How to Use ASTHMA IQ
for Specialists

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Introduction

Description of General Functions

ASTHMA IQ is divided into 3 sections: Patient Management, Practice Management and Clinic Management. You can switch sections by clicking Change Section link at the top of the ASTHMA IQ screen.

Patient Management

In the Patient Management section you can:

- Create a new patient record
- View existing patient records
- Search patient records
- Create patient notes
- Create patient visit
- Edit existing patient visit
- View patient asthma status

Practice Management

- Practice metrics (for individual doctor)
- Practice improvement module
- Quality measures for Pay for Performance

Clinic Management

- Clinic metrics (for all clinic doctors)
- Setup ASTHMA IQ including:
  - Clinic contact information
  - Setup and manage clinic staff
  - ASTHMA IQ preferences
  - Setup forms and reports
  - Record management
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Practice Management
In the Practice Management section you can:
- View practice metrics for an individual doctor
- Complete a Practice Improvement Plan for CME credit and Maintenance of Certification
- View and print performance for quality measures

Clinic Management
In the Clinic Management section you can:
- View clinic metrics (for all clinic doctors enrolled in ASTHMA IQ)
- Setup ASTHMA IQ including:
  - Clinic contact information
  - Setup and manage clinic staff
  - ASTHMA IQ preferences
  - Setup forms and reports
- Record management

This document describes how to use the features of all three sections.

Getting Started with ASTHMA IQ

Before you get started with ASTHMA IQ, you should decide how you want to use it.

Single Provider
It can be used by a single provider to track their patients, to learn about the EPR-3 Guidelines for CME credit, to demonstrate Practice Improvement, and to print reports of performance on quality measures for asthma care.

Clinic Use with Multiple Providers
It can also be used by a group of providers in a clinic practice. These providers will be able to access any clinic patient already in the ASTHMA IQ system. If you decide to use it as a Clinic, only 1 person needs to register. The first person to register for the Clinic is automatically granted full Provider and Administrator privileges. The other providers and users of the ASTHMA IQ system can be enrolled in the Clinic Management section. To do this, go to the first tab, Clinic Staff and click the New button.

Users of the ASTHMA IQ program can be assigned different roles, which allow different functions to be performed. The following is a list of roles and functions:
- Provider – full access to all functions in Patient, Provider and Clinic Management sections
- Report Administrator – limited access to the Clinic Management Report Generator functions
- User Administrator – limited access to the Clinic Management Clinic Staff section
- Clinic Administrator – access to all functions in the Clinic Management section
- Allied Clinic Staff – access to all functions in the Clinic Management section
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Patient Management Section
The main functions performed in Patient Management include:

- Create a new patient record
- View existing patient records
- Search patient records
- Create patient notes
- Create patient visits
- Edit an existing patient visit
- View patient asthma status and history

Step 1 Create a Patient Record

Select or Add Patient

When you first enter the ASTHMA IQ program you will see the Select Patient screen. To begin, click the “New Patient” button on the left of the screen to create aPatient Record.
Add New Patient

This is the New Patient page for creating a patient record. Notice that Patient ID number, Date of birth, Gender, Race/Ethnicity, and Primary Provider (as indicated by an asterisk) are required.

Privacy/Security
The lock symbol at the top of the screen (see arrow) indicates that the Patient Information on this page is encrypted and kept separate from the rest of the patient record. No one will be able to see the identity of the patient except the clinician and authorized staff. Some clinicians may chose not to use the patient name as an identifier, so the patient name is not required. If name is not used, all patients will be identified by the Patient ID number. You are required to enter a unique Patient ID number for all patient records in ASTHMA IQ.

Asthma/Allergy Information
Date of diagnosis
Asthma IQ is meant to be used for patients with a diagnosis of asthma. A patient receiving long-term control medication is an appropriate patient for ASTHMA IQ, even if the diagnosis of asthma is not confirmed.
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Entering Dates

To enter Date of birth, type the date in the box in the format: mm/dd/yyyy.

Using the Calendar

Another way to enter the Date of birth is to use the calendar. Use the up and down arrows in the top right corner to move between years.

