Provider Outreach Manual:
Prevention and Wellness

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1. Women’s Health Reminders
Covered Services Included as Part of a Well-Woman Preventative Care Visit

An annual well-woman preventative care visit is intended for the identification of risk factors for disease, identification of existing medical/mental health problems, and promotion of healthy lifestyle habits essential to reducing or preventing risk factors for various disease processes. As such, the well-woman preventative care visit is inclusive of a minimum of the following:

a. A physical exam (well exam) that assesses overall health.
b. Clinical breast exam.
c. Pelvic exam (as necessary, according to current recommendations and best standards of practice).
d. Review and administration of immunizations, screenings and testing as appropriate for age and risk factors.
e. Screening and counseling is included as part of the well-woman preventive care visit and is focused on maintaining a healthy lifestyle and minimizing health risks, that addresses at a minimum the following:
   i. Proper nutrition
   ii. Physical activity
   iii. Elevated BMI indicative of obesity
   iv. Tobacco/substance use, abuse, and/or dependency
   v. Depression screening
   vi. Interpersonal and domestic violence screening, that includes counseling involving elicitation of information from women and adolescents about current/past violence and abuse, in a culturally sensitive and supportive manner to address current health concerns about safety and other current or future health problems
   vii. Sexually transmitted infections
   viii. Human Immunodeficiency Virus (HIV)
   ix. Family planning counseling
   x. Preconception counseling that includes discussion regarding a healthy lifestyle before and between pregnancies that includes:
      a) Reproductive history and sexual practices
      b) Healthy weight, including diet and nutrition, as well as the use of nutritional supplements and folic acid intake
      c) Physical activity or exercise
      d) Oral health care
      e) Chronic disease management
      f) Emotional wellness
      g) Tobacco and substance use (caffeine, alcohol, marijuana and other drugs), including prescription drug use
      h) Recommended intervals between pregnancies
f. Initiation of necessary referrals when the need for further evaluation, diagnosis, and/or treatment is identified.

*Preconception counseling does not include genetic testing.

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Cervical Cancer Screening

**Goal:** To increase the percentage of women 21-65 years of age who are screened for cervical cancer using either of the following criteria:

- Women age 21–64 who have cervical cytology performed every 3 years.
- Women age 30-64 who have cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years.

Members are excluded with evidence of a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix any time during the member’s history. Documentation of “complete,” “total” or “radical” abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix. The following also meet criteria:

- Documentation of a “vaginal pap smear” in conjunction with documentation of “hysterectomy”.
- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening.

Documentation of hysterectomy alone does not meet the criteria because it is not sufficient evidence that the cervix was removed.

**Key Statistics:**

The American Cancer Society’s estimates for cervical cancer in the United States for 2014:

- About 12,360 new cases of invasive cervical cancer will be diagnosed.
- About 4,020 women will die from cervical cancer.

Cervical cancer can often be found early and sometimes even prevented entirely, by having regular Pap tests. If detected early, cervical cancer is one of the most successfully treatable cancers.

Start screening every woman at the age of 21, and continue with pap screening every 3 years until the age of 30.

At 30 years of age women should have a Pap test and a human papillomavirus (HPV) co-test every 5 years until the age of 65. It is also acceptable to screen every 3 years with a Pap test alone.

Women should be reminded to continue with yearly provider visits for well woman care and reproductive health care.
Testing for STDs: Chlamydia

**Goal:** To increase the percentage of women 18–24 years of age who are identified as sexually active and who have at least one test for chlamydia during the measurement year.

Two methods identify sexually active women: pharmacy data and claim/encounter data. Both methods are used to identify the eligible population; however, a member only needs to be identified in one method to be eligible for the measure.

Chlamydia is the most frequently reported bacterial sexually transmitted infection in the United States.

Chlamydia prevalence among sexually-active young persons aged 14–24 years is nearly three times the prevalence among persons aged 25–39 years.

- It is estimated that 1 in 15 sexually active females aged 14–19 has chlamydia.
- Chlamydia is known as a ‘silent’ infection because most infected people are asymptomatic and lack abnormal physical examination findings.

**Who should be tested for chlamydia?**

Any sexually active person can be infected with chlamydia. The Center for Disease Control recommends YEARLY chlamydia screening for all sexually active women age 25 or younger.

**Two ways to diagnose chlamydia:**

- Nucleic acid amplification tests (NAATs). This is the most sensitive test and can be performed on obtainable vaginal swabs or urine.
- Cell culture.

To help partners get treated quickly, healthcare providers in Arizona may give infected individuals extra medicine or prescriptions to give to their sex partners. This is called expedited partner therapy or EPT. This is associated with fewer persistent or recurrent chlamydial infections and a larger number of partners getting treated. Partners should still be encouraged to seek medical evaluation.
Chlamydia Clinical Practice Guidelines

1. Conduct medical/sexual history
2. Conduct a well visit for women 18-24 years old who are sexually active.
3. Repeat sexual/medical history annually.
4. Conduct Chlamydia laboratory testing and patient counseling with education.
5. Test result:
   - Negative: Repeat sexual/medical history annually.
   - Positive: Conduct Chlamydia laboratory testing annually until member’s 25th birthday, conduct genital/pelvic exam, test for gonorrhea, syphilis, HIV, treat as appropriate, provide patient counseling and education, partner management; utilize Expedited Partner Therapy as appropriate.

Information obtained from “Chlamydia Screening & Treatment Practice Guidelines” Published by the California Chlamydia Action Coalition

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Breast Cancer

**Goal:** To increase the percentage of women age 50–74 who receive a yearly mammogram screening.

*This measure evaluates primary screening. Biopsies, breast ultrasounds or MRIs do not count because they are not appropriate methods for primary breast cancer screening.*

Breast cancer is one of the most commonly found cancers in women, no matter the race or ethnicity.

It is one of the most common causes of death from cancer among Hispanic women.

It is the second most common cause of death from cancer among white, black, Asian/Pacific Islander, and American Indian/Alaska Native women.

Each year, approximately 190,000 women are diagnosed with breast cancer and 40,000 women die from the disease.

**Mammogram Locations**

- **Assured Imaging** - 520-744-6121
- **Valley Radiologists** - 623-847-2000
- **SimonMed** - 1-866-614-8555
- **Insight Imaging** - 602-627-9933
- **AZ -Tech Radiology** - 480-455-1850
- **Radiology Ltd.** - 520-733-7226
- **St. Mary’s Imaging Center** - 520-872-6900
- **Carondelet Imaging Center - Central** - 520-872-7200
- **Nogales Holy Cross Hospital** - 520-258-8092
2. Prenatal and Postpartum Care (PPC)
Prenatal and Postpartum Care (PPC)

**Goal:** Improve the timeliness of prenatal and postpartum care.

- Prenatal care within the first trimester or within 42 days of enrollment.
  - General exam to confirm pregnancy. Include LMP and EDC.
  - Physical OB exam with either FHT, pelvic exam with OB observations, or measurement of FH.
  - Labs/Testing- Any of the following: OB panel, TORCH antibody panel, Rubella and RH incompatibility typing, or echography of pregnant uterus.
  - Screen for chlamydia, and other STD’s depending on history and risk factors.
  - Complete OB history, or prenatal risk assessment and counseling or education.
    - Assess for substance use-tobacco, alcohol, drugs, prescriptive narcotics.
    - Preterm labor risk factors, education, prevention
    - Domestic violence
    - Adequate housing, support system, basic needs-Refer as needed to community resources or MCP case management.
    - Education on nutrition, lead exposure, safety measures, pathophysiology of pregnancy, labor and delivery, breastfeeding.
    - Screen for depression
- Postpartum visit on or between 21 days and 56 days after delivery.
  - Notation of postpartum care, including, but not limited to: notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”
  - Pelvic exam or
  - Evaluation of weight, BP, breasts and abdomen. Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component.
  - Screen for postpartum depression. Provide counseling and referrals if indicated.
  - Discuss sexual activity and contraception (See Family Planning Section).

