El Paso Health Medicare Advantage

MEDICARE GENERAL PRINCIPLES FOR THE DIAGNOSIS AND MANAGEMENT OF ASTHMA

The following guideline recommends general principles and key clinical activities for the diagnosis and management of asthma	
Eligible Population	People 65 years or older, people with disabilities and people with End Stage Renal Disease with the following: • Wheezing • History of cough (worse particularly at night), recurrent wheeze, recurrent difficulty in breathing, recurrent chest tightness • Symptoms occur or worsen in the presence of exercise, viral infection, inhalant allergens, irritants, changes in weather, strong emotional expression (laughing or crying hard), stress, menstrual cycles • Symptoms occur or worsen at night, awakening the patient • Symptoms improve spontaneously or with bronchodilators (minutes) or ICS (days to weeks).
Key Components	**Recommendations**
Diagnosis and management goals	• Detailed medical history and physical exam to determine that symptoms of recurrent episodes of airflow obstruction are present • Use of spirometry (FEV_1, FEV_6, FVC, FEV_1/FVC) in all patients ≥ 5 years of age to determine that airway obstruction is at least partially reversible * Consider alternative causes of airway obstruction **Goals of therapy are to achieve control by:** • reducing impairment: chronic symptoms, need for rescue therapy and maintain near-normal lung function and activity level • Reducing risk: exacerbations, need for emergency care or hospitalization, loss of lung function, or adverse effects of therapy
Education	• Develop written action plan in partnership with patient. Update annually, more frequently if needed. • Provide self-management education. Teach and reinforce: self-monitoring to assess control and signs of worsening asthma (either symptoms or peak flow monitoring); using written asthma action plan; taking medication correctly (inhaler technique and use of devices); avoiding environmental and occupational Factors that worsen asthma. • Tailor education to literacy level of patient; appreciate potential role of patient's cultural beliefs and practices in asthma management.
Control environmental factors and comorbid conditions	• Recommend measures to control exposure to allergens and pollutants or irritants that make asthma worse • Consider allergen immunotherapy for patients with persistent asthma and when there is a clear evidence of a relationship between symptoms and exposure to an allergen to which the patient is sensitive. • Treat comorbid conditions (e.g., allergic bronchopulmonary aspergillosis, gastroesophageal reflux, obesity, obstructive sleep apnea, rhinitis and sinusitis, chronic stress or depression). • Inactivated influenza vaccine for all patients unless contraindicated.

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Medications	ICS-containing treatment should be initiated as soon as possible after asthma diagnosis. Medications should be added or deleted as the frequency and severity of the patient's symptoms change. Track 1 is the preferred management approach with low dose ICS-formoterol taken at any step when the patient is symptomatic. Steps are as follows: • Step 1-2: As-needed low-dose ICS-formoterol • Step 3: Daily low-dose ICS-formoterol as maintenance and reliever • Step 4: Daily medium-dose ICS-formoterol as maintenance and reliever • Step 5: Refer for expert investigation and add-on LAMA treatment If Track 1 is not possible, or if a patient is stable, with good adherence and no exacerbations in the past year on their current therapy. Steps are as follows: • Step 1: As-needed SABA and a low dose ICS are taken together (in combination, or with the ICS taken right after the SABA) • Step 2: Daily low-dose ICS as maintenance plus as-needed SABA as reliever • Step 3: Daily low-dose ICS-LABA as maintenance plus as-needed SABA as reliever • Step 4: Medium- to high-dose ICS-LABA as maintenance plus as-needed SABA as reliever • Step 5: Refer for expert investigation and add-on LAMA treatment Assess Control • First check adherence, inhaler technique, written asthma action plan, environmental factors and comorbid conditions • Step up if needed; reassess in 2-6 weeks • Step down if possible (if asthma is well controlled for at least 3 consecutive months) • Obtain spirometry (FEV_1, FEV_6, FVC, FEV_1/FVC) to confirm control, and at least every 1-2 years, more frequently for not well-controlled asthma.

This guideline is based on the 2007 National Asthma Education and Prevention Program Expert Panel Report 3, Guidelines for the Diagnosis and Management of Asthma. National Heart, Lung and Blood Institute (www.nhlbi.nih.gov), Global Strategy for Asthma Management and Prevention, 2020 Update (ginasthma.org) Rev: 07/27/2021