



**North Dakota Tobacco Prevention and Control Executive Committee
Center for Tobacco Prevention and Control Policy**

Ask-Advise-Refer Chart Audit – FAQ

What is the definition of a client-based program?

- A program in your health agency where there is one-on-one interaction between the client and the public health professional, excluding mass walk-in immunization clinics. Client-based programs have charts and medical records on each client.

Why does the Center need AAR data from the local public health units?

- The Center needs to know that local public health units have reviewed the implementation of the AAR process and that each health unit has an understanding of how complete the implementation of AAR is in the agency's client-based programs. Continuous quality improvement is the goal. The chart audit is not intended to be used to penalize an agency. However, it is the standard process to release quarterly tobacco state aid payments only when all required documents are received. Therefore, if your health unit does not submit the agency audit form by June 30, 2011, the Center would not issue the next tobacco state aid payment until the audit is complete and documentation has been received by the Center.

Can we use initials for the client identifier?

- Yes, small local public health units that currently use client initials for chart identification may continue to use the initials for the AAR program chart audit.

When do we have to have all programs implementing Ask-Advise-Refer?

- All local public health units must have AAR implemented in 100% of their client-based programs by April 1, 2011.

What if a program has not fully implemented the PHS guidelines by the time the chart audit needs to be done?

- The annual AAR chart audit data must be collected for the time period January 1 through March 31. Full implementation of the PHS guidelines is not required until April 1, 2011. Therefore, some programs may not have sufficient audit data. These programs should be left out of the first annual audit (January 1, 2011 – March 31, 2011).

What are the ages that are being collected on each measure?

- Measure 1 – age 10 and over
- Measure 2 – age 10 and over
- Measure 3 – age 10 and over
- Measure 4 – age 10 and over (*Note: Optional this 1st biennium, required after 1st biennium*)

Is it legal to ask tobacco related questions to clients age 18 and under without their parents present?

- There is no reason a public health provider may not ask minors about tobacco usage and provide the minor and parent with education and referral options for the tobacco usage.

Does private healthcare use the age of 10 when assessing for client tobacco use?

- Yes. The age of 10 was determined to be used to remain consistent with the Health Care Guideline: Tobacco Use Prevention and Cessation for Infants, Children and Adolescents from the Institute for Clinical Systems Improvement.

What cessation services are available for clients age 10-13?

- Local public health providers can provide the following options for clients age 10-13 (with the parent present or at a minimum notified):
 - One on one counseling
 - Educational materials
 - Referral to their family physician
 - Referral the QuitNet (referral to the Quitline is not available until the age of 14)

What if one chart is used for multiple programs?

- All clients should be asked at least every 30 days and at times it may be repetitive. However, if the program staff does not communicate with each other about the patients or have some way to document the date AAR was asked, it is best to complete AAR rather than assume it was done in another program. This audit process is to audit programs, not staff or clients.
- Preferably, there should be a client chart for each individual program. However, if there isn't, staff should devise a system to keep track of AAR each time the patient visits a program. Local public health units could create a flow sheet or some type of system to ensure that when a patient visits several programs within a 30 day period, there is documentation in that chart that the patient has been asked-advised-referred at least once in that 30 day period.

Will I have problems collecting information from the WIC program?

- The Center understands that agencies must follow the WIC Federal guidelines. We encourage those collecting the AAR data to work with your administrator and the WIC staff to complete the chart audit. Keep in mind the only audit form that is submitted to the Center is the agency chart audit form which does not have any client identifiers.

Why are we not collecting data from our school health programs?

- Implementing PHS guidelines into school settings is challenging. School health is not as straightforward as many other health unit programs and therefore, will be exempt until further information is gathered about the proper procedures. If your health unit is currently addressing school health, you may continue to implement and audit that program.

What about our car seat program or immunizations where the child is under age 10?

- Only clients age 10 and over are included in Measures 1 – 4.
- We encourage public health units to ask all ages regarding second hand smoke exposure. However, we are only requiring you to audit those clients age 10 and over.

For Measure 4 (SHS screening), what amount of exposure should be reported as SHS exposure?

- There is no safe level of second hand smoke exposure. Any amount of SHS exposure is too much. Therefore, providers should ask, “Have you had any exposure to Second Hand Smoke?”

Do we have each program print out the program chart audit forms and submit them to the tobacco prevention coordinator or should each program coordinator record the information electronically?

- Every health unit may collect the data differently depending on how the unit is set up and the individual staff responsibilities. The program chart audit forms should be completed by someone who has attended some sort of training on how the audit process works (it is imperative that whoever is completing the program chart audit form understands how to sample and correctly audit the program). It does not matter if that person is the tobacco program coordinator or the individual program coordinator.
- However, the tobacco program coordinator should receive all the program audit forms (whether via electronically or via print out) to complete the agency chart audit form. The tobacco program coordinator would complete the agency audit form, send it to the Center and keep the program audit forms on file.

Do we send both the program chart audit form and the agency chart audit form to the Center?

