## FIGURE 3–4a. CLASSIFYING ASTHMA SEVERITY IN CHILDREN 0–4 YEARS OF AGE

- **Classifying severity in children who are not currently taking long-term control medication.**

| Components of Severity | | Classification of Asthma Severity (Children 0–4 years of age) | | | |
|---|---|---|---|---|---|
| | | | Persistent | | |
| | | Intermittent | Mild | Moderate | Severe |
| Impairment | Symptoms | ≤2 days/week | >2 days/week but not daily | Daily | Throughout the day |
| | Nighttime awakenings | 0 | 1–2x/month | 3–4x/month | >1x/week |
| | Short-acting $beta_2$-agonist use for symptom control (not prevention of EIB) | ≤2 days/week | >2 days/week but not daily | Daily | Several times per day |
| | Interference with normal activity | None | Minor limitation | Some limitation | Extremely limited |
| Risk | Exacerbations requiring oral systemic corticosteroids | 0–1/year | ≥2 exacerbations in 6 months requiring oral steroids, or ≥4 wheezing episodes/1 year lasting >1 day AND risk factors for persistent asthma | | |
| | | ← Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time. → | | | |
| | | Exacerbations of any severity may occur in patients in any severity category | | | |

## FIGURE 3–5a. ASSESSING ASTHMA CONTROL IN CHILDREN 0–4 YEARS OF AGE

| Components of Control | | Classification of Asthma Control (Children 0–4 years of age) | | |
|---|---|---|---|---|
| | | **Well Controlled** | **Not Well Controlled** | **Very Poorly Controlled** |
| **Impairment** | Symptoms | ≤2 days/week | >2 days/week | Throughout the day |
| | Nighttime awakenings | 1x/month | >1x/month | >1x/week |
| | Interference with normal activity | None | Some limitation | Extremely limited |
| | Short-acting $beta_2$-agonist use for symptom control (not prevention of EIB) | ≤2 days/week | >2 days/week | Several times per day |
| **Risk** | Exacerbations requiring oral systemic corticosteroids | 0–1/year | 2–3/year | >3/year |
| | Treatment-related adverse effects | Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk. | | |

## ASTHMA CONTROL TEST™

This survey was designed to help you describe your asthma and how your asthma affects how you feel and what you are able to do. To complete it, please mark an X in the one box that best describes your answer.

1. In the <u>past 4 weeks,</u> how much of the time did your asthma keep you from getting as much done at work or at home?

| All of the time | Most of the time | Some of the time | A little of the time | None of the time |
|---|---|---|---|---|
| ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

2. During the <u>past 4 weeks</u>, how often have you had shortness of breath?

| More than once a day | Once a day | 3 to 6 times a week | Once or twice a week | Not at all |
|---|---|---|---|---|
| ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

3. During the <u>past 4 weeks</u>, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

| 4 or more nights a week | 2 to 3 nights a week | Once a week | Once or Twice | Not at all |
|---|---|---|---|---|
| ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

4. During the <u>past 4 weeks</u>, how often have you used your rescue inhaler or nebulizer medication (such as Albuterol, Ventolin®, Proventil®, Maxair®, or Primatene Mist®)?

| 3 or more times per day | 1 or 2 times per day | 2 or 3 times per week | Once a week or less | Not at all |
|---|---|---|---|---|
| ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

5. How would you rate your asthma control during the <u>past 4 weeks</u>?

| Not Controlled at all | Poorly Controlled | Somewhat Controlled | Well Controlled | Completely Controlled |
|---|---|---|---|---|
| ☐1 | ☐2 | ☐3 | ☐4 | ☐5 |

## FIGURE 3–10a. SAMPLE ASTHMA ACTION PLAN

# *My Asthma Action Plan*

Patient Name: _____

Medical Record #: _____

Physician's Name: _____ DOB: _____

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

| Long-Term-Control Medicines | How Much To Take | How Often | Other Instructions |
|---|---|---|---|
| | | _____ times per day EVERY DAY! | |
| | | _____ times per day EVERY DAY! | |
| | | _____ times per day EVERY DAY! | |
| | | _____ times per day EVERY DAY! | |

| Quick-Relief Medicines | How Much To Take | How Often | Other Instructions |
|---|---|---|---|
| | | Take ONLY as needed | NOTE: If this medicine is needed frequently, call physician to consider increasing long-term-control medications. |

Special instructions when I feel good, not good, and awful.

**GREEN ZONE**

I feel ***good.***

(My **peak flow** is in the **GREEN** zone.)

