Healthy Homes Program Asthma Diagnostic

General Information

Case Manager:		
Date of Last Contact:		
Child's Name:	Child's Date of Birth	Gender: M / F
Parent/Guardian's Name:	Home Phone Number:	
Home Address:		
Primary Caregiver:		

I. Assess and Monitor Asthma Control Status (*SR-self reported)

1. Date of enrollment in the Healthy Homes Program:	
2. Calculate Asthma Control Test (ACT):	ACT1_____ ACT2_____ ACT3_____ ACT 4_____
3. Do you think your child's asthma is under control?	☐Yes ☐ No If no what is causing your child to have problems controlling his or her asthma?
4. In the past three months, has your child had an unscheduled urgent care visit, emergency room or health care provider visit or, overnight hospitalization? (Please specify)	
5. In the past three months how many asthma episodes has your child experienced?	
6a. At the time of the asthma episode was your child following their action plan?	☐Yes ☐ No
6b. Did the episode result in your child receiving oral prednisone (oral systemic corticosteroids) or intravenous methylprednisolone?	☐Yes ☐No
7a. Is your child currently in school or childcare? (circle one)	☐Yes ☐ No
7b. If yes, how many days have they missed from school due to their asthma?	
8a. (SR) Does your child have any physical activity limitation?	☐Yes ☐ No
8b. (SR) If yes, can you describe the exact limitation?	
8c. (SR) Can you please describe the approximate level of activity limitation over past 3 months (select one):	☐Mild ☐Moderate ☐Severe
9. (SR) Please tell me the number of times your child has experienced the following in the past 14 days?	☐Wheezing: Approximate # of episodes per week__ ☐Tightness in chest: Approximate # of episodes per week____ ☐Cough: Approximate # of episodes per week__ ☐Shortness of breath: Approximate # of episodes per week___ ☐Interference with sleep: Approximate # of days per week___

10. SR) Since your child's last physician visit has your child's asthma symptoms? (select one):
☐Significantly improved
☐Slightly improved ☐Unchanged
☐Slightly worse ☐Significantly worse ☐Unsure

11. Does your child currently see any medical specialist (e.g., allergist, pulmonologist)?		☐Yes ☐ No If yes, specify:
Name:	Phone:	Specialty Type:
Number:		**a.** Has your child had Pulmonary Lung Function test/ Spirometry_____☐Yes ☐ No **b.** If yes, please provide date_____

II. Use of Asthma Action Plan *(SR- self reported)

1. Does your child have a written asthma action plan?	☐Yes ☐No
2. Date of your child's last asthma action plan:	
3. Has your child's asthma action plan been distributed to their school or daycare?	☐Yes ☐No
4. Do you utilize your child's asthma action plan?	☐Yes ☐ No If no, specify why:
5. How often do you refer to the asthma action plan?	☐Never ☐Sometimes ☐Often If never, specify why:
6. Does your child use a peak flow meter as needed?	☐Yes ☐No
7. What is your child's personal best as measured by peak flow?	
8. How often are peak flows measured?	
9. Correct Peak Flow monitoring technique:	☐Yes ☐No

III. A. Inhaled Corticosteroids and other Medications

List the prescribed medications/over the counter drugs taken by child, in the past 3 months:

Name	How Taken	Dosage	Frequency	Last Dose Taken
a.				
b.				
c.				
d.				
e.				
f.				

III. B. Medication Usage *(SR-self-reported)

1. (SR) Does your child take their medicine when feeling fine?	☐Yes ☐No
2. How many times in the last 14 days has your child used their rescue inhaler?	
3. Can you recall the number of rescue medication refills that your child has had in the last 3 months?	
4. Does your child need refills?	☐Yes ☐No
5. Please select any side effects from child's medication experienced in the past 14 days:	☐Sleeping difficulty ☐Shakiness ☐Rapid heart rate ☐Headaches ☐Moodiness ☐Hoarseness
6. Prescribed devices: Child has age appropriate medication delivery device	☐Yes ☐No
7. Does the child use (Select all that apply):	☐Peak Flow Meter ☐Spacer ☐Nebulizer
8. (SR) Do you as the caregiver feel comfortable administering asthma medicines?	☐Yes ☐No
9. Do you as the caregiver know how to clean asthma devices?	☐Yes ☐No
10. Are you satisfied with how medications treat your child's asthma?	☐Never ☐Sometimes ☐Often
11. Do you believe your child's asthma medications need review by their doctor?	☐Yes ☐No
12. Have any particular issues prohibited you from obtaining the prescribed medication?	
13. Have you been declined reimbursement of medications or medication devices from your insurance carrier?	☐Yes ☐ No
14. Do you feel like the medicine techniques demonstrated at your doctor's office are sustainable at home?	☐Yes ☐ No If no, specify reasons why

