2020 Asthma QIDA Survey - What Counts as a Yes
(ages 5 – 8)

1. Is there documentation in the medical record that the patient has been seen for a scheduled asthma visit in the past 6 months?
   **What counts as a yes:** Did the patient have a dedicated Asthma visit at least once in the past 6 months.

2. Is there documentation in the medical record of the level of asthma severity?
   **What counts as a yes:** 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).

3. Is the patient prescribed an appropriate medication based on the level of severity?
   **What counts as a yes:** 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)

4. Is there documentation in the medical record indicating that functional status was checked in the past 12 months?
   **What counts as a yes:** Documentation of a functional assessment done (ACT, Spirometry or Peak flow) at least once in the past year.

5. Is there documentation in the medical record that an asthma action plan was given to the family in the past 12 months?
   **What counts as a yes:** Is there documentation that an Asthma action plan was given.

6. Is there documentation in the medical record that the patient is up to date on flu vaccine?
   **What counts as a yes:** Is there documentation that the patient was given a Flu vaccine in the past 12 months.

7. Is there documentation that the family was educated on asthma device use?
   **What counts as a yes:** 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.

8. Is there documentation that the family was educated on the patient’s asthma triggers?
   **What counts as a yes:** Is there documentation that the patient/family was educated on Asthma triggers and how to avoid the triggers.

9. Did the patient have a well visit in the past 12 months?
   **What counts as a yes:** Was there a well check done in the past one year (could be the visit the chart was pulled)
10. Was the patient screened for tobacco exposure including cigarettes, e-cigarettes, and other tobacco products?

**What counts as a yes:** Using a standardized screener or documented in the EMR

a) Was the screen positive?

**What counts as a yes:** 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.

i. Was the family (or patient) given advice to quit?

**What counts as a yes:** 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. Did you tell the family that it would benefit the asthmatic child if the tobacco users in the child’s life would quit smoking and limit the child’s exposure to smoke and vapor.

ii. Were cessation strategies discussed?

**What counts as a yes:** Documentation that the family was referred to the Quitline or discussed the use of NRTs to help the tobacco user to quit.

11. Is there documentation that the patient had been to the ER for asthma in the past 12 months?

**What counts as a yes:** 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.

a) Was the patient seen for as ER follow up in the PCP office?

**What counts as a yes:** Was the patient see at PCP office for follow up after ER visit (Ideally should within 1-2 weeks after ER visit)