- No. The program chart audit form is used to complete the agency chart audit form and is for your files. The agency chart audit form is to be sent to the Center for Tobacco Prevention and Control Policy by June 30 of each year.

Why is second hand smoke exposure (Measure 4) not required in this first biennium data collection?

- SHS screening is extremely important so if your local public health unit has the ability to collect this data for the 2009-2011 biennium, the Center strongly encourages you to do so. SHS screening is not required this first year in order to give local public health programs a chance to phase it into their AAR protocol.

- As stated in the model policy, “SHS exposure documentation will not be a reporting requirement on the first chart audit due in April 2011. Local public health units are encouraged to put the SHS component in their local policy and implementation plan at this time in order to facilitate compliance later. SHS exposure query and documentation will be a reporting requirement during the 2011-13 biennium.”

What if a client is seen more than once per month? Is it OK to ask the client every time he/she is seen?

- Yes. The goal is for every program to ask every patient frequently (the more the better). If a patient was asked more than once every 30 days because he/she is seeing two different programs and programs do not share data that is okay. It is more important for a patient to be asked several times within the 30 days rather than to not be asked because the provider assumed it was asked earlier in the month.

What is the sampling time frame for this first biennium chart audit?

- For this first biennium chart audit (conducted January 1, 2010 – March 31, 2010), public health units will include active charts starting when AAR was implemented in that program through December 31, 2010. For example if your health unit implemented AAR in a program July 1, 2010, then your sampling time frame is July 1, 2010 – December 31, 2010. If AAR was implemented November 1, 2010, then your sampling time frame is November 1, 2010 – December 31, 2010. If a program was not implemented until January 1, 2011, then you would not audit that program this first biennium.
- The next AAR chart audit will be conducted January 1, 2012 – March 31, 2012 with a sampling time frame of April 1, 2011 – December 31, 2011.

Can I pull my charts during one month or do I have to pull “x” amount of charts in each month (January – March)?

- Local public health units can audit the client-based programs all in one month or you may audit some programs each month. The three month period to audit the programs is a courtesy to allow health units time to audit the programs, not to require that a certain number of charts are pulled each month.

How many charts are we supposed to pull?

- If you want to track a measure over time or you want the results to be representative of the population assessed, sample size is vital. To provide more statistically accurate data, larger local public health units should audit 10% of eligible charts from each program (depending on the available resources to complete the audit). Smaller public health units may choose to audit 10% or 20 charts from each program, whichever is less. However, if a program in your agency has 20 charts or less, you must audit a minimum of three charts.
- If you would like further clarification on how many charts to audit, please contact the Center for Tobacco Prevention and Control Policy at 701.328.5130.

I know that we are supposed to only pull active charts, but what if our health unit has no way to determine active versus inactive charts in a program?

- Health units should only be auditing active charts or those charts that were seen during the sampling time frame. If your health unit has no way to determine active versus inactive charts, then the health unit will need to exclude those inactive charts when auditing the program. For example, if the program has 500 charts and you need to audit 50 charts ($500 \times 10\% = 50$), you would then determine a starting point in the files and pull every 10th chart ($500 / 50 = 10$). If your first chart (chart #1) was seen within the sampling time frame (active), you audit that chart and move to the next 10th chart (chart #2). If chart #2 is active, you audit the chart. If your next 10th chart (chart #3) was not seen within the sampling time frame (inactive), you do not audit chart #3 and it does not count towards your total number of charts to audit. Chart #3 should be put back and you would then count another 10 (chart #3) and pull that chart to audit. Continue pulling every 10th chart until 50 active charts have been audited (start over at the beginning as many times as needed to reach the desired sample size).

When completing the agency chart audit form, what if our health unit has a program listed on the form, but does not consider the program client-based?

- If your health unit has a program, but does not consider the program client-based, then you would indicate a “0” (No, you did not audit the program because the agency does not have the program, the program did not implement AAR until after January 1, 2011 or because you do not consider the program client-based).
- **For the Center to gain a better understanding of the client-based programs in each local public health unit, please complete the Client-Based Programs List document and submit to Kelli Ulberg via email at krulberg@nd.gov by June 30, 2011.**

Other bits of information:

- Do not audit charts in programs that have not been implemented 100% by January 1, 2011.
- This process is not auditing staff or clients; it is to audit the program.
- Only audit those charts that are active (those clients that have been seen within the time frame provided in the Program Chart Audit Protocol, page 3 Method of Data Collection).
- Do not include mass immunizations or mass clinics.
- In rare circumstances, agencies may be requested to complete additional audit procedures. (Additional audit procedures may be requested if there are concerns that the program has not implemented AAR or if there appears to be no improvement in the assessment of AAR over time)

If you have questions regarding any of the Ask, Advise, Refer Chart Audit process, please call Kelli Ulberg, Community Intervention Coordinator, Center for Tobacco Prevention and Control Policy at 701.328.5134 (toll free 1.877.277.5090).