Thank you for your interest in the Easy Breathing program. Enclosed are all of the materials you will need to implement the program in your clinic or in your practice.

Easy Breathing is an asthma management program that translates the national asthma guidelines into a usable format for busy primary care providers. All of the program elements have been field tested in multiple languages including English, Spanish, Polish, Bosnian, Creole and Portuguese. (If your patient population speaks a different language, please let us know and we may be able to help with a translation and testing.) When implemented as outlined, the program can significantly reduce emergency room visits and hospitalizations in children with asthma.\(^1\) Use of the program has also been associated with a significant decrease in oral corticosteroids and a significant increase in inhaled corticosteroids.\(^2\) Taken together, these changes suggest improved health for children with asthma.

Easy Breathing consists of 5 elements:

- The Easy Breathing Survey
- The Provider Assessment
- The Asthma Treatment Selection Guide
- The Asthma Treatment Plan
- The Asthma Control Test™

Each element and how to use it is described below.

All of the elements of the program adhere to the National Asthma Education and Prevention Program (NAEPP EPR-3) Guidelines which were first released in 1997 and last revised in December 2007. It is important to remember that these are consensus Guidelines and that some aspects of the Guidelines are evidence-based while other aspects are based on expert opinion. Thus, asthma specialists in your community may disagree with some of the recommendations in the Guidelines. In developing a program that would be used by many different individuals, we chose to strictly adhere to the Guidelines rather than interject our own personal opinions about asthma management. In this way, clinicians who do not know us can use the program with confidence.

Numerous asthma tools and instruments are currently available. Why is Easy Breathing different? Easy Breathing is different because:

1. Every program element has been tested in low literacy people in English, Spanish (Hispanic/Puerto Rican), Polish, Bosnian, Creole and Portuguese.
2. Primary care clinicians have been involved in all aspects of the program including program development, testing and implementation.
3. Extraneous program elements have been removed and streamlined to meet the needs of the busy primary care clinician.
4. This is a program of proven effectiveness. Use of the program by primary care clinicians has resulted in decreased medical services utilization.\(^3\)
Easy Breathing is currently being used by more than 300 pediatric clinicians in 100 practices in 57 cities and towns throughout the state of Connecticut. The program has also expanded nationally into the states of Florida, Kansas, Kentucky, Puerto Rico, Hawaii, Massachusetts, Colorado, Ohio, and Vermont. More than 200 primary care clinicians in private practices have used the program in their own practice as a quality improvement program and many have chosen to use the program to meet Part IV of Maintenance of Certification by the American Board of Pediatrics.

Thus, Easy Breathing can be used both within a private practice and by multiple practices/clinics in large and small communities. The infrastructure that is needed to support the program is different for each of these settings.

If you plan to use the program in your own practice, identify a leader (that is most likely you) from your group. Learn the program well and then train your colleagues (it takes approximately an hour to train a practice). Decide as a practice who will distribute the survey, where program materials will be kept and monitor the use (# of surveys is the easiest) of the program. After the training, your time commitment will be no more than 1 hour per month depending upon the size of your practice and the data you decide to collect for quality improvement projects.

If you plan to use the program in multiple practices in your community, you should identify an overall physician champion as well as a leader in each of the individual practices. Your overall physician champion will lead the community, will assure form availability, will help to reduce barriers to implementation and sustain enthusiasm. At the community/multi-practice level, a program coordinator (part-time or full-time) is essential to sustain the program. Detailed training for the program coordinator and for the overall physician champion is available through the Easy Breathing program at a cost that covers the trainer’s time and materials. A detailed database and training are also available at a similar cost. Contact the Easy Breathing program to learn more about community-based implementation.

Easy Breathing is not for every clinic or practice but the majority of the clinics and practices participating in the program will be successful. In our experience, approximately 80% of private practices will be successful in implementing the program and approximately 75% of the urban clinics will be successful.

On the following pages, we provide detailed instructions for using Easy Breathing in a private practice setting. This is followed by information specific to MOC. A CME lecture on Easy Breathing is available at cme.connecticutchildrens.org and can reinforce the information in this manual.
THE EASY BREATHING® SURVEY

The Easy Breathing Survey was adapted from the respiratory survey questionnaire developed by the International Union against Tuberculosis and Lung Disease, a survey that has been used for many years by thousands of individuals throughout the world. The Easy Breathing Survey was adapted for children, tested in English, Spanish, Polish, Bosnian, Creole and Portuguese and the first four questions were validated using pulmonary function testing and clinical judgment by a specialist. (4)

The Survey is completed by the parent and should be completed one time on every child 6 months to 18 years of age and again on children with the new onset of respiratory symptoms. A teenage version of the survey is also available for self-administration in adolescent clinics.