***PREVENT*** asthma symptoms everyday:

- ☐ Take my long-term-control medicines (above) every day.
- ☐ Before exercise, take _____ puffs of _____
- ☐ Avoid things that make my asthma worse like: _____

**YELLOW ZONE**

I do ***not*** feel ***good.***

(My **peak flow** is in the **YELLOW** zone.)

My symptoms may include one or more of the following:

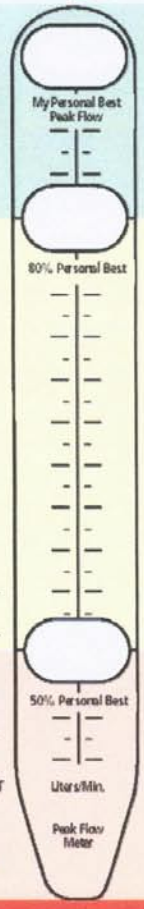
- Wheeze
- Tight chest
- Cough
- Shortness of breath
- Waking up at night with asthma symptoms
- Decreased ability to do usual activities
- _____

***CAUTION.*** I should continue taking my long-term-control asthma medicines every day AND:

- ☐ Take _____

If I still do not feel good, or my peak flow is not back in the ***Green Zone*** within 1 hour, then I should:

- ☐ Increase _____
- ☐ Add _____
- ☐ Call _____




**RED ZONE**

I feel ***awful.***

(My **peak flow** is in the **RED** zone.)

Warning signs may include one or more of the following:

- It's getting harder and harder to breathe
- Unable to sleep or do usual activities because of trouble breathing

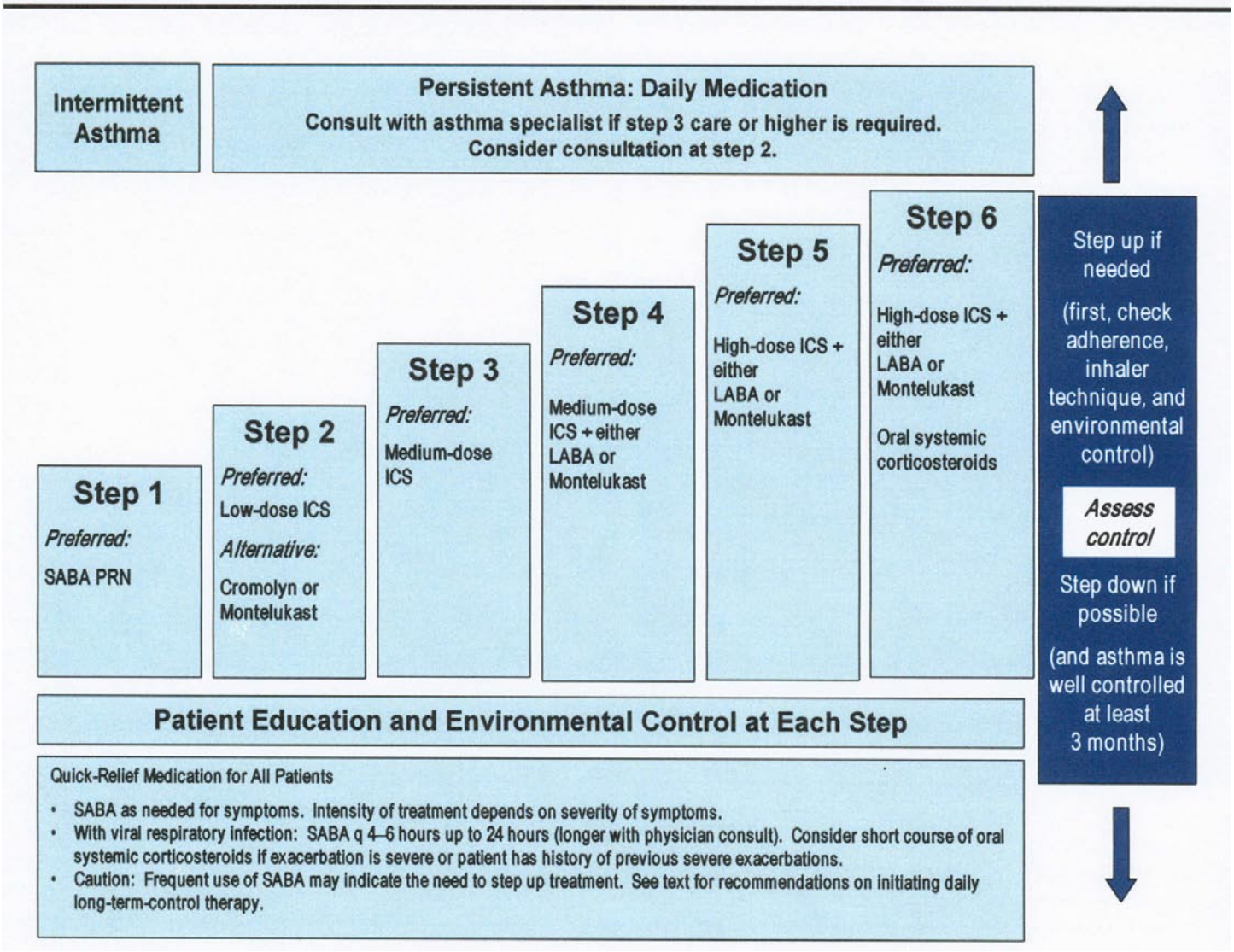
***MEDICAL ALERT! Get help!***

- ☐ Take _____ until I get help immediately.
- ☐ Take _____
- ☐ Call _____

**Danger! Get help immediately!** Call 9–1–1 if you have trouble walking or talking due to shortness of breath or lips or fingernails are gray or blue.

Source: Adapted and reprinted with permission from the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute. http://www.calasthma.org/uploads/resources/actionplanpdf.pdf; San Francisco Bay Area Regional Asthma Management Plan, http://www.rampasthma.org

## FIGURE 4–1a. STEPWISE APPROACH FOR MANAGING ASTHMA IN CHILDREN 0–4 YEARS OF AGE



## FIGURE 4–2a. CLASSIFYING ASTHMA SEVERITY AND INITIATING TREATMENT IN CHILDREN 0–4 YEARS OF AGE

**Assessing severity and initiating therapy in children who are not currently taking long-term control medication**

| Components of Severity | | Classification of Asthma Severity (0–4 years of age) | | | |
|---|---|---|---|---|---|
| | | | Persistent | | |
| | | Intermittent | Mild | Moderate | Severe |
| Impairment | Symptoms | ≤2 days/week | >2 days/week but not daily | Daily | Throughout the day |
| | Nighttime awakenings | 0 | 1–2x/month | 3–4x/month | >1x/week |
| | Short-acting $beta_2$-agonist use for symptom control (not prevention of EIB) | ≤2 days/week | >2 days/week but not daily | Daily | Several times per day |
| | Interference with normal activity | None | Minor limitation | Some limitation | Extremely limited |
| Risk | Exacerbations requiring oral systemic corticosteroids | 0–1/year | ≥2 exacerbations in 6 months requiring oral systemic corticosteroids, or ≥4 wheezing episodes/1 year lasting >1 day AND risk factors for persistent asthma | | |
| | | ← Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time. → Exacerbations of any severity may occur in patients in any severity category. | | | |
| **Recommended Step for Initiating Therapy** (See figure 4–1a for treatment steps.) | | Step 1 | Step 2 | Step 3 and consider short course of oral systemic corticosteroids | |
| | | In 2–6 weeks, depending on severity, evaluate level of asthma control that is achieved. If no clear benefit is observed in 4–6 weeks, consider adjusting therapy or alternative diagnoses. | | | |

## FIGURE 4–3a. ASSESSING ASTHMA CONTROL AND ADJUSTING THERAPY IN CHILDREN 0–4 YEARS OF AGE

| Components of Control | | Classification of Asthma Control (0–4 years of age) | | |
|---|---|---|---|---|
| | | **Well Controlled** | **Not Well Controlled** | **Very Poorly Controlled** |
| **Impairment** | Symptoms | ≤2 days/week | >2 days/week | Throughout the day |
| | Nighttime awakenings | ≤1x/month | >1x/month | >1x/week |
| | Interference with normal activity | None | Some limitation | Extremely limited |
| | Short-acting $beta_2$-agonist use for symptom control (not prevention of EIB) | ≤2 days/week | >2 days/week | Several times per day |
| **Risk** | Exacerbations requiring oral systemic corticosteroids | 0–1/year | 2–3/year | >3/year |
| | Treatment-related adverse effects | Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk. | | |
| **Recommended Action for Treatment**<br><br>**(See figure 4–1a for treatment steps.)** | | • Maintain current treatment.<br>• Regular followup every 1–6 months.<br>• Consider step down if well controlled for at least 3 months. | • Step up (1 step) and<br>• Reevaluate in 2–6 weeks.<br>• If no clear benefit in 4–6 weeks, consider alternative diagnoses or adjusting therapy.<br>• For side effects, consider alternative treatment options. | • Consider short course of oral systemic corticosteroids,<br>• Step up (1–2 steps), and<br>• Reevaluate in 2 weeks.<br>• If no clear benefit in 4–6 weeks, consider alternative diagnoses or adjusting therapy.<br>• For side effects, consider alternative treatment options. |