



Management of Asthma in Children and Adults

Purpose

To improve asthma management in children and adults.

Key Recommendations/Messages

- Assess and Monitor - assess and document asthma severity, identify triggers, conduct medical history and physical exam, assess medication use. Schedule a medical appointment for asthma at least every six months.
- Pharmacological Therapy - use stepwise approach to gaining control as quickly as possible and provide a rescue plan for acute exacerbations.
- Control Factors that Contribute to Severity- asthma exacerbations may be caused by a variety of triggers including allergens, pollutants, foods and drugs.
- Patient Education - education is an essential part of the overall management of asthma. Education includes the development of an asthma action plan.
- Asthma in all age groups may present only as repeated coughing, especially at night, with exercise and with viral illnesses, but these are particularly common patterns of presentation of asthma in children.

High Risk Populations/Disparities

- In the elderly, the diagnosis of asthma is often not made or is missed. It is now becoming increasingly recognized that undiagnosed asthma is a frequent cause of treatable respiratory symptoms.
- Workers who are exposed to inhalant chemicals or allergens in the workplace can develop asthma and may be misdiagnosed as having bronchitis or chronic obstructive disease.
- More boys develop asthma during childhood; the prevalence of asthma in girls surpasses boys during adolescence.
- Among 20-30-year olds, the prevalence in women is nearly twice as high as in men.
- According to the New York State Department of Health Prevention Agenda (2013 – 2017), Monroe County has the highest emergency department visits for asthma in Western and Central New York.
 - According to the New York State Department of Health Statewide Planning and Research Cooperative System (SPARCS) 2010-2012 SPARCS Data, within the “crescent” of Rochester, asthma admission rates are about 40% higher than the state average. A child or adult living in this area is more than nine times more likely to be hospitalized for their asthma compared to a similar individual living in the 14534 (Pittsford) zip code.
 - Three zip codes stand out for asthma hospitalizations: 14605, 14604 and 14621. These three zip codes combined comprise the bulk of all the asthma hospitalizations in the County. In fact, the asthma admissions for these zip codes are nearly double the state rate. When broken down by race, the Health Department data shows that the admission rate for blacks is nearly twice that of whites.
- For tree, grass, and weed pollen, pollen counting stations in Rochester reported that the annual mean daily concentrations met or exceeded the National Allergy Bureau threshold for high concentration of pollen on 25% or more days per season. ([New York State Asthma Surveillance](#), October 2013).

Four Components of Asthma Care

1. Assessment and Monitoring of Asthma Severity and Control

Assessment and monitoring of asthma are tied to the concepts of severity, control and responsiveness and the domains of impairment and risk.

For assessing asthma severity and asthma control by impairment and risk, see age specific charts.

Medical history and physical exam:

Assess and document asthma severity and control, including impairment and risk domains.

Spirometry recommended for patients ≥ 5 years:

- (1) at time of initial assessment;
- (2) after treatment has begun and symptoms and peak expiratory flow (PEF) have stabilized;
- (3) during periods of loss of asthma control and
- (4) at least every 1–2 years.

Identify or review triggers and precipitating factors

(e.g. allergens, exercise, upper respiratory infection, tobacco smoke, chemicals, weather, strong emotions).

Assess family, psychosocial, occupational history including stressors.

Assess medication use, including CAM*. At every visit, review beta-agonist use.

Assess for co-morbidities (rhinitis, sinusitis, GERD**, obesity, ABPA***, OSA****, stress or depression).

Conduct physical exam focusing on upper and lower airways, nose and skin.

Assess impact of asthma on patient and family, patient and family perception of disease, and knowledge and skills for self-management.

* complementary alternative medication, ** gastroesophageal reflux disease, *** allergic bronchopulmonary aspergillosis, **** obstructive sleep apnea

Recommended Approach to Care Management

Initial asthma visit

Assess severity using both the impairment and risk domains (See *Classifying Asthma Severity and Initiating Treatment in specific age charts*).

Perform spirometry measurement (FEV₁, FVC, FEV₁/FVC) in all patients ≥ 5 years old before and after the patient inhales a SABA.

Assess skills for self-management, including medication administration technique.

Prescribe appropriate pharmacological therapy based on severity assessment (See *age specific stepwise chart*).

Develop and review Asthma Action Plan and provide education.

Monitor at least at 2–6-week intervals until control is achieved.

Chronic maintenance asthma visit

Assess asthma control based on impairment and risk (See *Classifying Asthma Control and Adjusting Therapy in specific age charts*).

Perform spirometry measurement (FEV₁, FVC, FEV₁/FVC) in all patients ≥ 5 years old at least every 1–2 years when asthma is stable, more often when asthma is unstable, or when clinically indicated by a change in the patient's condition or medication.

Consider validated questionnaires to assess impairment such as the Asthma Control Test (ACT) (www.asthmacontrol.com) and the Asthma Control Questionnaire (ACQ) (www.qoltech.co.uk/index.htm).

Step up or step-down treatment based on assessment of control (See *age specific stepwise chart*).

Update and review written Asthma Action Plan.

Provide inactivated influenza vaccine for all patients over 6 months of age unless a vaccine contraindication exists.

Provide 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23) to adults 19 to 64 years (see: <http://www.cdc.gov/vaccines/schedules/index.html>).

Provide 1 dose of PPSV23 to children aged ≥ 2 years requiring treatment with high-dose oral corticosteroid therapy. For the appropriate timing see the ACIP schedule at: <http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html>

Review methods of reducing exposure to relevant allergens and irritants.

Provide education, emphasizing medication adherence and medication administration technique.

Schedule an appointment for asthma at least every 6 months after asthma control is achieved and prior to predicted seasonal exacerbations.

Acute exacerbation asthma visit

Do not underestimate the severity of an exacerbation. Severe exacerbations can be life threatening and can occur in patients at any level of asthma severity or control.

Assess severity and control and consider co-morbid conditions. For emergency asthma exacerbations, see *Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma – Summary Report 2007*. NIH Publication No 08-5846, October 2007, page 53 (www.nhlbi.nih.gov/guidelines/asthma/asthsumm.pdf).

Perform spirometry for patients ≥ 5 years during periods of loss of asthma control.

Prescribe appropriate pharmacological therapy based on assessment of severity and control (See *age specific stepwise chart*).

Provide a rescue plan of systemic corticosteroids or other medications if needed for acute exacerbations at any step.

Check patient's inhaler, spacer/holding chamber, and peak flow technique.

Review symptom/peak flow monitoring.

Provide education, emphasizing medication adherence and medication administration technique.

Review methods of reducing exposure to relevant allergens and irritants.

Update and review written Asthma Action Plan.

Monitor closely until control is achieved.

Referrals

Asthma Specialist

Consider referral to asthma specialist such as an allergist or pulmonologist when:

Patient has had a life-threatening asthma exacerbation.

Patient is not meeting the goals of asthma therapy after 3–6 months of treatment. An earlier referral or consultation is appropriate if the physician concludes that the patient is unresponsive to therapy;

Signs and symptoms are atypical, or there are problems in differential diagnosis;

Other conditions complicate asthma, e.g., sinusitis, nasal polyps, ABPA, severe rhinitis, vocal cord dysfunction (VCD), GERD, chronic obstructive pulmonary disease (COPD);

Additional diagnostic testing is indicated (e.g., allergy skin testing, rhinoscopy, complete pulmonary function studies, provocative challenge, bronchoscopy);

Patient requires additional education and guidance on complications of therapy, problems with adherence, or allergen avoidance;

Patient is being considered for immunotherapy;

Patient requires step 4 care or higher (step 3 for children 0–4 years of age). Consider referral if patient requires step 3 care (step 2 for children 0–4 years of age) (See *age specific stepwise charts*);

Patient has required more than two bursts of oral corticosteroids in 1 year or has an exacerbation requiring hospitalization;

Patient requires confirmation of a history that suggests that an occupational or environmental inhalant or ingested substance is provoking or contributing to asthma. Depending on the complexities of diagnosis, treatment, or the intervention required in the work environment, it may be appropriate in some cases for the specialist to manage the patient over a period of time or to co-manage with the primary care provider (PCP).

Behavioral Specialist

Refer patients with significant psychiatric, psychosocial, or family stressors, which adversely affect their asthma control, to a behavioral health professional for treatment.

