Asthma among adults enrolled in Medicaid

Asthma disproportionally affects lower-income populations

People who live in poverty have a higher prevalence of asthma than people who do not live in poverty.[1] Furthermore, people with asthma who report lower incomes are less likely to have well-controlled asthma and are more likely to use an emergency department (ED) for crisis oriented care than are people with asthma and higher incomes.[2,3] Lack of regular outpatient care and poorly controlled asthma may lead to activity limitation, missed work days, and increased medical costs which add hardships for a person already on a limited income.

Montana Medicaid provides health care coverage to qualifying low income adults. Adults are eligible for Medicaid if they meet specific financial requirements and are parents, are pregnant, have breast or cervical cancer, aged 65 years or older, or are blind or disabled.[4] The following report describes asthma prevalence and symptoms among Montana adults aged 18-64 years enrolled in Medicaid. Data are from self-reported information collected during the 2012 Montana Medicaid Health and Chronic Disease Survey (MHCDS).

In Montana, adults with a household income of less than $25,000 a year have a significantly higher prevalence of asthma than do adults with higher incomes*

Data source: BRFSS, 2011

**This value may be higher than most Medicaid-qualifying income levels*

Survey methods

The MHCDS is a telephone survey of adults aged 18-64 years. Participants are recruited randomly from the Montana Medicaid Program. During the MHCDS, participants are asked about their health risks and behaviors. The Behavioral Risk Factor Surveillance System (BRFSS) survey is also a survey of adults aged18 years and older about health risks and behaviors. During the BRFSS, if an adult indicates that they either had or currently have asthma they are asked to participate in the Asthma Call-Back Survey (ACBS). If they agree, they are called again and asked more in-depth questions about their experience with asthma and their use of specific asthma medications.

Current asthma refers to people who responded ‘yes’ to ‘Has a health care provider ever told you that you have asthma?’ and ‘Do you still have asthma?’

Asthma Prevalence

More than one in four adults enrolled in Medicaid in Montana reported having an asthma diagnosis in their lifetime, and one in five currently has the disease (Figure 1). Both the lifetime and current prevalence of asthma were significantly higher among adults enrolled in Medicaid than among the general adult population in the state.

Sixty-one percent of adults with asthma enrolled in Medicaid reported their health status was fair or poor (Figure 2). This is 1.5 times higher than for adults enrolled in Medicaid without asthma

and twice as high as reported by the general adult population with asthma.

Tobacco smoke is a common asthma trigger. In spite of this, 40% of Medicaid respondents with asthma and 32% of the general adult population with asthma reported being current smokers (Figure 2).

Figure 1. Prevalence of lifetime and current asthma among adults aged 18-64 years, Montana, BRFSS and MHCDS, 2011

