Appendix 6: Michigan Child Cohort 2-Week Follow-up Form

FU Form Cohort Child/Version: 8/02/01

Interviewer's initials __ __ __

Pt. initials __ __ __ PtInit

Patient Study Number __ - __ __ __ PSN

IntVwr

LAST VISIT REVIEW

Emergency Department (check one) o 1. GERBER o 2. BLODGETT o 3. BUTTERWORTH ED

ED Visit Date (mm/dd) ..... |__|__|/|__|__| Eddate

ED Triage time (hh: mm) ..... |__|__|:|__|__| EDICtime

ED disposition:

Sent home .....01 ⇒ **SKIP TO 5**
Observation.....02
Admt reg 03
Admt ICU 04
Ama/lwt .....05 ⇒ **SKIP TO 5**
Other (Specify: _____) .....06 ⇒ **SKIP TO 5**

EDDispo6, EDDispo

Date of hospital discharge? (mm/dd) ..... |__|__|/|__|__| Discharg

Subsequent relapse ED visit? o 0. No o 1. Yes (specify date (mm/dd)|__|__|/|__|__| Relapse1, Relapse

Discharged on oral steroids? o 2. No o 1. Yes (specify Rx regimen: DisOral1, DisOral

CALLING LOG

Date ATCDate+1-8	Time ATCTime+1-8	Caller initials Caller+1-8	Comment ATCComm+1-8 (ATCDate+1-8, Caller+1-8, ATCComm+1-8)
__ __/__ __	__ __:__ __	__ __ __	
__ __/__ __	__ __:__ __	__ __ __	
__ __/__ __	__ __:__ __	__ __ __	
__ __/__ __	__ __:__ __	__ __ __	
__ __/__ __	__ __:__ __	__ __ __	
__ __/__ __	__ __:__ __	__ __ __	
__ __/__ __	__ __:__ __	__ __ __	
__ __/__ __	__ __:__ __	__ __ __	

INTERVIEW STATUS

o 1. Agreed to participate	o 2. refused f/u interview	o 3. unreachable x 8 (over at least 10 days)	o 4. Other (specify) Int2Sta4 Int2Sta

CALLING SCRIPT

Phone I: _____

Phone II: _____

Hello. May I speak with _____ ? My name is ____ and I work for the MSU/Grand Rapids Asthma Project.

On _____ (date) you took _____ [*child*] to the _____ (hospital) emergency dept for an asthma attack.

I 'm calling to learn how [*child*] is doing. Is this a good time to talk for 5 minutes?

NO: When would be a better time to contact you? _____

YES: Great. Please remember that all of your answers will be kept confidential, and will be used for asthma research only.

1. Date Interview Completed? (mm/dd) |__|__|/|__|__| DateIC

2. Who was interviewed? o 1. Mother o 2. Father o 3. Grandparent o 4. Other (specify: WhoInter4, WhoInter

2a. Name _____

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SECTION A: EMERGENCY ASTHMA VISITS

FIRST CONFIRM REGULAR ASTHMA CARE PROVIDER (RACP) INFORMATION:

When we completed the survey during the child's visit to the emergency department on __/__, we noted that the doctor/provider/clinic that takes primary responsibility for you child's asthma - that is, directs your child's care and writes most of your prescriptions was:

(name)_____ RACP

Type of health care provider:

PCP/CLINIC 01
SPECIALIST 02
ED 03
MEDCENTER 04
OTHER 05
NONE .....06 RACPType

1. Is this correct?

No (Specify who is: _____ ...01 RACPTrue
Yes .....02 RACPTrue

2. Since [*child*] left the hospital emergency department on |__|__| / |__|__| / |__|__|, has he/she had a worsening of his/her asthma that led you to take him/her for *urgent* medical treatment?

No .....01 ⇒ **SKIP TO 8**
Yes .....02 UV

3. How many times has this happened since you left the emergency department?

(times) ..... |___|___| UVCnt

4. Thinking about the first time this happened. When did you take [*child*] for urgent medical treatment for his/her asthma?