Health Plan and Community Agencies

Contact individual health plan, local health department, or community agency for availability of:

Individualized case management;

Individualized asthma education;

Asthma classes/support groups;

Smoking cessation classes;

Assistance with durable medical equipment and medical supplies such as peak flow meters, spacers/holding chambers, nebulizers and compressors;

Home or school environmental assessment and remediation when possible.

Occupational Lung Disease

Notify the New York State Department of Health Occupational Lung Disease registry at 1-866-807-2130 for patients suspected of having occupational asthma/lung disease. Services may include education and workplace evaluation.

Managing Special Situations

Patients who have asthma may encounter situations that will require adjustments to their asthma management to keep their asthma under control, such as exercise induced bronchospasm (EIB), pregnancy, and surgery.

Four Components of Asthma Care (Continued)

Heightened awareness of disparities and cultural barriers, improving access to quality care, and improving communication strategies between clinicians and ethnic or racial minority patients regarding use of asthma medications may improve asthma outcomes. *See Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma – Summary Report 2007.* NIH Publication No 08-5846, October 2007, page 38-39 (www.nhlbi.nih.gov/guidelines/asthma/asthsumm.pdf).

Exercise-Induced Bronchoconstriction (EIB):

EIB should be anticipated in all asthma patients. A history of cough, shortness of breath, chest pain or tightness, wheezing, or endurance problems during exercise suggests EIB.

Pregnancy:

Maintaining adequate control of asthma during pregnancy is important for the health of the mother and her baby.

Monitor asthma status during prenatal visits.

Albuterol is the preferred short acting beta agonist (SABA).

Inhaled corticosteroids (ICS), particularly budesonide, are the preferred long-term control medication because of documented safety and efficacy.

Surgery:

Patients who have asthma are at risk for specific complications during and after surgery.

2. Education for a Partnership in Care

A partnership between the clinician and the person who has asthma (and the caregiver, for children) is required for effective asthma management.

Asthma self-management education improves patient outcomes and can be cost effective.

Asthma education and self-management support should be tailored to the needs and literacy levels of the patient and maintain sensitivity to cultural beliefs and ethnocultural practices.

Key Educational Messages: Teach and Reinforce at Every Opportunity

Basic Facts About Asthma

The contrast between airways of a person who has and a person who does not have asthma, the role of the inflammation.

What happens to the airways during an asthma attack.

Role of Medications

Understanding the Difference Between:

Long-Term Control Medications: Prevents symptoms, often by reducing inflammation. Must be taken daily. Do not expect long-term control medications to give quick relief.

Quick-Relief Medications: SABAs relax airway muscles to provide prompt relief of symptoms. Do not expect long-term asthma control. Using SABA >2 days a week indicates the need for starting or increasing long-term control medications.

Patent Skills

Taking medications correctly:

Inhaler technique (demonstrate to the patient and have the patient return the demonstration);

Use of devices, as prescribed (e.g., valved holding chamber (VHC) or spacer, nebulizer).

Identifying and avoiding environmental exposures that worsen the patient's asthma, e.g., allergens, irritants, tobacco smoke.

Self-monitoring:

Assess level of asthma control.

Monitor symptoms and, if prescribed, PEF measures;

Recognize early signs and symptoms of worsening asthma.

Using a written asthma action plan to know when and how to:

Take daily actions to control asthma;

Adjust medication in response to signs of worsening asthma;

Seeking medical care as appropriate.

Asthma Action Plan

A written Asthma Action Plan based on peak flow and/or symptom monitoring, developed jointly with the patient, assists in managing asthma exacerbations. Update the Asthma Action Plan at every visit (at least every six months).

A written Asthma Action Plan should include:

Recommended doses and frequencies of daily controller medications and quick relief medications;

Information on what to do in case of an exacerbation (worsening symptoms and/or nocturnal awakenings);

Recommendations on avoidance of known allergens/irritants;

How to adjust medicines at home in response to particular signs, symptoms, and/or peak flow measurements;

A list of Peak Expiratory Flow (PEF) levels and/or symptoms indicating the need for acute care;

When and how to activate the EMS (Emergency Medical System) including emergency telephone numbers for the physician, and rapid transportation.

A copy of a patient's written Asthma Action Plan should be:

Carried with the patient;

in the patient's medical record;

Provided to the patient's family;

Provided to the patient's school/daycare;

Provided to other contacts of the patient as needed, including extended care and camp.

Free Asthma Action Plans:

Free Asthma Action Plans: (English and Spanish) are available at: www.health.state.ny.us/diseases/asthma/brochures.htm

3. Control of Environmental Factors and Co-morbid Conditions that Affect Asthma

Environmental Control Measures

If patients with asthma are exposed to irritants or inhalant allergens to which they are sensitive, their asthma symptoms may increase and precipitate an asthma exacerbation. Substantially reducing exposure to these factors may reduce inflammation, symptoms, and need for medication.

For the patient's environment the provider should:

Assess patient's exposure to and clinical significance of: **irritants** (e.g. tobacco smoke, smoke from wood burning stoves and fireplaces, dust generated by vacuum cleaning, and substances with strong odors and sprays, including volatile organic compounds (VOCs), chemicals); **exercise or sports** and **allergens** (e.g. animal dander, dust mites, cockroaches, mold, pollen, chemicals) and consider allergen testing. *See Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma – Summary Report 2007.* NIH Publication No 08-5846, October 2007, pages 26-27 (www.nhlbi.nih.gov/guidelines/asthma/asthsumm.pdf).

Counsel, provide information and refer patients to appropriate services to reduce exposure to relevant allergens and irritants and prevent infections where possible.

For Example: Tobacco Smoke Exposure

Assess for smoking and exposure to second-hand smoke;

Routinely advise and encourage patients and families to quit smoking;

Strongly advise against smoking indoors or in automobiles;

Initiate and/or refer to smoking cessation interventions and counseling and consider pharmacotherapy for patients and household members;

Inform patients that smoking cessation information and FREE Stop Smoking Kits are available through the New York State Smoker's Quitline.

The toll-free number is 1-888-697-8487, or visit the website at www.nysmokefree.com.

Effective allergen avoidance requires a comprehensive approach (such as a multifaceted allergen-control education program provided in the home setting); single steps alone are generally ineffective.

Consider subcutaneous immunotherapy for patients who have allergies at steps 2-4 of care (mild or moderate persistent asthma) when there is a clear relationship between symptoms and exposure to an allergen to which the patient is sensitive.

Co-morbidity Management

Manage, if present, allergic bronchopulmonary aspergillosis (ABPA), gastroesophageal reflux disease (GERD), obesity or overweight patients, obstructive sleep apnea (OSA), rhinitis/sinusitis, chronic stress/depression.

Four Components of Asthma Care (Continued)

4. Medications

Stepwise Approach to Asthma Management

(See Stepwise Approach for Managing Asthma in age specific charts)

The stepwise approach incorporates all four components of care:

- (1) assessment of severity to initiate therapy or assessment of control to monitor and adjust therapy;
- (2) patient education;
- (3) environmental control measures, and management of co-morbid conditions at every step; and
- (4) selection of medication.

The type, amount, and scheduling of medication is determined by the level of asthma severity or asthma control.

Therapy is increased (stepped up) as necessary and decreased (stepped down) when possible. Gain control as quickly as possible, then decrease treatment to the least medication necessary to maintain control. The preferred approach is to start with more intensive therapy in order to more rapidly suppress airway inflammation and thus gain prompt control.

ICSs are the most consistently effective anti-inflammatory therapy for all age groups, at all steps of care for persistent asthma and the preferred first line treatment that results in improved asthma control.

Provide a rescue plan of systemic corticosteroids or other medications if needed for acute exacerbations at any step.

Spacers/holding chambers should be used with metered dose inhalers (MDIs).

See Long-Term Control and Quick-Relief charts for medications and usual dosages.

Check for availability and the health plan/insurance formulary when applicable.