III. C. Device/Drugs

Can you demonstrate how your child uses their asthma medication device?

Device/Drugs	Population	Optimal Technique Observed	Therapeutic Issues/ Recommendations	Overall technique on return demo adequate
14 a.Metered-dose inhaler (MDI) **Beta $_2$- agonists** **Corticosteriods** **Cromolyn sodium** **Anticholinergics**	≥ 5 years old(<5 with spacer or valved holding chamber (VHC) or mask)	Actuation during a slow (30 L/min or 3-5 seconds) deep inhalation, followed by 10-second breath hold	A) Slow inhalation and coordination of actuation B) Incorrectly stopped inhalation at actuation C) Did not mention rinsing mouth and spitting	**YES NO**
14 b.Breath-actuated MDI **Beta $_2$ agonist**	≥ 5 years old	Tight seal around mouthpiece and slightly more rapid inhalation then standard MDI (see above) followed by 10-second breath hold	A) Patient unable to coordinate inhalation and actuation. B) Patient incorrectly stopped inhalation at actuation C) Should not be use MDI with spacer/valved holding chamber (VHC) devices	**YES NO**
14 c.Dry powder inhaler (DPI) **Beta$_2$- agonist** **Corticosteriods** **Anticholinergics**	≥ 4 years old < 4 years old VHC	Rapid (60 L/min or 1-2 seconds), deep inhalation. Most children under <4 years of age may not generate sufficient inspiratory flow to activate inhaler	A) Dose is lost if patient exhales through devices after actuating. B) Delivery may be greater or lesser than MDI, depending in device and technique. C) Rapid inhalation promotes greater deposition in larger central airways.	**YES NO**
14 d.Spacer or valved holding chamber (VHC)	≥4 years old < 4 years old VHC with face mask	Slow (30 l/min) or 3-5 seconds) deep inhalation, followed by 10-second breath hold immediately following actuation Actuate only once into spacer/VHC	A) Indicated for patients who have difficulty performing adequate MDI technique B) Face mask allows MDIs to be used with small children	**YES NO**
14 e.Nebulizer **Beta $_2$ agonists** **Corticosteriods** **Cromolyn sodium** **Anticholinergics**	Patients of any age who cannot use MDI with VHC and face mask	Slow tidal breathing with occasional deep breaths. Tightly fitting face mask for those unable to use mouthpiece	A) Less dependent on patients coordination and cooperation B) May be expensive C) Potential for bacterial infections if not properly cleared	**YES NO**

IV. Assess Asthma Severity *(SR-self-reported)

1. Has your child increased their medication use in the past 14 days?	☐Yes ☐No
2. Do you or your child recognize the signs of worsening asthma such as coughing, shortness of breath, chest tightness and wheezing?	☐Yes ☐No
3. Describe for me how you know when to call the doctor or go to the hospital for your child's asthma?	
4. What part of the day does your child experience asthma symptoms the most? (select all that apply):	☐Randomly throughout the entire day ☐Early a.m. ☐Early p.m. ☐Middle of the night ☐During exercise ☐Following exercise
5. (**SR**) Are you confident on how to control/manage your child's asthma?	☐Yes ☐No
6. Do you keep a daily diary or log of symptoms for your child self-assessment?	☐Yes ☐No
7. Does your child have an additional health condition that may contribute to their current asthma symptoms?	☐Yes ☐ No If yes, specify:
8. Have you tried any over-the-counter medication or remedies to treat your child's asthma?	☐Yes ☐ No If yes, specify:
9. Are you or your child able to describe how he/she feels during an asthma attack?	☐Yes ☐No

