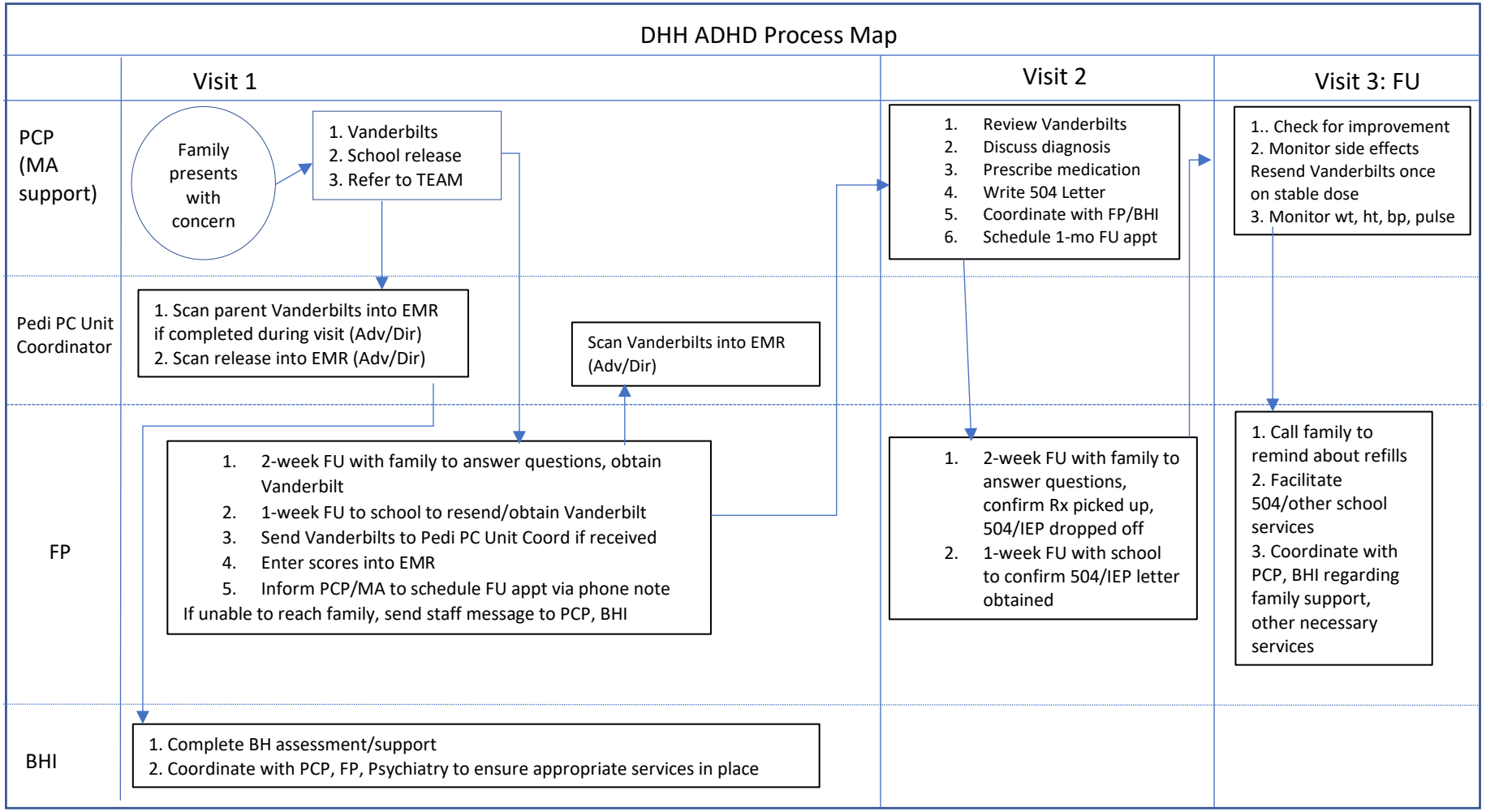
TEAM UP FOR CHILDREN

TEAM UP Implementation & Practice Transformation
Compilation of ADHD Workflows
December 13, 2022