To move between months, use the left and right arrows at the top of the calendar.
Components of the Patient Record

There are 3 components of the Patient Record as indicated by the 3 tabs at the top of the screen. They are:

- Visits
- Asthma Status
- Patient Notes

Patient Visits are displayed after you select a patient. Click the “Add New Visit” button to create a visit for this patient.
Step 2 Create a Patient Visit

The Components of the Patient Visit

There are 9 components to the Patient Visit questionnaire as indicated by the 10 tabs at the top of the page. They are:

- Tab 1: Visit Info (completed when beginning a new patient visit)
- Tab 2: History
- Tab 3: Vitals
- Tab 4: Asthma Tests
- Tab 5: Exam
- Tab 6: Severity/Control/Exacerbation Assessment
- Tab 7: Recommendations
- Tab 8: Plan
- Tab 9: Education
- Tab 10: Summary

List of Patient Visit Questions

Tab 1: Initial Visit Information/Visit Information
1. Visit date
2. Provider
3. Exacerbation Y/N
4. On long-term control medication Y/N
4. a. ACT test score*  
5. Persistent asthma Y/N
6. What type(s) of asthma does the patient have?
* Required to see Asthma Severity or Control Classification - Result: ACT score and Peak Flow OR Spirometry results

Tab 2: History
1. Medication History
2. Medication Side Effects
3. Exacerbation History
4. Smoking History
5. Family History

Tab 3: Vitals
1. Height and Weight
2. Temperature
3. Blood Pressure and Pulse
4. Respirations
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Tab 4: Asthma Tests
1. Peak Flow Results*
2. Spirometry Results*
3. Fractional Exhaled Nitric Oxide (FeNO)
4. IgE Level

* Required to see Asthma Severity or Control Classification - Result: ACT score and Peak Flow OR Spirometry results

Tab 5: Exam
1. Review of Symptoms
2. Physical Exam

Tab 6: Severity/Control Assessment
1. Symptoms Frequency**
2. Nighttime Awakenings Frequency**
3. Use of Rescue Inhaler**
4. Interference with Normal Activity**
5. Severity/Control Assessment – Risk: Number of Recent Exacerbations (last 12 months)
6. Severity/Control Assessment - Result
   - Classify Severity (EPR-3 Guidelines Recommendations) – displays if patient is NOT on long-term control medications
   OR
   - Classify Control (EPR-3 Guidelines Recommendations) – displays if patient is on long-term control medications

** Required to see Severity Classification/Control Classification – Result if ACT score not entered.

Tab 6: Exacerbation Assessment (Alternate to Severity/Control Assessment)
1. Fever
2. Exacerbation Duration
3. Exacerbation Trigger
4. Interference with Sleep
5. Use of Rescue Inhaler
6. Patient Missed School
7. Patient Missed Work
8. Management of the patient prior to visit
9. Management of the patient during this visit

Tab 7: Recommendations
1. Seasonal Influenza Vaccination
2. Medication Adherence
3. Inhaler/Nebulizer Technique
4. Asthma Allergens & Triggers
5. Comorbidities
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Tab 8: Plan
1. EPR-3 Recommendation/Treatment Plan
2. Followup Plan
3. Action Plan
4. Billing Information

Tab 9: Education
1. General Education Topics
2. Allergic Trigger Avoidance
3. Non-allergic Trigger Avoidance
4. Skills

Tab 10: Summary
1. Summary Report
2. Text Summary
3. Export as CCR
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Initial Visit Questions/Visit Information

Tab 1: Visit Information
Questions include:
1. Visit date
2. Provider
3. Exacerbation Y/N
4. On long-term control medication Y/N
4a. ACT test score*
5. Persistent asthma Y/N
* Required to see Asthma Severity or Control Classification - Result

It is important to complete all the questions in the Initial Visit screen because the answers to these questions determine the questions asked in the Tab 5: Severity/Control/Exacerbation Assessment area of the patient visit.

1. If the answer to question 3 is Yes, then Exacerbation Assessment questions are asked.
2. If the answer to question 4 is No, then Severity Assessment questions are asked.
3. If the answer to question 4 is Yes, then Control Assessment questions are asked
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Note: If an ACT score is entered, the Control Assessment questions are not shown in Tab 5.

Other Features

- The Visit Date defaults to today’s date. If the Visit Date is different than today’s date, make sure you enter the date of the visit by typing the visit date in the box or by clicking on the calendar icon.
- Question 4a asks for the results of the ACT score. If it has not been done ahead of time, the link to the ACT calculator can be used to indicate the answers to the questions and get the ACT score. ACT or Child ACT forms can be printed from the Forms section in the Clinic Management section.
- Links to topics in the EPR-3 Library are on the right and are indicated by [ ].
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Tab 2: History
Questions include:
1. Medication History
2. Medication Side Effects
3. Exacerbation History
4. Smoking History
5. Family History

Medication History

To add a medication to the list, click the + Add Prescription button.