Bibliography

- Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma. NIH Publication No. 07-4051, August 2007.
- Expert Panel Report 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma – Summary Report 2007. NIH Publication No. 08-5846, October 2007. www.alvesco.us
www.dulera.com
- Prevention of Pneumococcal Disease Among Infants and Children – Use of 13-Valent Pneumococcal Conjugate Vaccine and 23-Valent Pneumococcal Polysaccharide Vaccine, MMWR Recommendations and Reports, December 10, 2010, Volume 59 No. RR-11; 1-18.
- Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23), MMWR Weekly, September 3, 2010, Volume 59, No. 34: 1102-1106.

Classifying Asthma Severity & 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: Children 0 – 4 Years of Age			
		Intermittent	Persistent		
			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 (see note)	≥ 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 <i>(See Stepwise Charts for Treatment Steps.)</i>		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.			

Notes:

- Level of severity is determined by both impairment and risk. Assess impairment domain by caregiver's recall of previous 2– 4 weeks. Assign severity to the most severe category in which any feature occurs.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. For treatment purposes, patients who had ≥ 2 exacerbations requiring oral systemic corticosteroids in the past 6 months, or ≥ 4 wheezing episodes in the past year, and who have risk factors for persistent asthma may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

Classifying severity in patients after asthma becomes well controlled, by lowest level of treatment required to maintain control*

Lowest level of treatment required to maintain control <i>(See Stepwise Charts for Treatment Steps.)</i>	Classification of Asthma Severity			
	Intermittent	Persistent		
		Mild	Moderate	Severe
	Step 1	Step 2	Step 3 or 4	Step 5 or 6

*Notes:

- For population-based evaluations, clinical research, or characterization of a patient's overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.

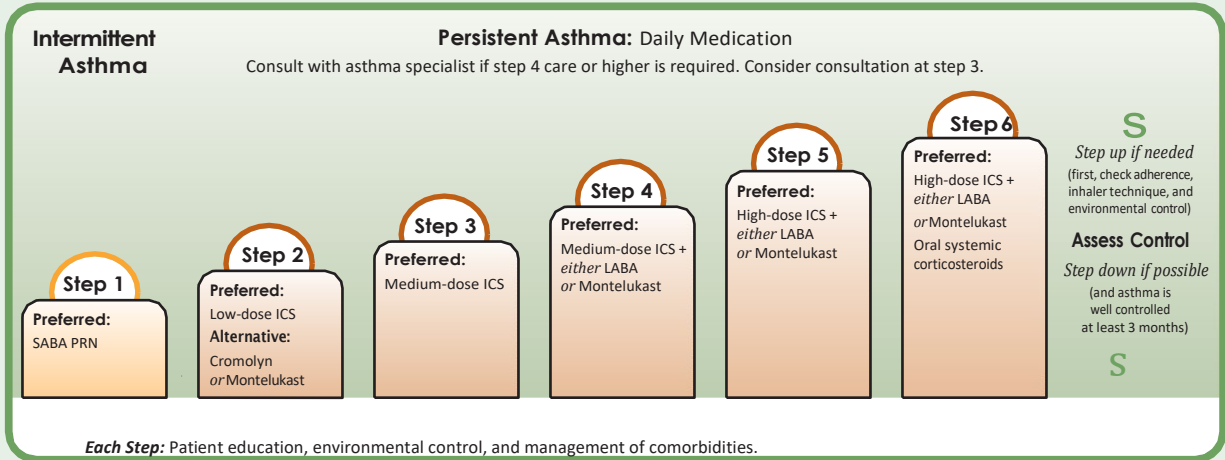
Assessing Asthma Control & Adjusting Therapy in Children 0 – 4 Years of Age

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.		
Recommended Action for Treatment <i>(See "Stepwise Approach for Managing Asthma" for treatment steps.)</i> The stepwise approach is meant to assist, not replace, clinical decision making required to meet individual patient needs.		<ul style="list-style-type: none"> • Maintain current treatment. • Regular follow up every 1– 6 months. • Consider step down if well controlled for at least 3 months. 	<ul style="list-style-type: none"> • Step up 1 step, and • Reevaluate in 2–6 weeks. • If no clear benefit in 4–6 weeks, consider alternative diagnoses or adjusting therapy. • For side effects, consider alternative treatment options. 	<ul style="list-style-type: none"> • Consider short course of oral systemic corticosteroids. • Step up 1– 2 steps, and • Reevaluate in 2 weeks. • If no clear benefit in 4–6 weeks, consider alternative diagnoses or adjusting therapy. • For side effects, consider alternative treatment options.
		Before step up in therapy: <ul style="list-style-type: none"> • Review adherence to medication, inhaler technique, and environmental control. If alternative treatment was used, discontinue it and use preferred treatment for that step. 		

Notes:

- The level of control is based on the most severe impairment or risk category. Assess impairment domain by caregiver's recall of previous 2– 4 weeks. 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 are 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 ICU admission) indicate poorer disease control. For treatment purposes, patients who had ≥ 2 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.

Stepwise Approach for Managing Asthma in Children 0 – 4 Years of Age



Key: Alphabetical order is used when more than one treatment option is listed within either preferred or alternative therapy. ICS, inhaled corticosteroid; LABA, inhaled long-acting beta₂-agonist; SABA, inhaled short-acting beta₂-agonist.

Notes:

- If alternative treatment is used and response is inadequate, discontinue it and use the preferred treatment before stepping up.
- If clear benefit is not observed within 4 – 6 weeks and patient/family medication technique and adherence are satisfactory, consider adjusting therapy or alternative diagnosis.

Quick-Relief Medication for All Patients

- SABA as needed for symptoms. Intensity of treatment depends on severity of symptoms.
- With viral respiratory infection: SABA q 4– 6 hours up to 24 hours (longer with physician consult). Consider short course of oral systemic corticosteroids if exacerbation is severe or patient has history of previous severe exacerbations.
- **CAUTION:** Frequent use of SABA may indicate the need to step up treatment.

Classifying Asthma Severity & Initiating Treatment in Children 5–11 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: Children 5–11 Years of Age			
		Intermittent	Mild	Moderate	Severe
Impairment	Symptoms	≤ 2 days/week	> 2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤ 2x/month	3 – 4x/month	> 1x/week but not nightly	Often 7x/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
	Lung function	<ul style="list-style-type: none"> Normal FEV₁ between exacerbations FEV₁ > 80% predicted FEV₁/FVC > 85% 	<ul style="list-style-type: none"> FEV₁ = > 80% predicted FEV₁/FVC > 80% 	<ul style="list-style-type: none"> FEV₁ > 60–80% predicted FEV₁/FVC = 75–80% 	<ul style="list-style-type: none"> FEV₁ < 60% predicted FEV₁/FVC < 75%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/ year (<i>see note</i>)			
		≥ 2 in 1 year (<i>see note</i>)			
		Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time for patients in any severity category. Relative annual risk of exacerbations may be related to FEV ₁ .			
Recommended Step for Initiating Therapy <i>(See Stepwise Charts for Treatment Steps.)</i>		Step 1	Step 2	Step 3, medium-dose ICS option and consider short course of oral systemic corticosteroids	Step 3, medium-dose ICS option, or step 4
In 2 – 6 weeks, evaluate level of asthma control that is achieved, and adjust therapy accordingly.					

Notes:

- Level of severity is determined by assessment of both impairment and risk. Assess impairment domain by patient's/caregiver's recall of previous 2–4 weeks and spirometry. Assign severity to the most severe category in which any feature occurs.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g. requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients who had 2 exacerbations requiring oral corticosteroids in the past 6 months, or 4 wheezing episodes in the past year, and who have risk factors for persistent asthma may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

Classifying severity in patients after asthma becomes well controlled, by lowest level of treatment required to maintain control*

Lowest level of treatment required to maintain control <i>(See Stepwise Charts for Treatment Steps.)</i>	Classification of Asthma Severity			
	Intermittent	Mild	Moderate	Severe
	Step 1	Step 2	Step 3 or 4	Step 5 or 6

*Notes:

- For population-based evaluations, clinical research, or characterization of a patient's overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.