DHH ADHD Process Map
Visit 1
Visit 2
Visit 3: FU
PCP (MA support)
Family presents with concern
1. Vanderbilts
2. School release
3. Refer to TEAM
1. Review Vanderbilts
2. Discuss diagnosis
3. Prescribe medication
4. Write 504 Letter
5. Coordinate with FP/BHI
6. Schedule 1-mo FU appt
1.. Check for improvement
2. Monitor side effects
Resend Vanderbilts once on stable dose
3. Monitor wt, ht, bp, pulse
Pedi PC Unit Coordinator
1. Scan parent Vanderbilts into EMR if completed during visit (Adv/Dir)
2. Scan release into EMR (Adv/Dir)
Scan Vanderbilts into EMR (Adv/Dir)
FP
1. 2-week FU with family to answer questions, obtain Vanderbilt
2. 1-week FU to school to resend/obtain Vanderbilt
3. Send Vanderbilts to Pedi PC Unit Coord if received
4. Enter scores into EMR
5. Inform PCP/MA to schedule FU appt via phone note
If unable to reach family, send staff message to PCP, BHI
1. 2-week FU with family to answer questions, confirm Rx picked up, 504/IEP dropped off
2. 1-week FU with school to confirm 504/IEP letter obtained
1. Call family to remind about refills
2. Facilitate 504/other school services
3. Coordinate with PCP, BHI regarding family support, other necessary services
BHI
1. Complete BH assessment/support
2. Coordinate with PCP, FP, Psychiatry to ensure appropriate services in place

South Boston Community Health Center
ADHD Workflow

PCP Role

- Discusses ADHD evaluation with family
- Discusses evaluation for co-morbid conditions
- Does WHO to CHW for introduction and ROI (referral has been placed)
- Places referral to BHC
- Provides parent Vanderbilt
- Refers to psychiatry if age or other factors need secondary input based on judgement of PCP