(mm/dd) ..... |___|___| / |___|___| UVDate

5. Where did you first take [*child*] for this urgent asthma visit?

Regular asthma care provider (as defined above) .....01 ⇒ **SKIP TO 6**
Hospital ED (specify: _____ 02 UVWhen2
Med care center (specify: _____ 03 UVWhen3
An asthma specialist: pulmonologist 04
An asthma specialist: allergist 05
An asthma specialist: asthma clinic 06
Other provider/site (specify: _____ ...07 UVWhen7
No specific location/provider .....08 UVWhen

5a. Why did you use this particular place for asthma care?
(CHECK ALL THAT APPLY)

No regular asthma care provider 01
Regular asthma care provider not available 02
Insurance company dictates 03
No insurance 04
Other cost issues (specify: _____ 05 UVPlace5
Transport issues (specify: _____ 06 UVPLace6
Convenience 07
Best medical care 08
Past experience/comfort with people/place 09
Other (specify: _____ 10 UVPlace10
Severity of episode – EMERGENCY! ....11 UVPlace

6. At this visit did the doctor change [*child*]'s asthma medicines or make any other changes in the management of his/her asthma? (PROMPT – FOR EXAMPLE, GIVE YOU A NEW MEDICATION, OR CHANGE THE WAY YOU USE YOUR EXISITING MEDICATIONS, OR CHANGE THE WAY YOU MONITOR OR MANAGE YOUR ASTHMA)

No asthma treatment given (including no inhaled ß-agonist) 01
Given inhaled ß-agonist treatment but no new asthma Rx 02
Change in treatment plan (specify below) 03

.... ChngRx

Details_____

_____

_____ ChnRxTxt

7. Did this visit result in child being transferred to an emergency department or hospital?

No 01 Trans2
Yes (Specify ED: _____ ..02 Trans

If Yes, 7a. Was [*child*] then admitted to the hospital overnight?

No 01
Yes (Specify hospital: _____ ....02 TransNit

IF Q3 = MORE THAN ONE "RELAPSE" VISIT — REPEAT QUESTIONS FOR SECOND VISIT SINCE PATIENT LEFT HOSPITAL. AT END OF THIS SECTION CONFIRM SINCE PATIENT FIRST LEFT EMERGENCY DEPARTMENT:

Total (cumulative) number of ED/Urgent Care visits .... |___|___| EDUCCnt

Total (cumulative) number of overnight hospitalizations .... |___|___| NightCnt

SECTION B: ROUTINE ASTHMA VISITS

8. Since [*child*] left the hospital emergency department on ___/__ have you made a follow-up appointment with the child's regular asthma care provider *(RACP)* for an asthma check up?

No.....01 ⇒ **SKIP TO 9**
Yes .....02 RACPApt

8a. When did [*child*] first see this doctor/nurse/clinic *(RACP)* for an asthma check-up?

(mm/dd)..... |___|___| / |___|___| ChkDate
or number of days after ED visit (days).....|___|___|___| ChkDays

8b. How many asthma check-ups has child had with this doctor/nurse/clinic (*RACP*) since he/she left the emergency department?

(number of checkups)..... |___|___| ChkCnt

8c. As a result of this visit (these visits), did the doctor change [*child*]'s asthma medicines or make any other changes in the management of his/her asthma? (PROMPT – NEW MEDS?, OR CHANGE EXISITING MEDS?, OR CHANGE IN MANAGEMENT OF ASTHMA?)

No.....01
Yes .....02 NewRx

Describe: _____

_____

_____ NewRxTxt

9. Has child had any other doctor visits specifically related to his/her asthma care and treatment since leaving the emergency department? (i.e., NOT WITH RACP, e.g., ASTHMA SPECIALISTS)

No.....01 ⇒ **SKIP TO 10**
Yes .....02 ODV

9a. When did [*child*] first see ANOTHER doctor/nurse/clinic (*NOT RACP)* for an asthma related visit?

(mm/dd)..... |___|___| / |___|___| ODVDate
or number of days after ED visit (days).....|___|___|___| ODVDays

9b. How many asthma related visits has child had with ANOTHER doctor/nurse/clinic (*NOT RACP*) since he/she left the emergency department?

(number of visits)..... |___|___| ARVCnt

9c. Where did the visit take place and who was it with? (CHECK MORE THAN ONE RESPONSE IF VISITS TO MORE THAN ONE SPECIALIST)

Asthma specialist (specify type: _____...01 ARVLoc1

Specialty Asthma Clinic.....02

Other primary care type doctor/clinic 03

Other (specify: _____..04 ARVLoc2 ARVLoc

Name & location _____ ARVLocNL

9d. What was the primary purpose of this(these) visit(s)?

(Describe: _____

_____ ARVWhy

9e. As a result of this(these) visit(s), did the doctor change [*child*]'s asthma medicines or make any other changes in the management of his/her asthma? (PROMPT – NEW MEDS?, OR CHANGE EXISITING MEDS?, OR CHANGE IN MANAGEMENT OF ASTHMA?)