If the parent responds “no” to questions #1 through 4, and is not currently (or in the past 12 months) on any asthma medications, the child has a <2% chance of having asthma. If the parent responds “yes” to any of these 4 questions, the child has a 95% chance of having asthma. The caveat is as follows: If the parent responds “yes” to question #2 and the cough occurs only with colds, then the child is likely to have asthma only if the parent also responds “yes” to the cough of a cold usually lasting more than 10 days (Question #4). The cough of a cold, in general, lasts only 5-7 days.

Questions 5 and 6 are used to determine a previous diagnosis of asthma. If a parent answers “no” to questions 5 and 6 and the clinician states that this child has asthma, this is considered a “New Diagnosis of Asthma”. If a parent states “yes” to either of these questions and the clinician states this child has asthma, it is considered a previous diagnosis. If a parent states that this child has asthma and the clinician says “no”, this child does not have asthma, the child is considered not to have asthma. You as the clinician are always the final decision maker regarding whether a child has asthma.

Question 7 is used to determine whether the child has eczema, a major risk factor for the future development of asthma and question 8 examines family history of asthma. Questions 9-13 provide demographic information. You do not need to ask these questions because you already have this information. Question 14 provides information about environmental exposures at home. A copy of the Survey modified for use in a private practice is included in the Appendix. You may add your practice name and/or logo to this form.

The Survey meets all of the requirements of the HIPAA Guidelines if you plan to use patient specific information for MOC purposes.
THE PROVIDER ASSESSMENT

Once the Survey has been completed, you answer the following question on the Provider Assessment Form located at the bottom of the Survey page: Does this child have asthma? Using the responses on the survey, additional questioning as needed and review of the medical record including your personal knowledge of the child, you respond. If the child has asthma and has previously been diagnosed with asthma, you should assess the adequacy of asthma control on the child’s current therapy. If you determine that the child has asthma but did not know that the child had asthma, you are guided in determining asthma severity by the responses to a scripted series of questions.

In using the Provider Assessment Form, asthma severity is determined primarily by the frequency of symptoms. You circle the frequency of each of the specific symptoms in the appropriate column. The asthma severity for new diagnoses is the highest number circled in the column with any response. For example, if the parent reports that the child wakes up 1 night a week, the frequency of nocturnal symptom response would fall in column 2. If all other responses are in column 1, the child’s asthma severity is “2”-mild, persistent disease. In general, the responses will be in several columns. You are encouraged to use the highest number column as the severity but in reality, most clinicians will under-estimate asthma severity. This is all right as long as the child’s symptoms are re-assessed in the next 4-8 weeks on therapy and therapy is adjusted as needed. The determination of asthma severity is most useful as a place to start therapy and then is used to assess the child’s response to that therapy. The NAEPP EPR-3 Guidelines, however, encourage providers to start “high” and work their way down. Our experience is that most pediatric clinicians prefer to start “low” and work their way up.

For children less than 4 years of age who were previously diagnosed with asthma and are currently on therapy, you would assess the adequacy of control. For any response in the third column (Inadequate Control), you should change therapy (assuming that the child is actually taking the prescribed medication). You should also consider escalating therapy for any response in the second column (marginally adequate) but this is left to your discretion. The child’s asthma severity is then determined by the therapy that is needed to achieve adequate control using the Asthma Treatment Selection Guide described below.

For all other children with a previous diagnosis of asthma we recommend the patient fills out the Asthma Control Test (children >12 years of age) or the childhood Asthma Control Test for children (4-12 years of age) to determine adequacy of control (copies of these forms are included in the appendix). The NAEPP EPR-3 Guidelines suggest the following frequency of follow up visits for asthma:

<table>
<thead>
<tr>
<th>Asthma Severity</th>
<th>Frequency of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermittent</td>
<td>Yearly</td>
</tr>
<tr>
<td>Mild, persistent</td>
<td>2 times a year</td>
</tr>
<tr>
<td>Moderate, persistent</td>
<td>3-4 times/year</td>
</tr>
<tr>
<td>Severe, persistent</td>
<td>every 2 months*</td>
</tr>
</tbody>
</table>

*Patients should be co-managed with a specialist.