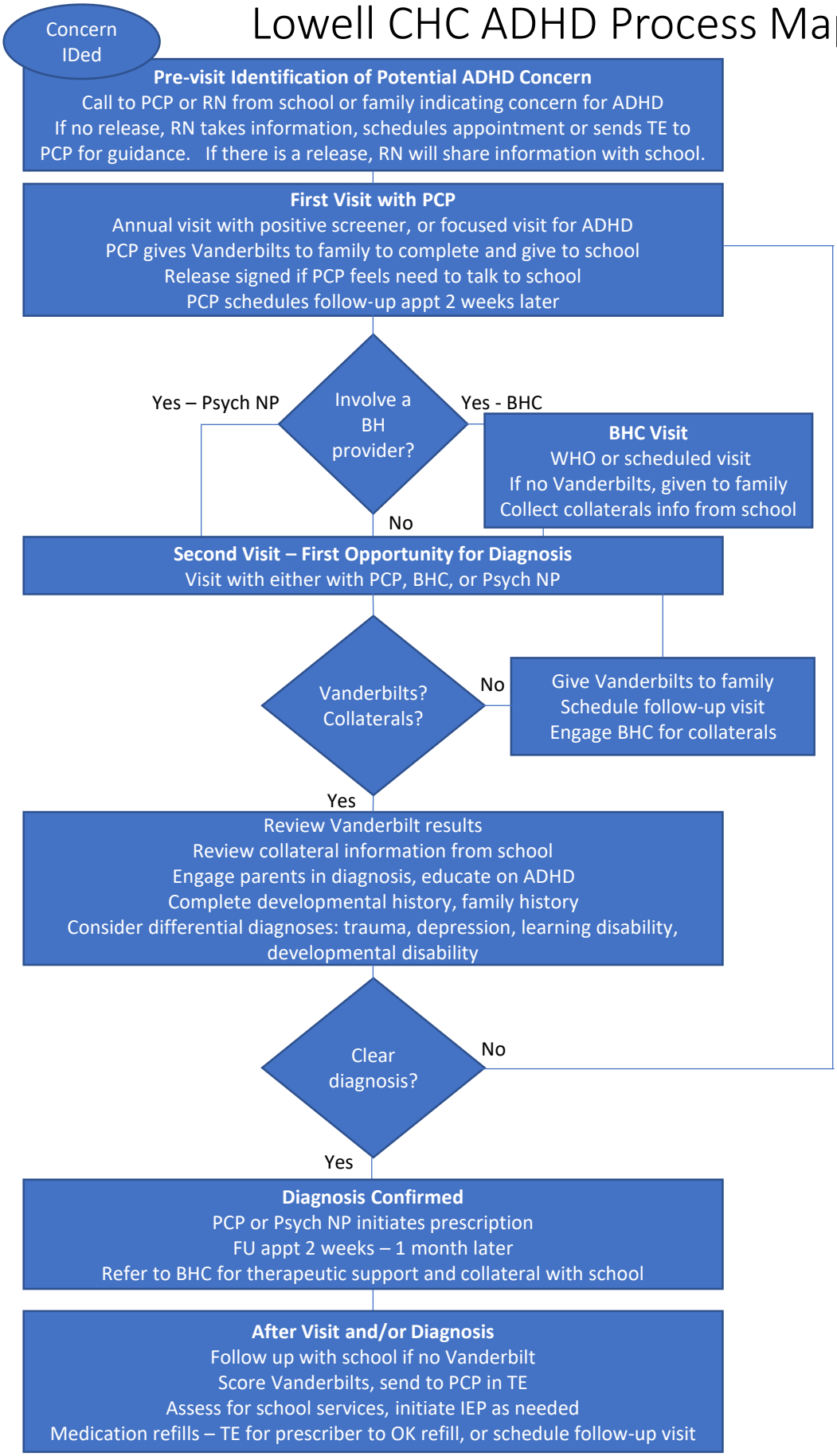
CHW Role

- Provides education on testing process, possible services, allows parent to ask questions
- Obtains ROIs for school/other necessary providers
- Assists parent in filling out parent Vanderbilt
- Coordinates with school to fill out teacher Vanderbilt
- Provides screening forms (Eg: Vanderbilt, SCARED) forms to PCP or to Psychiatry
- Follow-up after diagnosis visit
- Coordinate IEP/504 (Separate workflow)

BHC Role

- Does intake with all families to evaluate for other psychosocial stressors and what services BHC can offer
    - Occurs before first appointment with Psychiatry

Lowell CHC ADHD Process Map



Aspirational Goals:

- Standardize process and decrease variability
- Documentation check-list
- Engage whole care team in workflow and define roles: who does collaterals, RNs checking MassPat, getting release signed)
- Decrease barriers to engaging in BH care

Response from Family/School:

- At least 1 Vanderbilt 80% of the time from family
- 40-50% of time from school; 60% for Psych NP
- Release 75% of the time by second attempt

CHW Role:

- Support as needed with language, navigation, school coordination, navigation to further diagnostic testing
- Role not specific to ADHD clinical pathway
- Release could be done by PCP, or could ask a CHW for help based on language, family need

BNHC ADHD Workflow

Definitions

ADHD= Attention deficit hyperactivity disorder

CHW= Community health worker

BHIC=Behavioral Health Integrated Clinician

Pt=patient

PCP= Primary Care Provider

Vanderbilt's=ADHD screening tool

IEP= Individualized Education Plan

504 Plan= a formal plans that schools develop to give kids with disabilities the support they need

ADHD Workflow First visit and follow up.

Family presents with concerns of ADHD

MA give family Vanderbilt's parent completes (if possible) and has parent sign release for school.

Fax Vanderbilt's to school

Provider task Teamlet

CHW/BHIC talk about case and days to schedule pt

CHW call to follow up on Vanderbilt (if not completed in house same day)
Explain the next steps in the process.