Start typing a drug name in the list and a list of asthma drugs will appear that match what you have typed. Select one and then fill in the other boxes. If the drug you want is not in the list, click the Drug not listed button and fill in the fields. When you click the Save Prescription button, the drug and dosage will be added to the medication list. If the drug combination matches an EPR-3 Treatment Step, the step will be highlighted in the Current Treatment Step graphic. You can refer to the EPR-3 Treatment Step diagram by clicking the link in the right.

Medication Side Effects
The medication side effects question appears only if there is a medication listed in the Medication History list.
Exacerbation History

This question is required in order to receive feedback from the EPR-3 Guidelines for Severity or Control Classification. Click the Add/Change Exacerbations button to make changes to the list.

Add New Exacerbations

First select a date by typing in the box (mm/yyyy). Then select one or more options and click “Save”.

Repeat this process to enter all exacerbation events, especially those that have occurred in the last 12 months.

It is important to keep track of exacerbation events. A count of the number of exacerbations requiring oral/systemic corticosteroids that have occurred in the last 12 months shows up on the Severity/Control Assessment tab and it impacts the Asthma Severity/Control level.
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Tab 3: Vitals
1. Height and Weight
2. Temperature
3. Blood Pressure and Pulse
4. Respiration

* Required to see Asthma Severity or Control Classification - Result: Peak Flow OR Spirometry results

Useful Features
- After the height and weight are entered, the BMI is calculated and the BMI category is displayed.

Tab 4: Asthma Tests
1. Peak Flow Results*
2. Spirometry Results*
3. Fractional Exhaled Nitric Oxide (FeNO)
4. IgE Level

Useful Features
- The patient’s history charts for Spirometry, Peak Flow, FeNO, and IgE tests can be seen by clicking the links on the right side of the screen.
- In Peak Flow, after Current and Personal Best values are entered the calculated %Personal Best and %Predicted are displayed. The %Predicted is calculated only if a height has already been entered.
- In the Spirometry area, a recommendation appears about whether or not a Spirometry assessment is recommended for this visit, according to the EPR-3 Guidelines. If you click the Assess button, the Spirometry window opens up. After entering the FEV1 and FVC values for either Pre or Post, the FEV1/FVC ratio and FEV1 % predicted values are calculated (if height is also entered in the Vitals tab). These values can be overridden. (See EPR-3 library for recommendations about when to perform Spirometry testing).
- If pre and post FEV1 values are entered, the program automatically calculates the percent change.

Tab 5: Exam
1. Review of Symptoms
2. Physical Exam

Click on a component of the Review of Symptoms or Physical Exam and options will be displayed under each item.
Tab 5: Severity/Control/Assessment

Severity/Control Assessment - Impairment

The following questions are displayed for a Severity or Control Assessment. If in a Control Assessment and an ACT test score has been entered, these questions will not be shown. If they are showing, all are required to receive feedback from the EPR-3 Guidelines for Severity or Control Classification.

1. Symptoms Frequency
2. Nighttime Awakenings Frequency
3. Use of Rescue Inhaler
4. Interference with Normal Activity

Lung function test results, FEV1 %Predicted and Peak Flow %Personal Best, are displayed here if entered in the Vitals tab.
Severity/Control Assessment – Risk

The number of Exacerbations requiring oral corticosteroids in the last 12 months is displayed. 2 or more exacerbations in 12 months may increase the Severity or Control level.

Severity/Control Assessment – Result

If all required information has been entered, the Severity or Control level will be displayed with feedback if appropriate. The recommended levels may be overridden based on clinical judgment.
Tab 5: Exacerbation Assessment
Exacerbation Assessment (Alternate to Severity/Control Assessment)

If it was indicated that the patient is currently experiencing an exacerbation, a different set of questions will be displayed, as shown below.

1. Fever
2. Exacerbation Duration
3. Exacerbation Trigger
4. Interference with Sleep
5. Use of Rescue Inhaler
6. Patient Missed School
7. Patient Missed Work
8. Management of the patient prior to visit
9. Management of the patient during this visit
Tab 6: Recommendations

1. Seasonal Influenza Vaccination
2. Medication Adherence
3. Inhaler/Nebulizer Technique
4. Asthma Allergens & Triggers
5. Comorbidities

The questions in the Recommendations section each indicate whether or not it is recommended to assess or not. When you click the Assess button the choices are revealed. You must select one of the choices for Influenza Vaccination, Medication Adherence, and Inhaler/Nebulizer technique.