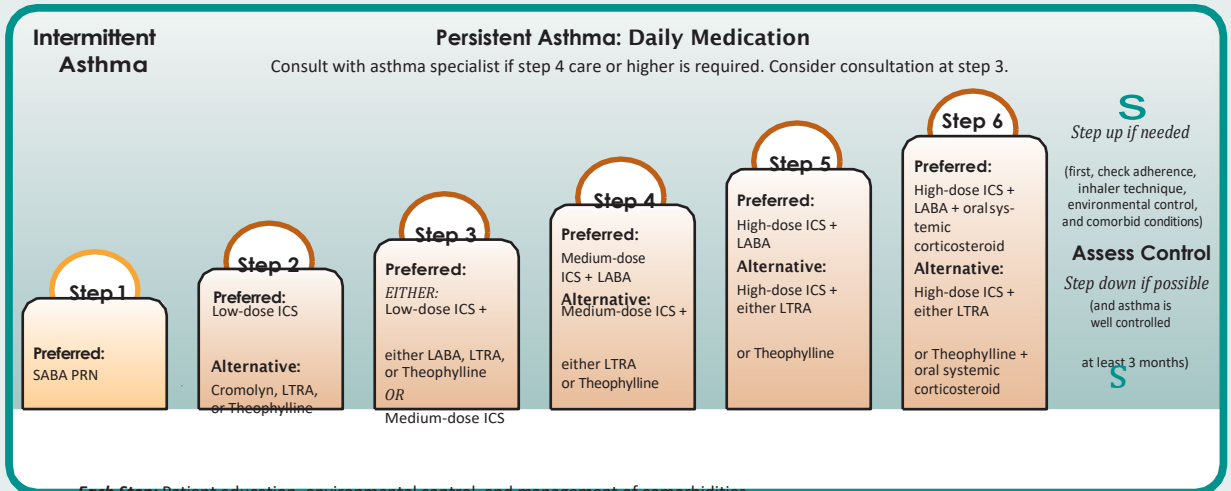
Assessing Asthma Control & Adjusting Therapy in Children 5–11 Years of Age

Components of Control		Classification of Asthma Control: Children 5–11 Years of Age		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤ 2 days/week but not more than once on each day	> 2 days/week or multiple times on ≤ 2 days/week	Throughout the day
	Nighttime awakenings	≤ 1x/month	≥ 2x/month	≥ 2x/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
	Lung Function: <ul style="list-style-type: none"> • FEV₁ or peak flow • FEV₁/FVC 	<ul style="list-style-type: none"> > 80% predicted/personal best > 80% 	<ul style="list-style-type: none"> 60 – 80% predicted/personal best 75 – 80% 	<ul style="list-style-type: none"> 60% predicted/personal best < 75%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	> 2/year (<i>see note</i>)	
	Reduction in lung growth	Evaluation requires long-term follow-up.		
	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 <i>(See "Stepwise Approach for Managing Asthma" for treatment steps.)</i> The stepwise approach is meant to assist, not replace, clinical decision making required to meet individual patient needs.		<ul style="list-style-type: none"> Maintain current step. Regular followup every 1– 6 months. Consider step down if well controlled for at least 3 months. 	<ul style="list-style-type: none"> Step up at least 1 step, and Reevaluate in 2 – 6 weeks. For side effects, consider alternative treatment options. 	<ul style="list-style-type: none"> Consider short course of oral systemic corticosteroids. Step up 1 – 2 steps, and Reevaluate in 2 weeks. For side effects, consider alternative treatment options.
		Before step up in therapy: <ul style="list-style-type: none"> Review adherence to medication, inhaler technique, and environmental control. If alternative treatment was used, discontinue it and use preferred treatment for that step. 		

Notes:

- The level of control is based on the most severe impairment or risk category. Assess impairment domain by patient's/caregiver's recall of previous 2– 4 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 are 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 ICU admission) indicate poorer disease control. For treatment purposes, patients who had 2 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 persistent asthma.

Stepwise Approach for Managing Asthma in Children 5–11 Years of Age



Each Step: Patient education, environmental control, and management of comorbidities.

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

Key: Alphabetical order is used when more than one treatment option is listed within either preferred or alternative therapy. ICS, inhaled corticosteroid; LABA, inhaled long-acting beta₂-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta₂-agonist.

Notes:

- If alternative treatment is used and response is inadequate, discontinue it and use the preferred treatment before stepping up.

Quick-Relief Medication for All Patients

- SABA as needed for symptoms. Intensity of treatment depends on severity of symptoms: up to 3 treatments at 20-minute intervals as needed. Short course of oral systemic corticosteroids may be needed.
- **CAUTION:** Increasing use of SABA or use > 2 days a week for symptom relief (not prevention of EIB) generally indicates inadequate control and the need to step up treatment.

Classifying Asthma Severity & Initiating Treatment in Youths ≥12 Years of Age & Adults

Assessing severity and initiating treatment for patients who are not currently taking long-term control medications

Components of Severity		Classification of Asthma Severity: Youths ≥12 Years of Age & Adults			
		Intermittent	Persistent		
			Mild	Moderate	Severe
Impairment Normal FEV ₁ /FVC: 8-19 yr 85%; 20-39 yr 80%; 40-59 yr 75%; 60-80 yr 70%	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout day
	Nighttime awakenings	≤2x/month	3 – 4x/month	>1x/week but not nightly	Often 7x/week
	Short-acting beta ₂ -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily, and not more than 1x on any day	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	• Norm. FEV ₁ between exacerbations • FEV ₁ > 80% predicted • FEV ₂ /FVC normal	• FEV ₁ ≥80% predicted • FEV ₂ /FVC normal	• FEV ₁ > 60% but < 80% predicted • FEV ₂ /FVC reduced 5%	• FEV ₁ < 60% predicted • FEV ₂ /FVC reduced 5%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/ year (see note)	≥2 in 1 year (see note)		
		Consider severity & interval since last exacerbation. Frequency & severity may fluctuate over time for patients in any severity category. Relative annual risk of exacerbations may be related to FEV ₁ .			
Recommended Step for Initiating Therapy <i>(See Stepwise Charts for Treatment Steps.)</i>		Step 1	Step 2	Step 3	Step 4 or Step 5 and consider short course of oral systemic corticosteroids
In 2 – 6 weeks, evaluate level of asthma control that is achieved and adjust therapy accordingly.					

Notes:

- Level of severity is determined by assessment of both impairment and risk. Assess impairment domain by patient's/caregiver's recall of previous 2–4 weeks and spirometry. Assign severity to the most severe category in which any feature occurs.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients who had >2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

Classifying severity in patients after asthma becomes well controlled, by lowest level of treatment required to maintain control*

Lowest level of treatment required to maintain control <i>(See Stepwise Charts for Treatment Steps.)</i>	Classification of Asthma Severity			
	Intermittent	Persistent		
		Mild	Moderate	Severe
	Step 1	Step 2	Step 3 or 4	Step 5 or 6

Key: FEV₁, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit.

*Notes:

- For population-based evaluations, clinical research, or characterization of a patient's overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control, not the level of severity, once treatment is established.