THE ASTHMA TREATMENT SELECTION GUIDE
a.k.a.: THE ASTHMA BUFFET

The centerpiece of Easy Breathing is the Asthma Treatment Selection Guide, also known as the “Asthma Buffet”. For each of the four asthma severities, there is a single sheet of possible treatment
selections. Each page has lists of medications appropriate for asthma of that severity for daily use, for sick therapy and for emergency therapy (most often, prednisone). Brackets along the left hand side of each page show equivalent medications. As you move down the page from one bracketed area to the next, the amount of medication increases. Within each bracket, all of the medications are of equivalent potency (not the same as the number of micrograms of the drug). For each level of persistent disease, the first group of brackets has anti-inflammatory therapy at the “low” end of that severity and the last group of brackets is for asthma at the “high” end of that severity. Inhaled corticosteroids are considered low dose in the mild persistent category, medium dose in the moderate persistent category and high dose in the severe persistent category. Recall that the 2002 NAEPP Guidelines confirmed the safety of inhaled corticosteroid therapy in children with asthma. All evidence confirms the safety of low dose inhaled corticosteroids in children.

Along the right hand side of the Buffet is a place to record the insurance companies that you use and whether or not they cover these asthma drugs. Since this varies from state to state this area is blank on your form which is included in the appendix. The enclosed Buffet reflects the 2007 Guidelines. The Buffet is updated yearly by the Easy Breathing program to reflect new recommendations for therapy and new drugs on the market. You should make changes along the right hand side to reflect changes to the insurance company formularies.

Use of the Buffet is best illustrated by an example:

For a child with mild, persistent asthma (see mild, persistent asthma Treatment Selection Guide), the daily treatment could consist of Flovent (44 mcg) 1 puff 2 times a day (lowest inhaled corticosteroid dose). If the child is on this medication but his asthma is not well controlled, the daily therapy could be increased to Flovent (44 mcg) 2 puffs 2 times a day (still mild, persistent disease but now at the “higher” end of this severity). You would not, however, want to change the child to Qvar (40mcg) 1 puff 2 times a day because that dose is equivalent to Flovent (44 mcg) 1 puff 2 times a day (in the same bracket area).

The only time you would consider changing drugs but staying in the same bracket area would be if you were concerned that the child was unable to use the medication appropriately or if the insurance company no longer covered that particular formulation. For example, if a child was on Flovent (44 mcg) 1 puff 2 times a day and for some reason was not using that therapy appropriately, you might consider changing them to Pulmicort Flexhaler (90mcg) 1 puff 2 times a day - in the same bracket but a different delivery system.

For inadequate control in the highest bracket of a particular severity, go to asthma of the next highest severity. For example, if this same patient above was still inadequately controlled on Flovent (44 mcg) 2 puffs 2 times a day, then the patient actually has moderate, persistent asthma. Escalating therapy for that patient using the 2007 NAEPP Guidelines would be to add a long acting beta agonist to the child’s current therapy (now available only as a combination in the first bracket area) or to add a leukotriene receptor antagonist. And if that combination was insufficient, you would then increase the steroid strength and continue the long-acting beta agonist (second bracketed area) or the leukotriene receptor antagonist. Alternatively, you could have increased the child to a medium dose of the inhaled corticosteroid alone.

Every child with persistent disease should have a daily asthma treatment plan that consists of an anti-inflammatory drug with instructions to use a bronchodilator if needed. Note that the leukotriene antagonists are used as mono therapy only for patients with mild, persistent disease. In the 2007 guidelines, leukotriene antagonists are recommended in combination with low dose inhaled corticosteroids for moderate, persistent asthma; however the preferred treatment is a long-acting bronchodilator in combination with a low dose inhaled corticosteroid.
The **sick plan** for children with persistent disease consists of regular bronchodilator therapy and either the same dose of the inhaled corticosteroid medication or quadrupling the dose. Consider quadrupling the dose for those children who with exacerbations are seen in the emergency room, in the hospital or on prednisone frequently. Never increase the dose of the long acting bronchodilator or the leukotriene receptor antagonist.