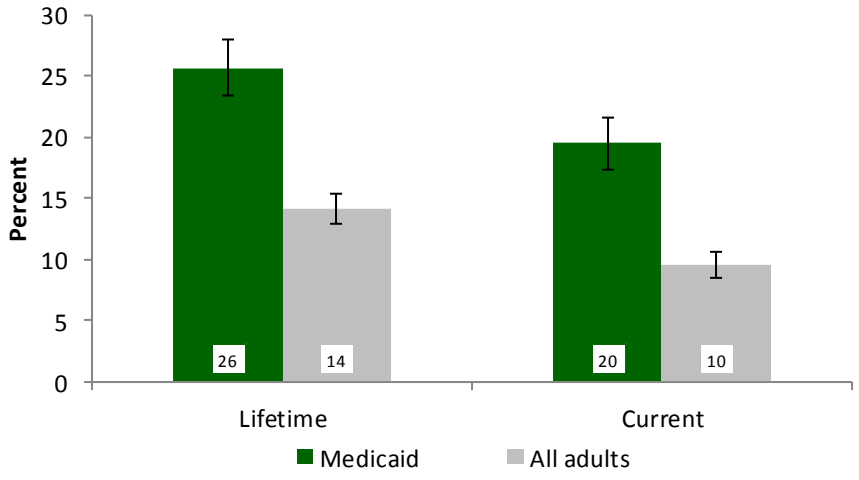
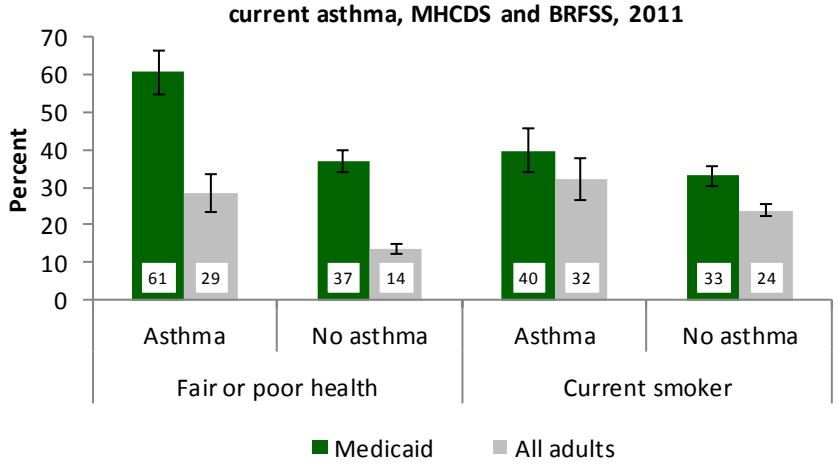


Figure 2. Self-reported quality of life and smoking prevalence of adults aged 18-64 years with and without current asthma, MHCDS and BRFSS, 2011



Health Care Utilization and Asthma Symptoms

Establishing and maintaining asthma control is a primary goal of clinical asthma therapy. Control is assessed based on a person's asthma symptoms and lung function and is classified accordingly (see EPR-3 Guidelines, Figure 3-5c[5]). Adults with asthma enrolled in Medicaid experienced more constant asthma symptoms and more urgent healthcare needs despite receiving preventive care at similar rates as the general adult population with asthma (Figures 3, 4).

· Asthma is a chronic condition that requires regular monitoring. Of adults with asthma more than 80% in both the general population and in the Medicaid population have a personal doctor. About half reported having a routine checkup for asthma in the last year.

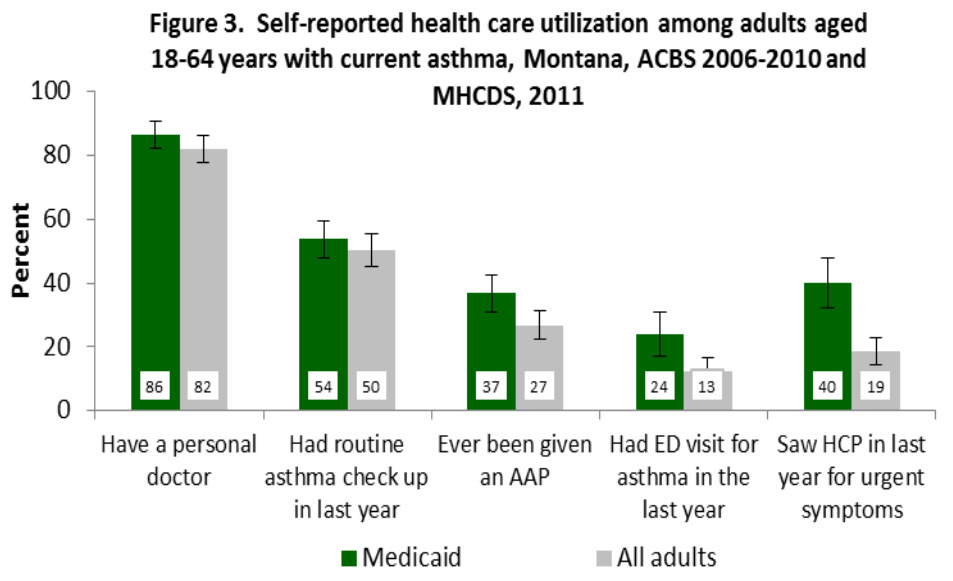
· An asthma action plan (AAP) provides a personalized plan for responding to worsening asthma symptoms. There was no significant difference in the frequency of having received an AAP among adults with asthma in the Medicaid population and the general adult population. Less than half of each group had ever been given an AAP.