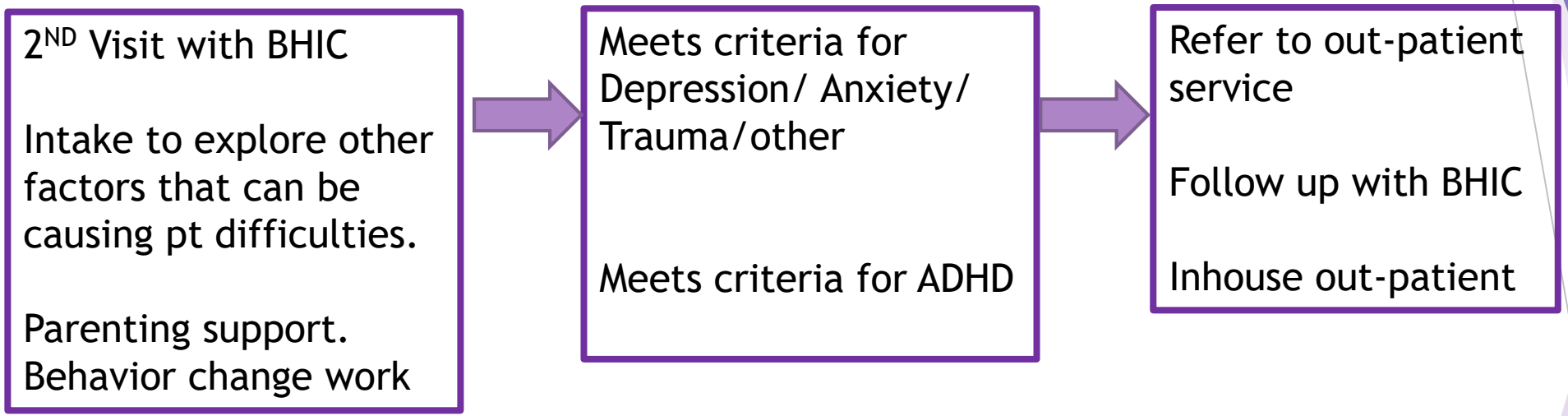
Schedules intake with BHIC

BHIC will call school and explore patient academic performance and behavior.
Follow up on school Vanderbilt.

Provider will receive Vanderbilt's and review

BHIC can also receive Vanderbilt's and review and share with Provider

ADHD Workflow 2nd visit and follow up.



ADHD Workflow- Medication- 3rd visit and follow up.

Goal: Teamlet review Vanderbilt's, feedback from school/other providers and BHIC intake. Plan for patient. Talk about further evaluations.

3rd Visit Provider
Backup BHIC/CHW

Review of Vanderbilts

Diagnosis

Explain plan for follow up

Therapy for behavioral change and management of ADHD

Medication

Follow up
CHW/BHIC School support (IEP/504PLAN)

For medication:
PCP 3 week follow up then,
Every 3m follow up with PCP (telehealth) or monthly until they are stable.
Pcp will task teamlet if there are concern after follow up visit

Weekly to biweekly therapy

Nurse 1 week follow up for meds
Pick up, dose, side effects

ADHD Workflow-No Medication 3rd visit and follow up.

3rd Visit Provider/ Backup BHIC/CHW

Review of Vanderbilt's

Diagnosis

Explain plan for follow up

Therapy for behavioral change and management of ADHD

Follow up
CHW/BHIC School support (IEP/504PLAN)

If we refer out CHW will follow up in two weeks after referral to make sure pt is connected.

Short term work with BHIC (depending on case)

In house outpatient.

PCP follow up in 3m to give therapy some time

ADHD workflow

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Agenda

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- Content refresher for Primary Care stff
- Review of workflow, anchored to case example through role play.
- Handouts: hard copies of vanderbilts, toolkits

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- **ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents. Pediatrics 2011:128(5):1007-102**

Initiate an Evaluation

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- *Key Action Statement 1: The primary care clinician should initiate an evaluation for ADHD for any child 4-18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity (quality of evidence B/strong recommendation).*

Use DSM IV, collaterals and r/o alternatives

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- *Key Action Statement 2: To make a diagnosis of ADHD, the primary care clinician should determine that DSM-IV-TR criteria have been met (including documentation of impairment in more than 1 major setting), and information should be obtained primarily from reports from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care. The primary care clinician should also rule out any alternative cause (quality of evidence B/strong recommendation).*

Assess for Coexisting Conditions

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- *Key Action Statement 3: In the evaluation of a child for ADHD, the primary care clinician should include assessment for other conditions that might coexist with ADHD, including emotional or behavioral (e.g., anxiety, depressive, oppositional defiant, and conduct disorders), developmental (e.g., learning and language disorder or other neurodevelopmental disorders), and physical (e.g., tics, sleep apnea) conditions (quality of evidence B/strong recommendation)*

Treat ADHD with a Chronic Care Model

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- *Key Action Statement 4: The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (quality of evidence B/strong recommendation).*

Preschoolers: Start with Therapy

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- *Key Action Statement 5: Recommendations for treatment vary depending on the patient's age.*
- *Action Statement 5a: For preschool-aged children (4-5 years of age), the primary care clinician should prescribe evidence-based parent- and/or teacher-administered behavior therapy as first line of treatment (quality of evidence A/strong recommendation) and may prescribe methylphenidate if the behavior interventions do not provide significant improvement and there is moderate-to-severe continuing disturbance in the child's function. In areas in which evidence-based behavioral treatments are not available, the clinician needs to weight the risks of starting medication at an early age against the harm of delaying diagnosis and treatment (quality of evidence B/recommendation**).***