For visits to a PCP, a diagnosis of pregnancy must be present. A referral is not required for a member to see OB/GYN.

MCP assigns newly identified pregnant members to a PCP to manage their routine non-OB care. The OB provider manages the pregnancy care for the member and is reimbursed in accordance with their contract.

If a member chooses to have an OB as their PCP during their pregnancy, MCP will assign the member to an OB PCP. If an OB provider has been assigned for OB services for a pregnant member, the member will remain with their OB PCP until after their post-partum visit when they will return to their previously assigned PCP.

Federal and state mandates govern the provision of EPSDT services for members under the age of 21 years. The PCP is responsible for providing these services to pregnant members under the age of 21, unless the member has selected an OB provider to serve as both the OB and PCP. In that instance, the OB provider must provide EPSDT services to the pregnant member.
TOOL KIT
FOR THE
MANAGEMENT OF
ADULT
POSTPARTUM
DEPRESSION
TOOL KIT FOR THE MANAGEMENT OF ADULT POSTPARTUM DEPRESSION

The clinical tool kit is intended to assist the PCP in assessing the postpartum needs of women regarding depression and decisions regarding health care services provided by the PCP or subsequent referral to the Regional Behavioral Health Authority (RBHA) if clinically indicated. Tools include:

- The decision making algorithm for depression
- Edinburgh Postnatal Depression Scale with accompanying scoring instructions
- The Postpartum Safety Screening
- The list of medications universally available through AHCCCS Health Plans and the RBHA.

**CLINICIAN NOTE:**

In the assessment of postpartum depression, the clinician should review for the possible existence of psychotic symptoms since 1/1000 women may suffer with psychotic symptoms as part of this mood disorder. These symptoms include:

1) Delusions
2) Hallucinations
3) Disorganized Speech
4) Inappropriate Behavior

These severe symptoms can last for one day or up to a month. In some cases, the symptoms of psychosis may accompany periods of restlessness or agitation. Psychiatric consultation and/or emergency referral should occur.

**A RBHA consultation is available at any time.**
Depression

Danger to Self or Others

Refer to RBHA

YES

Treatment By PCP

NO

Refer to RBHA

*Sole usage of Algorithms is not a substitute for a comprehensive clinical assessment
# Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: ______________________________  Address: ______________________________

Your Date of Birth: ____________________  ___________________________

Baby’s Date of Birth: ___________________  Phone: _________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- Yes, all the time
- Yes, most of the time  This would mean: “I have felt happy most of the time” during the past week.
- No, not very often  Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer Options</th>
</tr>
</thead>
</table>
| 1. I have been able to laugh and see the funny side of things | - As much as I always could  
- Not quite so much now  
- Definitely not so much now  
- Not at all |
| 2. I have looked forward with enjoyment to things | - As much as I ever did  
- Rather less than I used to  
- Definitely less than I used to  
- Hardly at all |
| 3. I have blamed myself unnecessarily when things went wrong | - Yes, most of the time  
- Yes, some of the time  
- Not very often  
- No, never |
| 4. I have been anxious or worried for no good reason | - No, not at all  
- Hardly ever  
- Yes, sometimes  
- Yes, very often |
| I have felt scared or panicky for no very good reason | - Yes, quite a lot  
- Yes, sometimes  
- No, not much  
- No, not at all |
| 6. Things have been getting on top of me | - Yes, most of the time I haven’t been able  
- Yes, sometimes I haven’t been coping as well as usual  
- No, most of the time I have coped quite well  
- No, I have been coping as well as ever |
| 7. I have been so unhappy that I have had difficulty sleeping | - Yes, most of the time  
- Yes, sometimes  
- Not very often  
- No, not at all |
| 8. I have felt sad or miserable | - Yes, most of the time  
- Yes, quite often  
- Not very often  
- No, not at all |
| 9. I have been so unhappy that I have been crying | - Yes, most of the time  
- Yes, quite often  
- Only occasionally  
- No, never |
| I have been so unhappy that I have been crying | - Yes, quite often  
- Sometimes  
- Hardly ever  
- Never |

Administered/Reviewed by ______________________________  Date ______________________________


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Edinburgh Postnatal Depression Scale\(^1\) (EPDS)

Postpartum depression is the most common complication of childbearing.\(^2\) The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women’s Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

<table>
<thead>
<tr>
<th>SCORING</th>
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| **QUESTIONS 1, 2, & 4 (without an *)**  
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3. |
| **QUESTIONS 3, 5-10 (marked with an *)**  
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0. |
| Maximum score: 30  
Possible Depression: 10 or greater  
Always look at item 10 (suicidal thoughts) |

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.


**Postpartum Safety Screening**

The PCP, Mother and/or her family is concerned about the new mother’s mood or behaviors or the new mother has a score of 10 or greater on the Edinburgh (EPDS)

- **yes**
  - Mother is exhibiting bizarre or unusual behavior or beliefs (e.g. extremes of mood, especially elation, seeming lack of sleep; strange ideas about the baby)
  - **yes**
    - Assess and refer to Emergency Department – If no other responsible parent/caregiver is available; refer to Child Protective Services (1-888-767-2445)
  - **no**
    - Is she exhibiting suicidal or infanticidal thoughts or thoughts of wanting to run away with infant?
    - **yes**
      - 1) Refer to RBHA provider
      - 2) Request updates daily from the co-parent, partner, family member until the person is evaluated by the RBHA Provider
    - **no**
      - Do the symptoms impair the new mother’s ability to care for herself, the infant, other children (e.g. she is unable to out of bed)?
      - **yes**
        - 1) Evaluate or refer to the RBHA provider
        - 2) If treating, follow-up as clinically appropriate to assess the effectiveness of treatment
        - 3) After two weeks, if there is no evidence of symptom reduction, refer to the RBHA provider or the Emergency Department, if appropriate
      - **no**
        - Have symptoms (mood or behavior changes) been present for two or more weeks?
        - **yes**
          - 1) Refer to community supports, including new homes groups or post-partum groups in the area
          - 2) Educate the parent on Arizona’s **Safe Haven Law**
          - 3) Evaluate chronic stressors (e.g. inadequate or unsafe housing, social isolation) and refer to social services or to the RBHA for psychotherapy
          - 4) Provide the local RBHAs crisis helpline
          - 5) Follow up as clinically indicated
        - **no**
          - Have symptoms resulted in significant disruptions to appetite or sleep pattern, or physical symptoms such as racing heart, shortness of breath, dizziness, or GI upset
          - **yes**
            - 1) Evaluate or refer to RBHA provider
            - 2) If treating, follow-up as clinically appropriate to assess the effectiveness of treatment
            - 3) After two weeks, if there is no evidence of symptom reduction, refer to the RBHA provider or the Emergency Department, if appropriate
          - **no**
            - Continue to Evaluate

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*Safe Haven Law*

According to Arizona State Law you can give your baby to a Safe Haven provider without fear of being arrested or anyone trying to identify or find you as long as the baby is less than 3 days old and is left with a staff member at a fire station or hospital, the baby has not been physically harmed and you do not plan to return for the baby at a later time.