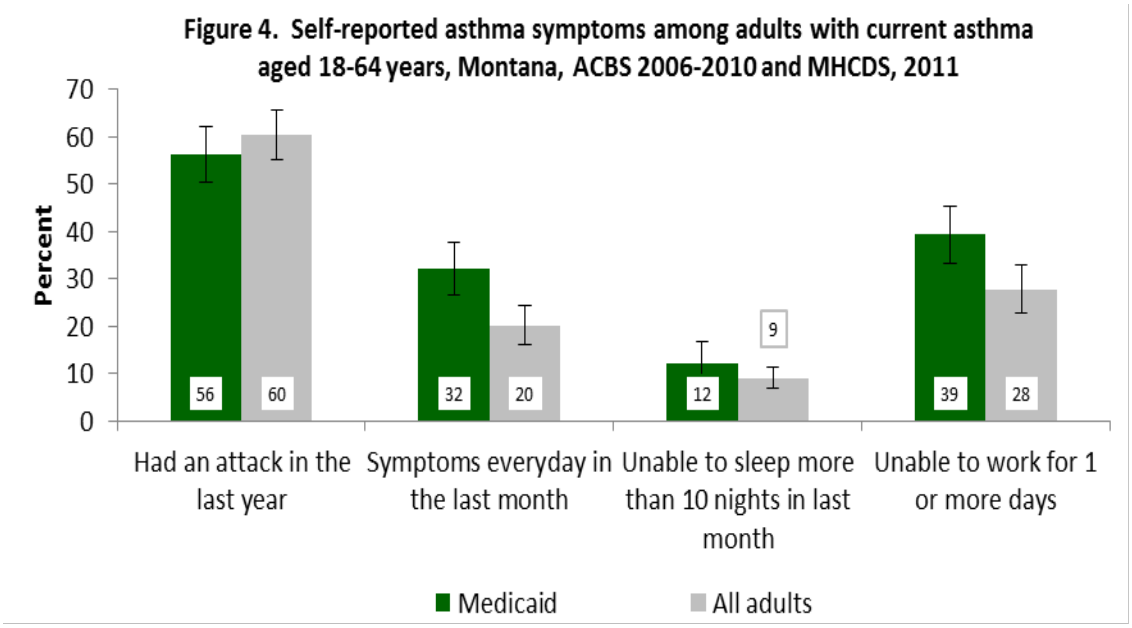
· Visiting an ED or a health care provider (HCP) for urgent symptoms in the last year was reported twice as often by adults with asthma enrolled in Medicaid as by those in the general population.

· Adults with asthma enrolled in Medicaid had a higher rate of having symptoms every day in the last month than did adults with asthma in the general population.

· Significantly more adults with asthma enrolled in Medicaid missed a day of work due to asthma than did those with asthma in the general adult population.

Providers treating adults with asthma enrolled in Medicaid for their asthma should consider the poorer health status, exposure to tobacco smoke, constant daytime symptoms, and more frequent use of the ED that these patients report.





Clinical Recommendations

· Recall asthma patients at least twice a year for regular review of symptoms, medication, and overall well-being.

· Assess a patient's asthma control at each visit and make adjustments to medication based on the EPR-3 Guidelines.

· Provide an Asthma Action Plan to patients and instruct them on how to respond to symptoms.

· Council patients who smoke to quit smoking and to quit use of other tobacco products. Refer them to the Montana Quit Line at 1-800– QUIT-NOW.

References

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