El Paso Health Advantage Dual SNP MEDICARE

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 reduced lung growth in children, or adverse effects of therapy
Assessment and monitoring	• Assess asthma severity to initiate therapy using severity classification chart for impairment and risk. • Assess asthma control to monitor and adjust therapy. (Use asthma control chart, for impairment and risk. Step up if necessary; step down if possible). • 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. **Schedule follow-up care: within 1 week, or sooner, if acute exacerbation; at 2- to 6-week intervals while gaining control; monitor control at 1- to 6-month intervals, at 3-month interval if a step-down in therapy is anticipated)** • Assess asthma control, medication technique, written asthma action plan, patience adherence at every visit.
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

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	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.
Medications	• Initial treatment should be based on the severity of asthma, both impairment and risk. Pharmacotherapy is based on Inhaled Corticosteroids (ICS) to reduce the risk of severe exacerbations and death and to improve symptom control, with add-on treatment as required e.g. add-on LABA and/or Lama. As needed low dose ICS-formoterol may be used as the reliever, on its own in mild asthma or in addition to maintenance ICS-formoterol in patients with moderate-severe asthma prescribed maintenance and reliver therapy. Inhaled therapy should be optimized to minimize the need for oral corticosteroids (OCS).
	Warning for use of Long-acting beta-agonists (LABA), i.e. budesonide-formoterol and fluticasone with salmeterol. • Do not use LABA as monotherapy. Use only with an asthma controller such as inhaled corticosteroids. • Use for the shortest duration possible • Only use if not controlled on medium-dose ICS.
Referral	• Refer to an asthma specialist for consultation or co-management if there are difficulties achieving or maintaining control; immunotherapy or omalizumab is considered; additional testing is indicated; or if the patient required 2 bursts of oral corticosteroids in the past year or a hospitalization.

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