(Arizona Revised Statute-13-3623)
POSTPARTUM DEPRESSION

UNIVERSALLY AVAILABLE MEDICATIONS THROUGH AHCCCS HEALTH PLANS AND RBHA PROVIDERS*

<table>
<thead>
<tr>
<th>SELECTIVE SEROTONIN REUPTAKE INHIBITOR</th>
</tr>
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<tbody>
<tr>
<td>Fluoxetine (Prozac)</td>
</tr>
<tr>
<td>Citalopram (Celexa)</td>
</tr>
<tr>
<td>Paroxetine (Paxil)</td>
</tr>
<tr>
<td>Sertraline (Zoloft)</td>
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<thead>
<tr>
<th>SEROTONIN NOREPINEPHRINE REUPTAKE INHIBITOR</th>
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<tbody>
<tr>
<td>Venlafaxine (Effexor)</td>
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<table>
<thead>
<tr>
<th>NOREPINEPHRINE DOPAMINE REUPTAKE INHIBITOR</th>
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<tbody>
<tr>
<td>Bupropion (Wellbutrin)</td>
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Note for Use by Lactating Women:

- For lactating mothers who have no history of antidepressant treatment, an antidepressant, such as paroxetine or sertraline should be first choice due to the evidence that these drugs produce very low drug levels in breast milk and infant serum and have few side effects.

- For lactating mothers who have been successfully treated with a particular SSRI, TCA, or SNRI in the past, the data and information for the previous specific antidepressant should be reviewed and carefully considered for first-line treatment if there are no contraindications.

- There are insufficient reports to support the use of venlafaxine, bupropion and duloxetine, however if a member was stable on one of these medications previously then the specific medication should be evaluated and considered for first-line treatment.

- Strategies to decrease infant exposure to the drug include administering the drug after feedings or pumping and discarding breast milk obtained during expected peak infant serum levels.

*Refer to health plan for prior authorization requirements.
3. Family Planning
Family Planning

In order to allow members to make informed decisions, counseling should provide accurate, up-to-date information regarding available family planning methods and prevention of sexually transmitted diseases.

Provide counseling and education to members of both genders that is age appropriate and includes information on:

• Prevention of unplanned pregnancies.
• Counseling for unwanted pregnancies. Counseling should include the member’s short and long-term goals.
• Spacing of births to promote better outcomes for future pregnancies.
• Preconception counseling to assist members in deciding on the advisability and timing of pregnancy, to assess risks and to reinforce habits that promote a healthy pregnancy.
• Sexually transmitted diseases, to include methods of prevention, abstinence, and changes in sexual behavior and lifestyle that promote the development of good health habits.

Contraceptives should be recommended and prescribed for sexually active members. PHPs are required to discuss the availability of family planning services annually. If a member’s sexual activity presents a risk or potential risk, the provider should initiate an in-depth discussion on the variety of contraceptives available and their use and effectiveness in preventing sexually transmitted diseases (including AIDS). Such discussions must be documented in the member’s medical record.

Full health care coverage and voluntary family planning services are covered. The following services are not covered for the purposes of family planning:

• Treatment of infertility
• Pregnancy termination counseling
• Pregnancy terminations
• Hysterectomies
• Hysteroscopic tubal sterilization
• Services to reduce voluntary, surgically induced fertilized embryos
4. Asthma
**Approved Asthma Controller Medicines**

**Goal:** To increase the percentage of members 5–64 years of age, who were identified as having persistent asthma, and were appropriately prescribed medication during the measurement year.

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescriptions</th>
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<tbody>
<tr>
<td>Long Term Control Medications</td>
<td></td>
</tr>
<tr>
<td>Inhaled steroid combinations</td>
<td>• budesonide-formoterol (Symbicort)°</td>
</tr>
<tr>
<td></td>
<td>• fluticasone-salmeterol (Advair Diskus)°</td>
</tr>
<tr>
<td>Inhaled corticosteroids</td>
<td>• budesonide (Pulmicort)°</td>
</tr>
<tr>
<td></td>
<td>• fluticasone CFC free (Flovent)°</td>
</tr>
<tr>
<td>Leukotriene modifiers</td>
<td>• montelukast (Singulair)°</td>
</tr>
<tr>
<td></td>
<td>• zafirlukast (Accolate)°</td>
</tr>
<tr>
<td>Long-acting, inhaled beta-2 agonists</td>
<td>• salmeterol (Serevent Diskus)°</td>
</tr>
<tr>
<td>Mast cell stabilizers</td>
<td>• cromolyn°</td>
</tr>
<tr>
<td></td>
<td>• nedocromil</td>
</tr>
<tr>
<td>Methylxanthines</td>
<td>• theophylline°</td>
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</tbody>
</table>

° Mercy Care Preferred Drug - Refer to Mercy Care Plan Preferred Drug List for details.
Asthma Visit Checklist for Healthcare Providers

Initial Visit
- What worries you most about your asthma?
  - Provide empathy. “I can understand how you feel...”; “I want to help...”
- What do you want to be able to do that you can’t do now because of your asthma?
  - Assess severity as specified in the NAEPP guidelines.
  - Restate your understanding of the patient’s goals.
- What do you want to accomplish at this visit?
  - Negotiate an agenda for the visit with the patient.
  - Provide basic facts about asthma (chronic, inflammatory). Explain controller and rescue medications.
- Are you taking medicines for other medical conditions?
  - Remind patient to bring all medications to every visit.
- What other questions or concerns do you have?

Follow-up Visits
- What medicines are you taking?
- How and when are you taking them?
- Are you having asthma symptoms at night or using your rescue medicine more than twice a week?
  - Assess control as specified in the NAEPP guidelines.
- Please show me how you use your inhaled medicines.
  - Review all medications and interpret peak flow.
- Have you noticed anything in your home, work, or school that makes your asthma worse?
- Have you tried to avoid things that make your asthma worse?
- What questions do you have about your Asthma Action Plan?
- Describe how you know when to call me or go to the hospital for asthma care.
- What other questions or concerns do you have?

Follow-up Visits
- Record patient history.
- Assess reversibility of airflow obstruction using spirometry.
- Exclude alternative diagnoses.

Patient Education
General
- Provide basic asthma facts.
- Ask:
  - “What worries you most about your asthma?”
  - “What questions do you have for me today?”
- Assess patient’s exposure and sensitivity to triggers.
- Provide written and verbal instructions on avoiding triggers.
- Advise on use of ER and when to call clinician.

Medications
- Explain use of controller and rescue medications.
- Provide Asthma Action Plan for medication use.
- Demonstrate and provide instruction on inhaler use.

Monitoring and Reporting
- Establish therapeutic goals.
- Provide instructions for monitoring and reporting.
  - Practice use of peak flow meter and explain its use as a monitoring tool (for patients with moderate-to-severe persistent asthma).
  - Instruct patients to record missed school/work days, reduced activity, and changes in symptoms.

Follow-up
- Depending on the level of asthma control, reevaluate patient in 2 weeks - 6 months as recommended in the NAEPP guidelines.
- Assess attainment of goals and patient’s concerns.
- Make necessary adjustments to treatment.
- Provide updated written Asthma Action Plan.
- Check patient’s peak flow and inhaler technique.
National Asthma Control Initiative
The National Heart, Lung, and Blood Institute Launches New Effort to Put What Works into Action

The Challenge
Today, 23 million people in the United States have asthma, including seven million children under 18 years of age. More than half of these individuals had at least one asthma attack in the previous year.

Asthma accounts for more than 10 million missed work days and almost 13 million missed school days each year. Moreover, ethnic and racial disparities in asthma morbidity and mortality persist, as does the disproportionate burden of asthma on individuals who live in lower-income, inner-city environments.