V. Control Environmental Exposures and Asthma Triggers*(SR-self-reported)

1. Case manager comment on Housing condition-Summary of Hazards as noted in TAR

2. Do you have a pet?	☐Yes ☐No If yes what type: ☐Dog ☐ Cat ☐Bird ☐ Rodent ☐ Reptile ☐Fish ☐Other
3. Where are pets allowed to be in the home?	
4. (SR) Are any of the following a trigger for your child's asthma?	☐ Change in temperature ☐ Emotions ☐ Respiratory Infections/Colds ☐ Seasonal Allergies: (Spring Summer Fall Winter) ☐Following exposure to (specify): ☐Allergens/Triggers (specify): ☐Other:

5. Do you have pests (such as cockroaches or mice)?	☐Yes ☐No
6. Does anyone in the home smoke?	☐Yes ☐No If Yes, can you tell me who smokes in the home? ☐ Parent ☐ Both Parents ☐ Visitors ☐Child
7. Can you make changes to help your child avoid their known asthma triggers?	? ☐Yes ☐No If no please indicate why not:
8. Can you recall your child's most recent asthma episodes? Please provide details regarding type of activity, location, possible trigger and if it resulted in seeking medical help.	

VI. Schedule Follow-up visits *(SR-self-reported)

1.Case manager: In your own words please write down anything you would like the doctor to know about this patient's asthma:	
2. Has your child had at least one routine follow-up visit in the past 12 months?	☐Yes ☐No - If not please specify why:
3. Do you believe your child can benefit from additional time with their physician?	☐Yes ☐No If yes, how:
4. Where do you see your child's physician doctor's clinic, mobile unit, emergency room?	
5. Do you see the same physician each time?	☐Yes ☐No
6. Is your work schedule flexible enough to allow for provider visits?	☐Yes ☐No If not please specify why
7. Is your child embarrassed or shy about taking asthma medicine in front of friends?	☐Never ☐Sometimes ☐Often
8. How often does your child experience anger/frustration because of their asthma	☐Never ☐Sometimes ☐Often
9. (SR) Do you feel your child's treatment is tailored to easily fit into their lifestyle (school, work or leisure)?	☐Yes ☐No
10. What worries you the most about your child's asthma?	
11. Are there any situations that are impacting your ability to manage your child's asthma? (i.e alcohol or drug abuse, psychological illness, recent family loss or disruption, recent unemployment, domestic violence, other ill family members, multiple parental responsibilities)?	
12. Do you believe that asthma medication is the responsibility of your child or do you participate in providing medication reminders and assist with the administration?	
13. Are there multiple caregivers for your child?	☐Yes ☐No If yes, who?
14. (SR) Does your child's asthma affect your overall life in terms of work & home	☐Yes ☐ No If yes, specify:
15. Have you experienced difficulty in getting in touch with doctors or experienced long waiting times to see the doctor?	☐Yes ☐ No If yes, specify:
16. Is there anything we missed in terms of things that we may not have discussed today that make it easy or hard to manage your child's asthma?	

17. Describe for me how you know when to call the doctor or go to the hospital for asthma care?

18. On your next visit the doctor should discuss (circle all that apply):	a. Different types of drugs available to control asthma? b. Your child's asthma treatment options? c. How your child prefers to take his/her asthma medicine(s)? d. Other issues

VII. A. Asthma Educator Visit

Activities during visit:

☐Education on General Home Safety was provided

☐Principles of Healthy Homes explained

☐Environmental triggers of Asthma explained

☐Smoking cessation information offered

☐Health Care utilization questions asked

☐Recent Asthma symptoms reviewed

☐Observed use of Asthma medication devices

VII. B. AE-C Narrative of Findings

VII. C. Applicable Additional Services and Comments

☐Patient needs medical supplies (need physician approval)

☐Patient require social service resources (requires physician approval)

☐Patient needs to see physician (directed parent to call and make the appointment)

