Asthma 2020

#	Question	Yes	No
1	Is there documentation in the medical record that the patient has been seen for a scheduled asthma visit in the past 6 months?		
2	Is there documentation in the medical record of the level of asthma severity?		
3	Is the patient prescribed an appropriate medication based on the level of severity?		
4	Is there documentation in the medical record indicating that functional status was checked in the past 12 months		
5	Is there documentation in the medical record that an asthma action plan was given to the family in the past 12 months?		
6	Is there documentation in the medical record that the patient is up to date on flu vaccine?		
7	Is there documentation that the family was educated on asthma device use?		
8	Is there documentation that the family was educated on the patients asthma triggers?		
9	Did the patient have a well visit in the past 12 months?		
10	Was the patient screened for tobacco exposure including cigarettes, e-cigarettes, and other tobacco products?		
10a	Was the screen positive?		
10 a i	Was the family (or patient) given advice to quit?		
10 a ii	Were cessation strategies discussed?		
11	Is there documentation that the patient had been to the ER for asthma in the past 12 months?		
11a	Was the patient seen for as ER follow up in the PCP office?		

Teens 2020

#	Question	Yes	No	Not a Practice Priority
1	Did the patient have a well visit in the past 12 months?			
2	Is there documentation that the patient was screened for depression?			
2a	Was the screen positive?			
2ai	Is there documentation that depression management was done in the office?			
2aii	Was the patient referred for additional services			
2aiii	Was the patient started on medication in the office?			
3	Is there documentation that the patient was screened for anxiety?			
3a	Was the screen positive?			
3ai	Is there documentation that anxiety management was done in the office?			
3aii	Was the patient referred for additional services?			
3aiii	Was the patient started on medication in the office?			
4	Is there documentation in the record that the patient was screened suicidal ideation?			
4a	Was the screen positive?			
4ai	Is there documentation that suicide management was done in the office?			
4aii	Was the patient referred to additional services?			
4aiii	Was the patient sent to the ER?			
5	Is there documentation that the patient was asked about their substance use?			
5a	Was the answer positive?			
5ai	Was the patient counseled/ referred for treatment?			
6	Is there documentation in the record that the patient was given anticipatory guidance about social media use?			
7	Is there documentation in the medical record that safe sex was discussed with the patient?			
8	Is there documentation in the record that birth control options were discussed with the patient?			
9	Is there documentation in the record that the patient was screened for HIV?			
10	Is there documentation in the record that the patient was screened for GC/Chlamydia?			
11	Is there documentation in the record that the patient has completed the HPV series?			
12	Is the patient's BMI over the 85th percentile?			
12a	Is there documentation that the weight counseling was provided to the patient and family?			
13	Was the patient screened for tobacco exposure including cigarettes, e-cigarettes, and other tobacco products?			
13a	Was the screen positive?			
13ai	Was the family (or patient) given advice to quit?			
13aii	Were cessation strategies discussed?			