Implementing evidence-based clinical practice guidelines for asthma has demonstrated effectiveness. Yet, getting most clinicians to implement guidelines-based care for their patients with asthma and getting patients to adhere to their treatment plan remain a challenge.

Moving from Evidence to Action
The National Asthma Control Initiative (NACI) is a new initiative of the National Asthma Education and Prevention Program (NAEPP), coordinated by the National Heart, Lung, and Blood Institute (NHLBI). The NACI aims to use the recommendations of the NAEPP’s Expert Panel Report 3 (EPR-3)—Guidelines for the Diagnosis and Management of Asthma and its companion Guidelines Implementation Panel (GIP) Report to mobilize multisector stakeholders and bring about meaningful change in asthma clinical care practices and quality of life for people who have asthma.

NACI Action Items
- Develop a communication infrastructure for information sharing and accessing resources
- Demonstrate evidence-based and best practice approaches for specific audiences in various settings with emphasis on closing the asthma disparity gap
- Monitor and assess NACI progress toward its goals by measuring outcomes and sharing lessons learned
- Convene and energize national, regional, state, and local leaders
- Mobilize champion networks to implement and integrate clinical and community-based interventions with emphasis on sustainability

GOAL: Improved asthma care, asthma control, and quality of life for all people with asthma

GIP Priority Messages
The NACI will build on the GIP’s six priority messages, selected for their feasibility and potential to positively impact patient outcomes:
1. Use inhaled corticosteroids
2. Use asthma action plans
3. Assess asthma severity
4. Assess and monitor asthma control
5. Schedule follow-up visits
6. Control environmental exposures

Get Involved:
To learn more about the NACI, sign up for NACI updates, or become a NACI champion, go to the NACI Web site at http://naci.nhlbi.nih.gov

www.MercyCarePlan.com
### Summary of GIP Priority Messages and the Underlying EPR-3 Recommendations

<table>
<thead>
<tr>
<th>Message: Use Inhaled Corticosteroids</th>
<th>Message: Assess and Monitor Asthma Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inhaled corticosteroids are the most effective medications for long-term management of persistent asthma, and should be utilized by patients and clinicians as is recommended in the guidelines for control of asthma.</td>
<td>At planned follow-up visits, asthma patients should review level of control with their health care provider based on multiple measures of current impairment and future risk in order to guide clinician decisions to either maintain or adjust therapy.</td>
</tr>
<tr>
<td><strong>EPR-3 Recommendation:</strong> The Expert Panel recommends that long-term control medications be taken on a long-term basis to achieve and maintain control of persistent asthma, and that inhaled corticosteroids (ICS) are the most potent and consistently effective long-term control medication for asthma (Evidence A).</td>
<td><strong>EPR-3 Recommendation:</strong> The Expert Panel recommends that every patient who has asthma be taught to recognize symptom patterns and/or Peak Expiratory Flow (PEF) measures that indicate inadequate asthma control and the need for additional therapy (Evidence A), and that control be routinely monitored to assess whether the goals of therapy are being met – that is, whether impairment and risk are reduced (Evidence B).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Message: Use Asthma Action Plans</th>
<th>Message: Schedule Follow-up Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>All people who have asthma should receive a written asthma action plan to guide their self-management efforts.</td>
<td>Patients who have asthma should be scheduled for planned follow-up visits at periodic intervals in order to assess their asthma control and modify treatment if needed.</td>
</tr>
<tr>
<td><strong>EPR-3 Recommendation:</strong> The Expert Panel recommends that all patients who have asthma be provided a written asthma action plan that includes instructions for: (1) daily treatment (including medications and environmental controls), and (2) how to recognize and handle worsening asthma (Evidence B).</td>
<td><strong>EPR-3 Recommendation:</strong> The Expert Panel recommends that monitoring and follow up is essential (Evidence B), and that the stepwise approach to therapy—in which the dose and number of medications and frequency of administration are increased as necessary (Evidence A) and decreased when possible (Evidence C, D) be used to achieve and maintain asthma control.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Message: Assess Asthma Severity</th>
<th>Message: Control Environmental Exposures</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients should have an initial severity assessment based on measures of current impairment and future risk in order to determine type and level of initial therapy needed.</td>
<td>Clinicians should review each patient’s exposure to allergens and irritants and provide a multipronged strategy to reduce exposure to those allergens and irritants to which a patient is sensitive and exposed, i.e., that make the patient’s asthma worse.</td>
</tr>
<tr>
<td><strong>EPR-3 Recommendation:</strong> The Expert Panel recommends that once a diagnosis of asthma is made, clinicians classify asthma severity using the domains of current impairment (Evidence B) and future risk (Evidence C, D) for guiding decisions in selecting initial therapy. Note: While there is not strong evidence from clinical trials for determining therapy based on the domain of future risk, the Expert Panel considers that this is an important domain for clinicians to consider due to the strong association between history of exacerbations and the risk for future exacerbations.</td>
<td><strong>EPR-3 Recommendation:</strong> The Expert Panel recommends that patients who have asthma at any level of severity be queried about exposure to inhalant allergens, particularly indoor inhalant allergens (Evidence A) and tobacco smoke and other irritants (Evidence C), and be advised as to their potential effect on the patient’s asthma. The Expert Panel recommends that allergen avoidance requires a multifaceted, comprehensive approach that focuses on the allergens and irritants to which the patient is sensitive and exposed—individual steps alone are generally ineffective (Evidence A).</td>
</tr>
</tbody>
</table>

**Resources:**

- **Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma:** [www.nhlbi.nih.gov/guidelines/asthma](http://www.nhlbi.nih.gov/guidelines/asthma)
- **Guidelines Implementation Panel Report:** [www.nhlbi.nih.gov/guidelines/asthma/gip_rpt.htm](http://www.nhlbi.nih.gov/guidelines/asthma/gip_rpt.htm)
Asthma Action Plan

General Information:
■ Name ____________________________________________________________
■ Emergency contact ____________________________________________  Phone numbers _________________________
■ Physician/healthcare provider ______________________________________  Phone numbers _________________________
■ Physician signature ____________________________________________  Date _________________________________

Severity Classification
❍ Intermittent
❍ Moderate Persistent
❍ Mild Persistent
❍ Severe Persistent

Triggers
❍ Colds
❍ Smoke
❍ Weather
❍ Exercise
❍ Dust
❍ Air Pollution
❍ Animals
❍ Food
❍ Other ______________________

Exercise
1. Premedication (how much and when) ______
2. Exercise modifications _________________

Green Zone: Doing Well
Symptoms
■ Breathing is good
■ No cough or wheeze
■ Can work and play
■ Sleeps well at night

Peak Flow Meter
More than 80% of personal best or __________

Peak Flow Meter Personal Best =

Yellow Zone: Getting Worse
Symptoms
■ Some problems breathing
■ Cough, wheeze, or chest tight
■ Problems working or playing
■ Wake at night

Peak Flow Meter
Between 50% and 80% of personal best or __________ to __________

Control Medications:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much to Take</th>
<th>When to Take It</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Contact physician if using quick relief more than 2 times per week.
Continue control medicines and add:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much to Take</th>
<th>When to Take It</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN
❍ Take quick-relief medication every 4 hours for 1 to 2 days.
❍ Change your long-term control medicine by ____________________
❍ Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN
❍ Take quick-relief treatment again.
❍ Change your long-term control medicine by ____________________
❍ Call your physician/Healthcare provider within ____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert
Symptoms
■ Lots of problems breathing
■ Cannot work or play
■ Getting worse instead of better
■ Medicine is not helping

Peak Flow Meter
Less than 50% of personal best or __________ to __________

Ambulance/Emergency Phone Number:
Continue control medicines and add:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much to Take</th>
<th>When to Take It</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Go to the hospital or call for an ambulance if:
❍ Still in the red zone after 15 minutes.
❍ You have not been able to reach your physician/healthcare provider for help.
❍ ____________________

Call an ambulance immediately if the following danger signs are present:
❍ Trouble walking/talking due to shortness of breath.
❍ Lips or fingernails are blue.

