Asthma Clinic - working document

Asthma Cycle of Care

The Asthma Cycle of Care is a new approach to working with your GP to manage your asthma and replaces the Asthma 3+ Visit Plan.

It has been developed by asthma experts and is based on the latest knowledge about how to treat asthma most effectively.

It has been shown that people who learn and understand more about their asthma, who actively talk to their doctor about their asthma, who have an Asthma Action Plan and who take medications correctly:

- Have better control over their asthma
- Experience less attacks
- Have fewer days off work/school due to their asthma

This allows them to stay in the best of health at all times.

The Asthma Cycle of Care is targeted towards people with moderate to severe asthma. One or more of the following criteria classifies moderate to severe asthma:

- Use of a reliever medication (blue puffer) more than three times per week; or
- Wheeze or cough on most days or at night; or
- Often be short of breath; or
- Have frequent asthma attacks; or
- Sometimes go to hospital with bad asthma attacks; or
- Are on a preventer medication

Visit and interval between previous visit	Action	Person performing the action	Materials and equipment required	Item numbers billed
1 Initial visit	Identify asthma, engage patient, transfer to nurse immediately or book asthma attendance “for lung function test”	GP		23
1 initial visit (if fit in immediately) or 2 Asthma dedicated visit (if booked separately)	● Assess level of control ● Spirometry ● Explain asthma ● Explain how to manage ● Explain risks of not managing asthma ● Try to introduce 2 week peakflow monitoring, especially, for kids ● If hay fever, allergies - reduction techniques ● Check reliever medication technique ● If preventer - preventer technique ● Emergency management of asthma ● Schedule follow up in 2 weeks (generally) *Must be seen by GP * Identify comorbidities e.g. chronic pain, nutritional problems, obesity, high CVD risk	GP + Nurse	Spirometer 4x4 management of asthma print out peak flow monitor MDI inhaler placebo	721, 11506 * If co-morbidity identified - ?723 + referral to relevant AHP e.g. physio *if Care Plan 721+723 previously in place - think 732+732 and 10997

3 Asthma dedicated 2 weeks	• Reinforce knowledge received last visit • Spirometry • Assess how preventer works - to titrate up or down • Action plan based on relevant data •	GP + Nurse	Spirometer 4x4 management of asthma print out MDI inhaler placebo	23, 11506 *10997 if 721 + 723 billed before * Long term smoker - ? ABI Doppler - 11610 *If age between 40 and 49 - AusdRisk assessment - 703
4 Asthma dedicated visit 4 weeks	• Reinforce knowledge received last visit • Spirometry • Assess how preventer works - to titrate up or down	GP + Nurse	Spirometer 4x4 management of asthma print out MDI inhaler placebo	23, 11506 *10997 if 721 + 723 billed before
5 Asthma dedicated visit 12 weeks	• Reinforce knowledge received last visit • Spirometry • Assess how preventer works - to titrate up or down	GP + Nurse	Spirometer 4x4 management of asthma print out MDI inhaler placebo	732, 11506 * 732+732 if 721+723 billed before *10997 if 721 + 723 billed before

6 Asthma dedicated visit 12 weeks	• Reinforce knowledge received last visit • Spirometry • Assess how preventer works - to titrate up or down	GP + Nurse	Spirometer 4x4 management of asthma print out MDI inhaler placebo	732, 11506 * 732+732 if 721+723 billed before *10997 if 721 + 723 billed before

Notes: