Proposal to the American Academy of Pediatrics and Pfizer from the Administrators of the Tulane Educational Fund

A. COVER PAGE

1. Title: Improving Pediatric ADHD Care for Young Children Through Clinical Education and Clinical and Systems Consultations

2. Abstract:

Goal: This project will increase adherence to the recommendations for assessment and treatment of young children (4-11) in the 2011 American Academy of Pediatrics (AAP) Clinical Guidelines for ADHD.

Rationale: The guidelines defined developmentally specific assessment and treatment approaches for young children, reflecting their unique developmental contexts, clinical presentations, and intervention evidence bases. In Louisiana, high rates of ADHD medication prescriptions to young children indicate a need for enhanced education and consultation on appropriate assessments, accurate diagnosis, and developmentally-specific treatments. Access to behavioral health supports is also limited in our region.

Target Participants: Pediatric faculty and residents in seven practices in the greater New Orleans area will be invited to participate. These practices include five residency continuity clinics for Tulane pediatrics as well as two federally qualified health center sites already engaged in a partnership with Tulane. These pediatricians serve a diverse group of patients representative of New Orleans.

Core Project Components: The proposed project will develop electronic and print based educational resources including point of care webinars and handouts. In addition, the team will offer clinical and systems consultation to promote quality ADHD assessment and address barriers identified in the ADHD CQHN pilot project, especially time burdens, and knowledge of and access to behavioral therapy. Consultation will include monthly ADHD Rounds via videoconference and priority access to behavioral therapy for children identified by participating practices. Monthly review of specific indicators and adjustment of interventions based on these data using a Plan-Do-Study-Act cycle will guide the specifics of the interventions.

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C. PROPOSAL: Improving Pediatric ADHD Care for Young Children Through Clinical Education and Clinical and Systems Consultation

1. Goal and Objectives

***i. Overall Goal*:** The overall goal of the proposed project is to increase adherence to the American Academy of Pediatrics ADHD Guidelines with a focus on the developmentally specific components for young children (4-11 years old) by providing ADHD-focused clinical education as well as clinical and systems consultation. The consultation will include access to evidence-based behavioral treatment. To meet this goal, the project will involve monthly Plan-Do-Study-Act (PDSA) cycles using principles of the Model for Improvement to guide education, consultation, and practice transformation support.

Alignment with AAP ADHD Guidelines: The project will emphasize the developmentally specific aspects of ADHD assessment *(Action Statement 2)* and treatment (*Action Statements 5a and 5b)* for preschoolers and young children. Clinical education activities will address assessment strategies *(Action Statements 1 and 3)*, behavioral and pharmacologic treatment approaches, *(Action Statements 5a, 5b, Medications, Behavioral Therapy, and 6),* and monitoring strategies *(Action Statements 4 and 6)*. On-site ADHD consultation in the clinic will provide support to primary care providers (PCPs) around all aspects of ADHD care for young children, as well as other AAP-recommended, empirically supported communication strategies (e.g., HELP[1]) and motivational enhancement techniques to improve engagement and adherence *(Areas for Future Research*).[2] The project will also offer provide brief, clinic based, evidence-based behavioral treatment (Parent Child Interaction Therapy) *(Action Statement 5: Behavioral Training).*

Alignment with the RFP: This proposal closely aligns with the focus of the RFP by providing broad clinical and systems support around comprehensive care for children and families with ADHD. Specifically, the proposal meets the goals of this RFP in two ways: by addressing barriers identified in the CQN ADHD pilot program and through innovative strategies for supporting knowledge and skill development among partner PCPs.