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Rev_July_2008
Plan de acción contra el asma

Información general:
- Nombre ____________________________
- Contacto en caso de emergencia ____________________________ Números telefónicos ____________________________
- Médico/Proveedor de atención médica ____________________________ Números telefónicos ____________________________
- Firma del médico ____________________________ Fecha ____________________________

<table>
<thead>
<tr>
<th>Clasificación de la gravedad</th>
<th>Desencadenantes</th>
<th>Actividad física</th>
</tr>
</thead>
<tbody>
<tr>
<td>O Intermitten te</td>
<td>O Resfíos</td>
<td>1. Previa al medicamento (cuánta y cuándo) ____________________________</td>
</tr>
<tr>
<td>O Leve persistente</td>
<td>O Fumar</td>
<td></td>
</tr>
<tr>
<td>O Moderada persistente</td>
<td>O Ejercicio</td>
<td></td>
</tr>
<tr>
<td>O Severa persistente</td>
<td>O Polvo</td>
<td></td>
</tr>
<tr>
<td>O Otros</td>
<td>O Contaminación</td>
<td></td>
</tr>
<tr>
<td>O Animales</td>
<td>O Alimentos</td>
<td></td>
</tr>
</tbody>
</table>

Zona verde: se encuentra bien

Síntomas
- Respira bien
- No tiene tos ni respiración ruidosa
- Puede trabajar y jugar
- Duermo toda la noche

Medidor de flujo máximo
Más del 80% del récord o ________

Récord obtenido en el medidor de flujo máximo:

<table>
<thead>
<tr>
<th>Medicamentos de control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicamento</td>
</tr>
<tr>
<td>__________________</td>
</tr>
<tr>
<td>__________________</td>
</tr>
<tr>
<td>__________________</td>
</tr>
</tbody>
</table>

Zona amarilla: está empeorando

Síntomas
- Algunas dificultades para respirar
- Tes, respiración ruidosa u opresión en el pecho
- Problemas para trabajar o jugar
- Se despierta por las noches

Medidor de flujo máximo
Entre el 50% y el 80% del récord, o entre ________ y ________

Si los síntomas (y el flujo máximo, si se mide) regresan a la zona verde después de una hora del tratamiento de alivio rápido:
- Tome el medicamento de alivio rápido cada 4 horas durante 1 ó 2 días
- Cambie sus medicamentos de control a largo plazo por ________
- Comuníquese con su médico para obtener atención de seguimiento

Comuníquese con el médico si utiliza el medicamento más de 2 veces por semana.

Continúe con los medicamentos de control y agregue:

<table>
<thead>
<tr>
<th>Medicamento</th>
<th>Cantidad que debe tomar</th>
<th>Horarios en que debe tomarlo</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________</td>
<td>__________________</td>
<td>__________________</td>
</tr>
<tr>
<td>__________________</td>
<td>__________________</td>
<td>__________________</td>
</tr>
<tr>
<td>__________________</td>
<td>__________________</td>
<td>__________________</td>
</tr>
</tbody>
</table>

Zona roja: alerta médica

Síntomas
- Muchas dificultades para respirar
- No puede trabajar a jugar
- Se empeora en lugar de mejorar
- El medicamento no ayuda

Medidor de flujo máximo
Menos del 50% del récord, o entre ________ y ________

Diríjase al hospital o llame a una ambulancia si:
- Persiste en la zona roja luego de 15 minutos
- No puede comunicarse con su médico/proveedor de atención médica para solicitar ayuda

Número telefónico de emergencias/ la ambulancia:

<table>
<thead>
<tr>
<th>Medicamento</th>
<th>Cantidad que debe tomar</th>
<th>Horarios en que debe tomarlo</th>
</tr>
</thead>
<tbody>
<tr>
<td>__________________</td>
<td>__________________</td>
<td>__________________</td>
</tr>
<tr>
<td>__________________</td>
<td>__________________</td>
<td>__________________</td>
</tr>
<tr>
<td>__________________</td>
<td>__________________</td>
<td>__________________</td>
</tr>
</tbody>
</table>

Diríjase al hospital o llame a una ambulancia si se presentan las siguientes señales de peligro:
- Tiene problemas para caminar/hablar debido a la falta de aire
- Los labios o las uñas se tornan de color azul

Lléme a un ambulancia inmediatamente si se presentan las siguientes señales de peligro:

Rev. July 2008

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**Childhood Asthma Control Test for children 4 to 11 years.**

This test will provide a score that may help the doctor determine if your child’s asthma treatment plan is working or if it might be time for a change.

**How to take the Childhood Asthma Control Test**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Let your child respond to the first four questions (1 to 4). If your child needs help reading or understanding the question, you may help, but let your child select the response. Complete the remaining three questions (5 to 7) on your own and without letting your child’s response influence your answers. There are no right or wrong answers.</td>
</tr>
<tr>
<td>2</td>
<td>Write the number of each answer in the score box provided.</td>
</tr>
<tr>
<td>3</td>
<td>Add up each score box for the total.</td>
</tr>
<tr>
<td>4</td>
<td>Take the test to the doctor to talk about your child’s total score.</td>
</tr>
</tbody>
</table>

**Have your child complete these questions.**

1. How is your asthma today?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Very bad</td>
</tr>
<tr>
<td>1</td>
<td>Bad</td>
</tr>
<tr>
<td>2</td>
<td>Good</td>
</tr>
<tr>
<td>3</td>
<td>Very good</td>
</tr>
</tbody>
</table>

2. How much of a problem is your asthma when you run, exercise or play sports?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>It’s a big problem, I can’t do what I want to do.</td>
</tr>
<tr>
<td>1</td>
<td>It’s a problem and I don’t like it.</td>
</tr>
<tr>
<td>2</td>
<td>It’s a little problem but it’s okay.</td>
</tr>
<tr>
<td>3</td>
<td>It’s not a problem.</td>
</tr>
</tbody>
</table>

3. Do you cough because of your asthma?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Yes, all of the time.</td>
</tr>
<tr>
<td>1</td>
<td>Yes, most of the time.</td>
</tr>
<tr>
<td>2</td>
<td>Yes, some of the time.</td>
</tr>
<tr>
<td>3</td>
<td>No, none of the time.</td>
</tr>
</tbody>
</table>

4. Do you wake up during the night because of your asthma?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Yes, all of the time.</td>
</tr>
<tr>
<td>1</td>
<td>Yes, most of the time.</td>
</tr>
<tr>
<td>2</td>
<td>Yes, some of the time.</td>
</tr>
<tr>
<td>3</td>
<td>No, none of the time.</td>
</tr>
</tbody>
</table>

**Please complete the following questions on your own.**

5. During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Not at all</td>
</tr>
<tr>
<td>4</td>
<td>1-3 days</td>
</tr>
<tr>
<td>3</td>
<td>4-10 days</td>
</tr>
<tr>
<td>2</td>
<td>11-18 days</td>
</tr>
<tr>
<td>1</td>
<td>19-24 days</td>
</tr>
<tr>
<td>0</td>
<td>Everyday</td>
</tr>
</tbody>
</table>

6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Not at all</td>
</tr>
<tr>
<td>4</td>
<td>1-3 days</td>
</tr>
<tr>
<td>3</td>
<td>4-10 days</td>
</tr>
<tr>
<td>2</td>
<td>11-18 days</td>
</tr>
<tr>
<td>1</td>
<td>19-24 days</td>
</tr>
<tr>
<td>0</td>
<td>Everyday</td>
</tr>
</tbody>
</table>

7. During the last 4 weeks, how many days did your child wake up during the night because of asthma?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Not at all</td>
</tr>
<tr>
<td>4</td>
<td>1-3 days</td>
</tr>
<tr>
<td>3</td>
<td>4-10 days</td>
</tr>
<tr>
<td>2</td>
<td>11-18 days</td>
</tr>
<tr>
<td>1</td>
<td>19-24 days</td>
</tr>
<tr>
<td>0</td>
<td>Everyday</td>
</tr>
</tbody>
</table>

**TOTAL**
Prueba de control del asma de la infancia para niños/as de 4 a 11 años

Esta prueba le dará un puntaje que puede ayudar al médico a evaluar si el tratamiento para el asma de su niño/a está funcionando o si puede ser el momento adecuado para cambiarlo.