The **emergency plan** is not given to the parent but can be recorded in the chart for use by your triage nurse or by one of your colleagues. This usually has the prednisone dose that you wish to be used when your patient’s sick plan does not work.

The **Asthma Treatment Selection Guide** is not given to the parent. It is for use by the clinician as a reference to guide the selection of therapy appropriate for the level of the child’s asthma severity. We update the insurance information yearly (and Guideline changes as needed) and print the form on colored paper (a new color every year) and laminate it. This way it can be found quickly; “old” buffets can easily be discarded (the “old” color) and they stay crisp for the entire year. We place one Buffet in every exam room.

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**THE ASTHMA TREATMENT PLAN**

The fourth element of *Easy Breathing* is the Asthma Treatment Plan. Many practices have their own printed form and these can be used as long as they have a daily, sick and emergency plan and are in accordance with the NAEPP Guidelines. The enclosed Asthma Treatment Plan has been field tested in patients and their families and is clearly understood by even low literacy families. We print ours on Non Carbon Reproduction (NCR) paper; we then give the original copy to the parent, 1 copy to the school nurse and keep one for our chart. In the original *Easy Breathing* project, we used pre-printed colored labels for the medications. They worked well but were cumbersome because of the large number of different medications. If your practice only uses 1-2 different medications, consider pre-printing labels or forms for your use.

*Here are some key suggestions on writing out asthma instructions for patients:*

1. Give a written Asthma Treatment Plan to every patient with asthma. Even patients on as needed albuterol (intermittent asthma) forget what to do when they have an asthma attack especially if there is significant time in between such attacks.

2. Write the medication strengths and carefully write out the dosing frequency. Thus, if you are on call and at home and the family needs a refill, they can tell you the correct strength. Do not use “bid” and “tid”- write out “two times a day” etc. Do not use the word “once” for “one time a day”. “Once” is the number “11” in Spanish.

Notice that peak expiratory flow is not part of the Asthma Treatment Plan. In our experience, families lose their peak flow meter and if their treatment is dependent on it, the treatment plan becomes useless. Peak flow values can, however, be used and placed along the left side of the treatment plan.

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**THE ASTHMA CONTROL TEST™ (ACT)**
The fifth element of Easy Breathing is the childhood Asthma Control Test (cACT) for children 4-11 years of age and the ACT for children 12 years and older. The NAEPP EPR-3 2007 Guidelines recommend assessing asthma control and the Easy Breathing Program uses the ACT during all follow-up visits with permission from GSK. The ACT is a patient-based 5 question, 5-response questionnaire that has been validated for individuals over 12 years of age. Its companion is the cACT, a 4 question patient based and 3 question parent based questionnaire that has been validated for children 4-11 years of age.

MAINTENANCE OF CERTIFICATION (MOC)

Easy Breathing is a quality improvement program which meets the requirements for Part 4 of Maintenance of Certification (MOC) by the American Board of Pediatrician (ABP). Successful use of the program receives 25 points toward recertification. Upon completion of the process, the pediatrician will receive 25 points toward Part 4.

The MOC process monitors the use of the Easy Breathing program over the course of four quarters, plus a review of baseline activity. It can be used on an individual basis or at the practice level. Based upon previous successes in the program the outcome measures and goals for this program are as follows:

1. Individuals should engage 100 children/encounters over the 12 month period (25/quarter) in Easy Breathing (at the practice level this number will be adjusted). This includes newly enrolled children (via an Easy Breathing Survey) with and without asthma as well as children with asthma who have a follow up asthma assessment of asthma control using the Asthma Control Test/childhood Asthma Control Test.
2. % of children with asthma who have a documented asthma severity. The goal is at least 90%.
3. % of children with persistent asthma with a written treatment plan. The goal is at least 95%.
4. % of children with a treatment plan that adheres to the national guidelines. The goal is at least 95%.

You do not need to meet all of these goals for MOC, but you must be working toward their achievement. If you have not met the goal for a specific outcome measure, you will need to create a plan to achieve the goal. Each quarter you will review and assess your progress and create a new plan (if needed). This process of improvement is often referred to as a PDSA cycle (Plan, Do, Study, Act). You can download a PDF version of a very helpful brochure called “Roadmap for Quality Improvement – A Guide for Doctors” about this process at the following website: http://mjain.net/medicine/quality_improvement.html. If you need help creating a PDSA cycle, we can help you create the structure to do this. As documentation of this process, you will need to send us a very brief report of your plan.

