

## Catholic IPA Asthma Performance Measures

Physician Name: \_\_\_\_\_

CHS ID: \_\_\_\_\_

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Insurance: \_\_\_\_\_

Member ID: \_\_\_\_\_

Member Inappropriate, Reason: \_\_\_\_\_

Ongoing Measurements: to represent date of most recent visit when asthma was addressed				
Does this patient see a specialist? <input type="checkbox"/> Allergist <input type="checkbox"/> Pulmonologist <input type="checkbox"/> Other specialist <input type="checkbox"/> Does not see specialist				
Severity Class Guide: Severe Persistent = Continual daytime symptoms, Freq night time symptoms; Moderate Persistent (3) = Daily daytime symptoms, ≥ 5 night time symptoms/month; Mild Persistent (2) = 3-6 x week daily symptoms, 3-4 x month night time symptoms; Mild Intermittent (1) ≤2 daily symptoms/week, ≤ 2 night time symptoms/month				
Date of visit	____/____/____	____/____/____	____/____/____	____/____/____
Severity Class (4,3,2,1)				
Date of yearly flu vaccine	____/____/____	____/____/____	____/____/____	____/____/____
<b>Spirometry: Recommended at least once every 12 months:</b>				
Date Performed	____/____/____ <input type="checkbox"/> N/A < 6 yrs old	____/____/____ <input type="checkbox"/> N/A < 6 yrs old	____/____/____ <input type="checkbox"/> N/A < 6 yrs old	____/____/____ <input type="checkbox"/> N/A < 6 yrs old
FEV <sub>1</sub> % Predicted				
<b>Asthma Action Plan: All patients should have a current action plan.</b>				
Plan reviewed	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is Patient's Asthma in Control?</b>				
Does patient have good control (4 or more answers no) since last visit	Limitations on activities <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma episode related Office/ER/hospital visit <input type="checkbox"/> Yes <input type="checkbox"/> No Nocturnal symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No School or work missed <input type="checkbox"/> Yes <input type="checkbox"/> No Required SABA > 2 days per week (not to include use for exercise induced asthma) <input type="checkbox"/> Yes <input type="checkbox"/> No	Limitations on activities <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma episode related Office/ER/hospital visit <input type="checkbox"/> Yes <input type="checkbox"/> No Nocturnal symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No School or work missed <input type="checkbox"/> Yes <input type="checkbox"/> No Required SABA > 2 days per week (not to include use for exercise induced asthma) <input type="checkbox"/> Yes <input type="checkbox"/> No	Limitations on activities <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma episode related Office/ER/hospital visit <input type="checkbox"/> Yes <input type="checkbox"/> No Nocturnal symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No School or work missed <input type="checkbox"/> Yes <input type="checkbox"/> No Required SABA > 2 days per week (not to include use for exercise induced asthma) <input type="checkbox"/> Yes <input type="checkbox"/> No	Limitations on activities <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma episode related Office/ER/hospital visit <input type="checkbox"/> Yes <input type="checkbox"/> No Nocturnal symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No School or work missed <input type="checkbox"/> Yes <input type="checkbox"/> No Required SABA > 2 days per week(not to include use for exercise induced asthma) <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Medication recommended for all patients with <i>persistent asthma</i> or other asthma which in not controlled, includes EITHER Inhaled Corticosteroid (ICS), Leukotriene Inhibitor or Intal/Chromolyn. Controlled intermittent pt are N/A.</b>				
Medication Name:	<input type="checkbox"/> ICS <input type="checkbox"/> Leukotriene Inhibitor <input type="checkbox"/> Intal/Chromolyn <input type="checkbox"/> Not Prescribed (contraindicated or N/A) Reason: _____ <input type="checkbox"/> Risk Discussed <input type="checkbox"/> LABA <input type="checkbox"/> Theophylline <input type="checkbox"/> Oral Steroid	<input type="checkbox"/> ICS <input type="checkbox"/> Leukotriene Inhibitor <input type="checkbox"/> Intal/Chromolyn <input type="checkbox"/> Not Prescribed (contraindicated or N/A) Reason: _____ <input type="checkbox"/> Risk Discussed <input type="checkbox"/> LABA <input type="checkbox"/> Theophylline <input type="checkbox"/> Oral Steroid	<input type="checkbox"/> ICS <input type="checkbox"/> Leukotriene Inhibitor <input type="checkbox"/> Intal/Chromolyn <input type="checkbox"/> Not Prescribed (contraindicated or N/A) Reason: _____ <input type="checkbox"/> Risk Discussed <input type="checkbox"/> LABA <input type="checkbox"/> Theophylline <input type="checkbox"/> Oral Steroid	<input type="checkbox"/> ICS <input type="checkbox"/> Leukotriene Inhibitor <input type="checkbox"/> Intal/Chromolyn <input type="checkbox"/> Not Prescribed (contraindicated or N/A) Reason: _____ <input type="checkbox"/> Risk Discussed <input type="checkbox"/> LABA <input type="checkbox"/> Theophylline <input type="checkbox"/> Oral Steroid

❖ Please rate patient compliance with treatment plan:  Excellent  Very Good  Good  Fair  Poor

❖ Would this patient benefit from a health plan sponsored Disease Management program for Asthma:  Yes  No

*This tool is based on HEDIS and AMA guidelines and has been approved by the CIPA Medical Management Committee*

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