Cómo contestar la prueba de control del asma de la infancia

Paso 1 Deje que su niño/a conteste las primeras cuatro preguntas (de la 1 a la 4). Si su niño/a necesita ayuda para leer o entender alguna pregunta, usted puede ayudar pero deje que él/ella sea quien elija la respuesta. Conteste usted las tres preguntas restantes (de la 5 a la 7) y no permita que las respuestas de su niño/a afecten sus respuestas. No hay respuestas correctas o incorrectas.

Paso 2 Escriba el número de cada respuesta en el cuadrito de puntaje que se encuentra a la derecha de cada pregunta.

Paso 3 Sume cada uno de los puntajes de los cuadritos para obtener el total.

Paso 4 Enseñe la prueba a su médico para hablar sobre el puntaje total de su niño/a.

Deje que su niño/a conteste estas preguntas.

1. ¿Cómo está su asma hoy?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muy mala</td>
<td>Mala</td>
<td>Buena</td>
<td>Muy buena</td>
</tr>
</tbody>
</table>

2. ¿Qué tan problemática es su asma cuando corres, haces ejercicio o practicas algún deporte?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Es un problema grande, no puedo hacer lo que quiero hacer.</td>
<td>Es un problema y no me siento bien.</td>
<td>Es un problema pequeño pero está bien.</td>
<td>No es un problema.</td>
</tr>
</tbody>
</table>

3. ¿Tienes tos debido a tu asma?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sí, siempre.</td>
<td>Sí, la mayoría del tiempo.</td>
<td>Sí, algo del tiempo.</td>
<td>No, nunca.</td>
</tr>
</tbody>
</table>

4. ¿Te despertas durante la noche debido a tu asma?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sí, siempre.</td>
<td>Sí, la mayoría del tiempo.</td>
<td>Sí, algo del tiempo.</td>
<td>No, nunca.</td>
</tr>
</tbody>
</table>

Por favor conteste usted las siguientes preguntas.

5. Durante las últimas 4 semanas, ¿cuántos días tuvo su niño/a síntomas de asma durante el día?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nunca</td>
<td>De 1 a 3 días</td>
<td>De 4 a 10 días</td>
<td>De 11 a 18 días</td>
<td>De 19 a 24 días</td>
</tr>
</tbody>
</table>

6. Durante las últimas 4 semanas, ¿cuántos días tuvo su niño/a respiración sibilante (un silbido en el pecho) durante el día debido al asma?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nunca</td>
<td>De 1 a 3 días</td>
<td>De 4 a 10 días</td>
<td>De 11 a 18 días</td>
<td>De 19 a 24 días</td>
</tr>
</tbody>
</table>

7. Durante las últimas 4 semanas, ¿cuántos días se despertó su niño/a durante la noche debido al asma?

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nunca</td>
<td>De 1 a 3 días</td>
<td>De 4 a 10 días</td>
<td>De 11 a 18 días</td>
<td>De 19 a 24 días</td>
</tr>
</tbody>
</table>

Si el puntaje de su niño/a es 19 o menos, puede ser una señal de que el asma de su niño/a no está tan bien controlada como podría estar. Sin importar el resultado, lleve esta prueba a su médico para hablar sobre los resultados de su niño/a.

www.MercyCarePlan.com
5. Tobacco Cessation
3

Easy Steps

1. Patient must receive a prescription for a smoking cessation product from their primary care provider (max supply – 12-week supply in a 6-month time period).

2. Prior Authorization is required for the following:
   • Patient is under 18 years old
   • Brand name medication when a generic for that brand is available
   • Bupropion 24 hour

3. Patient is encouraged to enroll in a smoking cessation program through Arizona's Smokers' Helpline (ASHLine). To enroll call toll-free 1-800-55-66-222 or visit www.ashline.org/webquit

Note: Coverage is not authorized for non-title XIX members, indications other than for a smoking cessation aid, doses greater than FDA max allowable, combination treatment with more than one smoking cessation agent, or specific drug disease condition contraindications.

Coverage for Dual Eligibles: Medications that are available by prescription only and bear the federal legend, “Federal law Prohibits Dispensing without a Prescription” are to be obtained from and covered by the Medicare Part D Plan. Medications that are available over-the-counter are to be covered by the AHCCCS Contracted Health Plans and ordered in accordance with Section B, Guidelines for Approval.
# Medications for Tobacco Cessation

There are seven FDA-approved first-line medications available for tobacco cessation:
- over-the-counter nicotine replacement patch, gum, and lozenge
- Prescription nicotine replacement inhaler and nasal spray
- Zyban® and Chantix™ (prescription)