Addressing barriers identified in the CQN ADHD pilot:

- Time investment: This project will support participating PCPs in identifying barriers to guideline adherence, implementing changes, and studying the effects, with particular attention to efficient collection of validated parent and teacher reports.
- Ability to diagnose ADHD and co-morbidities: Educational and consultative approaches will emphasize the diagnostic strategies necessary to identify co-morbid conditions or differential diagnoses in young children presenting with ADHD-like symptoms.
- Behavioral Therapy Awareness: Educational and consultative approaches will emphasize the core principles of behavioral therapies, especially elements than can be offered in the primary care setting as part of the Common Factors approach to behavioral health in primary care.[3,4]
- Behavioral Therapy Access: This project will offer Group Parent Child Interaction Therapy[5,6] for children identified by participating PCPs in the project, in clinic or with transportation provided.

Focusing on global ADHD clinical education: Clinical education will target faculty and trainees, thereby influencing care of current and future patients, exponentially expanding the influence of the project.

Applying Model for Improvement (MFI) principles: The project will implement principles of MFI, beginning with the definition of our aim, defining observable signs of progress and changes that can result in improvement, and implementation of monthly PDSA cycles with iterative changes in clinical education, consultation, service delivery, and/or practice transformation to move closer to the aim.

Alignment with our organizational goals: The proposed project closely aligns with Tulane's mission and the mission of Tulane Early Childhood Collaborative. As an academic program, Tulane's mission is to enhance pediatric residency education, which will be an important product of this project. Secondly, our group is committed to pursuing innovative approaches to integrated physical and behavioral health care, and this project brings together pediatrics, psychology, and child psychiatry faculty and trainees to improve the care that young children with ADHD receive. Lastly, this project builds on the Tulane Institute of Infant and Early Childhood Mental Health's internationally recognized expertise in clinical care, research, and advocacy for the behavioral health of young children.

ii. Objectives: Through educational activities and consultation, this project will 1) increase participating pediatricians' knowledge about care of ADHD in young children, 2) improve adherence to AAP ADHD Guidelines, 3) improve clinical outcomes among children with ADHD.

(a) Outcome Objectives:

Increase participating pediatricians' knowledge, comfort, and self-reported practice of the recommended care of young children with concerns of ADHD as demonstrated by achieving the following targets:

Measurement	**Outcome**	**Target (%)**
Accuracy on post-didactic knowledge assessments	% correct	80
Correct responses on ADHD knowledge	% increase (baseline to end of project)	25
Self-reported knowledge	% "I know most of what I need to know" or "all"	80
Self-reported use of recommended ADHD care	% "most of the time" or "all" of the time	80

Improve adherence to AAP ADHD Guidelines as demonstrated by clinical documentation of:

Age	**Documented action or outcome**	**Target /Current rate (%)**
4-11	Standardized adult report measures from parent and another observer*	90/40
4-11	Review of mood, anxiety, trauma-related symptoms, and developmental status*	90/60

4-11	Age-appropriate standardized measures collected from 2 reporters at least twice within the last 180 days (Exception: child engaged in behavioral therapy only)*	60/30
4-11	Recommendation of at least 1 Common-Factors based behavioral strategy	90/40
4-11	Decrease in total symptom score reported on age-appropriate measure from initial assessment to end of project	25/NA
4-11	Initial engagement with treatment, demonstrated by percentage of "kept" first follow-up appointment, parent-reported medication trial initiation, and/or behavioral treatment (defined as at least 1 appointment with behavioral health provider)	60/80
4-5	Behavioral therapies are recommended as first line treatment*	80/100(n=1)
4-5	Children access behavioral therapy through the project or in the community within 60 days of diagnosis	60/n/a
4-5	Families are contacted at least once for follow-up within 180 days to confirm status of treatment and/or symptoms	60/n/a
6-11	Behavioral interventions recommended*	80/50
6-11	Children are seen within 30 days for follow-up with an age-appropriate standardized measure	60/80

*** CHIPRA standard**

Improve clinical outcomes among all children diagnosed with ADHD as documented by:

Measurement	**Outcome**	**Target %**
Total symptom score reported on age-appropriate measure	Decrease baseline to end of project*	25

(b) Process Objective:

Provide acceptable PCP-focused early childhood ADHD educational programming and consultation including didactics, print and web-based point of care tools, remote (email/phone/telehealth) consultation, on-site ADHD clinical and systems consultation, on-site behavioral counseling for parents, weekly Parent-Child Interaction Therapy group, and psychopharmacologic support.

