Asthma Flow Sheet

Age 12 to adult

Patient name: ____________ **Identification number:** ____________

Date of birth: ____________ **Current date:** ____________

Chart ID: ____________

Vital signs and lung function tests

Height:		**Blood pressure:**	/	**Spirometry/FEV$_1$:** (☐ unable to perform)					%
Weight:		**Pulse:**		**Peak flow:** personal best			**Est. for height:**		
Temp.:		**Pulse oximetry:**	%	**Peak flow rate:**		#	**Peak flow rate:**		%
Resp. rate:		**Post treatment:**	%	**Post-tx peak flow rate:**		#	**Post-tx peak flow rate:**		%

Education

Self-management strategies and return demonstration where appropriate.

- ☐ Medication
  - Controller
  - Rescue
- ☐ Exercise
- ☐ Medication administration
- ☐ Peak flow meter use (if applicable)
- ☐ Set and review treatment goals
- ☐ Avoiding triggers

Presenting issues

Is the patient having an exacerbation? ☐ Yes ☐ No

Has the patient had a recent trigger exposure? ☐ Yes ☐ No

Physical exam

Chest/respiratory

☐ Lungs clear to auscultation ☐ Prolonged expiration ☐ Nasal flaring

☐ Shallow breath sounds (describe): ____________

☐ Wheeze (describe): ____________

☐ Retractions (describe): ____________

☐ Other sounds (describe): ____________

Eye-ear-nose-throat ____________

Skin ____________

Treatment at visit

Xopenex/levalbuterol neb: ☐ 0.63mg ☐ 1.25mg/3ml

Albuterol neb: ☐ 2.5mg/3ml

☐ Other: ____________ # of treatments: ______

☐ Prelone given; dose: ____________

____

Referred to:

☐ Allergist ☐ Pulmonologist

Asthma action plan

☐ Reviewed with patient

☐ Provided and/or updated

☐ Copy for daycare or school

Current symptoms

☐ No symptoms

☐ Wheeze ☐ Cough

☐ Sputum ☐ Chest tight/dyspnea

☐ Shortness of breath (SOB)

☐ Other: ____________

Recent daytime symptoms

☐ 0 days/week

☐ 1–2 days/week

☐ 3–6 days/week

☐ Every day

☐ Continual (multiple symptoms/day)

Recent nighttime symptoms

☐ 0x/month ☐ 1–2x/month

☐ 3–4x/month ☐ 5–11x/month (1–2x/week)

☐ Greater than or equal to 12x/month (greater than 3x/week)

B$_2$-agonist use

☐ None ☐ 1–2 days/week

☐ 3–6 days/week

☐ 7 days/week

☐ Greater than 2x every day

Avg. # puffs/day ________

Emergency room visits for asthma

(due to asthma, last month)

☐ 0 ☐ 1 ☐ 2

☐ 3 ☐ 4 ☐ Greater than 4

Hospitalizations in last year: ______

Missed school/work

(due to asthma, last 2 weeks)

☐ None ☐ 5–6 days

☐ 1–2 days ☐ 7–8 days

☐ 3–4 days ☐ 9–10 days

Home peak flow rates

Personal best: ________ ☐ N/A

☐ Green zone ______ to ______

☐ Yellow zone ______ to ______

☐ Red zone ______ to ______

Co-morbidities

☐ Allergies ☐ Eczema ☐ Hypertension

☐ GERD ☐ Depression ☐ None

☐ Anxiety ☐ Sinusitis ☐ Other

Triggers

☐ Mold ☐ Dust

☐ Cat ☐ Dog

☐ Cigarette smoker

☐ Cockroach

☐ Other: ____________

Impact on activity

☐ No effect on any activity

☐ May affect physical activity

☐ Activity often affected

☐ Limited physical activity

Describe: ____________

Medication compliance

Missed or stopped taking medications? ☐ Yes ☐ No If yes, why? ________

Any side effects?

☐ Nervousness ☐ Shakiness ☐ Sore throat

☐ Bad taste ☐ Cough ☐ Bruising

Any barriers getting the ordered medications? ____________

Today's control rating

Symptoms (SOB, coughing, wheezing)	Nighttime awakening	B$_2$-agonist use	Interference with normal activity	FEV$_1$/PEF	Exacerbation requiring oral systemic corticosteroids	Control rating
☐ Throughout the day	☐ Greater than or equal to 4x/week	☐ Several times per day	☐ Extremely limited	☐ Less than 60% predicted/ personal best	☐ Greater than or equal to 2/year	☐ Very poorly controlled
☐ Greater than 2 days/week	☐ 1–3x/month	☐ Greater than 2 days/week	☐ Some limitations	☐ 60–80% predicted/personal best		☐ Not well-controlled
☐ Less than or equal to 2 days/week	☐ Less than or equal to 2x/month	☐ Less than or equal to 2 days/week	☐ None	☐ Greater than 80% predicted/ personal best	☐ 0–1/year	☐ Well-controlled

Follow-up

☐ 2 weeks ☐ 4 weeks ☐ 2 months ☐ 3 months ☐ 4 months ☐ 6 months

Medications prescribed

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HEDIS ASTHMA MGMT WKSHT 12-ADULT

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PERISCOPE®

JOB # UCS120067 **DATE** 6.11.12

CLIENT UHC Community and State

NAME HEDIS Collateral

LIVE

TRIM 8.5" x 11"

BLEED .125"

FILE CREATED AT: 100%

COLOR CMYK

C M Y K

INITIALS DATE

CD Bruce B ______

AD/DS Nick C. ______

CW Linda L ______

AM Sarah M. & Jonathan C. ______

PM Mandi T. ______

STAGE: FINAL

Recommended action for treatment

See chart below for treatment steps.