Elementary aged: use a stimulant +/- behavioral therapy

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- *Action Statement 5b: For elementary school-aged children (6-11 years of age), the primary care clinician should prescribe FDA-approved medication for ADHD (quality of evidence A/strong recommendation) and/or evidence-based parent- and/or teacher- administered behavior therapy as treatment for ADHD, preferably both (quality of evidence B/strong recommendation). The evidence is particularly strong for stimulant medications and sufficient but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order) (quality of evidence A/strong recommendation). The school environment, program, or placement is a part of any treatment plan.*

Teens: more challenging, medication +/- therapy

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- *Action Statement 5c: For adolescents (12-18 years of age), the primary care clinician should prescribe FDA-approved medications for ADHD with the assent of the adolescent (quality of evidence A/strong recommendation) and may prescribe behavior therapy as treatment for ADHD (quality of evidence C/recommendation), preferably both.*

NICHQ ADHD workflow/timeline

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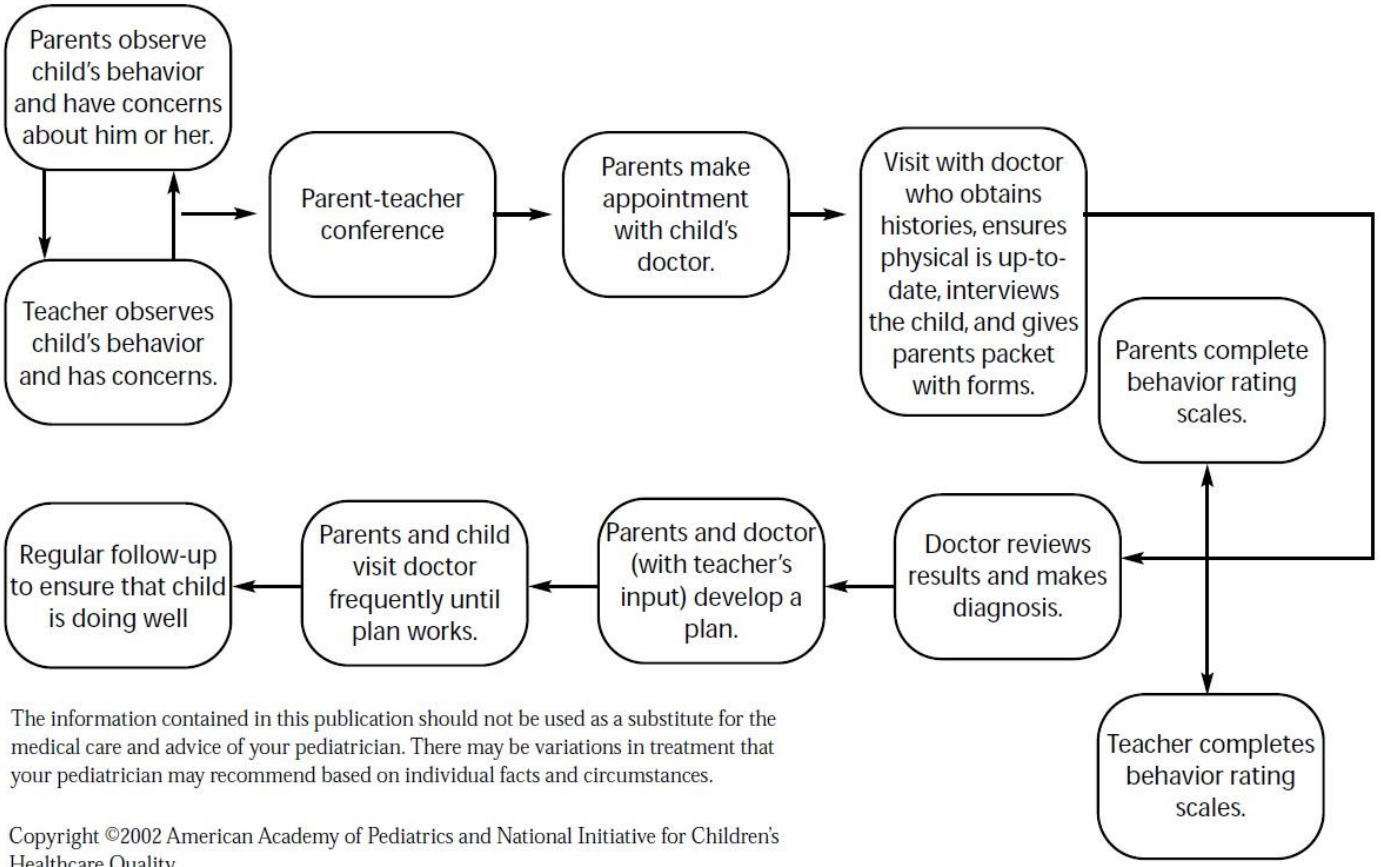
ADHD Evaluation Timeline