**Enrolled ASHLine clients are eligible for:**
- 2 weeks of no-cost nicotine patch, gum, or lozenge

**Members of Arizona Health Care Cost Containment System (AHCCCS) plan are eligible for:**
- 12 weeks of any of the 7 FDA-approved medications by obtaining a provider description and presenting it at an approved pharmacy (www.azahccs.gov)
- For more details on AHCCCS Coverage, please contact your ASHLine Regional Outreach Coordinator or visit www.azahccs.gov.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Nicotine Gum (2 mg or 4 mg)</th>
<th>Nicotine Lozenge</th>
<th>Nicotine Patches</th>
<th>Nicotine Inhaler</th>
<th>Nicotine Nasal Spray</th>
<th>Varencline (Chantix™)</th>
<th>Bupropion SR (Zyban®)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>The nicotine in the gum is absorbed through the lining of the mouth.</td>
<td>The nicotine in the lozenge is absorbed through the lining of the mouth.</td>
<td>Most common form of NRT. Patch contains nicotine which is absorbed through the skin.</td>
<td>Nicotine inhaled though mouth.</td>
<td>A nicotine solution designed to be used in same fashion as other nasal sprays.</td>
<td>Varencline binds to nicotinic receptors. Block effects of nicotine and eases withdrawal symptoms.</td>
<td>Can be used with NRT products. Reduces withdrawal symptoms.</td>
</tr>
<tr>
<td><strong>Dosage</strong></td>
<td>1 piece every 1 to 2 hours. If ≤ 24 cigs: 2 mg. If ≥ 25 cigs: 4 mg.</td>
<td>2 mg: If smoking after first 30 min. of waking. 4 mg: if smoking with first 30 minutes of waking Weeks 1 - 6: 1 every 1-2 hrs. Weeks 7 - 9: 1 every 2 - 4 hrs. Weeks 10 - 12: 1 every 4 - 8 hrs.</td>
<td>One patch per day if ≥ 10 cigs/day: 21 mg for 4 wks, then 14 mg for 2 wks, 7 mg for 2 wks if ≤ 10/day: 14 mg for 4 wks, 7 mg for 4 wks.</td>
<td>6 - 12 cartridges/day. Inhale 80 times/cartridge.</td>
<td>1 dose = 1 squirt per nostril 1 - 2 doses per hours 8 - 40 sprays per day.</td>
<td>Dosage must be set in consultation with medical provider. Generally: Day 1 - 3.5 mg every morning. Day 4 - 7.5 mg twice daily. Day 8 - end: 1 mg twice daily.</td>
<td>Dosage must be set in consultation with medical provider. Generally, days 1-3: 150 mg each morning. Days 4 - end: 150 mg twice daily.</td>
</tr>
<tr>
<td><strong>Use</strong></td>
<td>Up to 12 weeks or as needed.</td>
<td>Up to 12 weeks.</td>
<td>3 - 6 month taper at end.</td>
<td>Up to 6 months; tapered at end.</td>
<td>3 - 6 months: taper at end.</td>
<td>Start 1 week before quit date: use 3 - 6 months.</td>
<td>Start 1 - 2 weeks before quit date. Use 2 - 6 months.</td>
</tr>
<tr>
<td><strong>Availability</strong></td>
<td>OTC: Nicorette or Generic ASHLine enrolled clients (2 weeks, if applicable). AHCCCS members with Physician prescription.</td>
<td>OTC: Habitrol; Nicoderm CQ: Nicotrol: Prostep. ASHLine enrolled clients (2 weeks, if applicable). AHCCCS members with Physician prescription.</td>
<td>Prescription only: Nicotrol Inhaler.</td>
<td>Prescription only: Nicotrol NS AHCCCS members may qualify for 12 weeks medication benefit with doctor’s prescription.</td>
<td>Prescription only: Nicotrol NS AHCCCS members may qualify for 12 weeks medication benefit with doctor’s prescription.</td>
<td>Prescription only. AHCCCS members may qualify for 12 weeks medication benefit with doctor’s prescription.</td>
<td></td>
</tr>
</tbody>
</table>
FAX TO:  Arizona Smokers’ Helpline
1-866-897-1263

TODAY’S DATE: ___/___/___

| Type of Setting: | FAX BACK #: (___) _____ - _______
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Physician Office ☐ W/C</td>
<td>Referred by: ____________________</td>
</tr>
<tr>
<td>☐ Dental Office ☐ Community Group</td>
<td>Location/Site: __________________</td>
</tr>
<tr>
<td>☐ Health Clinic ☐ Insurance Provider</td>
<td>Address: _________________________</td>
</tr>
</tbody>
</table>
| ☐ Hospital ☐ Worksite             | City: ___________________________ Zip: _______
| ☐ Other: _________________         | Phone: (___) _____ - ____________ |

Client Consent and Personal Information Section:

☐ I understand that the ASHLine (Arizona Smokers’ Helpline) will be contacting me with quit tobacco information, community referrals and/or coaching. My participation is voluntary. I understand that any information I provide will be kept confidential. I give the ASHLine and the referring agency or physician permission to discuss my use of service.

__________
Client Name (please print)

__________
Client or Guardian Signature

☐ Verbal consent received

__________
Person obtaining verbal consent (sign and print)

☐ Spanish Speaker ☐ English Speaker

Best time to call:

☐ 8am to 12pm
☐ 12pm to 5pm
☐ 5pm to 8:00pm
☐ Specific:__________

Phone: ☐ home ☐ work ☐ cell ☐ other

Date of Birth: ____/____/_____

County of Residence: ____________

Comments:
Sección para Obtener Información y Permiso del Paciente:

☐ Estoy consciente que la Línea de Asistencia Para Fumadores (Arizona Smokers’ Helpline) me llamaré por teléfono con información, referencias y consejería. Mi participación es voluntaria. Cualquier información que yo les dé se mantendrá confidencial. La Línea, el agente o el doctor que me referió, tienen mi permiso, para hablar sobre mi uso del servicio.

<table>
<thead>
<tr>
<th>Nombre del paciente (en letra imprenta)</th>
</tr>
</thead>
<tbody>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Firma del paciente o guardiano</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
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</table>

☐ Permiso se obtuvo verbalmente

<table>
<thead>
<tr>
<th>Persona que obtuvo el permiso verbal (firma y en letra de imprenta)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

☐ Se habla español ☐ Se habla inglés

Mejor hora para comunicarnos con el paciente:

☐ 8am to 12pm
☐ 12pm to 5pm
☐ 5pm to 8:00pm
☐ Specific: __________

FAX TO: Arizona Smokers’ Helpline
1-866-897-1263

TODAY’S DATE: __/__/__
6. Division of Developmental Disabilities (DDD) and Behavioral Health Services
Eligibility for DDD Services

Must be diagnosed with:
• Mental Retardation
• Cerebral Palsy
• Epilepsy
• Autism

Have limitations in:
• Self Care
• Receptive and Expressive Language
• Learning
• Mobility
• Self Direction
• Capacity for Independent Living
• Economic Self-Sufficiency

DDD and Long Term Care (LTC)
• DDD is the contractor with LTC and subcontracts with AHCCCS Health Plans to provide ACUTE medical supports and services to their consumers

Division of Developmental Disabilities

DDD may provide the following LTC services to their consumers:
• Attendant care
• Augmentation devises
• Case management services
• Communication devices
• Day treatment and training
• Habilitation

• Home health for long term needs
• Housekeeping services
• Nursing facility and/or ICFMR
• Nursing for long term needs
• Home modifications
• Respite
• Support coordination
• Therapies for long term needs

Mercy Care Plan
• Mercy Care Plan is one of three AHCCCS Health Plans that subcontract with DDD to provide ACUTE medical supports and services to DDD and LTC consumers
• Mercy Care Plan covers 10 counties

Mercy Care Plan Supports and Services
• Acute care services including doctor visits, hospitalization, specialists, medications, DME, laboratory and x-rays, ACUTE home health and family planning
• Nursing facility (90 day benefit), Hospice (unlimited), rehabilitative therapies
• Emergency room visits
• Transportation to medically necessary appointments covered through acute services
• Sterilization
• External nutritional programs

www.MercyCarePlan.com
Resources

Department of Education
• 602-542-4013
• www.ade.state.az.us/ess/

Pilot Parents of Southern AZ
• 520-324-3150 or 877-365-7220
• www.pilotparents.org

Raising Special Kids
• 602-242-4366 or 800-237-3007
• www.raisingspecialkids.org

AZ Center for Disability Law
• 602-274-6287 or 800-927-2260
• www.acdl.com

Children’s Rehabilitative Services (CRS)
CRS is a program of the Department of Health Services, provides medical treatment, rehabilitation and related support and services to medically and financially qualified people who have certain medical, disabling conditions that have the potential for functional improvement. CRS services are managed by United Health Services.

Conditions accepted for care include but are not limited to:
• Conditions present at birth or acquired, such as club feet, cleft palate, malunited fracture, scoliosis, spina bifida, and congenital genitourinary and gastrointestinal anomalies
• Muscle and nerve disorder
• Some conditions of epilepsy
• Certain heart conditions
Behavioral Health

- Primary Care Physicians (PCPs) can provide medication management services (i.e. prescriptions, med visits, labs and other diagnostic tests) for members enrolled in Arizona Health Care Cost Containment System (AHCCCS) that have a diagnosis of depression, anxiety or Attention Deficit Hyperactivity Disorder (ADHD).
- Each AHCCCS health plan is responsible for having psychotropic medications on their formularies for treating depression, anxiety and ADHD.
- AHCCCS has developed evidence-based practice guidelines for the treatment of anxiety, depression, and ADHD. Included in these guidelines are, for example, helpful screening tools to assist in screening for anxiety, depression and ADHD. The guidelines are located on the Mercy Care Plan (MCP) provider website. PCPs should become familiar with these guidelines.
- PCPs may also refer their members to the Regional Behavioral Health Authority (RBHA) for services to treat these conditions. In addition, for members who present with a behavioral health disorder other than anxiety, depression, or ADD/ADHD, PCPs should refer members to the RBHA.
- RBHAs provide comprehensive behavioral health services that includes counseling, psychiatric services, and emergency behavioral health care (please see MCP provider manual for a listing of additional RBHA services).
- Consultation for PCPs regarding member treatment options, medications, referrals and transition of care is available from the RBHAs. Contact the RBHAs directly for these consultations.

How to refer to the RBHA:
- Member or PCP office can call the RBHA directly for services (RBHA contact information included).
- PCPs office can fax PM Form 3.3.1 to RBHA directly for member to receive BH services (this PM form is included, as well as RBHA contact information).

When to transfer psychiatric care to the RBHA:
- When a member presents with a behavioral health disorder other than anxiety, depression, or ADD/ADHD. When a member has experienced a sentinel event (i.e. attempted suicide) or an inpatient hospitalization for a behavioral health diagnosis.
- When the PCP is not comfortable treating the member’s behavioral health disorder.

Transferring care to the RBHA
- PCPs need to make sure they give the member enough of his/her psychotropic medication to last through the transition so that there is no interruption in the medication regime (an appointment for a member to see a RBHA prescriber may take up to 30 days or longer. Therefore, the PCP’s oversight is very important).
- PCPs need to transfer all applicable records to the RBHA provider per HIPPA guidelines, including but not limited to, reason for referral/transfer, diagnostic information, medical history, medication history and all current prescriptions provided for the member, including timeframes for dispensing and refilling medications during the transition period (all this information needs to be forwarded to the RBHA prescriber prior to the member’s first appointment with the RBHA prescriber).
- PCPs need to maintain documentation in the member’s medical record related to the transition to the RBHA that includes at least the following:  
  - Ongoing treatment during the transition  
  - The date the member was referred  
  - The reason the member was referred  
  - Receiving contact name and pertinent information  
  - The date that the medical record was forwarded to the RBHA, as well as what medical records were provided to the RBHA, and  
  - Any other pertinent information
- During the transfer of care to the RBHA, and on an ongoing basis, the PCP’s office needs to be responsive to a RBHA’s request for medical information within 10 business days.
- The response to the RBHA should comprise, but is not limited to, all pertinent information including:  
  - Current diagnoses  
  - Current medications
• Lab results
• Date of last PCP visit
• Recent hospitalizations (last 6 months)
• When behavioral health information is received by the PCP, the PCP needs to establish a
  medical record or appropriately labeled file even if the PCP has yet to see the assigned member.
• When a member is enrolled in the RBHA, the PCP needs to provide to the RBHA provider updates regarding:
  – Diagnosis of chronic conditions
  – All medications prescribed
  – Support for the petitioning process
  – Any other clinically significant information
• Behavioral health and step-therapy.
  – If a member was referred back to the PCP by the RBHA for treatment of anxiety, depression or ADHD, the PCP should provide the same
    medication at the same dose as the RBHA, unless there was a subsequent change in medical condition of the member. MCP will
    provide this medication, even if it is not on MCP preferred drug list.
  – If the member/parent reports member having tried several medications/have participated in step therapy for anxiety, depression or ADHD, the PCP should consult, or obtain information from the member’s previous RBHA provider prior to the current treatment regime.
• Please contact Member Services with any questions.
7. Forms
Missed Appointment Log

In an effort to improve our member’s health and assist your office with missed and “No Show” appointments, please fill in the requested information for Mercy Care Plan or Mercy Care Advantage members only. With this information, our outreach staff can call each member to offer assistance with issues that may be hindering the member from keeping their appointments, such as transportation. Please notify Mercy Care Plan or Mercy Care Advantage within one week of the appointment by faxing this form to 1-800-624-3879. If you have any questions, please call 602-263-3000 or toll-free 1-800-624-3879.

<table>
<thead>
<tr>
<th>Member ID#</th>
<th>Member Name</th>
<th>Date of birth</th>
<th>Missed appointment date and time</th>
<th>Late and not seen</th>
<th>No Show</th>
<th>Cancelled &lt;24 hrs.</th>
<th>Reason for Appointment</th>
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<tbody>
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</table>

This message is intended only for the use of the individual or entity to which it is addressed and may contain confidential and/or proprietary information. If you are not the intended recipient or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is prohibited. If you received this communication in error, please notify the sender at the phone number above.
Member’s PCP Change Request Form

I, _____________________________am requesting to be assigned to the following Primary Care Physician (PCP): ________________________________ effective_____________________.

I understand it is my choice to select a PCP, and I am freely requesting this change be processed on my behalf by ________________________________ personnel. I have recorded my information below to confirm my identity.

Member’s Name: __________________________________________________________

Date of Birth: ___________________ AHCCCS ID number: _______________________

Mailing Address: ___________________________________________________________

Contact Telephone Number: _________________________________________________

Member’s Signature: ___________________________ Date: _______________________

Witness Name: ___________________________ Date: ___________________________

-------------------------------------------------------------------------------------------------------------------------------

For Office Use Only

Demographic Information of Group Requesting Change

Group Name: __________________________________________________________________

Address: ___________________________________________________________________

Tax Id Number: _______________________________________________________________

PCP Information

PCP’s Name: __________________________________________________________________

Physical Address (Location): ___________________________________________________

PCP’s Individual NPI: _________________________________________________________

Office Staff Name (Print): ___________________________________________________________________ Date: ________________________

Email Request to: MBU-MCP_Enrollment@AETNA.com or FAX Request to: 602-351-2313

www.MercyCarePlan.com
# Quick Reference Guide - Appointment Availability Standards

## Primary Care

<table>
<thead>
<tr>
<th>EMERGENCY</th>
<th>URGENT</th>
<th>ROUTINE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Same day of request or within 24 hours of call or notification</strong></td>
<td><strong>Within 2 days of request</strong></td>
<td><strong>Within 21 days of request</strong></td>
</tr>
</tbody>
</table>

## Specialty Care

<table>
<thead>
<tr>
<th>EMERGENCY</th>
<th>URGENT</th>
<th>ROUTINE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within 24 hours of referral</strong></td>
<td><strong>Within 3 days of referral</strong></td>
<td><strong>Within 45 days of referral</strong></td>
</tr>
</tbody>
</table>

## Dental Care

<table>
<thead>
<tr>
<th>EMERGENCY</th>
<th>URGENT</th>
<th>ROUTINE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within 24 hours of referral</strong></td>
<td><strong>Within 3 days of referral</strong></td>
<td><strong>Within 45 days of referral</strong></td>
</tr>
</tbody>
</table>

## Maternity Care

<table>
<thead>
<tr>
<th>FIRST TRIMESTER</th>
<th>SECOND TRIMESTER</th>
<th>THIRD TRIMESTER</th>
<th>HIGH RISK PREGNANCIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Within 14 days of request</strong></td>
<td><strong>Within 7 days of request</strong></td>
<td><strong>Within 3 days of request</strong></td>
<td><strong>Within 3 days of identification of High Risk</strong></td>
</tr>
</tbody>
</table>

## Wait Time

Should not be more than 45 minutes from appointment time (except if provider is unavailable due to an emergency).