12. Below are strategies that could be used to help patients control their asthma. Please specify whether you use each strategy. If you do not use a strategy specify the most important barrier (if any) that you face to using that strategy. You may also indicate that you face no barrier or that you view that strategy as not effective).

	Do you use this Mark (X) or			e box for each "NO" response.							
		strategy please ind barrier I the I Mark (r? It no, dicate one listed to right. X) one	 No barrier 	Not effective	Poor patient adherence	Low patient health literacy	Lack of staff/ equipment	Lack of training	Lack of time	Lack of payment
(a)	Written asthma action plans	1	2□→	 1 []	2	3	4	5	6	7	8
(b)	A control assessment tool (e.g., ACT or similar tool)	1	2□→	 1	2	3	4	5	6	7	8
(c)	Home peak flow monitors	1	2□→	 1	2	3	4	5	6	7	8
(d)	In-office spirometry	1	2□→	 1 	2	3	4	5	6	7	8
(e)	Educating patients to recognize symptoms	1	2□→	 1	2	3	4	5	6	7	8
(f)	Educating patients to avoid risk factors	1	2□→	 1□	2	3	4	5	6	7	8
(g)	Involve patients in treatment decision-making	1	2□→	 1	2	3	4	5	6	7	8
(h)	Observe inhaler use by patients	1	2□→	 1	2	3	4	5	6	7	8
(i)	Advise patients to change their home environment	1	2□→		2	3	4	5	6	7	8
(j)	Advise employed patients to seek changes in the work environment	1	2□→	 1	2	3	4	5 🗌	6	7	8
(k)	Schedule routine follow-up visits to assess asthma control	1	2□→	 1 🗆	2	3	4	5	6	7	8
13. How	often do vou encounte	er these pa	tient conce	erns or	misunders	tandings	M	ark (X) one	box in e	each ro	W.
about asthma therapies?					Never (0%)	Sometime (1–24%)	s Oft (25–7	en 4%) (Almost always 75–100%)		
(a) Misunderstanding of medication risks or side effects, or belief in myths (e.g., muscle development, addiction)					1	2	3		4		
(b) Concern about short-term side effects from inhaled corticosteroids (e.g., thrush)					1	2	3		4		
(c) Concern about long-term side effects of inhaled corticosteriods (e.g., delayed growth in children)					1	2	3		4		
(d) Confusion between symptom relief medications and daily control medications						1	2	3		4	
4. Pleas	se indicate your role?										
1 🗌 F 2 🗌 C 3 🗌 C	Physician to whom this Other clinical role (e.g. Other office staff	s survey wa , PA, NP,	as address RN)	sed							
Closing	g Statement – Than	k you for c	ompleting	this spe	ecial surve	y. We app	reciate yo	ur time and	l coopera	ation.	

FORM NAMCS-91 (9-29-2011)

Census Bureau

NATIONAL AMBULATORY MEDICAL CARE SURVEY 2012 ASTHMA SUPPLEMENT

NO instr may com Infor	TICE – Public reporting burden of this collection of information uctions, searching existing data sources, gathering and mainta not conduct or sponsor, and a person is not required to response ments regarding this burden estimate or any other aspect of the mation Collection Review Office, 1600 Clifton Road, MS D-74,
Ass will relea	Burance of Confidentiality – All information which would be used for statistical purposes only by NCHS staff, contractor ased to other persons without the consent of the individual or t m) and the Confidential Information Protection and Statistical E
•	BACK Brouider's sorial number
А.	Flovider S Senar number
B.	Provider's specialty (Mark (X) only ONE.)
	1 General/Family Practice 3 Pediatrics
	2 Internal Medicine 4 CHC Mid-level Provid
IN	TRODUCTION The National Institutes of H Protection Agency are cond and physician office settings day practice and not what r following questions, please or clinical decisions made b
1.	Which of the following patient age groups do Mark (X) all that apply. 1 0–11 years 2 12–17 years 3 18–24 years 4 25–64 years 5 65 years and above
2.	Which type of system, if any, do you use to tr (e.g., schedule regular follow-up visits)?
	 1 Electronic medical record-based system 2 An electronic system separate from medic 3 Paper reminder/recall system
3.	How frequently do you use an asthma-specifi visit checklist) when asthma is the primary real 1 No form available 2 Never (0%) 3 Sometimes (1–24%)
4.	During your last normal week of practice, app asthma regardless of the reason for the
	Number of visits

OMB No. 0920-0234 Exp. Date 2/28/2013

U.S. DEPARTMENT OF COMMERCE Economics and Statistics Administration U.S. CENSUS BUREAU ACTING AS DATA COLLECTION AGENT FOR THE U.S. Department of Health and Human Services Centers for Disease Control and Prevention National Center for Health Statistics

n is estimated to average 20 minutes per response, including the time for reviewing taining the data needed, and completing and reviewing the collection of information. An agency ond to a collection of information unless it displays a currently valid OMB control number. Send this collection of information, including suggestions for reducing this burden to: CDC/ATSDR 4, Atlanta, GA 30333, ATTN: PRA(0920-0234).

permit identification of any individual, a practice, or an establishment will be held confidential; rs; and agents only when required and with necessary controls, and will not be disclosed or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC Efficiency Act (PL-107-347).

GROUND INFORMATION								
C. Ce	ensus contact nar	ne						
5 Other- <i>Specify</i>	D. Census contact telephone	Area code Number 						

ealth, Centers for Disease Control and Prevention, and the US Environmental ducting a special survey on asthma care provided in community health centers s. We are interested in the clinical decisions you make about asthma in every may be ideal or best practice. Your answers will remain anonymous.For all the answer only for patients you personally see. Do not include patients seen by by other practitioners at your site.

you see?

rack and manage your patients with asthma

cal records

4 ☐ Other type of system 5 ☐ No system 6 ☐ Don't know

c structured encounter form (i.e., an asthma template or an asthma ason for the visit?

