Practice name here: ________________________________ Date completed: _________

Office Systems Inventory to Improve Asthma Care and Treatment in Primary Care Practices*

Developed by VCHIP and adapted for use in the PQMP San Francisco Learning Collborative, the following are strategies that healthcare professionals and practices can use to improve office systems to address and promote optimal asthma treatment.

The Measure# corresponds to the 8 measures selected by SF for improvement during the learning collaborative (see Document: *4. Asthma_2b.Phase1.4_SF Measures)*.

Strategy	Measure#	1 Is not done	2 Inconsistently done (less than 75% of the time)	3 Consistently done (75% of the time or more)	4 Consistently done and based on best practice
Asthma Diagnosis					
We establish an asthma diagnosis based on history & exam.	NA				
We consistently ask patients standardized questions to determine if they may have asthma.	NA				
Assessment and Monitoring of Asthma Severity					
We assess and document the child's severity classification at least yearly, and more if needed.	1				
The classification determines the child's follow-up plan.	1				
Asthma Control					
We assess the child's asthma control at every visit using a validated tool: ACT, ACQ, TRACK, or ATAQ.	3				
We provide patients with appropriate information/details if there are new medications that may be beneficial.	3				
Asthma Action Plan (AAP)					
We use an Asthma Action Plan (AAP) as a communication tool with the family. We talk with them about their asthma, and use the action plan to help guide the conversation. We encourage adherence to the AAP.	4				
We keep their AAP updated and in their medical record.	4				
For children with asthma we send an updated Asthma Action Plan to their school or early childhood center every school year. We collaborate appropriately and effectively with school nurses or other school personnel.	4				
Maximize Medications					
We select medication and delivery devices that meet the patient's needs and circumstances. We use an evidence based stepwise approach to identify appropriate treatment options.	2				
We prescribe inhaled corticosteroids (ICS) or leukotriene modifiers for effective long-term control therapy.	2				
We help patients with medication adherence by encouraging patients to bring their medications with them to every visit, reviewing them together during the visit, and discussing any medication changes and/or need for a refill.	2				
We help patients with medication techniques by making sure they are using the correct device, and providing instruction on how to use their asthma medication delivery device (spacer) as needed.	9				

Practice name here: ______________________________ Date completed: _________

Strategy	Measure#	1 Is not done	2 Inconsistently done (less than 75% of the time)	3 Consistently done (75% of the time or more)	4 Consistently done and based on best practice
Planned Asthma Visits					
We have a planned asthma encounter at least every 6 months or have documentation that they saw a pulmonologist or allergist specific to their asthma. The type of interaction depends on their asthma severity; management and control based on best practices are discussed. One planned visit can happen during the Health Supervision Visit (HSV).	5				
Tobacco Exposure and Interventions					
We assess tobacco use/exposure.	6				
If there is tobacco use or exposure we talk with the family about smoking cessation intervention and offer cessation counseling.	6				
Asthma Education					
We discuss the patient/family home environment to help them to focus on any problems that may trigger asthma exacerbations. This may include: pets, woodstoves, dust mites, or other triggers.	8				
We help patients/families with their decisions regarding allergy testing to help identify and minimize triggers.	8				
We provide asthma education that includes teaching patients about: self-monitoring to assess level of asthma control and to recognize signs of worsening asthma; taking medications correctly; avoiding environmental factors that worsen asthma; and agreeing on treatment goals.	8				
We integrate education into all points of care involving interactions with patients by including members of all health care disciplines (physicians, pharmacists, nurses, respiratory therapists, and asthma educators).	8				
We discuss social stressors that may impact asthma care with the patient/family (for example a change in housing, a change in insurance, etc.).	8				
Use of Registry and Communication					
We have implemented and demonstrated effective use of an asthma registry for reminder for annual influenza immunization and to assure at least semi-annual visit for children with asthma.	NA				
We have a system in place to ensure optimal adherence for annual influenza immunization for patients with asthma.	NA				
We know when patients have been to urgent or emergent care and we have a system for contacting them for appropriate follow-up care.	NA				
We have a system in place to communicate with asthma specialists (pulmonologist, allergist).	NA				

*Strategies adapted using the following sources:
(1) National Improvement Partnership Network: Asthma Measures - Core and Optional Process and Outcome; Version 1; February 1, 2015.
(2) National Heart, Lung, and Blood Institute (NHLBI) National Asthma Education and Prevention Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma – Full Report 2007 and NHLBI Asthma Care Quick reference: Diagnosing and Managing Asthma (2011).