Uncovering Persistent Asthma In Child Health Supervision Visits
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BACKGROUND

• Continuity of care for asthma is recommended by NHLBI guidelines at a frequency of 1-6 months depending on severity/control. PCPs may care for asthma mainly during Health Supervision Visits (HSVs)
• However, HSVs must cover concerns, exam, anticipatory guidance, and screening, limiting time to address asthma
• PCPs have been shown to be poor at identifying severity/control levels without an assessment tool.
• Treatment is predicated on perceived a control level often milder than the actual level.

OBJECTIVES

1. To explore automated use of a standard monitoring tool (Pediatric Asthma Control and Communication Instrument or PACCI) at HSVs for children with asthma to identify persistent asthma, rather than relying on parental priorities of symptoms.
2. To compare asthma control levels between specific “asthma visits” and HSVs with and without parental concerns about symptoms.

DESIGN/METHODS

• 25 community pediatric practices across the US over 14 months used the CHADIS online system for collecting pre-visit data. For HSVs, a questionnaire collected parent priorities (“What would you like to talk about during the visit”) with “breathing or cough” as one option.
• The priorities questionnaire also asked for any prior diagnoses from a list of chronic conditions, including asthma. If asthma was endorsed PACCI, a brief validated asthma questionnaire was automatically administered. PACCI collects interval symptoms, interventions, adherence and impact information and results in an asthma severity/control level.
• PACCI was also completed prior to visits scheduled specifically for addressing asthma.

RESULTS

• Of 33,366 HS visits, 2,211 (6.6%) included an asthma diagnosis, similar to national prevalence.
• Persistent asthma was present in less (but still many) children with asthma coming for HSVs 34.5% vs 41.9% of “asthma visits” (x2 = 30.42, df= 1, p<0.01).
• Persistent asthma was found in: 41.9% of 3271 “asthma visits”; 57.8% of 296 HSVs with parental priorities of “breathing or cough”; 30.9% of 1915 HSVs without such endorsed priority.
• Severity levels differed significantly between visit groups (x2 = 119.06, df=6, p<0.01).
• Parents of 77.6% of children with persistent asthma attending HSVs did not list “breathing or cough” as a priority.

DISCUSSION

Lack of Asthma Symptom Priority in HSVs for Children with Persistent Asthma

| Total with Persistent Asthma at HSVs | 763 | 34.5% of HSVs for Patients with Asthma |
| Persistent Asthma at HSV and No Visit | 592 | 77.6% |
| Priority for Asthma Symptoms | 763 | 340 |
| with Persistent Asthma at HSVs | 763 | 340 |

CONCLUSIONS

• If only parent priority of “breathing or cough” were used to determine whether to assess asthma status during HSVs, 77.6% of children with persistent asthma potentially needing step up care may be overlooked.
• Use of a monitoring questionnaire triggered by a parent-reported asthma diagnosis can facilitate valid assessment of asthma symptoms and change in management.
• Pre-visit assessment allows for appropriate scheduling, visit prioritization and billing (i.e. 96160 for measure plus 25 extender for documented additional issue & visit code 9921x).
• HSVs are a critical opportunity for guideline-based asthma care.

KEY REFERENCES