Other features:
- There are calculators available to help you answer the medication adherence and depression questions.
Tab 7: Plan

The Plan tab includes:

1. Treatment Plan
2. Followup Plan
3. Referral Plan
4. Action Plan
5. Billing Information

Treatment Plan

Follow these steps in the Treatment Plan section:

- First read the recommendations from EPR-3.
- Then compare the recommended treatment step to the Current Treatment Step (shown by arrows to the left).
- Make changes to the Treatment Plan (ideally the new treatment plan will match the EPR-3 recommended step).
- To change the Treatment Plan use the same procedure for adding medications to the list as described in the History Tab section.
Followup Plan

<table>
<thead>
<tr>
<th>Followup Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Followup interval:</td>
</tr>
<tr>
<td>Recommended Followup Date:</td>
</tr>
<tr>
<td>EPR-3 Recommendation</td>
</tr>
<tr>
<td>Reevaluate in 2-6 weeks.</td>
</tr>
</tbody>
</table>

In the Followup section, indicate how soon the patient should return for a return visit.

Action Plan

An interactive Action Plan (see next page) is available that is pre-populated with information entered in the visit, such as name, the treatment plan and peak flow results. You can indicate what actions you want the patient to take in certain situations. Print the form to give to the patient or save as a pdf for your records, or email to the patient.

Billing Information

<table>
<thead>
<tr>
<th>Billing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time spent in visit:</td>
</tr>
<tr>
<td>Time spent in counseling and coordinating care:</td>
</tr>
</tbody>
</table>

Another convenient feature for billing purposes is a place to record time spent in visit and time spent in counseling or coordinating care.
Example of Interactive Action Plan

Complete the checkboxes and input directions for the patients to take specific medications if they are in the Yellow or Red zones.
Tab 8: Education
Topics in the Education tab include:
1. General Education Topics
2. Allergic Trigger Avoidance
3. Non-Allergic Trigger Avoidance
4. Skills

Important Note: In order for the system to know that the education topics were discussed or information was given you MUST check the box in the bottom right corner that Education was provided during this visit. Clicking the View button will also automatically check this box.
Tab 9: Summary
Functions included in the Summary Tab include:
1. Summary Report
2. Text Summary
3. Export as CCR

Summary Report

Different templates are available to create summary reports of the patient visit. You can preview by clicking the button on the left. Either save the report as a pdf file or print.

Report templates are created for the Clinic in the Clinic Management Section in the Report Templates Tab.
Text Summary

A complete summary of the patient visit is generated in the Summary tab. This can be copied to the clipboard in either plain text or html. The text can be pasted into any other computer application including an EMR system.

Export as CCR

Select Generate to create a CCR (Continuity of Care Record) for the current visit. The CCR saves the visit information in a format that can be imported into most electronic health record systems. You will be asked where you want to save the CCR on your computer’s hard drive. By default, the CCR will be saved as an .XML file.

Saving a Visit

The “Save Visit” button is located at the bottom of the Patient Visit window. You may save the Patient Visit at any time. After clicking “Save Visit” you will see a confirmation message. The Patient Visit window will close and you will return to the Patient Visits screen with the list of all the visits entered for that patient.
Step 3: Review Asthma Status Screen

The Asthma Status screen provides a snapshot view of the patient’s asthma status as of the last visit as well as Control/Treatment Step History and Spirometry History.

The left side displays:
- The Last Visit Summary
- Active Treatment Plan
- Exacerbation Summary

The right side displays:
- Control Level History
- Spirometry History
Step 4: Notes

You can type a note about the current patient by clicking the “Add Note” button. Patient notes added in the Patient Visit can be viewed here. The date the note was entered and who entered the note is recorded. Notes can be edited or deleted in this view.
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Step 5: Select a Different Patient

To change to a different patient or to create a new patient, click the “Change Patient” button.
Repeat Step 1 as described in this document.

Feedback

Click the Feedback link on the bottom left corner of the screen to easily log Bug Reports, General Comments/Suggestions or New Feature Requests about the ASTHMA IQ program. Your Name and Email address will automatically be filled in.

