Asthma Action Plan

PROVIDER INSTRUCTIONS

At initial presentation, determine the level of asthma severity

- Level of severity is determined by both impairment and risk and is assigned to the most severe category in which any feature occurs.

At subsequent visits, assess control to adjust therapy

- Level of control is determined by both impairment and risk and is assigned to the most severe category in which any feature occurs.
- Address adherence to medication, inhaler technique, and environmental control measures.
- Sample patient self-assessment tools for asthma control can be found at https://rampasthma.org/blog/asthma-control-tests/

Stepwise approach for managing asthma:

- Therapy is increased (stepped up) if necessary and decreased (stepped down) when possible as determined by the level of asthma severity or asthma control.

Asthma severity and asthma control include the domains of current impairment and future risk.

Impairment: frequency and intensity of symptoms and functional limitations the patient is currently experiencing or has recently experienced.

Risk:the likelihood of either asthma exacerbations, progressive decline in lung function (or, for children, reduced lung growth), or risk of adverse effects from medication.

ASTHMA MANAGEMENT RECOMMENDATIONS:

- Ensure that patient/family receive education about asthma and how to use spacers and other medication delivery devices.
- Assess asthma control at every visit by self-administered standardized test or verbal history.
- Perform spirometry at baseline and at least every 1 to 2 years for patients >5 years of age.
- Update or review the Asthma Action Plan every 6 to 12 months.
- Perform skin or blood allergy tests for all patients with persistent asthma.
- Encourage patient/family to continue follow-up with their clinician every 6 to 12 months even if asthma is well controlled.
- Refer patients to a specialist if:
  - there are difficulties achieving or maintaining control OR
  - step 4 care or higher is required (step 3 care or higher for children 0-4 years of age) OR
  - immunotherapy or biologics is considered OR
  - additional testing is indicated OR
  - if the patient required 2 bursts of oral systemic corticosteroids in the past year or a hospitalization.

FOR MORE INFORMATION:

To access the full version of the NHLBI Guidelines for the Diagnosis and Treatment of Asthma (EPR-3), visit https://www.nhlbi.nih.gov/health-topics/guidelines-for-diagnosis-management-of-asthma

HOW TO USE THE ASTHMA ACTION PLAN:

- Enter specific medication information and review the instructions with the patient and/or family.
- If using SMART therapy, add "Corticosteroid/Formoterol" under Controller Medicines and check the box next to "Corticosteroid/Formoterol" under Quick-Relief Medicines.
- Educate patient and/or family about factors that make asthma worse and the remediation steps on pages 3 and 4.
- Complete and sign the bottom of the form and give pages 2 through 4 of the form to the patient.
- Provide page 5 for school-aged children. Educate the parent/guardian on the need for their signature on page 5 of the form in order to authorize student self-carry and self-administration of asthma medications at school and also to authorize sharing student health information with school staff.

REFER FOR ASTHMA HOME VISITING

- If your patient's asthma is poorly controlled, they may benefit from asthma home visiting services.
- If you are in California, you can identify asthma home visiting programs at https://rampasthma.org/asthma-home-visiting-directory/ or contact their Medi-Cal Managed Care Plan to refer for Asthma Remediation services.

© 2008, Public Health Institute (RAMP)

My Asthma Plan

Patient Name: _____

Medical Record #: _____

Provider's Name: _____

DOB: _____

Provider's Phone #: _____ Completed by: _____ Date: _____

Controller Medicines	How Much to Take	How Often	Other Instructions
		_____ times per day EVERYDAY!	❑ Gargle or rinse mouth after use ❑ Always use a spacer with your inhaler
		_____ times per day EVERYDAY!	❑ Gargle or rinse mouth after use ❑ Always use a spacer with your inhaler
Quick-Relief Medicines	**How Much to Take**	**How Often**	**Other Instructions**
❑ Albuterol (ProAir, Ventolin, Proventil) ❑ Levalbuterol (Xopenex) ❑ Corticosteroid/Formoterol (Symbicort, Breyna, Dulera, Other: _____)	❑ ____ puffs ❑ 1 nebulizer treatment ❑ Maximum 8 puffs daily for children under 12; 12 puffs daily for ages 12+	Take ONLY as needed (see below — starting in Yellow Zone or before excercise)	NOTE: If you need this medicine more than two days a week, call physician to consider increasing controller medications and discuss your treatment plan.