Assessing Asthma Control & Adjusting Therapy in Youths ≥12 Years of Age & Adults

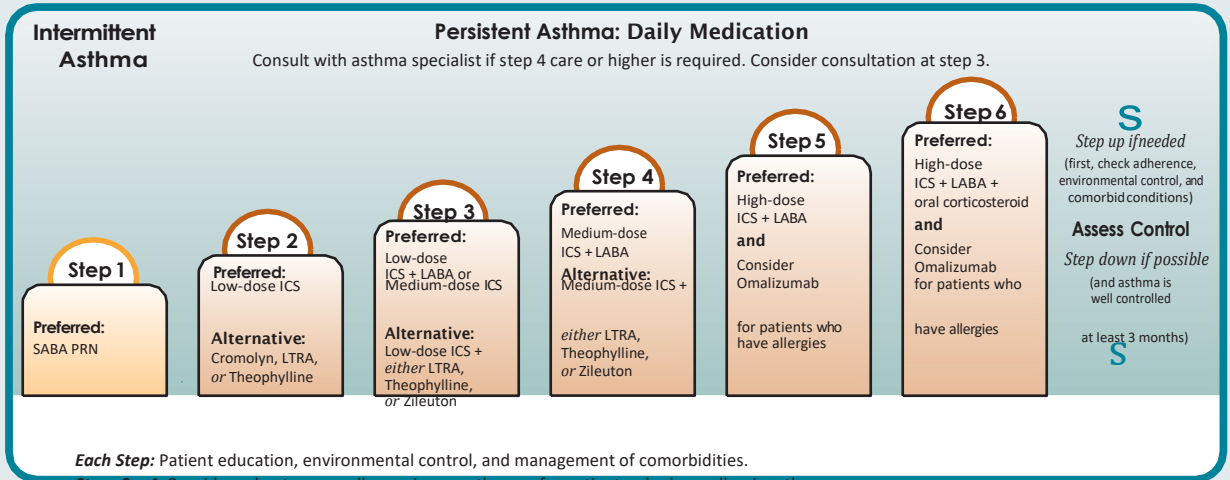
Components of Control		Classification of Asthma Control: Youths ≥12 Years of Age & Adults		
		Well Controlled	Not Well Controlled	Very Poorly Controlled
Impairment	Symptoms	≤2 days/week	> 2 days/week	Throughout the day
	Nighttime awakenings	≤2x/month	1–3x/week	≥4x/week
	Interference with normal activity	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
	Lung Function: FEV ₁ or peak flow	>80% predicted/personal best	60 - 80% predicted/personal best	<60% predicted/personal best
	Validated Questionnaires ATAQ ACQ ACT	0 ≤ 0.75* ≥ 20	1-2 ≥1.5 16–19	3–4 N/A ≤15
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year	≥2/year (see note)	
	Progressive loss of lung function	Consider severity and interval since last exacerbation. Evaluation requires long-term follow-up care.		
	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 <i>(See "Stepwise Approach for Managing Asthma" for treatment steps.)</i> The stepwise approach is meant to assist, not replace, clinical decision making required to meet individual patient needs.		<ul style="list-style-type: none"> Maintain current step. Regular follow-ups every 1–6 months to maintain control. Consider step down if well controlled for at least 3 months. 	<ul style="list-style-type: none"> Step up 1 step, and Reevaluate in 2–6 weeks. For side effects, consider alternative treatment options. 	<ul style="list-style-type: none"> Consider short course of oral systemic corticosteroids. Step up 1–2 steps, and Reevaluate in 2 weeks. For side effects, consider alternative treatment options.
		Before step up in therapy: <ul style="list-style-type: none"> Review adherence to medication, inhaler technique, environmental control, and comorbid conditions. If an alternative treatment option was used in a step, discontinue and use the preferred treatment for that step. 		

*ACQ values of .76 – 1.4 are indeterminate regarding well-controlled asthma.

Notes:

- The level of control is based on the most severe impairment or risk category. Assess impairment domain by patient's recall of previous 2–4 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 are 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 ICU admission) indicate poorer disease control. For treatment purposes, patients who had ≥2 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.
- ATAQ = Asthma Therapy Assessment Questionnaire®, ACQ = Asthma Control Questionnaire®, ACT = Asthma Control Test™, Minimal Important Difference: 1.0 for the ATAQ; 0.5 for the ACQ; not determined for the ACT.

Stepwise Approach for Managing Asthma in Youths ≥12 Years of Age & Adults



Key: Alphabetical order is used when more than one treatment option is listed within either preferred or alternative therapy. ICS, inhaled corticosteroid; LABA, inhaled long-acting beta₂-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta₂-agonist.

Notes:

- If alternative treatment is used and response is inadequate, discontinue it and use the preferred treatment before stepping up.

Quick-Relief Medication for All Patients

- SABA as needed for symptoms. Intensity of treatment depends on severity of symptoms: up to 3 treatments at 20-minute intervals as needed. Short course of oral systemic corticosteroids may be needed.
- **CAUTION:** Increasing use of SABA or use > 2 days a week for symptom relief (not prevention of EIB) generally indicates **inadequate control and the need to step up treatment.**

Long-Term Control Medications

Estimated Comparative Daily Doses for Inhaled Corticosteroids

Medication		Low Daily Dose		Medium Daily Dose		High Daily Dose			
Beclomethasone HFA 40 or 80 mcg/puff	NA	80 – 160 mcg	80 – 240 mcg	NA	>160 – 320 mcg	>240 – 480 mcg	NA	>320 mcg	>480 mcg
Budesonide DPI 90, 180, or 200 mcg/inhalation	NA	180 – 400 mcg	180 – 600 mcg	NA	>400 – 800 mcg	>600 – 1,200 mcg	NA	>800 mcg	1,200 mcg
Ciclesonide MDI 80 or 160 mcg/puff	NA	80–160 mcg	160–320 mcg	NA	>160–320 mcg	>320–640 mcg	NA	>320 mcg	>640 mcg
Fluticasone Furoate 100 or 200 mcg/actuation	NA	NA	100 mcg	NA	NA	200 mcg	NA	NA	>200 mcg
Fluticasone Propionate HFA/MDI 44, 110, or 220 mcg/puff	176 mcg	88 – 176 mcg	88 – 264 mcg	>176 – 352 mcg	>176 – 352 mcg	>264 – 440 mcg	>352 mcg	>352 mcg	>440 mcg
Fluticasone Propionate DPI 50, 100, or 250 mcg/inhalation	NA	100 – 200 mcg	100 – 300 mcg	NA	>200 – 400 mcg	>300 – 500 mcg	NA	>400 mcg	>500 mcg
Mometasone DPI# 110 or 220 mcg/inhalation	NA	110 mcg#	220 mcg	NA	110 mcg#	440 mcg	NA	110 mcg#	880 mcg

Key: DPI, dry powder inhaler; HFA, hydrofluoroalkane; MDI, metered-dose inhaler; NA, not available (either not approved, no data available, or safety and efficacy not established for this age group).

For children 4 to 11 years of age: Mometasone starting dose and maximum dose are the same, 110 mcg/day. See: www.asmanex.com.

Therapeutic Issues:

- The most important determinant of appropriate dosing is the clinician's judgment of the patient's response to therapy. The clinician must monitor the patient's response on several clinical parameters and adjust the dose accordingly. Once control of asthma is achieved, the dose should be carefully titrated to the minimum dose required to maintain control.
- Preparations are not interchangeable on a mcg or per puff basis. This figure presents estimated comparable daily doses. See *EPR-3 Full Report 2007 for full discussion*.
- Some doses may be outside package labeling, especially in the

- high-dose range. Budesonide nebulizer suspension is the only inhaled corticosteroid (ICS) with FDA-approved labeling for children <4 years of age.
- For children <4 years of age: The safety and efficacy of ICSs in children <1 year has not been established. Children <4 years of age generally require delivery of ICS (budesonide and fluticasone HFA) through a face mask that should fit snugly over nose and mouth and avoid nebulizing in the eyes. Wash face after each treatment to prevent local corticosteroid side effects. For budesonide, the dose may be administered 1– 3 times daily. Budesonide suspension is compatible with albuterol, ipratropium,

- and levalbuterol nebulizer solutions in the same nebulizer. Use only jet nebulizers, as ultrasonic nebulizers are ineffective for suspensions. For fluticasone HFA, the dose should be divided 2 times daily; the low dose for children <4 years of age is higher than for children 5–11 years of age due to lower dose delivered with face mask and data on efficacy in young children.
- Children ≤12 years of age (please refer to package insert for age appropriateness, drug interactions and potential adverse effects). Above list not all inclusive. Check for availability and health plan/insurance formulary when applicable. Use of spacer/holding chamber is recommended with use of metered-dose inhaler (MDI).

