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One day, about a year and a half into our asthma collaborative work, I was talking to a ten year old boy who presented for a scheduled asthma follow-up visit. After the MA finished with the spirometer, I entered with my asthma caddy in hand. After greeting the boy and his mom, I asked whether he thought his asthma was in control. He laughed and nodded yes, and I smiled because his spirometry confirmed this. Then he said, "*Hay un niño en mi clase que dice que no puede correr en PE, porque tiene asma. Yo le dije que debe de hablar con su doctora, porque no estan funcionando bien sus medicamientos de control. Uno puede controlar el asma. Yo lo hice. Yo puedo hacer todo lo que quiero.*" ("There is a kid in my class who said that he couldn't run in PE because he has asthma. I told him that he should speak to his doctor, because his controller meds are not working right. One can control asthma. I did it. I can do anything I want to.")

Cristian's sense of self-efficacy was a qualitative testimonial to the success of our efforts in the Bureau of Primary Health Care's Health Disparities Collaboratives. The monthly Excel reports and quarterly narratives had ceased to resonate for me. To hear a patient tell a story that shows that our asthma quality work may influence patients who never crossed the doorstep of our clinic is beyond my initial vision for the project.

Our asthma project is based in the chronic care model and includes an electronic registry we developed within Merritt, our patient management system. We chose to develop our registry within our own patient management system to avoid the need for double data entry on demographics and to ensure networking ability across our 22 sites. The registry allows us to run reports on NIH classification of asthma; prescriptions of controller meds for persistent asthmatics; presence of asthma action plans; referrals to specialists, home visitation programs, and educational classes; and receipt of a flu shot.

Ninety-nine percent of our 374 asthmatics at our Pediatrics site are classified according to NIH guidelines; 100% of persistent asthmatics have been given a prescription for a controller medication; all of our patients are given the opportunity to attend an asthma class, and those who qualify are referred for home visitation; and in a year of vaccine shortage we were able to document that 94% of our patients had received a flu vaccine by the end of October last year. (As I write, I'm anxiously awaiting this year's supply….)

Two *key components* of the project are a *standardized asthma progress note* that prompts providers to categorize asthmatic patients and lists most controller meds, and *monthly individualized provider reports* from the provider champion (that's me) that include lists of specific patients who are missing key measures. The provider receiving feedback can tell us if there is a data entry problem, or if indeed the patient needs to return for

updating. We started with all the patients of two providers who had been seen twice for a visit coded 493 (asthma) within the previous two years. When we spread to the other seven providers, we allowed them to refer in their patients prospectively, but when they realized that the registry list would be used to prioritize patients for flu shots, there was a sudden jump in referrals!

To optimize face-to-face time in the rooms with our asthma patients, we have adapted an asthma caddy given to us by the folks at Children's Oakland Asthma Clinic to include all the school forms, referral forms, asthma action plans, examples of controller and rescue meds and all medication delivery devices in one portable unit that can be brought in to any of our 15 exam rooms. This eliminates the need to stock every room with all of these items, but makes sure that the provider doesn't spend valuable time running from exam room to storage to find just what that patient needs.

The project is functioning well at our Pediatric site, and started at our Vallejo clinic three months ago. We look forward to the challenge of spreading to all our other sites. In particular, figuring out how to provide protected time to a local provider champion at each site and to carve out time for data entry for the support staff are our biggest challenges.

Advice to others: start small, make it easy for providers, have a local provider function as an opinion leader/provide feedback, protect support staff time for data entry (garbage in/garbage out!)

We hope that you, like Cristian, will feel that you can do anything you want to when it comes to controlling asthma!