- Maintain current step
- Regular follow-ups every one to six months to maintain control

- Consider step-down if well-controlled for at least three months
- Step-up one step and reevaluate in two to six weeks
- For side effects, consider alternative treatment options

- Consider short course of oral systemic corticosteroids
- Step-up one to two steps and reevaluate in two weeks
- For side effects, consider alternative treatment options

Key: EIB, exercise-induced bronchospasm; GERD, gastroesophageal reflux disease; FEV_1, forced expiratory volume in one second; PEF, peak expiratory flow; ICU, intensive care unit
*Asthma Control Questionnaire (ACQ) values of 0.76–1.4 are indeterminate regarding well-controlled asthma.

Notes

- The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
- The level of control is based on the most severe impairment or risk category. Assess impairment domain by patient's recall of previous two to four weeks and by spirometry or peak flow measures. Symptom assessment for longer periods should reflect a global assessment, such as inquiring whether the patient's asthma is better or worse since the last visit.
- At present, there is inadequate data to correspond frequencies of exacerbations with different levels of asthma control. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization or intensive care unit admission) indicate poor disease control. For treatment purposes, patients who had two or more exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have not-well-controlled asthma, even in the absence of impairment levels consistent with not-well-controlled asthma.
- Validated questionnaires for the impairment domain (the questionnaires do not assess lung function or the risk domain).
  - ATAQ = Asthma Therapy Assessment Questionnaire® (see sample in "Component 1: Measures of Asthma Assessment and Monitoring").
  - ACQ = Asthma Control Questionnaire® (user package may be obtained at www.qoltech.co.uk or juniper@qoltech.co.uk).
  - ACT = Asthma Control Test™ (see sample in "Component 1: Measures of Asthma Assessment and Monitoring").
    Minimal important difference: 1.0 for the ATAQ; 0.5 for the ACQ; not determined for the ACT.
- Before step-up in therapy:
  - Review adherence to medication, inhaler technique, environmental control and co-morbid conditions.
  - If alternative treatment option was used in a step, discontinue it and use preferred treatment for that step.

Stepwise approach for managing asthma in youths age 12 and older

Intermittent asthma	Persistent asthma: daily medication Consult with asthma specialist if Step 4 care or higher is required. Consider consultation at Step 3.						
Step 1 **Preferred:** SABA pro re nata	**Step 2** **Preferred:** Low-dose ICS **Alternative:** Cromolyn, LTRA, nedocromil or theophylline	**Step 3** **Preferred:** Low-dose ICS + LABA OR Medium-dose ICS **Alternative:** Low-dose ICS + either LTRA, theophylline or zileuton	**Step 4** **Preferred:** Medium-dose ICS + LABA **Alternative:** High-dose ICS + either LTRA, Theophylline or Zileuton	**Step 5** **Preferred:** High-dose ICS + LABA AND Consider omalizumab for patients who have allergies	**Step 6** **Preferred:** High-dose ICS + LABA + oral corticosteroid AND Consider omalizumab for patients who have allergies	**Step-up if needed** First, check adherence, environmental control and co-morbid conditions **Assess control** **Step-down if possible** If asthma is well controlled at least three months	

Key: Alphabetical order is used when more than one treatment option is listed within either preferred or alternative therapy. EIB, exercise-induced bronchospasm; ICS, inhaled corticosteroid; LABA, long-acting inhaled $beta_2$-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting $beta_2$-agonist

Each step: Patient education, environmental control and management of co-morbidities

Steps 2 to 4: Consider subcutaneous allergen immunotherapy for patients who have allergic asthma (see notes).

Quick-relief medication for all patients

- SABA as needed for symptoms. Intensity of treatment depends on severity of symptoms: up to three treatments at 20-minute intervals as needed. Short course of oral systemic corticosteroids may be needed.
- Use of SABA greater than two days a week for symptom relief (not prevention of EIB) generally indicates inadequate control and the need to step-up treatment.

Notes

- The stepwise approach is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.
- If alternative treatment is used and response is inadequate, discontinue it and use the preferred treatment before stepping up.
- Zileuton is a less desirable alternative due to limited studies as adjunctive therapy and the need to monitor liver function. Theophylline requires monitoring of serum concentration levels.
- In Step 6, before oral systemic corticosteroids are introduced, a trial of high-dose ICS plus LABA plus either LTRA, theophylline or zileuton may be considered, although this approach has not been studied in clinical trials.
- Step 1, 2 and 3 preferred therapies are based on Evidence A; Step 3 alternative therapy is based on Evidence A for LTRA, Evidence B for theophylline, and Evidence D for zileuton. Step 4 preferred therapy is based on Evidence B, and alternative therapy is based on Evidence B for LTRA and theophyline and Evidence D for zileuton. Step 5 preferred therapy is based on Evidence B. Step 6 preferred therapy is based on (Expert Panel Report (EPR)-2 1997) and Evidence B for omalizumab.
- Immunotherapy for Steps 2 to 4 is based on Evidence B for dust mites, animal danders, and pollens; evidence is weak or lacking for molds and cockroaches. Evidence is strongest for immunotherapy with single allergens. The role of allergy in asthma is greater in children than in adults.
- Clinicians who administer immunotherapy or omalizumab should be prepared and equipped to identify and treat anaphylaxis that may occur.

Source: www.nhlbi.nih.gov/guidelines/asthma/

Benefits vary by state. Please refer to the provider manual or the UnitedHealthcare website for applicable benefit information. Insurance coverage provided by UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of Oregon, Inc., and UnitedHealthcare of Washington, Inc. or other affiliates. Administrative services provided by United HealthCare Services, Inc. or its affiliates.