Measurement	**Outcome**	**Target (%)**
Monthly rate of use of consultation and services	Number of consultations Increase in use of web-based resources	48 10
Provider satisfaction	Satisfied or very satisfied	80

2. Current Assessment of Need

Louisiana has the highest rates of parent-reported ADHD and of prescriptions for pediatric ADHD medications in the country and is in the region with the lowest rate of behavioral therapy for young children (34% vs 82% in Northeast).[7,8,9] In response, the Louisiana legislature convened a Task Force in 2014 with ongoing work. The Task Force studied the issue and now

works to promote interventions to improve adherence to the AAP ADHD guide, with specific attention to ensuring access to behavioral interventions for young children.

Within Louisiana, the New Orleans region is a particularly important target for improved attention to ADHD assessment and treatment. The extraordinarily high rates of exposure to adverse child experiences[10-12] are associated with higher rates of ADHD, but they also necessitate careful assessment to identify trauma-related disorders in the differential diagnosis of ADHD-like symptoms. Access to specialty mental health care is quite limited in the New Orleans system of care, with prolonged waiting lists and extraordinarily limited access to evidence-based behavioral services. The area has only one developmental-behavioral pediatrician, and child psychiatrists will rarely see preschoolers. To our knowledge, the city's health care system has a reliable capacity to serve about 200 young children, whereas in a population the size of New Orleans, epidemiologic estimates suggest 10,000 young children have impairing behavioral health problems.[13] Thus, primary care providers serve as the front line, addressing both children with simple and complex presentations.

The recent AAP Technical Report and Policy Statement on addressing early childhood emotional and behavioral problems highlights age-specific clinical, workforce, and training barriers that limit the quality of care for young children, and many of these needs are even more prominent in our region.[4,14] Limited training in early childhood ADHD among PCPs and other clinicians is a substantial barrier. Our team has assessed providers' perspectives about local resources. In our 2014 survey of 95 New Orleans-area PCPs, 81% reported that their ability to meet young children's behavioral health needs was "inadequate" or "grossly inadequate".[15] Similar proportions reported an inadequate workforce of clinicians for young children. Only one quarter of PCPs reported they were "very comfortable" or "moderately comfortable" assessing and managing disruptive behavior problems in children under 6 years of age.

Nationally, practices did change for young children after the publication of the AAP ADHD guidelines. Rates of preschool ADHD diagnosis, which had been increasing, plateaued after the guidelines.[16] While this pattern may represent a decrease in less stringent assessment approaches, rates of diagnosis in claims data (0.7-0.9%) are 25-50% of epidemiologically determined prevalence rates (2-4%), raising a question of possible under-diagnosis.[17,18] This difference emphasizes the importance of ensuring that pediatric primary care providers have sufficient training in the recommended approach to diagnosis of ADHD in preschoolers so that children with ADHD are identified early and those without ADHD are not diagnosed with it.

faculty or board eligible pediatricians and 61 pediatric, medicine-pediatrics, and triple board residents.

Other practices may participate in the off-site consultation and access educational resources. They will have the option to provide monthly data to be included in the PDSA cycles, but they would not be primary partners in the quality improvement aspects of this project.

3. **Target Participants and Recruitment**

iv. Who Will Benefit: The project will benefit children and families and providers locally and will have the potential to influence care across the state.

Children and family benefits: Children whose PCPs participate in the project will experience higher quality care as their providers follow the AAP ADHD Guidelines. Because the project will emphasize the use of the Common Factors and the HELP communication strategies, this project will likely enhance care of children not specifically affected with ADHD. Additionally, children will benefit from direct access to evidence-based behavioral treatment, which is often not available. Behavioral interventions result in parenting confidence, likely reducing stresses associated with a child's uncontrolled symptoms on the family.[19]

By partnering with training sites, the project will not only influence the care of the children at the sites, but also the children seen by the residents after they graduate.

