Asthma CYCLE OF CARE

Australian Government
Department of Health and Ageing

NATIONAL ASTHMA COUNCIL AUSTRALIA

Completing the Asthma Cycle of Care — A guide for General Practitioners

The *Asthma Cycle of Care* has replaced the **Asthma 3+ Visit Plan**. This guide provides information on how to complete the *Asthma Cycle of Care* and claim the Medicare Benefits Schedule fee for an asthma specific item.

An *Asthma Cycle of Care* includes **at least two** asthma related consultations **within 12 months** for a patient with **moderate to severe asthma** noting that the review visit must be **planned**. To complete an *Asthma Cycle of Care* you must:

1. Document diagnosis and assessment of asthma severity and level of asthma control

Moderate to severe asthma or a poor level of asthma control can be assumed for patients who:

- have symptoms on most days, OR
- use regular preventer medications, OR
- use a bronchodilator at least 3 times per week, OR
- have experienced acute exacerbations leading to hospital admission or attendance

Spirometry is preferred for diagnostic testing and should be used for both diagnosis and assessment of severity. Most adults and children over seven years old can perform spirometry. When diagnosing asthma, Peak Expiratory Flow (PEF) Measurement is not a substitute for spirometry.

Good asthma control can be defined as having:

- minimal symptoms during day and night
- minimal need for reliever medication
- no exacerbations
- no limitation of physical activity

When spirometry has been performed, the results should be documented in the patient's medical record and/or the print out of results attached. Consider referral to a respiratory laboratory for spirometry if you are unable to perform it in your practice.

2. Review the patient's use of, and access to, asthma related medication and devices

To achieve the best possible asthma control with the lowest effective medication dose and minimum side effects, use of asthma related medications and devices should be regularly reviewed. Long-term adjustment of asthma maintenance medication needs to be tailored to each patient's individual condition.

Step down of medications should generally be considered 6–12 weeks after good control has been achieved. The step down of medications can be monitored by the frequency of symptoms, the use of reliever medication and objective measurement of lung function (preferably by spirometry).

3. Provide a written asthma action plan (or documented alternative if the patient is unable to use a written action plan)

Severe or life threatening asthma attacks are more likely to occur in patients with inadequate medical supervision.

An individualised written asthma action plan should be developed so that a person with asthma can recognise deterioration and respond appropriately. Action plans can be based on symptoms and/or peak flow measurements.

Deterioration can be recognised by:

- increasing frequency or severity of symptoms, especially waking at night
- increasing use of reliever medication
- failure of medication to completely relieve symptoms
- falling peak flow and/or increasing peak flow variability

4. Provide asthma self management education

Studies have shown that asthma self-management education will provide people with asthma with the knowledge and skills to better control their asthma, resulting in fewer emergency attendances at the doctor or hospital.

To meet the requirements of the ***Asthma Cycle of Care*** you must ensure that your patient has received self-management education. You may also wish to involve other health care providers such as nurses, asthma educators and pharmacists. For a patient with co-morbidities or complex needs you may consider using Team Care Arrangements (TCA) under the MBS (see below).

Your state or territory Asthma Foundation can also assist in providing asthma education and can be contacted on **1800 645 130**.

A person with moderate to severe asthma should be able to:

- monitor their asthma using either symptoms or peak flow measurements
- use their written asthma action plan to prevent and/or manage symptoms
- understand the triggers for their asthma and how to avoid them
- use medications and devices appropriately
- regularly review their asthma with their GP

5. Review the written or documented asthma action plan

The final requirement before you can complete the ***Asthma Cycle of Care*** is that you review the patient's asthma control and ongoing management as well as their written asthma action plan. This involves a complete review of asthma symptoms, lung function and response to treatment, medications and dosages and peak flow measurements (if appropriate).

For more detailed information regarding asthma diagnosis, assessment and best practice management refer to the National Asthma Council's website at **www.NationalAsthma.org.au** or call the NAC's information line on **1800 032 495**.

It is important to recall patients for regular assessment so that:

- symptoms and peak flow charts can be reviewed
- patient-initiated changes to therapy can be reviewed
- inhaler technique can be checked
- education and adherence to treatment plans can be reinforced
- asthma action plans can be reviewed and updated (medications and dosages)
- trigger factors and strategies for trigger avoidance can be reviewed
- lung function can be objectively assessed by spirometry

Claiming your Asthma Service Incentive Payment (SIP)

You must meet the ***Asthma Cycle of Care*** requirements in a minimum of two visits (within a 12 month period).

All visits should be billed under the normal attendance items with the exception of the visit that completes the ***Asthma Cycle of Care.*** When you have completed an ***Asthma Cycle of Care*** you may claim using the appropriate Medicare item numbers listed below:

GENERAL PRACTITIONER ATTENDANCE	
Level B Surgery Consultation	**2546**
Level B Out-of-Surgery Consultation	**2547**
Level C Surgery Consultation	**2552**
Level C Out-of-Surgery Consultation	**2553**
Level D Surgery Consultation	**2558**
Level D Out-of-Surgery Consultation	**2559**

OTHER NON-REFERRED ATTENDANCES	
Surgery Consultations	
Standard Consultation	**2664**
Long Consultation	**2666**
Prolonged Consultation	**2668**
Out-of-surgery Consultations	
Standard Consultation	**2673**
Long Consultation	**2675**
Prolonged Consultation	**2677**

Further information on this incentive is available from the PIP enquiry line on 1800 222 032 or www.medicareaustralia.gov.au/pip and in the Medicare Benefits Schedule Book.

Alternative asthma care using MBS Chronic Disease Management items

The Chronic Disease Management (CDM) items provide an alternative funding mechanism to the SIPs for providing best practice care of patients with chronic conditions, including patients with asthma. For patients with asthma alone a GP should choose to use either GP managed care through the CDM items (GP Management Plan—GPMP), or provide an ***Asthma Cycle of Care***, but not both services for the same patient as the work involved in both services overlaps (these items should not both be claimed in the same twelve months). For patients with asthma and complex needs requiring care from a multidisciplinary team, a GP may provide team-based care using the CDM items (for most patients this means a GPMP and a Team Care Arrangements—TCA), and the ***Asthma Cycle of Care***. A CDM review item and an ***Asthma Cycle of Care*** should not be claimed within three months of each other as the work involved overlaps.

More detailed information on the CDM items is available from Medicare Australia on **132 150** or in the Medicare Benefits Schedule Book.