No.....01

Yes .....02 ARVNewRx

Describe: _____

_____ ARVNTxt

10. Has child had any other doctor visits for health problems not related to asthma since he/she left the hospital? (# visits)..... |___|___| NonARV

If Yes, 10a. What was visit for? _____ NonARVTx

C. ORAL STEROIDS TREATMENT AND COMPLIANCE

[SEE FRONT PAGE OF THIS FORM — *ONLY* ASK QUESTION 11 IF PATIENT SENT HOME FROM ED ON SHORT-TERM ORAL STEROID REGIMEN]:

ORAL steroid:
When [*child*] left the emergency department, you were [or the person with (*child*)] was advised to give [*child*] an oral steroid medicine called _____ for ___ days.

11. How many days did [*child*] actually take this medicine? (days)..... |___|___| OralDays

11a. Was this fewer days than originally prescribed?

No.....01 ⇒ **SKIP TO 12**

Yes .....02 ODV

11b. Please think about why [*child*] did not take the _____ as prescribed. As I read you the following list, please let me know every reason that applies to you or your child. (CIRCLE ALL THAT APPLY):

[*child*] felt better and I didn't feel it was necessary.....01
[*child*] experienced side effects. [real or imagined].....02
I was scared about possible side effects.....03
The treatment plan was too complicated.....04
I had no money to fill prescription.....05
I lost the prescription.....06
[*child*] refused to take medicine.....07
Doctor changed treatment.....08
Other (Specify: _____).....09 OralNor9 OralNot

IF MULTIPLE RESPONSES ASK 11C. ELSE GO TO 12:

11c. Which was the most important reason that [*child*] did not take the _____ as prescribed? (Q11b code ##)..... |___|___| OralNotB

D. CURRENT SYMPTOMS, CONTROL AND QUALITY OF LIFE

12. How often in the last 2 weeks has your child had asthma symptoms during the day? (i.e., wheezing, a dry cough, shortness of breath, and/or chest tightness)

Never.....01
Less than once a week.....02
1 or 2 times a week.....03
3 to 6 times a week.....04
Every day.....05
Continually (all the time).....06 SympDay

13. How many times over the last 2 weeks did your child wake up at night because of asthma symptoms? (i.e., wheezing, a dry cough, shortness of breath, and/or chest tightness)

Never.....01
1 or 2 times.....02
3 to 4 times.....03
5 to 9 times.....04
10 or more times.....05 SympNit

14. How many times over the last 2 weeks has your child's activities been affected or restricted by his/her asthma symptoms?

Never.....01
1 or 2 times.....02
3 to 4 times.....03
5 or more times.....04
All the time.....05 Restrict

15. Over the past 2 weeks has your child's asthma symptoms been severe enough to limit your child's speech to only 1 or 2 words at a time between breaths?

No.....01 ⇒ **SKIP TO 16**
Yes.....02 Speech

15a. How many times has this occurred in the last 2 weeks?..... |___|___| SpeecCnt

16. Over the past 2 weeks how many days has your child had to use his/her quick relief medicine. (i.e., short acting bronchodilator or rescue medicine)

(days)..... |___|___| QuicDays

17. Over the past 2 weeks, how much discomfort or distress has [*child*] felt because of asthma symptoms? Would you say…

None.....01
Mild.....02
Moderate.....03
Severe.....04 Distress

18. How would you rate [*child*]'s asthma condition now compared to when he/she first arrived to the emergency department?

Much worse.....01
A little worse.....02
About the same.....03
A little better.....04
Much better.....05 CondNow

IF CHILD IS 7 YEARS OF AGE OR OLDER:

19. Over the past 2 weeks how often did your child use his/her peak flow meter?

None.....01 ⇒ **END**
< 1/week.....02
1-3/week.....03
4-6/week.....04
Daily.....05
Only during exacerbations.....06
Doesn't have a PFM.....07 PeakFreq

19a. Over the past 2 weeks, what were the highest and lowest peak flow readings?

Highest reading (liters/minute)..... |___|___|___| PeakHigh

Lowest reading (liters/minute)..... |___|___|___| PeakLow

19b. Over the past 2 weeks, has the peak flow dropped below 80% of [child's] personnel best?

No.....01 ⇒ **END**

Yes .....02 PeakDrop

19c. What did you do when this occurred?

(Details: _____ PkDropDo

That's it! Do you have any questions or comments? [pause] Thank you for your help with this asthma study.

NOTE: If child at home with dyspnea, encourage parent to contact child's primary careprovider for assistance.
If child does not have a primary care provider, encourage parent to take child to their local ED for evaluation.
In either case, please describe the situation below.

COMMENTS: Comments

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