Long-Term Control Medications

Usual Doses for Long-Term Control Medications*

		Dosage		
Medication		0–4 Years of Age	5–11 Years of Age	≥12 Years of Age & Adults
Inhaled Corticosteroids				
<i>See the above chart titled "Estimated Comparative Daily Dosages for Inhaled Corticosteroids."</i>				
Oral Systemic Corticosteroids	Methylprednisolone 2, 4, 8, 16, 32 mg tablets	0.25 – 2 mg/kg daily in single dose in a.m. or qod as needed for control Short-course "burst": 1–2 mg/kg/day, maximum 60 mg/day for 3–10 days	0.25 – 2 mg/kg daily in single dose in a.m. or qod as needed for control Short-course "burst": 1–2 mg/kg/day, maximum 60 mg/day for 3–10 days	7.5 – 60 mg daily in a single dose in a.m. or qod as needed for control Short-course "burst": to achieve control, 40–60 mg/day as single or two divided doses for 3–10 days
	Prednisolone 5 mg tablets; 5 mg/5 cc; 15 mg/5 cc			
	Prednisone 1, 2.5, 5, 10, 20, 50 mg tablets; 5 mg/cc; 5 mg/5 cc			
Inhaled Long-Acting Beta₂-Agonists (LABAs)	Salmeterol DPI: 50 mcg/ blister	NA	1 blister, q 12 hours Dose may be used for 4 years of age and older.	1 blister, q 12 hours
	Combined Medication	Formoterol DPI: 12 mcg/single-use capsule	NA	1 capsule, q 12 hours
Fluticasone/Salmeterol** DPI: 100 mcg/50 mcg, 250 mcg/50 mcg, or 500 mcg/50 mcg; HFA: 45 mcg/21 mcg, 115 mcg/21 mcg, 230 mcg/21 mcg		DPI Diskus for ≥ 4 years of age	DPI only 1 inhalation bid, dose depends on level of severity or control	DPI or HFA 1 inhalation bid, dose depends on level of severity or control
Fluticasone/Vilanterol DPI 100–25 mcg/inhalation or 200–25 mcg/inhalation		NA	NA	1 inhalation daily This is indicated only for those 18 years of age and older.
Budesonide/Formoterol HFA MDI: 80 mcg/4.5 mcg, 160 mcg/4.5 mcg		NA	2 puffs bid, dose depends on level of severity or control	2 puffs bid, dose depends on level of severity or control
Mometasone/Formoterol*** MDI: 100 mcg/5 mcg, 200 mcg/5 mcg		NA	NA	2 inhalations bid, dose depends on prior asthma therapy and asthma control
Cromolyn	Nebulizer 20 mg/ampule	1 ampule qid (NA <2 years of age)	1 ampule qid	1 ampule qid
Immunomodulators	Mepolizumab Subcutaneous injection, 10.0 mg/vial following reconstitution with 1.2 ml sterile water for injection	NA	NA	100 mg/1 ml SC q 4 weeks, for 12 years of age and older with eosinophilic phenotype
	Omalizumab (Anti IgE) Subcutaneous injection, 150mg/1.2 ml following reconstitution with 1.4 ml sterile water for injection	NA	75 to 375 mg SC q 2–4 weeks, depending on body weight and pretreatment serum IgE level	150–375 mg SC q 2–4 weeks, depending on body weight and pretreatment serum IgE level
	Reslizumab 100 mg/10 ml solution for intravenous infusion	NA	This is indicated for children 6 years of age and older. NA	3 mg/kg once every 4 weeks by intravenous infusion over 20–50 minutes
Leukotriene Modifiers	Montelukast 4 mg or 5 mg chewable tablet 4 mg granule packets 10 mg tablet	4 mg qhs (1–5 years of age)	5 mg qhs (6–14 years of age)	10 mg qhs
	Leukotriene Receptor Antagonists (LTRAs)	Zafirlukast 10 mg tablet, 20 mg tablet	NA	10 mg bid (7–11 years of age)
5-Lipoxygenase Inhibitor	Zileuton 600 mg	NA	NA	2,400 mg daily (give tablets qid)
	Zileuton CR 600 mg tablet extended-release tablet	NA	NA	2,400 mg daily (give two extended-release tablets bid)
Methylxanthines	Theophylline Liquids, sustained-release tablets, and capsules Monitor serum concentration levels	Starting dose 10 mg/kg/day; usual maximum: • < 1 year of age: 0.2 (age in weeks) + 5 = mg/kg/day • > 1 year of age: 16 mg/kg/day	Starting dose 10 mg/kg/day; usual maximum: 16 mg/kg/day	Starting dose 10 mg/kg/day up to 300 mg maximum; usual maximum 900 mg/day
Long-Acting Muscarinic Antagonists	Tiotropium Bromide 1.25 mcg per actuation	NA	2 inhalations qd This is indicated for children 6 years of age and older.	2 inhalations qd

Key: DPI, dry powder inhaler; EIB, exercise-induced bronchospasm; HFA, hydrofluoroalkane; ICS, inhaled corticosteroids; IgE, immunoglobulin E; MDI, metered-dose inhaler; NA, not available (either not approved, no data available, or safety and efficacy not established for this age group); SABA, short-acting beta₂-agonist.

** See www.advair.com

*** See www.dulera.com

*NOTE: Dosages are provided for those products that have been approved by the U.S. Food and Drug Administration or have sufficient clinical trial safety and efficacy data in the appropriate age ranges to support their use. For advisories and other relevant information see www.fda.gov/medwatch.

Above list not all inclusive. Check for availability and health plan/insurance formulary when applicable. Use of spacer/holding chamber is recommended with use of metered-dose inhaler (MDI).

Quick-Relief Medications

Usual Doses for Quick-Relief Medications*

For quick-relief medications for asthma exacerbations, other than Albuterol, see NAEPP EPR-3 Summary Report 2007, NIH Publication number 08-5846, pages 53-60. (www.nhlbi.nih.gov/guidelines/asthma/asthsumm.pdf, page 53)

Medication	Dosage		
Inhaled Short-Acting Beta₂-Agonists			
Albuterol HFA MDI 90 mcg/puff; 60 puffs/canister or 200 puffs/canister	2 puffs every 4 – 6 hours, as needed for symptoms; 1– 2 puffs 5 minutes before exercise	2 puffs every 4 – 6 hours, as needed for symptoms; 2 puffs 5 minutes before exercise	2 puffs every 4 – 6 hours, as needed for symptoms; 2 puffs 5 minutes before exercise
Albuterol Nebulizer Solution 0.63 mg/3 mL, 1.25 mg/3 mL, 2.5 mg/3 mL, 5 mg/mL (0.5%)	0.63 – 2.5 mg in 3 cc of saline q 4 – 6 hours, as needed	1.25 – 5 mg in 3 cc of saline q 4 – 8 hours, as needed	1.25 – 5 mg in 3 cc of saline q 4 – 8 hours, as needed
Albuterol Sulfate Inhalation Powder 108 mcg/actuation; 200 actuations/canister	NA	NA	2 inhalations q 4 – 6 hours, as needed for symptoms; 2 inhalations 15–30 minutes before exercise
Levalbuterol HFA 45 mcg/puff; 200 puffs/canister	NA < 4 years of age	2 puffs every 4 – 6 hours, as needed for symptoms; 2 puffs 5 minutes before exercise	2 puffs every 4 – 6 hours, as needed for symptoms; 2 puffs 5 minutes before exercise
Levalbuterol (R-albuterol) Nebulizer Solution 0.31 mg/3 mL, 0.63 mg/3 mL, 1.25 mg/0.5 mL, 1.25 mg/3 mL	0.31– 1.25 mg in 3 cc, q 4 – 6 hours, as needed for symptoms	0.31– 0.63 mg, q 8 hours, as needed for symptoms	0.63 – 1.25 mg, q 8 hours, as needed for symptoms
For Asthma Exacerbations	Children ≤ 12 years of age		> 12 Years of Age & Adults
Albuterol MDI 90 mcg/puff	4 – 8 puffs every 20 minutes for 3 doses, then every 1– 4 hours inhalation maneuver as needed. Use VHC; add mask in children < 4 years.		4 – 8 puffs every 20 minutes up to 4 hours, then every 1– 4 hours as needed.
Albuterol Nebulizer solution 0.63 mg/3 mL, 1.25 mg/3 mL, 2.5 mg/3 mL, 5 mg/mL (0.5%)	0.15 mg/kg (minimum dose 2.5 mg) every 20 minutes for 3 doses then 0.15 – 0.3 mg/kg up to 10 mg every 1– 4 hours as needed, or 0.5 mg/kg/hour by continuous nebulization.		2.5 – 5 mg every 20 minutes for 3 doses, then 2.5 – 10 mg every 1– 4 hours as needed, or 10 – 15 mg/hour continuously.
Anticholinergics			
Systemic Corticosteroids			

Key: CFC, chlorofluorocarbon; ED, emergency department; EIB, exercise-induced bronchospasm; HFA, hydrofluoroalkane; IM, intramuscular; MDI, metered-dose inhaler; NA, not available (either not approved, no data available, or safety and efficacy not established for this age group); PEF, peak expiratory flow; SABA, short-acting beta₂-agonist; VHC, valved holding chamber.

