

## 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 also see their PMD for care of their asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Does not have PMD				
Date of visit	___/___/___	___/___/___	___/___/___	___/___/___
Date of documentation of recommendation of yearly flu vac.	___/___/___	___/___/___	___/___/___	___/___/___
<b>Spirometry: Recommended at diagnosis and then at least once every 12 months:</b>				
Last Performed	___/___/___	___/___/___	___/___/___	___/___/___
FEV <sub>1</sub> % Predicted >80 well controlled 60-80 not controlled <60 poorly controlled				
Does patient have good control (3 or more answers no) since last visit	limitations on activities <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma 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 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 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 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>Asthma Action Plan: All patients should have a documented action plan</b>				
Plan in place and 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>Medication recommended for all patients with <i>persistent asthma</i> or other asthma not controlled, includes EITHER Inhaled Corticosteroid (ICS), Leukotriene Inhibitor or Intal/Chromolyn.</b>				
Medication	<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*