Add a note about the problem or issue. Be specific. When reporting bugs, issues, and cosmetic errors, please include the screen name that appears in the top title bar.

When you click Save, an email will automatically be sent and the window will close.

If you encounter technical problems or can’t access the feedback link, please send an email to: ASTHMA-IQ@aaaai.org.
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Library

Click the Library link on the bottom left corner of the screen to access all of the Library topics. The Library contains summaries of information on different topics from the EPR-3 Guidelines. Click on the arrows to the left of each topic to see the subtopics or pages.

Individual Topics or Subtopics may be printed by clicking the “Print” button.
Practice Management Section
In the Practice Management section you can:
- View practice metrics for an individual doctor
- Complete a Practice Improvement Plan for CME credit and Maintenance of Certification
- View and print performance for quality measures

Clinic Management
In the Clinic Management section you can:
- View clinic metrics (for all clinic doctors enrolled in ASTHMA IQ)
- Setup ASTHMA IQ including:
  - Clinic contact information
  - Setup and manage clinic staff
  - ASTHMA IQ preferences
  - Setup forms and reports
- Record management

Practice Metrics Tab
The Practice Metrics screen gives a valuable snapshot of the characteristics of the patients in your practice for which you are the primary provider.
Graphs include
- Patients by Control Classification
- Patients by Current Treatment Step
- Patients by BMI Category
- FEV1 Percent Predicted
Practice Improvement Tab

The Asthma Practice Improvement Module (PIM) is a self-evaluation tool designed to give you a snapshot of your practice. You will see how your outcomes and processes of care for your patients compare with the EPR-3 Guidelines for managing asthma. The goal of the PIM is to improve the quality of patient care.

Completion of the PIM in the ASTHMA IQ program is designed to fulfill the requirements of demonstrating practice improvement to satisfy Part 4 of the Maintenance of Certification process of the American Board of Internal Medicine.

The module is divided into 4 steps that must be completed in order. To learn more, click the more information buttons in each Stage of the Practice Improvement process.
Step 1 – Create Improvement Plan

Establish Baseline
Step 1 is the time when you enter patients for the baseline analysis. During this step, patients are entered into the ASTHMA IQ database. In order to create an Improvement Plan, a minimum of 25 patient visits must be entered. The Step 1 graphic shows how many visits have been entered and how many more are required. After you have entered at least the minimum required number of patients and you decide you have enough patients entered into the ASTHMA IQ database to determine an Improvement Plan, click the Create Improvement Plan button.

Create Improvement Plan
To create an Improvement Plan, you will first see a list of asthma quality measures. The baseline percentage for all your patients in the baseline period appears next to each measure. Up to three measures may be selected. You will then have an opportunity to enter a description of how you will make improvements. After the Improvement Plan is created, Step 2, the Monitoring Period, begins.
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Systems Analysis
Before developing and embarking on your improvement plan you will want to review and assess your practice systems and processes to identify areas that may be contributing to your current performance results. By reviewing this information in a systematic way, you will be able to get a clearer picture of where changes can be made in your practice that will help improve your performance results.

Links to several systems analysis and quality improvement tools are provided below. You are encouraged to review these tools and work through a systems analysis exercise with the staff in your practice, always keeping in mind the EPR-3 baseline area(s) you have identified for possible improvement. Once you have completed this activity you will be able to develop a problem statement and develop your improvement plan.

NOTE: After all three Stages of the Practice Improvement Module are completed or the Improvement Plan is deleted, the Baseline Start is set to the date of completion or deletion and the cycle can begin again.
Step 2 – Monitor Improvement Plan

In Step 2 you implement your Improvement Plan. You will need to enter at least another 25 patient visits. It is also expected that it will take you about 3 months to complete this phase.

You can monitor your progress against your practice improvement goals in the graphs on the right. When the required number of patients has been entered and you have decided you have enough patients to report, click the “End Monitoring Period” button.

You may also delete your Improvement Plan during the monitoring phase. This will allow you to start the Practice Improvement plan over again and will set the Baseline Start date to the date the plan was deleted.

**Warning:** If you delete your Improvement Plan, you will need to add another 25 patients in Step 1 to build a baseline analysis group.
Step 3 – Analyze Plan

In Step 3, Analyze Plan Results, you will evaluate how you did in meeting your practice improvement goals by answering a series of questions and printing a report that summarizes your practice improvement activities.

