CPHCS ASTHMA QUALITY OF CARE REVIEW*

Reviewer: _____ **Date of Review:** _____
Patient Name: _____ **CDCR #** _____ **DOB:** _____
PCP: _____ **Date(s) of Visit(s):** _____

1) Is the overall history/problem list documentation for asthma adequate?	❑ Yes ❑ No
• Are there current complaints documented? Pertinent symptoms (i.e. interference with activities, night time wakening, frequency of SABA use, etc) reviewed? • Is a review of medications documented? Is adherence to medications reviewed? • Is a review of vaccinations (Pneumovax given at least once, and Influenza Vaccine given/recommended < 1 yr) documented? • If new patient, was prior hospitalizations, intubations, and systemic steroid use obtained?	
2) Is the overall focused clinical examination for asthma adequate?	❑ Yes ❑ No
• Are vital signs documented? Are peak expiratory flows documented? O2% sat in symptomatic patients? • Are red flags identified (PEF < 50% predicted/personal best, ↑↑ SABA use, 02 Sat < 92%?), if applicable? • Does physical examination include chest exam (heart and lungs)? For symptomatic patients, were red flags identified (use of accessory muscles, skin color changes, inability to speak full sentences)?	
3) Is the overall assessment for asthma adequate?	❑ Yes ❑ No
• Is a diagnosis for asthma with severity classification documented (i.e. intermittent, mild persistent, etc.)? • Does the assessment address if asthma goal is met (i.e. good control, or ACAT > 19)? • Are the current severity classification and patient control of patient reflective of the subjective and objective findings? • Are comorbid conditions (i.e. CHF) or a differential diagnosis considered/documented, when applicable?	
4) Is the overall plan for asthma adequate?	❑ Yes ❑ No
• Are oral steroids prescribed, if patient is having an exacerbation? • Is the patient prescribed/maintained on an Inhaled Corticosteriod (ICS) inhaler, if classified as having persistent asthma? • Is patient reclassified appropriately to persistent if prescribed SABA alone and use is > 2x's/week? If not, is reason given (i.e. exercise induced bronchospasm)? • Is "step-up" therapy (i.e. increasing ICS dosage, starting a LABA) employed, if patient is not at goal/poor control (i.e. ACAT < 20, SABA use > 2x/week, night wakening >2/month)? • Is specialty referral made to appropriate specialty (i.e. Pulmonologist), when indicated? • Is appropriate follow-up ordered, per guidelines? A. If all goals met over the last 2 encounters, follow-up within 180 days. B. If all goals not met, follow-up typically ≤ 90 days, as clinically indicated?	
5) Is the overall education and effective communication for asthma adequate?	❑ Yes ❑ No
• Are Instructions/counseling on lifestyle modifications documented (weight loss, dietary changes, exercise, etc.)? • Are medication issues documented (adherence, side effects, etc.)? • Is there documentation that education was provided about trigger avoidance, Asthma Action Plan, and/or inhaler? • Is there documentation of effective communication, including identification of disability† & accommodations‡ employed to ensure effective communication, of applicable?	
RECOMMENDATIONS/COMMENTS:	

LABA: Long acting beta agonist; SABA: Short acting beta agonist

*All elements in each domain are suggestions for good documentation, not requirements.
Use clinical judgment when reviewing the documentation.
Patient disease severity and corresponding management should be clear to the reviewer, in all documentation.
Please consider the elements in this review tool when completing Access Measure Audit Tool.
† Disabilities may be identified on Problem List or in a progress note in plain language or be DVVP code, i.e. TABES <4.0, DPH, DPV etc.
‡ Accommodations should be specific to identify disability i.e. large print or magnifying device for visual impairment.