AmeriHealth Caritas
District of Columbia

To:	**All AmeriHealth Caritas DC Adult Providers**
Date:	**September 11, 2020**
Subject:	**Preventative Health Guideline Updates— Asthma and Tobacco Use**
Summary:	**The Michigan Quality Improvement Consortium (MQIC) has published updated recommendations for the General Principles for the Diagnosis and Management of Asthma Clinical Practice Guideline. Below is a summary of the updated recommendations and full details.**

Assessment and Monitoring:

- If suspected or confirmed of COVID-19 diagnosis, avoid spirometry and nebulizers.

Treatment of conditions and comorbidities:

- Recommend measures to control exposure to allergens (dust, pollen, and mold), smoke, pollutants, or other irritants that make asthma worse.
- Consider allergen immunotherapy for patients with persistent asthma where there is clear relationship between symptoms and exposure to an allergen to which patient is sensitive.
- Treat relevant conditions (e.g. gastroesophageal reflux, laryngotracheal reflux, allergic bronchopulmonary aspergillosis, obesity, obstructive sleep apnea, rhinitis and sinusitis, chronic stress or depression, vocal cord dysfunction) especially in adolescent females.

Medications:

- Inhaled short-acting beta agonist and/or inhaled corticosteroids (ICS) for intermittent asthma

Referral:

- Consider referral to an asthma specialist for consultation or co-management if there are difficulties achieving or maintaining control, if immunotherapy or biologics is considered, if additional testing is indicated, if the patient required 2 bursts of oral corticosteroids in the past year or a hospitalization, or if the diagnosis is in doubt.

The Clinical Practice Guideline for Management of Tobacco and Nicotine Use (formerly Tobacco Control) features the following updated recommendations. Please see below for the full details.

All Patients:

- Provide interventions (including education and brief counseling) to prevent initiation of tobacco/nicotine use.

All school aged children, adolescents, and adults:

- Assess tobacco use status including e-cigarettes (vaping), smokeless tobacco, pipe, snuff dip, cigars, hookah (water pipe). Document quantity, current and past use in the medical record/problem list.
- Assess second and third hand smoke exposure; recommend stop exposure, offer cessation materials to family.

All Patients identified as current Smokers/Tobacco Users:

- E-cigarettes (vaping) are not recommended as a healthy alternative to smoking or to facilitate smoking cessation.
- Offer nicotine replacement therapy and/or non-nicotine medications
- Refer to a smoking cessation program, or patient's health plan program. Acupuncture or hypnotism have not been found effective.

Special Populations:

- Pregnancy- at each prenatal visit, prescribe interventions (refer to the complete guideline) due to the serious risks to the mother and fetus (including low birth weight and pre-term birth). Weigh risks of nicotine replacement or bupropion.
- Psychiatric comorbidity- patients with behavioral health conditions have higher rates of smoking. Address ongoing behavioral health conditions. Nicotine withdrawal may exacerbate depression or anxiety. Stopping smoking may affect the pharmacokinetics of caffeine and certain psychiatric drugs. Clinicians should closely monitor the actions or side effects of psychiatric medications in smokers/ tobacco users who are attempting to quit. Caffeine levels may rise after smoking cessation.

Michigan Quality Improvement Consortium Guideline

September 2019

Management of Tobacco and Nicotine Use

The following guideline recommends specific interventions for management of tobacco or nicotine users.

Eligible Population	Key Components	Recommendation and Level of Evidence	Frequency
All patients	Prevent starting	Provide interventions (including education and brief counseling) to prevent initiation of tobacco/nicotine use. **[B]**	At least annually; ideally at each visit
All school-age children, adolescents and adults	Establish tobacco/nicotine exposure	**Assess:** Tobacco use status including use of e-cigarettes (vaping[1]), smokeless tobacco, pipe, snuff, dip, cigars, and hookah (waterpipe). **[A]** Document quantity, current and past use in the medical record and/or problem list. Second and third hand smoke exposure; recommend stop exposure, offer cessation resources to family. Provide positive reinforcement to former tobacco users and non-users.	
All patients identified as current smokers/tobacco users	Intervention to promote cessation of tobacco use	Patients are more likely to quit when providers clearly state their desire for the patient to quit, this patient's personalized risk of smoking, and their confidence in the patient's ability to quit. **Advise:** To quit. **[A]** E-cigarettes (vaping) are not recommended as a healthier alternative to smoking or to facilitate smoking cessation. Explain risks of vaping. **Agree:** To an action plan based on patient's willingness to attempt to quit or cut back. **[C]** **Assist:** Establish a quit date. Provide self-help materials (e.g. MDHHS Quit Line 1-800-784-8669). Offer nicotine replacement therapy and/or non-nicotine medications (varenicline, bupropion, others). **[A]** Refer to a smoking cessation program, or patient's health plan program. Acupuncture or hypnotism have not been found effective. The combination of medication plus a smoking cessation program is more effective than either alone **[A]** **Arrange:** Follow-up contact. **[D]**	At each periodic health exam, more frequently at the discretion of the physician Patient may be more receptive to quit during respiratory illness or hospitalization
SPECIAL POPULATIONS (SMOKERS AND NICOTINE USERS)			
Pregnancy	Prescribe interventions listed above due to the serious risks to the mother and fetus (including low birth weight <2500g) and perterm birth (<37 weeks). Weigh risks and benefits of nicotine replacement or bupropion.		At each prenatal visit
Hospitalized	Clinicians should provide appropriate pharmacotherapy and counseling during hospitalization to reduce nicotine withdrawal symptoms and assist smokers in quitting.		
Psychiatric Comorbidity	Patients with behavioral health conditions have higher rates of smoking. Address ongoing behavioral health conditions. Nicotine withdrawal may cause or exacerbate depression or anxiety. Stopping smoking may affect the pharmacokinetics of caffeine and certain psychiatric drugs. Clinicians should closely monitor the actions or side effects of psychiatric medications in smokers/tobacco users who are attempting to quit. Caffeine levels may rise after smoking cessation.		
Tobacco and nicotine users taking other medications	Nicotine withdrawal alters pharmacokinetics of other medications, e.g., beta blockers, warfarin, theophylline.		

