 months?
  • Documentation of a functional assessment done (ACT, Spirometry or Peak flow) at least once in the past year.
Is there documentation in the medical record that an asthma action plan was given to the family in the past 12 months?
  - Is there documentation that an up to date Asthma action plan was given to the family to share with other caregivers as needed.

Is there documentation that the family was educated on asthma device use?
  - Is there documentation that the Physician / nursing staff went over or reviewed proper asthma device/medication use with patient/Caregiver at least one time in the past 12 months.

Is there documentation that the family was educated on the patient’s asthma triggers?
  - Is there documentation that the patient/family was educated on Asthma triggers and how to avoid the triggers. Both indoor and outdoor trigger should be discussed.
Asthma 2020 (age 5 – 18)

- Did the patient have a well visit in the past 12 months?
  - Is there documentation that the patient was seen for a well check in the past 12 months (could be the visit the chart was pulled)
- Was the patient screened for tobacco exposure including cigarettes, e-cigarettes, and other tobacco products?
  - using a standardized screener or documented in the EMR
- Was the screen positive?
  - Admission for a caregiver that the patient is frequently around a tobacco user/ vaping, OR admission by the patient that they are using tobacco or vaping.
- Was the family (or patient) given advice to quit?
  - Is there documentation in the medical record that the family was educated about the dangers of second and thirdhand smoke, especially how tobacco smoke/vaping is detrimental to asthmatic’s health.
- Were cessation strategies discussed?
  - Documentation that the family was referred to the Quitline or discussed the use of NRTs to help the tobacco user to quit.
Is there documentation that the patient had been to the ER for asthma in the past 12 months?
  - Documentation in the record that the patient went to the ED for an asthma related issue either through patient reporting or through an ER report.

Was the patient seen for as ER follow up in the PCP office?
  - Was the patient see @ PCP office for follow up after ER visit (Ideally should within 1-2 weeks after ER visit)
• Did the patient have a well visit in the past 12 months?
  • What counts as a yes: Documentation that the patient was in for a well visit in the last 12 months or was in for a well visit for the visit being audited.

• Is there documentation that the patient was screened for depression?
  • What counts as a yes: Documentation that a standardized screening tool used- PHQ-2, 9, PSC-Y etc.

• Was the screen positive?

• Is there documentation that depression management was done in the office?
  • What counts as a yes: Any documentation of discussion about in office management- sleep hygiene, Relaxation techniques, breathing exercises etc.

• Was the patient referred for additional services?
  • What counts as a yes: Referral to a psychologist or psychiatrist

• Was the patient started on medication in the office?
  • What counts as a yes: Any antidepressant medication started in office.
• Is there documentation that the patient was screened for anxiety?
  • What counts as a yes: Was a standardized screening tool used- GLAD7, SCAARED etc.

• Was the screen positive?

• Is there documentation that anxiety management was done in the office?
  • What counts as a yes: Any discussion about in office management- Relaxation techniques, breathing exercises etc.

• Was the patient referred for additional services?
  • What counts as a yes: Referral to a psychologist or psychiatrist

• Was the patient started on medication in the office?
  • What counts as a yes: Any anti-anxiety medication started in office. (medication prescribed by a psychologist should be marked as a no)
• Is there documentation in the record that the patient was screened suicidal ideation?
  • What counts as a yes: Documentation that any standardized screening tool was used that screens for suicidal ideation, for example: PHQ-2, 9, PSC-Y.

• Was the screen positive?

• Is there documentation that suicide management was done in the office?
  • What counts as a yes: Documentation that a suicide prevention plan or safety plan discussed in office with the family and the patient.

• Was the patient referred to additional services?
  • What counts as a yes: Documentation that the patient was referred to services that are trained to handle teens with suicidal ideation such as Crisis line, DMH, Psychologist etc.

• Was the patient sent to the ER?
  • What counts as a yes: Documentation that the patient was sent from the office directly to the ER for inpatient admission.
• Is there documentation that the patient was asked about their substance use?
  • What counts as a yes: Documentation that a standardized screening tool like CRAAFT or the HEADSS assessment was used to determine if the patient is using illicit substances.

• Was the answer positive?

• Was the patient counseled/ referred for treatment?
  • What counts as a yes: Was referral made to a substance abuse addiction center or counselor.

• Is there documentation in the record that the patient was given anticipatory guidance about social media use?
  • What counts as a yes: Documentation that there was a discussion about appropriate social media use or documentation that a social media plan was discussed with the family.
Teen 2020 (ages 15 -18)

• Is there documentation in the medical record that safe sex was discussed with the patient?
  • What counts as a yes: Documentation that a discussion was had with the patient about safe sex which could include contraceptive options, discussion of STI risks, etc.

• Is there documentation in the record that birth control options were discussed with the patient?
  • What counts as a yes: any discussion about birth control options available to the patient.

• Is there documentation in the record that the patient was screened for HIV?
  • What counts as a yes: HIV antibody screening done, POC or sent out.

• Is there documentation in the record that the patient was screened for GC/Chlamydia?
  • What counts as a yes: Urine PCR for GC/Chlamydia done.
• Is there documentation in the record that the patient has completed the HPV series?
  • What counts as a yes: 2 doses completed before 16th birthday
• Is the patient's BMI over the 85th percentile?
• Is there documentation that the weight counseling was provided to the patient and family?
  • What counts as a yes: Documentation that the patient was given guidance on healthy eating and exercise habits.
• Was the patient screened for tobacco exposure including cigarettes, e-cigarettes, and other tobacco products?
  • What counts as a yes: Any evidence of tobacco use screening for both the family and a patient. This question should be asked in such a way that any tobacco exposure is recorded, including use of vaporizers and e-cigarettes.

• Was the screen positive?

• Was the family (or patient) given advice to quit?
  • What counts as a yes: Documentation in the medical record that the family was educated on the hazards to the patient's health from 1\textsuperscript{st} hand, 2\textsuperscript{nd} hand, and 3\textsuperscript{rd} hand tobacco exposure.

• Were cessation strategies discussed?
  • What counts as a yes: Documentation that the provider educated the family on cessation strategies which could include prescribing OTC nicotine replacements drugs and/or referral to the Quitline.