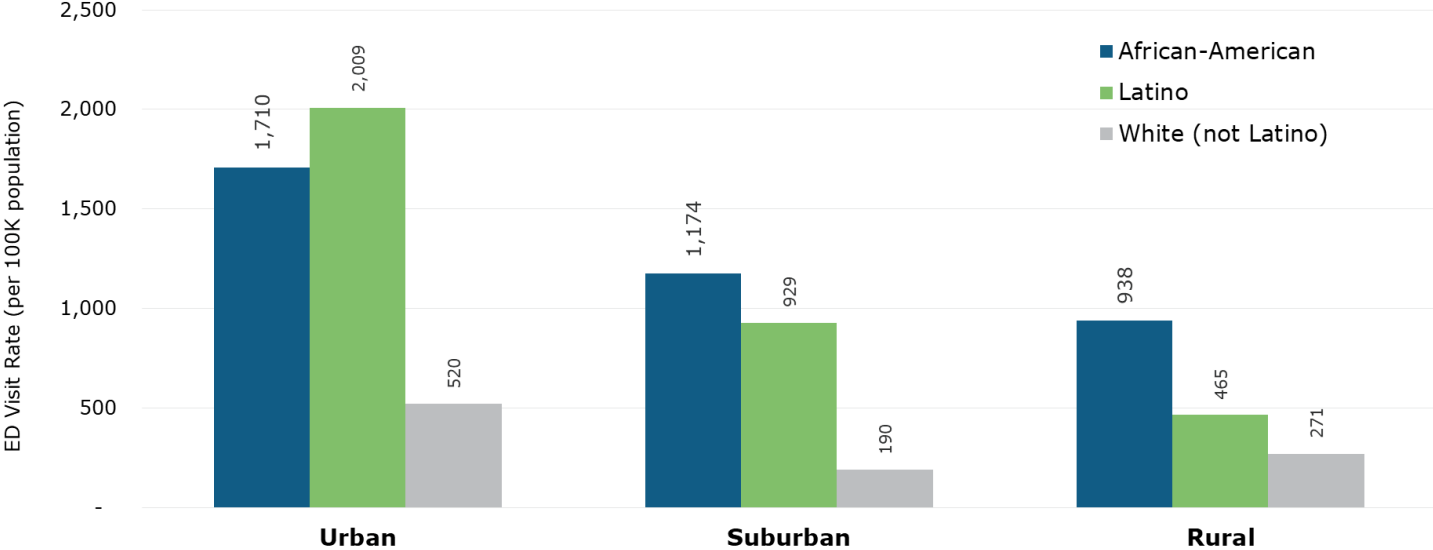
***NOTE:**

***NOTE:** Dosages are provided for those products that have been approved by the U.S. Food and Drug Administration or have sufficient clinical trial safety and efficacy data in the appropriate age ranges to support their use. For advisories and other relevant information see www.fda.gov/medwatch.

Above list not all inclusive. Check for availability and health plan/insurance formulary when applicable. Use of spacer/holding chamber is recommended with use of metered-dose inhaler (MDI).

The Common Ground Health Report *Barriers to Health Equity: Place-based Disparities in Clinical Care* reports data that shows the types of care utilized by the asthma population. The graphs below show large disparity gaps in ED visits for African Americans and Latinos compared to the white (non-Latino) population.

Asthma-driven ED visit rate by race/ethnicity and geography (2014-2016)

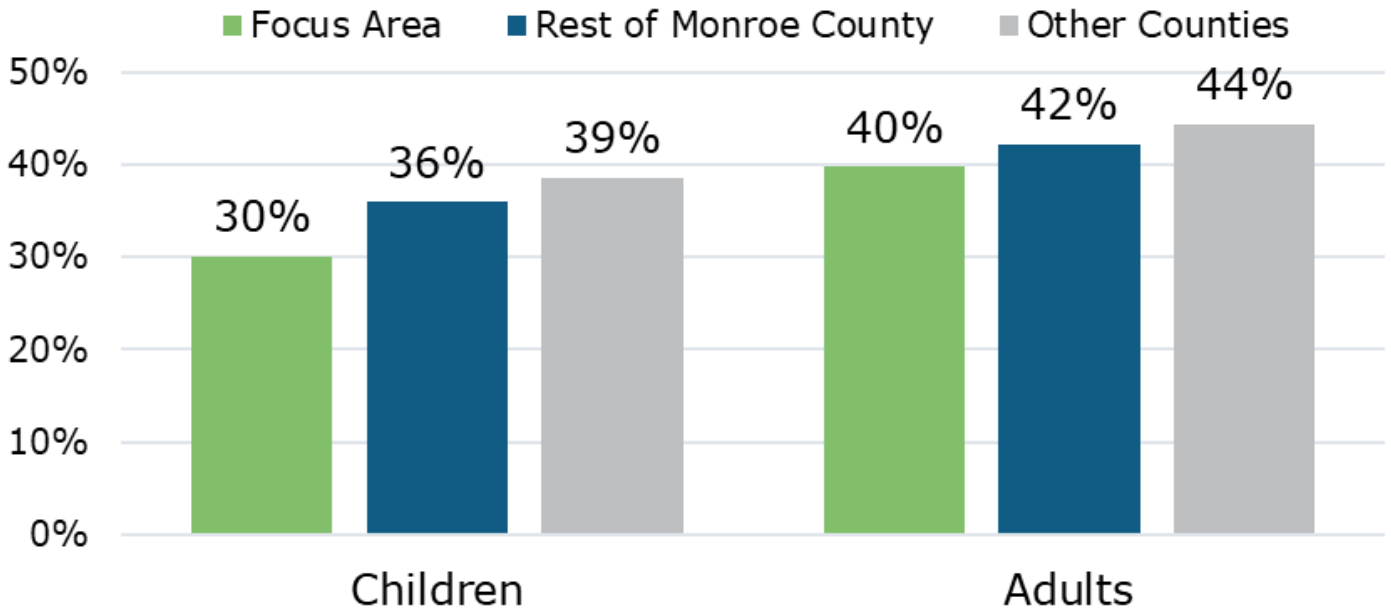


Source: NYSDOH SPARCS for nine county Finger Lakes region; Age-Sex adjusted analysis by Common Ground Health



The rate of ED visits due to asthma are significantly higher for African American and Latino populations regardless of location.

% of asthma patients with oral corticosteroid claim

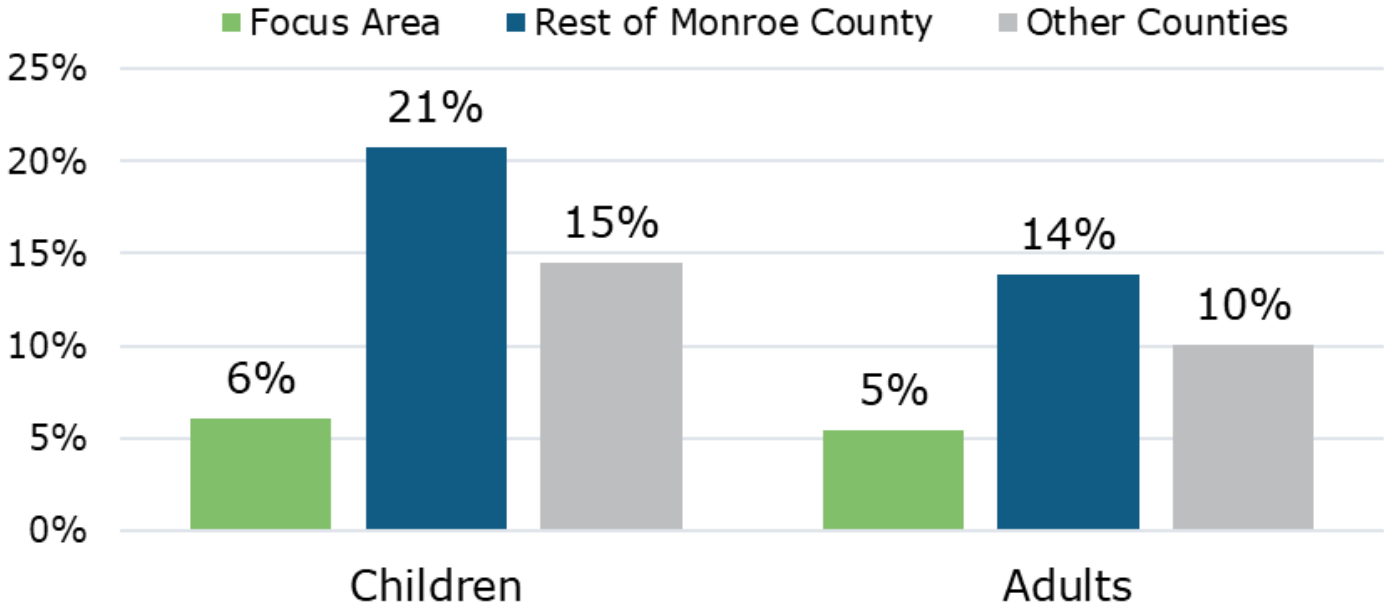


All location-based differences are statistically significant ($p < 0.01$)
Source: Common Ground Health Analysis of claims for asthma patients from 2014-2015



