Bree Collaborative | Pediatric Asthma
May 17, 2022| 8:00 – 9:30 a.m.
Virtual

MEMBERS PRESENT

Annie Hetzel, MSN, RN, Office of the Superintendent of Public Instruction
Brad Kramer, MPA, Public Health, Seattle & King County
Christopher Chen, MD, WA Health Care Authority
Doreen Kiss, MD, University of Washington
James Stout, MD, University of Washington
John Lynch, Community Health of Central Washington
Julee Christianson, Office of the Superintendent of Public Instruction
Kate Hastings, Scientific Consulting Group
Katie Paul, MD, MPH, Kaiser Permanente
LuAnn Chen, MD, MHA, Community Health Plan of Washington
Mark LaShell, MD, Kaiser Permanente
Vickie Kolios, MSHSA, CPHQ, Foundation for Health Care Quality

STAFF AND MEMBERS OF THE PUBLIC

Nick Locke, MPH, Bree Collaborative
Ginny Weir, MPH, Foundation for Health Care Quality

WELCOME

Nick Locke, Bree Collaborative, welcomed everyone to the Pediatric Asthma workgroup. Those present briefly introduced themselves and approved the April minutes

Decision: Adopt April 19th minutes. Unanimously adopted.

REVIEW: CLINICAL CONTROL

Mr. Locke reviewed the previous month's conversation on clinical control recommendations and picked up where last month's conversation left off. The workgroup discussed recommendations related to metrics – which metrics to include and how to use metrics to improve quality care.

- Workgroup members discussed potential metrics to recommend including:
    - The Asthma Medication Ratio (from HEDIS), which is currently the most widely used asthma quality metric
    - Measuring yearly flu shots administered for patients with asthma
    - Tracking severity and control using ICD-10 codes
- The workgroup discussed a measure related to spirometry and decided to keep spirometry as a diagnostic tool but not recommend specific metrics. Similarly, peak flow meters were not included as recommended metrics.
- Workgroup members expressed interest in finding way for the metrics to practically help connect patients to care. The biggest problem with existing metrics is that they don't tell us about individuals living with asthma not yet connected to the healthcare system.
    - Schools can be important partners as many kids with chronic absences are connected to nurses to develop health plans. Schools also ask families/caregivers to fill out a health form at the beginning of the year.

    - There is the potential to be more liberal with asthma metrics and to implement stronger screening and outreach protocol. If more people are screened for asthma, however, we should develop a more robust referral system.
- Those present also discussed how metrics could be used to notify the care team about new asthma cases. One potential idea was for the EHR to trigger an alert to attempt an asthma diagnosis after the third ED/urgent care visit for uncontrollable cough.

DISCUSSION: CARE COORDINATION/HOME-BASED INTERVENTIONS

Following the discussion on metrics, Mr. Locke transitioned the conversation to new material on care coordination and home based interventions. Recommendations were drafted with the assistance of Brad Kramer, MPA, at Public Health of Seattle and King County.

- Funding: suggestion to develop broad funding recommendations such as value-based payment, bundled payment, or multipayer initiatives, instead of recommending specific funding models from other states.
- Elements of Successful Programs: workgroup members discussed the necessary components of a successful multicomponent, home-based intervention
    - Motivational interviewing and goal setting are essential components.
    - Multicomponent interventions must be delivered over multiple visits to build trust and follow-up on action plans.
    - Some services may be delivered via video or audio telehealth, but certain components of the intervention ought to be delivered in-person. The workgroup discussed King County's community health worker asthma intervention as an example for determining appropriateness of telehealth modalities.
- Operational Concerns: workgroup members confirmed the importance of stable funding and longitudinal relationships for developing successful interventions. Programs should also consider offering expanded hours to accommodate school/work schedules.
    - Recommend that any pediatric patient admitted to the hospital should be referred to a home-based multicomponent intervention (if one is available in the community or clinic)
- Social Determinants of Health: those present discussed the importance of addressing social determinants of health via multicomponent interventions. Members proposed several options for how to address social determinants:
    - Several members suggested a direct recommendation to screen all patients (or all asthma patients) for social need using an SDoH screening tool. This process, however, can be time-consuming and difficult to implement. If we recommend screening for social determinants, we will need to recommend referral/follow-up strategies.
    - Alternatively, the workgroup could recommend aspirational goals such as social needs screening, that would facilitate value-based care but may not yet be possible.
    - Finally, social need could be a lens applied to all our recommendations for pediatric asthma, without the need for a specific recommendation for social need screening.
    - Several members have begun to screen for social need in their own clinics, and the Bree Collaborative has previously developed recommendations for social need screening and intervention.

The workgroup elected to continue thinking about social needs screening, and return to this conversation at the next workgroup meeting.

PUBLIC COMMENT AND GOOD OF THE ORDER

Mr. Locke invited final comments or public comments, then thanked all for attending. A follow-up email will be sent to workgroup members with links sent in the conversation chat. The next meeting will continue the conversation on how to integrate social determinants of health in the conversation as well as begin to discuss the school environment. The workgroup's next meeting will be on Tuesday, June 21st, 2022.