How to Complete an Asthma Action/Management Plan: A Step-by-Step Guide

Asthma Action Plans may look different, but they all serve the same important purpose!

STEP 1: Enter Demographics/Triggers/Peak Flow Information

- ✓ Complete patient/provider demographic/contact information
- ✓ Write the date the plan is written
- ✓ Check off known/identified asthma triggers (if triggers section is provided)
- ✓ If performing Peak Flow, enter value for Predicted/Personal Best Peak Flow Reading where indicated (if peak flow sections are provided)

STEP 2: Complete the Treatment Plan

- ✓ Write **daily asthma controller medicine(s)** that have been prescribed by the provider in the **green zone**, along with how much to take and when to take it* and if a spacer is to be used. Write only medicines used to control asthma on the plan. Do NOT use any medical abbreviations. If indicated, enter Peak Flow values (80-100%) in the **green zone.**

  For example: QVAR 1 puff 2 times/day, morning and night
  Clarinex 1 tablet everyday

  *Some action plans also have a space in the green zone to write in a rescue inhaler to be used with a spacer 5-15 minutes prior to activity to prevent exercise induced bronchospasm. If so, write in medicine and how many puffs to use.

- ✓ Write **quick relief/rescue medicine(s)** that have been prescribed by the provider in the **yellow zone**, along with how much to take, when to take it and to use a spacer. These should be used in addition to the daily controller medicine(s) to keep an asthma attack from getting bad and to help get asthma under good control. If indicated, enter Peak Flow values (50-80%) in the **yellow zone.**
- ✓ Write **quick relief/rescue medicine(s)** that have been prescribed by the provider in the **red zone**, along with how much to take, how often to take it and to use a spacer. If indicated, enter Peak Flow value (Less than 50%) in the **red zone.**

Step 3: Educate Using Teach and Teach-back

- ✓ All patients/caregivers should be able demonstrate (w/devices) how and when to implement all zones of the plan and be able to reflect this ability during a return demonstration or "teach-back" session

Remember! An Asthma Action Plan is only effective if the user understands how and when to use it...

Step 4: Provide Copies of Asthma Action Plan and Other Asthma Handouts

- ✓ Give copies of the most current Asthma Action Plan to patients/parents/caregivers and also provide copies to school nurses/childcare providers/case managers.
- ✓ Give additional asthma educational handouts to reinforce teaching and for referencing

ASTHMA ACTION PLANS: WHO-WHAT-WHEN-WHY?

WHO:

- Patients, parents and caregivers use the Asthma Action Plan as a guide to manage asthma symptoms in order to keep asthma well controlled and to intervene when needed to regain control.
- Physicians, Nurse Practitioners, Physician Assistants, Nurses and Medical Assistants complete Asthma Action Plans by using the current asthma medication regimen prescribed by the provider.
- Case managers, school nurses and child care providers use Asthma Action Plans in the community to educate patients/caregivers on how to effectively manage asthma symptoms and to reinforce the importance of following the Asthma Action Plan daily for better asthma control.

WHAT:

An Asthma Action Plan (AAP) is a written plan of action that uses 3 "stoplight" zones (green/yellow/ red) to help decide what treatment (relating to symptoms or peak flow results) is recommended to get and keep asthma under good control.

- **Green Zone=GO** No asthma symptoms are present. Use controller medicine daily with a spacer (if device is a metered dose inhaler and not a discus) as directed by provider.
- **Yellow Zone= CAUTION** Mild-moderate asthma symptoms are present. Add quick relief/rescue medicine with a spacer to attempt to get asthma symptoms under control.
- **Red Zone=EMERGENCY** Severe asthma symptoms are present. Call 911 and continue quick relief/rescue medicine with a spacer until help arrives.

WHEN:

An asthma action plan should be completed at the initial diagnosis and a new plan written any time these changes are made:

- medication changes (drug, dose, frequency)
- addition of SABA (Short Acting Beta Agonist) for EIB (Exercise Induced Bronchospasm)
- addition of oral corticosteroid

The AAP should be updated and reviewed with patient/caregiver at each asthma continued care visit at least twice a year. (An asthma continued care visit is an office visit when the patient is *not* having an asthma exacerbation.)

WHY:

Education in asthma self-management is a key component of asthma control. Written AAP's provide guidance for daily management and actions to manage worsening symptoms. The overall goal is to provide an understandable tool that can help a patient, parent or school personnel make decisions for appropriate action(s) when asthma symptoms deviate from baseline.

*NIH Guidelines Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma. US Department of Health and Human Services, National Institutes of Health, National Heart, Lung, and Blood Institute: 2007. http://www.nhlbi.nih.gov/guidelines/asthma/index.htm