Highlights from the U.S. Asthma Summit 2018

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THE U.S. ASTHMA SUMMIT, sponsored by the Asthma and Allergy Network and the American College of Allergy, Asthma, and Immunology was held in Seattle, Washington on November 16, 2018.

This event was attended by 96 invited guests from 26 states across the country as well as from Washington, D.C. and Puerto Rico. Participants represented academic and healthcare institutions, as well as advocacy, community, and governmental agencies. Families and individuals with asthma participated in the discussion to give a voice to those affected by the challenges of living with asthma. The event was streamed live to multiple sites across the U.S.

Selected sessions are highlighted.

The State of Asthma in the United States was presented by Dr. Bradley Chipps, President of the American College of Allergy, Asthma, and Immunology. This session focused on asthma as a syndrome with heterogeneous characteristics rather than as a specific disease and discussed strategies to address the tremendous burden on healthcare costs and quality of life associated with poorly controlled disease. In the United States, approximately 22 million individuals have been diagnosed with asthma. The healthcare burden imposed by asthma is substantial with annual costs estimated at 81.9 billion dollars. While individuals with severe asthma comprise about 5–10% of the total group of affected patients, they may represent up to 80% of the total costs of asthma-related healthcare. At the present time we have 2 major sets of guidelines for the Diagnosis and Management of Asthma. The GINA Guidelines, which were last updated in 2018, and the National Heart, Lung and Blood Institute, National Asthma Education and Prevention Program Expert Panel Report – 3 (EPR-3): Guidelines for the Diagnosis and Management of Asthma, which were last published in 2007. The EPR-3 guidelines are currently under revision. Despite present guidelines, Dr. Chipps reports a survey showing that 60% of asthmatics limited exercise because of asthma, 71% misused their inhalers, and 20% could not afford their medication. Recognizing the need to proactively address the sustained loss of asthma control at all severity levels, Dr. Chipps and colleagues proposed the use of an asthma yardstick for use as a practical tool to guide clinicians towards the goal of well-controlled asthma for every patient. The asthma yardstick is based on an understanding of the four phenotypic profiles that have been linked to difficult-to-treat and severe asthma patients: allergic IgE, eosinophilic, neutrophilic, and airway smooth muscle hypertrophy. The current literature regarding the four asthma phenotypes was

discussed with emphasis on the use of biomarkers and treatment options, including when the preferred treatment plans are ineffective. The references are provided.^{1–4}

Following the theme of addressing the need for improved control of asthma, Dr Randall Brown, (Director, Asthma and COPD programs, Center for Managing Chronic Disease, University of Michigan) focused on the need for ongoing education and skills training. The previous data presented by Dr Chipps where 71% of asthmatics who responded to the survey misused their inhalers is addressed with specific strategies in Dr. Brown's session, entitled **Inhaler Confusion – Quick Relief vs Controller: The Key for Patient Education**. Promoting his belief that “communication still trumps inflammation,” Dr. Brown reviews some of the many communication barriers faced by patients and providers, including patient beliefs that the clinician does not understand their social and cultural experience, doesn't listen to them, or they may feel that they are wasting the clinician's time. Some may omit details they deem unimportant or be embarrassed to discuss things that may make them look bad. Others may simply not understand the medical terminology.

This is further complicated by disparities in adherence that have been linked to age, gender, culture, duration of asthma, and level of control, as well as other internal and external factors. Addressing these factors requires a focused and organized approach that must be culturally sensitive, linguistically appropriate, and medically sound. Dr. Brown discussed a 2016 study of African American children with asthma in the United States that showed increased severity and morbidity (Increased hospitalizations and intensive care stays) prior to initial consultation with an asthma specialist. Multiple strategies are available to TAKE ACTION to improve asthma care: advocacy, education, outreach, research and communication. Each provider must help to develop priorities to most effectively address their community's needs. Resources and educational materials are available by contacting the Asthma and Allergy Network.

Supporting the theme that patient education is critical to success, Dr. Kari Trapsin of the Pharmacy Society of Wisconsin focused on **Pharmacists as Part of the Continuum of Asthma Care**. The Pharmacy Society of Wisconsin in collaboration with the Wisconsin Asthma Program developed sustainable programs to establish pharmacist-led asthma-care activities in community and ambulatory care clinic settings. Dr. Trapsin discussed educational and clinical practice

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initiatives that included a Pharmacy Quality Collaborative, an Adherence Toolkit, and collaborative practice agreement templates.

Wisconsin Pharmacy Quality Collaborative is a network of 230 accredited pharmacies with 534 certified pharmacists who provide medication therapy management services directly to patients. Focused on team-based care, the collaborative provides comprehensive medication review and assessment (CMR/A). CMR/A includes a 45–60 minute encounter with the pharmacist with the goal of identifying, resolving, and preventing medication-related problems. The results of the encounter are shared with both patients and providers. Eligible patients receive CMR/A services at discharge from hospital and may receive up to 3 follow-up visits per rolling year. The Collaborative Practice Toolkit provides templates for referral and patient education.

The Asthma Care Coverage Project: Access to Comprehensive and Consistent Asthma Care in Medicaid was presented by Hannah Green MPH, National Director for Health Policy from the American Lung Association (ALA). Medicaid provides health care coverage to over 66 million Americans nationwide and includes eligible individuals with low income or disabilities. Medicaid is jointly funded by federal and state government. Almost half of U.S. children with asthma receive health insurance coverage from Medicaid or Children's Health Insurance Program (CHIP). Adults in the Medicaid program are more likely to have asthma than those with private insurance. These are among the factors that led the ALA to initiate a program, entitled Asthma Guidelines-based Care Coverage Project, to track coverage of and related barriers to guideline-based asthma care each year and in every state with Medicaid enrolled individuals with asthma. Ms. Green's discussion focused on three major objectives for this project: increasing the understanding and available data regarding Medicaid coverage and barriers to access guidelines-based asthma care across 50 states, the District of Columbia and Puerto Rico; identifying gaps between best practices in improving outcomes and current coverage; and promoting collaboration between diverse stakeholder groups to increase access to guidelines-based asthma care. Transparency and uniformity of coverage are essential to the success of this project.

Uniformity of coverage across plans is challenging. Common formularies, contract language, and state plan amendments were discussed as potential strategies to address this challenge. Six categories of care were selected for analysis: quick-relief medication, controller medication, devices, allergy testing, allergen immunotherapy, home visits & interventions, and self-management education. The top three barriers were identified for each category. Not surprisingly, copays and prior approvals were consistently listed as a barrier, each in five of the six categories. Copays were not listed as a barrier for home visits but they required prior authorization. Prior authorization was not a barrier for devices but devices were often durable medical equipment, did have a copay, and availability was limited.

Ms. Green discussed how stakeholders can use this data to identify needs and gaps in coverage and/or access to care for individuals with asthma in their own states. She recommends networking and developing partnerships with asthma coalitions and other stakeholders in your state to improve advocacy and develop strategies to improve coverage and services for individuals affected by asthma. Additional information and resources for the asthma care coverage session can be found at <https://www.lung.org/asthma-care-coverage>.

References

1. Global Initiative for Asthma. Global Strategy for Asthma Management and Prevention, 2018. <https://www.ginasthma.org>. Accessed November 24, 2018.
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4. Chipps, BE, Corren, J, Israel, E et al, Asthma Yardstick: Practical recommendations for a sustained step up in asthma therapy for poorly controlled asthma. *Ann Allergy Asthma Immunol* 2017; 118(2): 133–142.