In the Analyze Plan Stage, you will evaluate how you did in meeting your practice improvement goals by answering a series of questions and printing a report that summarizes your practice improvement activities.

Your current status:
You have a plan analysis in progress.

What to do next:
Continue your Improvement Plan Analysis. You will be able to choose which goals you would like to report on and will need to answer some questions regarding those individual goal plans as well as some general questions about your entire improvement plan process.

Begin Plan Analysis
Delete this Improvement Plan and begin again with a new baseline of patient visits (starting from the present date)

Delete Improvement Plan

If you do not finish the analysis in a single session, you may save your answers to complete the analysis at a later time. You must answer all questions. After all questions are answered, you may print a report summarizing your practice improvement activities. The results will be sent to AAAAI for CME credit and for reporting to ABAI for Maintenance of Certification.

After Step 3 is completed, you will continue to Step 4, Print Summary/CME report.
In Step 4, you can print a Summary Report of your Practice Improvement activities. Make sure you complete the contact information in the box on the right before you print the report so that it shows correctly on the print-out.

The Submit button automatically forwards the Improvement Plan and your contact information to AAAAI. Your certificate will be mailed to the address shown in the box. You will also be emailed a summary of your report.

Clicking Submit completes the Practice Improvement activity. You will be returned to the main Practice Improvement page and Step 1 will now be the active Stage. If you need to reprint the Summary Report, you can do this by clicking the “History & Reports” button.
This window displays a list of all Practice Improvement activities to date, including fully completed and partially completed plans. If a plan was completed, the “Reprint Summary Report” button will be active.
Pay for Performance Tab

The Pay for Performance module contains measures from The Physician Quality of Care Measurement: Asthma Project is a joint effort between the National Committee for Quality Assurance (NCQA) and Physician Consortium for Performance Improvement®, convened by the American Medical Association (AMA-PCPI). It provides performance measurement sets and other resources to help physicians in their efforts to improve the quality of patient care.

These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. Performance measures provide important information to a physician, allowing him or her to enhance the quality of care delivered to patients.
Measure #1: Assessment of Asthma Control

Numerator
Patients (ages 5 to 50 years) who were evaluated at least once for asthma control*

*Evaluation of asthma control is defined as:
  - Documentation of an evaluation of asthma impairment which must include:
    - Daytime symptoms AND nighttime awakenings AND interference with normal activity AND short-acting beta2-agonist use for symptom control.
    
    Note: Completion of a validated questionnaire will also meet the numerator requirement for this component of the measure.

  AND

  - Documentation of asthma risk which must include the number of asthma exacerbations requiring oral systemic corticosteroids in the prior 12 months

Denominator
All patients aged 5 through 50 years with a diagnosis of asthma and with at least one medical encounter during the measurement period

Result
Percentage of patients aged 5-50 years with the diagnosis of Asthma who were evaluated during measurement period at least once for asthma control (comprising asthma impairment and asthma risk)
Measure #2: Tobacco Use - Screening

Tobacco Use - Screening

Between 01/21/2010 and 01/21/2011 there were 12 patient(s) aged 5 to 50 years with the diagnosis of asthma with at least one office visit. Of those 12 patients, 2 were evaluated at least once for the use of tobacco.

16.7%
2/12

Numerator
Patients who were queried about tobacco use and exposure to second hand smoke in their home environment at least once.

Denominator
All patients aged 5 through 50 years with a diagnosis of asthma with at least one medical encounter during the measurement period.

Result
Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were queried about tobacco use and exposure to second hand smoke in their home environment at least once during the measurement period.
How to Use ASTHMA IQ
for Specialists

Measure #3: Tobacco Use - Intervention

<table>
<thead>
<tr>
<th>Tobacco Use - Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between 01/21/2010 and 01/21/2011 there were 0 patient(s) aged 5 to 50 years with the diagnosis of asthma who at least one office visit where the patient indicated that they use tobacco products. Of those 0 patients, 0 were provided with smoking cessation intervention.</td>
</tr>
</tbody>
</table>

Numerator
Patients who received tobacco use cessation intervention*

Note: Practitioners providing tobacco cessation interventions to a pediatric patient’s primary caregiver are still numerator compliant even if the primary caregiver is not the source of second hand smoke in the home.

Denominator
All patients aged 5 through 50 years with a diagnosis of asthma identified as tobacco users** with at least one medical encounter during the measurement period

Result
Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were identified as tobacco users** who received tobacco cessation intervention during the measurement period.