Special instructions when I am ***doing well,*** ***getting worse,*** ***having a medical alert.***

GREEN ZONE

Doing *well.*

- No cough, wheeze, chest tightness, or shortness of breath during the day or night.
- Can do usual activities.

Peak Flow (for ages 5 and up):
is _____ or more.(80% or more of personal best)
Personal Best Peak Flow (for ages 5 and up): _____

PREVENT asthma symptoms every day:

- ❑ Take my controller medicines (above) every day.
- ❑ Before exercise, take ___ puff(s) of _____.
- ❑ Avoid things that make my asthma worse. *(See pages 3 and 4)*

YELLOW ZONE

Getting *worse.*

- Cough, wheeze, chest tightness, shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.

Peak Flow (for ages 5 and up):
_____ to _____ (50 to 79% of personal best)

CAUTION. Continue taking every day controller medicines, AND:

- ❑ Take __ puffs or one nebulizer treatment of quick relief medicine. If I am not back in the ***Green Zone*** within 20-30 minutes take __ more puffs or nebulizer treatments. If I am not back in the ***Green Zone*** within one hour, then I should:
- ❑ Increase _____
- ❑ Add _____
- ❑ Call _____
- ❑ Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in _____days.

RED ZONE

Medical Alert

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone.

Peak Flow (for ages 5 and up):
less than _____ (50% of personal best)

MEDICAL ALERT! Get help!

- ❑ Take quick relief medicine: _____ puffs every _____ minutes and get help immediately.
- ❑ Take _____
- ❑ Call _____

Danger! Get help immediately! Call 911 if trouble walking or talking due to shortness of breath or if lips or fingernails are gray or blue. For child, call 911 if skin is sucked in around neck and ribs during breaths or breathing is hard, fast, or labored and/or child doesn't respond normally.

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: ❑ Yes ❑ No Self administer asthma medications: ❑ Yes ❑ No
(This authorization is for a maximum of one year from signature date.)

_____ _____

Healthcare Provider Signature Date

© 2008, Public Health Institute (RAMP)

Controlling Things That Make Asthma Worse

OUTDOOR AIR POLLUTION AND WILDFIRE SMOKE

- Monitor air quality through www.airnow.gov. The site also provides suggestions for steps to take depending on the air pollution levels. During times of poor air quality, including wildfire smoke, steps include:
  - Stay inside with windows and doors closed. (If it is extremely hot and you don't have an air conditioner, staying inside with the windows closed may be unsafe. Learn more at: https://heatreadyca.com/.)
  - Use a mechanical HEPA air cleaner. Learn more at https://rampasthma.org/air-cleaners-for-asthma-programs/
  - For the home's HVAC system, use a MERV 13 filter, or as high of a filter as recommended by the manufacturer.
  - If you must go outside, wear an N95 mask and limit physical activity.



INDOOR AIR POLLUTION, ODORS, AND CLEANING PRODUCTS

- When cooking, use an exhaust fan or open a window. Do not use a gas cooking appliance for heating your living space.
- If using a wood burning fireplace, make sure it is properly vented to help ensure smoke escapes through the chimney.
- Avoid using strongly scented products, such as home deodorizers, incense, and perfumed laundry products and personal care products.
- When cleaning, people with asthma should stay away to reduce exposure to any chemicals. Don't use strong smelling cleaning products. Avoid ammonia, bleach, and disinfectants. Learn more at: https://rampasthma.org/wp-content/uploads/2024/11/TenantFactsheets_Cleaning.pdf



DUST

- Vacuum weekly with a HEPA vacuum. Try to make sure people with asthma are not home during vacuuming.
- Remove carpet if possible.
- Damp mop floors weekly.
- Wash bedding and stuffed toys in hot water every 1-2 weeks. Freeze stuffed toys that aren't washable for 24 hours.
- Cover mattresses and pillows in dust-mite proof zippered covers.
- Reduce clutter and remove stuffed animals, especially around the bed.



