

Asthma Visit Documentation

The following Pathway was developed, implemented, and refined by the American Lung Association in Minnesota. The pathway is intended to give other clinics a starting point for systems-change.

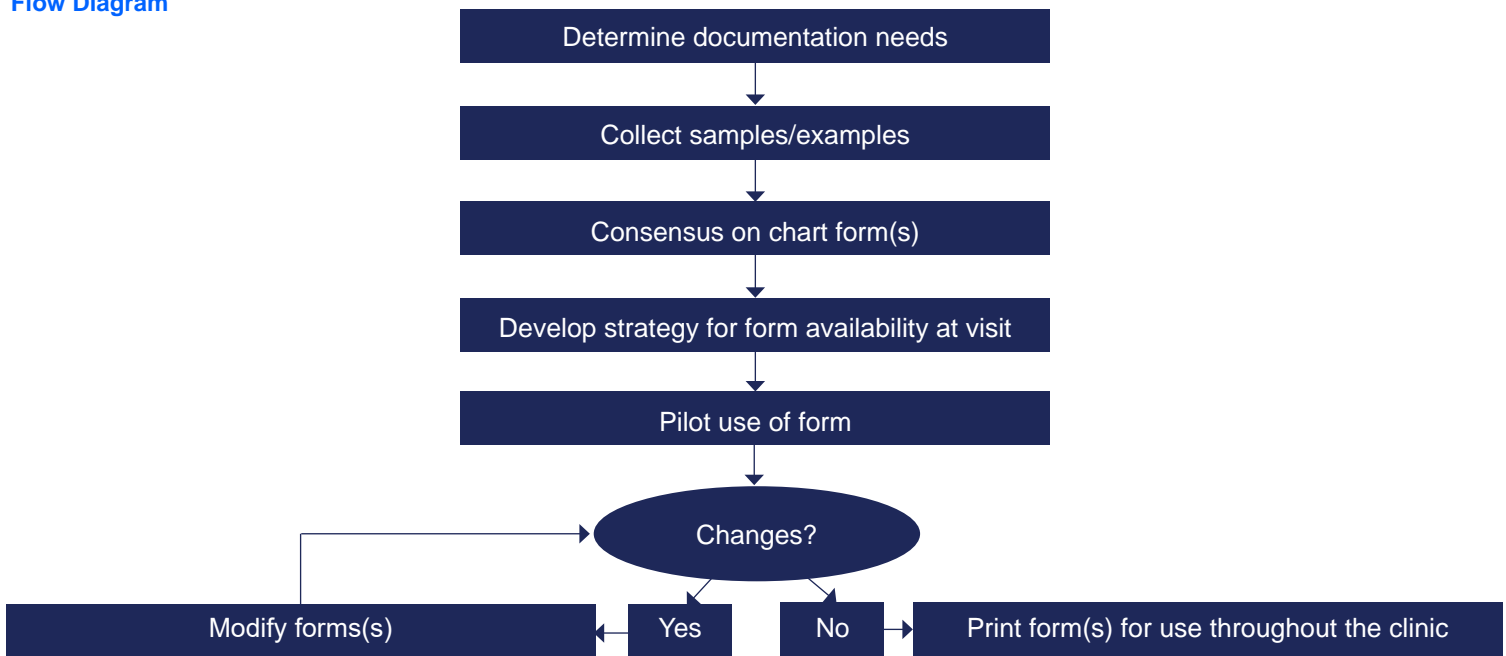
Goal: Develop appropriate asthma visit documentation tools/forms

Chronic Care Model: Delivery system design, decision support

Snapshot

1. Asthma team determined they needed an asthma documentation form/template
2. Asthma team reviewed asthma form from other clinics and their current form for other conditions
3. Asthma team drafted asthma form and discussed completion of each section, layout, and extraneous or missing items
4. Nurse manager re-drafted asthma form and one asthma team provider pilot-tested form
5. Asthma form was tested and revised
6. Clinic printed asthma form in bulk for entire staff to use
7. Asthma team taught patient care staff and providers how and when to use asthma form

Flow Diagram



Implementation Details/Considerations

Paper

1. Consider various types of chart documents and determine which type(s) fulfill your clinic's needs and will realistically be completed (visit shingle, flow sheet, checklist, patient history form).
2. Determine for which patients the form will be used and at what type of visit (asthma planned visit, asthma sick visit, all visits for patients with asthma).
3. Review examples of documents available from other clinics.
4. Choose "best examples" of forms or aspects you like from different forms.
5. Modify documents to meet your needs. Consider formatting similar to existing chart forms. Incorporate decision support tools into forms (such as severity rating table).
6. Have staff and providers on asthma team review form.
7. Print small number of forms to pilot.
8. Determine which staff will complete each section.
9. Identify any needed revisions after "real-world" use. Revise/retest as needed.
10. Determine where forms will be located and how they will get put on the chart.
11. Print appropriate number and spread use to entire clinic.

Electronic

1. Determine what currently exists within the EMR.
2. Consider various types of chart documents and determine which type(s) fulfill your clinic's needs and will realistically be completed (visit template, order sets, flow sheet, checklist). It may be helpful to use format similar to other chronic disease management strategies used already in your EMR.
3. Determine what can realistically be changed/modified.
4. Determine for which patients the special asthma documentation will be used and at what type of visit (asthma planned visit, asthma sick visit, all visits for patients with asthma).
5. Review examples of documents available from other clinics that may be appropriate basis for a template.
6. Modify documents to meet your needs. Is there a way to easily link to decision support tools (such as severity rating table)?
7. Have staff and providers on asthma team use new documentation tool.
8. Is there a way to have support staff complete and document part of asthma assessment?
9. Identify any needed revisions after "real-world" use. Revise/retest as needed.
10. Educate staff and providers about newly available tools/techniques.