Provider benefits: The project will benefit our pediatric partners by providing knowledge, confidence, and support in their daily care of children at high-risk for behavioral health concerns in this community. We anticipate that the project will also reduce burnout because of increased support and competency.[20]

Dissemination and Sustainability: This project addresses clinical and public health issues that are part of a larger conversation in Louisiana. We have been in conversation with state leaders about developing early childhood mental health consultation models around the state, and we believe this project could serve as an important demonstration project. We plan to disseminate the project's findings to the Louisiana Department of Health (LDH), the five state managed care organizations, private insurers, and large health care providers in the state. In addition, the

educational tools developed in this project will be made available to the state's pediatric providers in real time and can be disseminated by state partners, including LDH. It is possible the tools could be evaluated as possible educational tools for providers whose prescriptions do not follow the AAP guidelines.

4. Project Design and Measurement Strategy

***i (a). Implementation*:**

Phase 1 of the project will focus on specific needs assessment of the providers and practices, tailoring of the CQN ADHD Pilot project activities to our community and practices, and development of materials to support learning. Formalizing partnerships with non-Tulane hospitals to ensure appropriate data extraction approaches for QI will also be addressed. Phase 1 will also include recruitment of specific personnel, including the parent advisor, confirmation of the two physician champions, and project manager.

Needs assessments will target all office personnel, including clinic front desk and support staff, nursing, and pediatric providers to identify the strengths in each practice and the opportunities for growth, using the Institute for Healthcare Improvement (IHI)'s Model for Improvement approach.

In the planning phase, we will develop the IT infrastructure to offer the range of educational materials and track their use, develop a web-based dashboard for monthly feedback for providers, and ensure access to CMEs for providers who use the approved tools.

Phase 2 of the project will focus on dissemination of the learning materials, consultation, and monthly PDSA to examine implementation rates of ADHD guidelines and identify barriers to achieving the benchmarks. Specifically, PCPs will be offered access to:

- Educational activities and tools: Face-face and web-based didactics and point of care tools as well as didactic presentations emphasizing developmentally specific assessment approaches behavioral strategies for primary care using Common Factors approach, evidence-based treatment approaches for young (4-11 y.o.) children and local and web-based resources to support practice. Topics will address specific practice and/or provider needs as identified in needs assessment and review of PDSA outcomes. Whenever possible, CME Credits or Maintenance of Certification Credits will be offered.
- Systems consultation will address practice-specific needs, but may include support in development of ADHD-specific template(s) for the electronic medical record and a tool kit of commonly used handouts and local resources for patients and families with ADHD. Consultation will also address clinic policies related to identifying children with ADHD as children with special health care needs and ensuring effective strategies for communication with teachers and non-prescribing clinicians.
- Clinical consultation
    - i) *On-site didactics* in the practice
    - ii) *"ADHD Rounds"*- Monthly group case consultation by video telehealth connection for group case consultation to discuss ADHD assessment and/or treatment with specialty faculty from pediatrics, psychology, and child and adolescent psychiatry
    - iii) *Parent advisor* to provide input regarding parent perspectives of the systems

iv) *Phone/email consultation* to support PCPs in implementing AAP-recommended assessment, monitoring, and treatment strategies.
v) *Off-site consultation* evaluations to support PCPs in assessment of young children with complex hyperactivity, impulsivity, and/or inattention presentations.
vi) Priority access to *evidence-based parent management training* treatment groups using the Parent Child Interaction Therapy (PCIT) approach.[6] Groups will be offered in partner practices, if not on-site, and transportation will be supported to increase accessibility for families.
vii) *Onsite ADHD consultation* tailored to the needs of the practice and individual providers. Biweekly onsite consultation will promote implementation of the AAP ADHD guidelines with specific attention to multi-informant reports, DSM-5 criteria, inclusion of a review of common co-morbidities, and developmentally-specific treatment approaches that include recommended monitoring of progress and optimization of medication doses. Consultation may include direct contact with a patient, consulting about a patient not currently in clinic, and/or discussion of topics related to ADHD in young children.