* Tobacco use cessation intervention may include brief counseling (3 minutes or less) and/or pharmacotherapy.
** Tobacco users include patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment.
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Measure #4: Pharmacologic Therapy for Persistent Asthma

Pharmacologic Therapy for Persistent Asthma

Between 01/21/2010 and 01/21/2011 there were 5 patient(s) aged 5 to 50 years with the diagnosis of persistent asthma during at least one office visit. Of those 5 patients, 3 were placed on long-term control medications or refused treatment.

Numerator
Patients who were prescribed long-term control medication*

*Long-term control medication includes:

1. Patients prescribed inhaled corticosteroids (the preferred long-term control medication at any step of asthma pharmacological therapy)

OR

2. Patients prescribed alternative long-term control medications

Denominator
All patients aged 5 through 50 years with a diagnosis of persistent asthma and at least one medical encounter during the measurement period

Result
Percentage of patients aged 5 through 50 years with a diagnosis of persistent asthma and at least one medical encounter for asthma during the measurement period who were prescribed long-term control medication. Three rates are reported for this measure:

1. Patients prescribed inhaled corticosteroids (ICS) as their long term control medication
2. Patients prescribed other alternative long term control medications (non-ICS)
3. Total patients prescribed long-term control medication
The Clinic Management tabs include:

- Clinic Staff
- Preferences
- Clinic Info
- Report Templates
- Clinic Metrics
- Report Generator
- Record Management
- Forms
Clinic Staff Tab
In this area users with full administrative privileges can see a list of authorized users, create additional users, modify existing users, reset passwords, and delete users for your clinic. Click New to create a user account or select a user from the list and either click Edit to modify the user or click Delete to remove the user.

Preferences Tab
Update your clinic’s preferences for allowing exporting and emailing here. Changes are stored immediately and affect all users in your clinic.

Clinic Info Tab
In this area, you can update your clinic name, address and phone number. Changes are stored immediately. This information is used in patient reports, action plans, and patient education materials.

Report Templates Tab
In this area, you create report templates, modify existing templates, and delete report templates. Click New to create a new report template, or select an existing template from the list and either click Edit to modify the template, or Delete to delete it.
How to Use ASTHMA IQ
for Specialists

The report templates are available to all members of your clinic in the Summary Report area of the Summary Tab.

Clinic Metrics Tab

The Clinic Metrics Tab contains graphs of all patients and providers in the clinic. These include:

- Patients by Primary Provider
- Patient Visits by Provider Seen
- Patients by Control Classification
- Patients by Treatment Step
- BMI Category
- FEV1 Percent Predicted

Report Generator Tab

You can generate a customized report of individual patients who display certain characteristics to display on the screen. The report can also be saved on your computer as a Microsoft Excel spreadsheet. If you have used databases before, you may recognize that generating a report is similar to using the SELECT command in a database.
How to Use ASTHMA IQ for Specialists

To generate a report:

1. **Select a Report Filter**
   You select a report filter by clicking on it and then clicking the Add button that appears. Report filters are used to determine which patients will be selected for the report. The report filters that you choose are shown in the Current Report Filters box. If you choose no report filters, then all patients will be included in the report.

2. **Select Report Fields**
   Select which report fields will print on the report by dragging each filter to the Report Fields for Output box. The fields you select determine what kinds of patient information will be included in the report. For example, if you select Patient ID then patient IDs will be shown in the report. You must select at least one report field (otherwise there would be no information in the report).

3. **Build the Report**
   Select the Generate Report button. The report will be displayed in a window on your screen.

4. **Export the Report**
   Choose the Export to Spreadsheet button if you want to save the report as a Microsoft Excel spreadsheet.

You can use the buttons at the bottom of the Current Report Filters box to build more sophisticated report filters using Boolean logic:
- The Toggle AND/OR button toggles a filter between AND and OR
- The Group and Ungroup buttons allow you to add or remove parenthesis
Record Management Tab

In this section you can delete patients or patient visits. Select the patient record you want to modify and then either click the Delete Patient button to delete that patient record or click the Delete Specific Visits... button to select individual visits to delete from that patient record.
This is the list of blank forms that can be printed from the Forms window. The forms are all in a “pdf” format, so you will need to have the Adobe® Acrobat Reader® to view and print them.

Click the links to download these supplemental forms.

Note: Clicking the link will open another browser tab or window. You may need to disable pop-up blockers for this feature to work correctly.