SMOKING AND VAPING

- Do not smoke. Access tobacco cessation resources from a health care provider or help line. Learn more at: https://kickitca.org/.
- If you smoke, smoke outside to reduce smoke exposure inside your living space.
- Do not allow smoking in the home or car. Lingering smoke smell can trigger asthma.



© 2008, Public Health Institute (RAMP)

Controlling Things That Make Asthma Worse

PESTS



- Do not leave food or garbage out. Store food in airtight containers.
- Vacuum up cockroach bodies.
- Fill in cracks and holes in walls with caulking or copper wool to eliminate pest entry points.
- Fix leaky plumbing, roof, and other sources of water.
- Don't use pesticide sprays or bombs. Get help from an Integrated Pest Management provider to use safer, more sustainable methods of pest management.

PETS



- Avoid pets with fur or feathers when possible.
- Keep pets out of the bedroom of the person with asthma.
- Wash your hands and the hands of the person with asthma after petting animals.

POLLEN AND OUTDOOR MOLDS



- Try to stay indoors when pollen and mold counts are high. Track levels at: https://pollen.aaaai.org/#
- During pollen season, keep windows closed and use an air conditioner instead of fans, when possible.

COLDS AND OTHER RESPIRATORY INFECTIONS



- Keep your body healthy with regular exercise, sufficient sleep, and a well-balanced diet.
- Avoid close contact with people who have colds and respiratory illnesses.
- Wash your hands frequently and avoid touching your hands to your face.
- Get an annual flu shot and any other vaccines recommended by a physician.

MOLD



- Use exhaust fans or open windows for ventilation when showering.
- Fix leaky plumbing or other sources of water or moisture.
- Clean mold off hard surfaces with non-ammonia soap or detergent in hot water and scrub with stiff brush or cleaning pad, then rinse clean with water. Wear personal protective equipment while cleaning. Learn more at: https://www.cdph.ca.gov/Programs/cls/dehl/ehl/Pages/AQS/Mold.aspx
- Make sure people with asthma are not in the room when cleaning.
- Absorbent materials with mold may need to be replaced.
- If there is high humidity in your home, use a dehumidifier.

EXERCISE



- Warm up before exercising.
- Plan alternate indoor activities on high pollen or pollution days.
- If directed by a physician, take medication before exercise. (See Green Zone of Asthma Action Plan.)

© 2008, Public Health Institute (RAMP)

SCHOOL AUTHORIZATION FORM
To be completed by Parent/Guardian and turned in to the school

AUTHORIZATION AND DISCLAIMER FROM PARENT/GUARDIAN: I request that the school assist my child with the asthma medications listed on this form, and the Asthma Action Plan,in accordance with state laws and regulations.

❑ **Yes** ❑ **No**

My child may carry and self-administer asthma medications and I agree to release the school district and school personnel from all claims of liability if my child suffers any adverse reactions from self-administration of asthma medications:

❑ **Yes** ❑ **No**

_____ _____

Parent/Guardian Signature Date

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name:_____ / _____

Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1)_____ (2) _____ to

provide health information from the above-named child's medical record to and from:

_____ _____

School or school district to which disclosure is made Address / City and State / Zip Code

_____ _____

Contact person at school or school district Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

_____

Requested information shall be limited to the following: ❑ All health information; or

❑ Disease-specific information as described: _____

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____(enter date) or for one year from the date of signature,if no date entered.

RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe,appropriate,and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL: _____ _____ _____

Printed Name Signature Date

_____ _____

Relationship to Patient/Student Area Code and Telephone Number

This Asthma Plan was developed by a committee facilitated by the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute. This publication was supported by Cooperative Agreement Number 1U58DP001016-01 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.
This plan is based on the recommendations from the National Heart, Lung, and Blood Institute's, “Guidelines for the Diagnosis and Management of Asthma, ”NIH Publication No.07-4051 (August 2007). The information contained herein is intended for the use and convenience of physicians and other medical personnel and may not be appropriate for use in all circumstances. Decisions to adopt any particular recommendation must be made by qualified medical personnel in light of available resources and the circumstances presented by individual patients. No entity or individual involved in the funding or development of this plan makes any warranty or guarantee, express or implied, of the quality, fitness, performance or results of use of the information or products described in the plan or the Guidelines.

For additional information, please contact

RAMP at (510) 671-1756, http://www.rampasthma.org.