AmeriHealth Caritas
District of Columbia

To:	**All AmeriHealth Caritas DC Pediatric Providers**
Date:	**September 11, 2020**
Subject:	**Preventative Health Guideline Updates— Asthma, Tobacco Use, and Identification of Childhood Obesity**
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.

The Clinical Practice Guideline for Prevention and Identification of Childhood Overweight and Obesity was updated to include the following recommendations—
Infant/Toddler (ages 0-2):

- Discourage/avoid high-calorie, nutrient-poor beverages (e.g. soda, fruit punch, sports drinks, or any juice drinks)

Preschool (ages 3-5):

- Replace whole milk with skim milk or 2%, discourage/avoid high-calorie, nutrient-poor beverages.

Michigan Quality Improvement Consortium Guideline

Prevention and Identification of Childhood Overweight and Obesity

The following guideline recommends specific interventions for children and their parents/guardians for prevention and identification of childhood overweight and obesity.

Key Components, Recommendations and Level of Evidence

Education, Parental Modeling of Health Behaviors and Prevention of Risk

At each periodic health exam

General advice for all ages:

Promote a healthy diet and lifestyle with focus on 5-2-1-0: ≥ 5 fruits and vegetables, ≤ 2 hours recreational screen time, > 1 hour physical activity, 0 sugar-containing drinks daily.
Educate parents about importance of parental role modeling for a healthy lifestyle (diet and exercise) and parental controls.
Limit eating out; avoid fast food.
Avoid food as a reward.

Infant/Toddler (age 0-2):

Encourage breastfeeding for at least 12 months; discourage overfeeding of bottle fed infants. **[A]** Avoid bottle feeding as a sleep aid.
Avoid premature introduction of solids and base timing for introduction of solids on child's development, usually between 4 and 6 months of age.
Preserve natural satiety by respecting a child's appetite.
Discourage/avoid high-calorie, nutrient-poor beverages (e.g., soda, fruit punch, sports drinks, or any juice drink).
No television or other screen time under age 2. **[D]**

Preschool (ages 3-5):

Limit television and other screen time to at most 1-2 hours per day. No access to television and other screens in primary sleeping area.
Replace whole milk with skim or 2%; discourage/avoid high-calorie, nutrient-poor beverages (soda, fruit punch, sports drinks, juice drinks).
Respect the child's appetite and allow him or her to self-regulate food intake.
Provide structure and boundaries around healthy eating with adult supervision.
Promote physical activity including unstructured play at home, during child care and in the community.
Promote age-appropriate sleep durations (11-13 hours/night).

School-aged (ages 5-12), the above plus:

Accumulate ≥ 60 minutes, and up to several hours of age-appropriate physical activity on all or most days of the week (emphasize lifestyle exercise, i.e., outdoor play, yard work, and household chores).
Consider barriers (e.g., social support, unsafe neighborhoods or lack of school-based physical education) and explore individualized solutions.
Reinforce making healthy food and physical activity choices at home and outside of parental influence.
Promote age-appropriate sleep durations (10-11 hours/night).

Assessment of Body Mass Index, Risk Factors for Overweight and Excessive Weight Gain Linear to Growth

General assessment:

History (including focused family history) and physical exam.
Starting at age 2[1], calculate BMI percentile at each well child visit and record result.
Dietary patterns (e.g. frequency of eating outside the home, consumption of breakfast, adequate fruits and vegetables, excessive portion sizes, consumption of sugar-sweetened beverages, etc.)
Physical activity level.
Risk factors for overweight[3] including pattern of weight change. **[C]** Watch for increasing BMI percentile or BMI in the ≥ 85th percentile.
Sleep patterns.

[1] AAP recommends screening at age 2; USPSTF age 6+; NCQA HEDIS age 3+

[2] CDC growth charts

[3] Low or high birth weight, low income, minority, television or computer screen time > 2 hrs, low physical activity, poor eating, depression

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 US Preventive Services Task Force. Screening for Obesity in Children and Adolescents: US Preventive Services Task Force Recommendation Statement. JAMA. 2017; 317(23):2417-2426.doi:10.1001/jama.2017.6803; and the American Medical Association 2007 Expert Committee Recommendations on the Treatment of Pediatric Obesity. Individual patient considerations and advances in medical science may supersede or modify these recommendations.