%) s (75–100%)

proximately how many visits did you have with patients who have e visit?

5.	For each of the following statements, please indicate whether	Mark (X) one box in each row.						
	you agree or disagree:	Strongly agree	Agree	Neutral	Disagre	e Strongly disagree		
	a. Spirometry is an essential component of a clinical evaluation for an asthma diagnosis in patients able to perform it (spirometry does not include peak flow monitoring)	 1	2	3 4 5				
	 Inhaled corticosteroids are the most effective medications to control persistent asthma 	are the most effective medications				5		
	c. Asthma action plans are an effective tool to guide patient self-management efforts		2	3	4	5		
	d. Patients with persistent asthma should have follow-up visits at least every 6 months to assess control		2	3	4	5		
	 Assessing asthma severity is necessary to determine initial therapy 		2	3 4 5				
6.	Please rate your confidence in using the following actions	M	lark (X) o	ne box i	in each	row.		
		Very confiden	t Somew	vhat N lent co	Not all onfident	N/A (do not perform)		
	 Using spirometry data as a component of a clinical evaluation for an asthma diagnosis in patients able to perform it 	 1	2		3	4		
	b. Assessing underlying asthma severity using standard criteria	1	2		з 🗌	4		
	c. Prescribing the appropriate dose of inhaled corticosteroids		2		3	4		
	d. Evaluating the need to step up controller therapy	 1	2		3	4		
	e. Evaluating when to step down controller therapy	 1	2] 3		4		
	FOR QUESTIONS 7–10, PLEASE RESPOND REGARDING VIS FOR ASTHMA (INCLUDING ROUTINE AND ACU	ITS MADI ITE VISIT	E SPECIE 'S).	ICALL	Y			
7.	FOR QUESTIONS 7-10, PLEASE RESPOND REGARDING VIS FOR ASTHMA (INCLUDING ROUTINE AND ACU For what percent of asthma visits do you document overall asthma control? 1 0% (Never) 2 1-24% (Sometimes) 3 25-74% (Often) 4 75-100% (Almost always)	ITS MADI ITE VISIT	E SPECIF 'S).	FICALLY	Ŷ			
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9.	For what percent of asthma visits do you use each of the following	Mark (X) one box in each row.							
	strategies to help patients control and manage their asthma?	0% (Never)	1–24% (Sometimes) 25–74% (Often)	75 (A al	–100% Imost ways)			
	a. Provide a new or review an existing written asthma action plan outlining medications, triggers, and when to seek emergency care.	 1	2	3	2	1			
	 Assessment by history of triggers at home (e.g., pets, mold, tobacco smoke) 		2	3		1			
	c. Assessment by history of triggers at school (e.g., mold, dust, exhaust) <i>Skip to 9d if you do not see children</i>	 1	2	3	4	4			
	d. Ask adult patients about their occupation and place of employment <i>Skip to 9f if you do not see adults</i>	 1	2	3	2	1			
	e. Assessment by history of triggers at the workplace (e.g., dust, fumes, chemicals) Skip to 9f if you do not see adults		2	3	4	4			
	f. Testing for allergic sensitivity via skin or allergen-specific IgE (e.g., RAST) testing		2	3		4			
	g. Assessment of daily use of controller medication (e.g., inhaled corticosteroids) for patients with persistent asthma	 1	2	3		4			
	h. Repeated assessment of inhaler technique	1	2	3		1			
	i. Referral to a specialist <i>Skip to 10 if you are an asthma/allergy specialist</i>	 1	2	3		4			
0.	Under which circumstances do you make the following recommendation	ns about	Mark (J	X) one box i	n each i	row.			
			For most asthma patients	Only for patie with sensitiv to this trigg	ents vity ger re	Rarely or never ecommend			
	a. Using dust mite control measures (e.g. mattress covers)			2		2			
	b. Controlling household mold and pests (e.g., cockroaches)	I				3			
	c. Removing pets from the home		1	2		3			
	d. Avoiding pollen (e.g., limit outdoor time, close windows)					3			
	e. Avoiding air pollution (e.g., ozone warnings)		1	2		3			
	f. Making changes to cooking appliances (e.g., exhaust vents)	1		2		3			
	g. Avoiding second-hand tobacco smoke		1	2		з 🗌			
11.	How do you use the following medications? Mark (X) ALL that apply on each row.	Mar	Mark (X) ALL that apply on each row.						
		Symptom relief/acute exacerbation	Daily long term control therapy	Add on daily control therapy	For diffic to contr asthm	cult Do rol not a use			
	a. Short acting beta agonists (e.g., Albuterol)	1	2	3 🗌	4	5_			
	b. Inhaled corticosteroids (ICS)	1	2	3	4	5 🗌			
	c. Long acting beta agonists (LABA) (e.g., Serevent/salmeterol, Foradil/formoterol)	1	2	3 🗌	4	5			
	d. Combination medication that includes both LABA and ICS (e.g., Advair)	1	2	3 🗌	4 🗌	5			
	e. Leukotriene modifiers (e.g., Singulair/montelukast)	1	2	3	4	5			
	f. Anticholinergics (e.g., ipatropium, tiotropium)	1	2	3 🗌	4	5			
	g. Methylxanthines (e.g., theophylline)	1	2	3 🗌	4	5			
	h. Omalizumab/Xolair	1	2	3 🗌	4	5			
	i. Short course of oral/injectable corticosteroids	1	2	3	4	5			
	j. Long course of oral corticosteroids (>10 days)	1	2	3 🗌	4	5□			

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