***i (b). Measurement Strategy*:**

Data Collection and PDSA cycle

Baseline and end of project questionnaires will be collected from PCP partners and will include ADHD content questions and a questionnaire about self-reported practice, knowledge, and comfort of addressing ADHD in young children, burnout, and project satisfaction.

Specific phase 2 activities will be informed by the information gathered through monthly chart reviews and identification of needs during consultation activities, including ADHD Rounds. All providers will receive practice-level tracking of these process measures on the chart review data as well as individual-level tracking. These data will be used in a Plan-Do-Study-Act cycle to address areas of opportunity for growth towards the overall goal of the project.

Just in time analyses will be reviewed after specific interventions. For example, in on-site consultation focused on assessment of young children, the consultation team will offer real time feedback related to observed assessment and treatment strategies and collaborate with the PCP to identify strategies for improvement.

Outcome Measures

Objective: Participant comfort, knowledge, attitudes, and practice about ADHD treatment

The ADHD content questionnaire will be a 10 question survey focused on recommendations in the AAP ADHD guideline.

The Practice, Knowledge, and Comfort Scale[15,21] is an 18 item questionnaire in which providers report on 1) frequency of utilizing specific clinical management strategies in young child ADHD 2) perceived knowledge about young children's behavioral issues rated on a 4 point Likert scale, and 3) on comfort implementing specific strategies focused on young children's behavioral health rated on a 4 point Likert scale. This measure was developed for a local consultation project and is sensitive to changes over time in self-reported comfort and practice patterns. Knowledge questions will be adapted to focus specifically on ADHD.

The Maslach Burnout Inventory[22,23] is the state of the art measure of burnout, and the two question version has been used in measuring pediatric resident burnout.[22] The two questions are scored on a 7 point Likert scale and address emotional exhaustion and depersonalization.

Adherence to ADHD guidelines
Monthly, a chart review of 3 notes per provider will focus on visits with a chief complaint or problem list of ADHD or related symptoms. In Tulane practices, the chart review will be done by the team to support the providers and, with permission, this support will be offered to the other sites as well. Chart review will result in the data described in the objectives section with the addition of date of assessment, date last seen.

Improve clinical outcomes among all children diagnosed with ADHD
Chart review will also extract data as presented in objectives section.

Process Measurements
Provide effective PCP-focused early childhood ADHD educational programming and consultation
Use of all components of the program (consultation groups, use of web-based resources, consultation via phone/email, referral for off-site consultation evaluations, on-site consultation, and referral to PCIT group) will be measured monthly and analyzed by the activity, the practice, and the provider, with feedback provided to each provider.

PCPs will rate satisfaction with the project at midyear and at the end of the project, with the opportunity to provide monthly feedback as well.

Balancing Measures:
All participants will receive a quarterly 3 question Qualtrics survey about 1) requests for additional supports and 2) burden of reporting mechanism. Reports of excessive burden will guide adjustments to the process measurement plan.

ii. Addressing Established Need: The project will address the significant needs in our communities by:

- Providing needed educational supports to pediatric faculty and residents in a range of clinical settings
- Promoting use of careful assessment and implementation of behavioral strategies for young children with ADHD, which address trends of high rates of prescription rates in the state
- Promoting assessments that examine co-morbidities and differential diagnoses, which are critical when serving a population with particularly high rates of early adversity
- Providing direct evidence-based treatments that are extraordinarily difficult to access locally

5. Existing Projects
This project is a natural extension of an existing consultation model in Louisiana that began in 2014 and has funding through 2017. The Tulane Early Childhood Collaborative (TECC) provides mental health consultation to pediatric providers in the greater New Orleans area, focusing on the needs of children under 6 years of age (www.tulane.edu\som\tecc). Data collection, with IRB approval, has been established as a part of the project.