So what happens if you don’t reach the “100” mark? Of all the individuals previously enrolled in MOC, two did not meet this requirement and one was not certified. If this happens, however, we will look at the quality of your Asthma Treatment Plans, the action plans that you have prepared and the progress that you have made to achieve this goal. Our goal is to help you to use Easy Breathing to meet the spirit and the letter of the ABP’s MOC Part IV dictate but it is not a “free” ride.

If you would like to begin using Easy Breathing for MOC, please contact the Easy Breathing Program Coordinator (Jessica Hollenbach at jhollenbach@ccmckids.org). A Notice of Intent will be sent for you to fill out and return to the Asthma Center. Once the Notice of Intent is received we will contact you to discuss next steps.
CLOSING COMMENTS

Managing chronic disease can be time consuming. Use of *Easy Breathing* will minimize that time; however, asthma is still a chronic disease and it takes time to manage and educate your patient. If you use the program regularly, however, you will find that you can manage your patient’s asthma in a 7-10 minute office visit. In the long run, you will have fewer asthma emergencies in your office that prolong your day and distract you from caring from the other children seen in your practice. And your children with asthma will be able to manage their disease, to be well and to do anything they want.

The motto of *Easy Breathing*© is:

**Be well.**

**If you are not well, you are not on the right medication!**
Easy Breathing© is a copyrighted, asthma management program that is being offered to you as a professional courtesy free of charge by Dr. Michelle Cloutier, a faculty member of the University of Connecticut Health Center and Connecticut Children’s Medical Center. You may use the program materials in your own clinic or practice but you may not give the program or any of the program materials to anyone outside of your practice/clinic. You may not change any part or element of the program materials or use parts of the program or program materials in other programs without written permission by Dr. Michelle Cloutier.

The Easy Breathing© program must be cited in any and all grant applications and future publications as the “Easy Breathing© Program of the University of Connecticut Health Center and Connecticut Children’s Medical Center”.

Your signature below acknowledges that you understand these requirements and agree to abide by them. Please feel free to contact Dr. Michelle Cloutier at 860 837-5346 if you have any questions.

I have read the above and agree to the requirements for use of this program.

Name (Please print) ___________________________ Date ______

Signature ______________________________________

Please return this form to the following address or by fax at which time the program materials will be sent to you:

Michelle M. Cloutier, MD
Asthma Center
Connecticut Children’s Medical Center
282 Washington St.
Hartford, CT 06106
860-837-5342 (FAX)
REFERENCES


Easy Breathing® Program
Database Support Agreement

Easy Breathing® Program personnel from the Asthma Center at Connecticut Children’s Medical Center have trained your staff in the Easy Breathing® Program. Training of the Data Entry Specialist(s) was/were completed on xx/xx/xxx. In an effort to meet the on-going data support needs of Easy Breathing participants, we have outlined below specific information that may be helpful to you as you move forward.

I. Easy Breathing® Database Support

Easy Breathing Data personnel will provide the following services as part of our initial training and programmatic support efforts and at no cost to Easy Breathing participants:

a) Repair/fix software “bugs” or issues during the first 12 months after training.
b) Update database annually for 5 years.
c) Provide support services (up to 12 hours of database personnel in year 1) consisting of
   1) Telephone and/or email user support
   2) Customization of database
   3) Assistance in creation of custom queries and reports

Easy Breathing Data personnel are unable to support network or hardware-related problems which should be handled with your IT Department.

II. Easy Breathing® Database Support - Other Services

Database Support above and beyond the services noted above are available. For time and costs, please contact our Database Manager, who will evaluate the request and provide an estimate of the number of hours required to complete the request, where applicable.
III. Easy Breathing® Database Support Pricing

The hourly rate for database support ranges from $60 to $100 per hour (detailed below).

DATABASE SUPPORT FEE:

<table>
<thead>
<tr>
<th>SUPPORT FEE</th>
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</thead>
<tbody>
<tr>
<td>$60.00/ Hour</td>
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<tr>
<td>$100.00/ Hour</td>
<td>Private Insurers</td>
</tr>
</tbody>
</table>

Signature: ______________________________  DATE OF AGREEMENT: ______________________________

Client Name
Client Title
Client Organization
Address
P: (000) 000-0000
F: (000) 000-0000
Email: