

# QIDA 2020

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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).

# Asthma 2020 (age 5 – 18)

- 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.

# Asthma 2020 (age 5 – 18)

- 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.

# Asthma (age 5 – 18)

- 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)

# Teen 2020 (ages 15 -18)

- 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.

# Teen 2020 (ages 15 -18)

- 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)

# Teen 2020 (ages 15 -18)

- 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.

# Teen 2020 (ages 15 -18)

- 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, et
- 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.

# Teen 2020 (ages 15 -18)

- 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 patients was given guidance on healthy eating and exercise habits.

# Teen 2020 (ages 15 -18)

- 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<sup>st</sup> hand, 2<sup>nd</sup> hand, and 3<sup>rd</sup> 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.