Disparities exist in rate of rescue inhaler usage, with patients diagnosed with asthma who live in low-income zip codes of the City of Rochester accessing ICS medication less than their peers in the rest of Monroe County and in other areas of the Finger Lakes region. One potential explanation could be life circumstances that require patients with asthmatic living in poverty to choose between accessing their medications and paying for rent, food, transportation to their jobs or other essential living expenses.

% of asthma patients with allergist/immunologist Visit

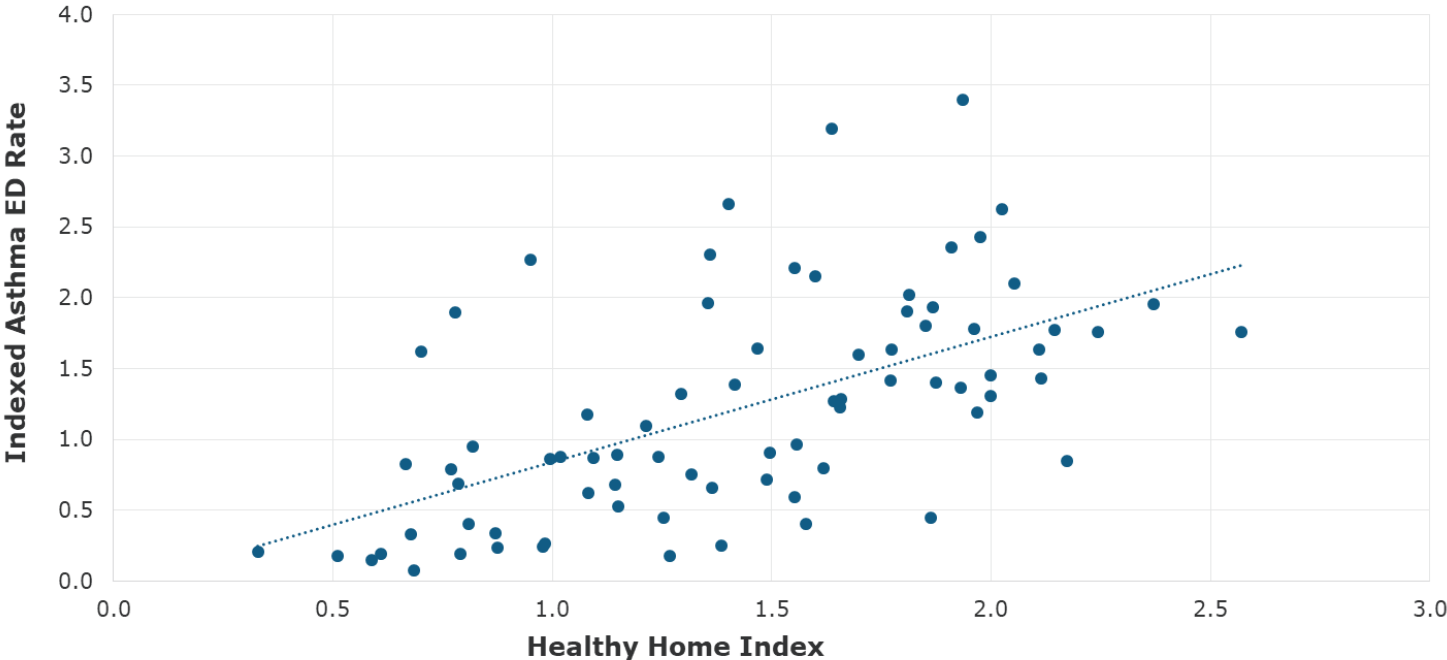


All location-based differences are statistically significant ($p < 0.01$)
Source: Common Ground Health Analysis of claims for asthma patients from 2014-2015



The prevalence of immunotherapy treatment is approximately 3.5 times lower for patients with asthma living in poverty than those in more affluent areas of Monroe County or other counties.

Asthma ED visit rate vs. Healthy Home Index by tract



Source (Healthy Home Index): City of Rochester Certificate of Occupancy records
Source (ED visit rate): NYSDOH SPARCS
Analysis by Common Ground Health



The above chart shows the correlation between housing quality and asthma ED visit rate. Each dot represents a census tract within Rochester. The trend shows, the tracts with higher (worse) Healthy Home Index scores also tend to have higher rates of ED visits due to asthma.

Management of Asthma in Children and Adults

Physician Resources

[American Lung Association](#)

Provides information including strategies for addressing asthma, educational materials, the Asthma Educator Institute and guides to asthma policies for home and school.

New York State Department of Health

Provides educational information for physicians to use in partnership with patients.

- An educational and communication tool to be used by physicians and their patients and families, designed to help families become proactive and anticipatory with respect to asthma exacerbations and their control.
 - Asthma Action Plan (in [English](#) and [Spanish](#))
- Tools for physicians and patients to use together to improve their partnership in managing asthma.
 - [Managing Asthma](#)
 - [Environmental Asthma Triggers](#)
 - [Peak Flow Meters and Logs](#)
- [Asthma Program Publication Request Form](#) – Publications available free of charge to New York organizations. Print and mail to address on form. (Some publications available for download only.)
- [https://www.commongroundhealth.org/Media/Default/Publications/Barriers%20to%20health%20equity%2010-4-2017%20\(002\)-20171004031159.pdf](https://www.commongroundhealth.org/Media/Default/Publications/Barriers%20to%20health%20equity%2010-4-2017%20(002)-20171004031159.pdf).

[United States Environmental Protection Agency](#)

Provides multimedia resources for use with patients to understand and manage environmental asthma triggers.

Patient Resources

[American Lung Association](#)

Offers online support and information about understanding and controlling asthma and creating asthma-friendly environments at home, the workplace and in schools.

- [Better Breathers Clubs](#) (in Canandaigua, Henrietta, Rochester and Webster)

[Center for Disease Control – National Asthma Control Program](#)

Helps patients with asthma achieve better health and improved quality of life.

[Kids Thrive 585](#)

A child-focused Rochester-area organization that provides resources and child-friendly web and printable material on asthma.

[NYS Healthy Neighborhoods Program](#)

Monroe County Department of Health provides in-home assessments and interventions to address asthma, tobacco cessation, indoor air quality, lead, fire safety, and other environmental health hazards in high-risk communities throughout the county. Eligible residents must reside in the following zip codes: 14605, 14608, 14609, 14611, and 14621. During an in-person visit, an outreach worker provides education, referrals and free products to help residents correct housing hazards. Call (585) 753-5073 to schedule an assessment.

New York State Department of Health

Provides educational information for families.

- Asthma Triggers at Home and in the Workplace
 - Have Asthma? Take A Look Around You (in [English](#) and [Spanish](#))
 - Asthma Trigger Tracker and Key Questions (in [English](#) and [Spanish](#))
 - [Is Your Asthma Work-Related?](#)
- Don't Let Asthma Knock the Wind Out of Your Child!
 - Brochure (in [English](#), [Spanish](#), [Creole](#) and [Chinese](#))

[United States Environmental Protection Agency](#)

Provides tools for parents, caregivers and children to understand and manage environmental asthma triggers.

Guidelines are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs.

Approved August 2020. Next scheduled review by August 2022.

Management of Asthma in Children and Adults

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