☐Referred to lead program

☐Recommended moving due to environmental trigger

☐Recommended home remediation

☐Patient needs additional educational services

☐Specialist physician referral

☐Facilitated parent to refill medication

☐Tenet to call code enforcement

VII. D. Items that were provided:

☐HEPA vacuum
☐Reusable mop/Swiffer
☐Smoke detectors
☐Carbon monoxide detectors
☐Cockroach traps
☐Food Storage containers
☐Mattress cover
☐Trash bags
☐Pillowcase covers
☐Bath Mat
☐Door Mat
☐Electrical outlet covers
☐Cabinet Locks
☐Carbon monoxide detector
☐Wet wipes

VIII. Case Management Notes:

Medication adherence	☐Yes ☐ No
Medication refill assistance	☐Yes ☐ No
Inhaler/nebulizer technique adequate	☐Yes ☐ No
Asthma allergens & triggers education provided	☐Yes ☐ No
Care Plan Needs (select all that apply):	☐More wet cleaning ☐Create or use storage system, ☐Remove stuffed animals from asthmatic child's bedroom ☐Use pillow and/or mattress covers ☐Use baits and traps for pest management ☐Reduce clutter ☐Additional Needs
Comment on Agency and Community referrals to update physician	
Additional Comments	

Overall Asthma Assessment Tool (adapted from Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma 2007, NIH Publication No. 10-7541)

Use Inhaled Corticosteroids **Interventions: The Expert Panel recommends that long-term control medications be taken on a long-term basis to achieve and maintain control of persistent asthma, and that inhaled corticosteroids (ICS) are the most potent and consistently effective long-term control medication for asthma (Evidence A). Modify therapy based on control, consider specialty referral, consider complicating factors or comorbidities** **Reassess Yes__ No___**	Assess and Monitor Asthma Control **Interventions: The Expert Panel recommends that every patient who has asthma be taught to recognize symptom patterns and/or Peak Expiratory Flow (PEF) measures that indicate inadequate asthma control and the need for additional therapy (Evidence A), and that control be routinely monitored to assess whether the goals of therapy are being met – that is, whether impairment and risk are reduced (Evidence B). Additionally important is symptom recognition, stepwise adjustments in therapy, peak expiratory flow usage to assess goals of therapy, consider patients circumstances and preferences.** **Reassess Yes___ No___**
Use Asthma Action Plans **Interventions: The Expert Panel recommends that all patients who have asthma be provided a written asthma action plan that includes instructions for: (1) daily treatment (including medications and environmental controls), and (2) how to recognize and handle worsening asthma (Evidence B). Additionally use of written material, computer programs, form active an physician patient partnership** **Reassess Yes__ No___**	Schedule Follow-up Visits **Interventions: The Expert Panel recommends that monitoring and follow up is essential (Evidence B), and that the stepwise approach to therapy–in which the dose and number of medications and frequency of administration are increased as necessary (Evidence A) and decreased when possible (Evidence C, D) be used to achieve and maintain asthma control. Additionally important is to periodically modify therapy, observe and teach optimal inhaler technique, assess adherence to prescribed treatment plan** **Reassess Yes__ No___**
All patients should have an initial severity assessment **Interventions: The Expert Panel recommends that once a diagnosis of asthma is made, clinicians classify asthma severity using the domains of current impairment (Evidence B) and future risk (Evidence C, D) for guiding decisions in selecting initial therapy. Addtionally recommended is to evaluate severity of underlying disease** **Reassess Yes___ No____**	Control Environmental Exposures **Interventions: The Expert Panel recommends that patients who have asthma at any level of severity be queried about exposure to inhalant allergens, particularly indoor inhalant allergens (Evidence A) and tobacco smoke and other irritants (Evidence C), and be advised as to their potential effect on the patient's asthma. The Expert Panel recommends that allergen avoidance requires a multifaceted, comprehensive approach that focuses on the allergens and irritants to which the patient is senstitive and exposed–individual steps alone are generally ineffective (Evidence A).Trigger avoidance-multifaceted approach to allergen control based on sensitivities. Avoid tobacco exposure and take the opportunity to educate household contacts of detrimental effects of tobacco smoke. Consider allergen skin testing, allergy skin testing, consider referral to allergist.** **Reassess Yes__No__**

Overall Impressions (Notes/Summary):

☐

☐

☐