[1] Surgeon General E-Cigarettes & Young People, Know the Risks

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on Fiore MC, Jaen CR, Baker TB, et al. Treating Tobacco Use and Dependence: 2008 Update. Clinical Practice Guideline. Rockville, MD: U.S. Department of Health and Human Services. Public Health Service. May 2008; and Smoking cessation during pregnancy. Committee Opinion No. 721. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e200–4. Individual patient considerations and advances in medical science may supersede or modify these recommendations.

Approved by MQIC Medical Directors 2001, 2003, 2005, 2007, 2009, 2011, 2013, 2015, 2017, 2019

Michigan Quality Improvement Consortium Guideline

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	Key Components	Recommendation and Level of Evidence
Children and adults 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	Diagnosis and management goals	Detailed medical history and physical exam to determine precipitating factors and that symptoms of recurrent episodes of airflow obstruction are present and reversed by bronchodilator. Use spirometry (FEV_1, FEV_6, FVC, FEV_1/FVC) in all patients age ≥ 5 to determine that airway obstruction is at least partially reversible. **[C]** 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. **[A]** Reducing risk: exacerbations, need for emergency care or hospitalization, loss of lung function or reduced lung growth in children, or adverse effects of therapy.**[A]**
	Assessment and monitoring	Assess asthma severity to initiate therapy using severity classification chart for impairment **[B]** and risk **[C]** Assess asthma control to monitor and adjust therapy **[B]**. (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 after symptoms have stabilized; and, at least every 1-2 years **[B]**, more frequently for not well-controlled asthma. If suspected or confirmed COVID-19, avoid nebulizers and spirometry. **Schedule follow-up care: within 1 week, or sooner, if acute exacerbation; at 2- to 6-week intervals while gaining control [D]; monitor control at 1- to 6-month intervals, at 3-month interval if a step-down in therapy is anticipated. [D]** Assess asthma control, medication technique, written asthma action plan, patient adherence and concerns at every visit.
	Education	Develop written asthma action plan in partnership with patient/family/caregiver. **[B]** Update annually, more frequently if needed. Provide self-management education. **[A]** Teach and reinforce: self-monitoring to assess control and signs of worsening asthma (either symptoms or peak flow monitoring) **[B]**; using written asthma action plan; taking medication correctly (inhaler technique and use of devices); recognizing, reporting and avoiding environmental and occupational factors that worsen asthma (outdoor activity, reflux; *see Eligible Population column*). Tailor education to literacy level of patient; appreciate potential role of patient's cultural beliefs and practices in asthma management. **[C]**
	Control environmental factors and comorbid conditions	Recommend measures to control exposures to allergens (dust, mold, pollen), smoke, pollutants, or other irritants (perfumes, chemicals) that make asthma worse. **[A]** Consider allergen immunotherapy for patients with persistent asthma and when there is clear evidence of a relationship between symptoms and exposure to an allergen (dust, mold, pollen, pets) to which the patient is sensitive. **[B]** Treat relevant conditions (e.g., gastroesophageal reflux/laryngotracheal reflux **[B]**, allergic bronchopulmonary aspergillosis **[A]**, obesity **[B]**, obstructive sleep apnea **[D]**, rhinitis and sinusitis **[B]**, chronic stress or depression **[D]**, vocal cord dysfunction, especially in adolescent females **[D]**.) Inactivated influenza vaccine for all patients over 6 months of age **[A]** unless contraindicated. Do not use intranasal influenza vaccine. Give 23-valent pneumococcal polysaccharide vaccine (PPSV23) age 19 and older (age 2-18 if using high-dose oral steroids).
	Medications (Link to national age-specific guidelines for treatment recommendations)	Initial treatment should be based on the severity of asthma, both impairment and risk. Inhaled short-acting beta agonist and/or inhaled corticosteroids (ICS), for intermittent asthma. For persistent asthma, **Inhaled corticosteroids (ICS) alone or in combination with Long-Acting Beta Agonist (LABA) appears to be the most effective long-term control strategy. [D]** Re-evaluate in 2 - 6 weeks for control. Modify treatment based on level of control. See asthma yardstick: Children Adults Consider step down if well-controlled for 3 months.
	Referral	Consider referral to an asthma specialist for consultation or co-management if there are difficulties achieving or maintaining control, if immunotherapy or biologics is considered, if additional testing is indicated, if the patient required 2 bursts of oral corticosteroids in the past year or a hospitalization, or if the diagnosis is in doubt. **[D]**

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on 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; Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2020; NHLBI Asthma Care Quick Reference Diagnosing and Managing Asthma NIH Publication No. 12-5075, Revised September 2012; Advisory Committee on Immunization Practices, Pneumococcal ACIP Vaccine Recommendations (cdc.gov).