Early findings demonstrate providers report higher comfort levels and higher rates of using recommended assessment approaches, including validated measures and identifying early adversity.[13,15] Feedback has been universally positive with requests to extend the age range beyond 6. Due to the success of the project, TECC received additional funding to expand the three-year grant to provide referral support and develop innovative support to increase the success of referrals.

Dr. Gleason is the clinical director for TECC and for a Substance Abuse and Mental Health Administration-funded consultation project focused on primary care, early intervention, and child care consultation, which has similarly successful systems and clinical outcomes and ongoing data collection.

The proposed project is complementary to efforts by the state ADHD Task Force described in the needs assessment section. This project could become an important demonstration project that could catalyze movement forward for a state-wide intervention approach. Similarly, the proposed project would be synergistic with Louisiana's Developmental Screening Task Force, which promotes developmental screening in young children but cannot provide clinical support. The Developmental Screening Task Force, to which Dr. Gleason consults, has generated enthusiasm for screening and recommends use of emotional and behavioral screening in preschool, which may increase attention to ADHD in young children.

Lastly, Dr. Gleason is working with general pediatricians and residents on AAP's DIG-IT project focused on developmental screening in well-child visits. This project has highlighted the importance of using validated measures in the Lakeside clinic and has increased attention to children with multi-domain developmental delays. This project can serve as a jumping off point for ongoing practice transformation in the clinic, as many clinic staff have been involved with the QI project and the level of engagement is high.

6. Anticipated Project Time Line

	2017					2018							
Activity	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Practice policy/ systems review		x	x										
IRB approval	x												
Needs assessments with providers to define MFI goals, indicators of change and first steps for change		x	+	+	+	+	+	+	+	+	+	+	+
Educational tool & dashboard development	x	x	x	x	x	+	+	+	+	+	+	+	+

Monthly chart review and dashboard		x	x	x	x	x	x	x	x	x	x	x	x
Monthly consultation groups		x	x	x	x	x	x	x	x	x	x	x	x
Referral support warm line		x	x	x	x	x	x	x	x	x	x	x	x
Remote (email/phone) consultation		x	x	x	x	x	x	x	x	x	x	x	x
PCIT groups				x	x	x	x	x	x	x	x	x	x
On-site consultation						x	x	x	x	x	x	x	x
Web-based and social medial dissemination		x	x	x	x	x	x	x	x	x	x	x	x
Develop abstracts, posters, and manuscripts for publication			x						x	x	x	x	x
Sustainability planning										x	x	x	x

7. Dissemination of Results

Dissemination will be intentional throughout the project. By providing each provider with both practice-level and provider-level trends in the monthly updates, information about the ADHD supports will be disseminated among providers naturally as part of the ongoing Model for Improvement strategies. The TECC program has a growing web presence focused on the behavioral and emotional needs of young children, with 1500-3000 impressions monthly on Twitter, a 1340 reach on Facebook, and an average of 2500 unique views on the website annually. This presence will allow us to disseminate tools, tips, and findings throughout the project on social media.

Working with our local AAP chapter, we also will request to present the status updates at the AAP Executive Board meetings and link with local pediatric societies to present at their local meetings (Pediatric Pot Pourri and Jambalaya). We plan to meet with the Louisiana Department of Health, led by Dr Savicki, to present the findings that may be helpful in informing state efforts to improve ADHD identification and treatment in our state. In addition, to highlight the importance of awareness of the AAP recommendations for identification and appropriate treatment of ADHD, especially in our state, we plan to submit an abstract to present at the Southern Society for Pediatrics Research describing the model and baseline findings (Feb. 2018) and nationally at the Society for Developmental and Behavioral Pediatrics (Oct. 2018). We plan to develop a manuscript to describe the planned model of intervention and the final outcomes to submit for peer-review or chapter publication.

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