Integrated Pedi Timeline

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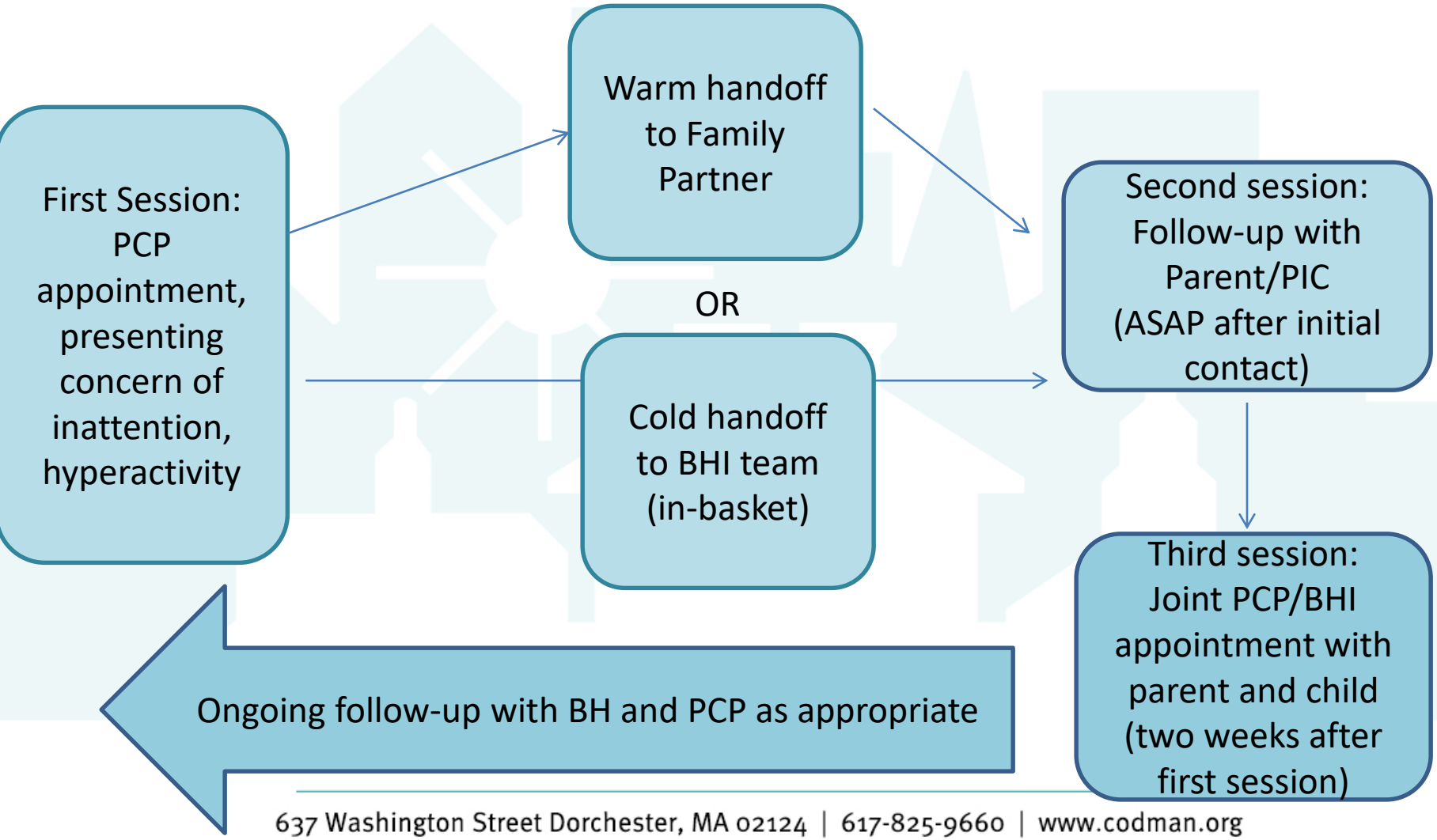

First session: PCP Visit (warm handoff)

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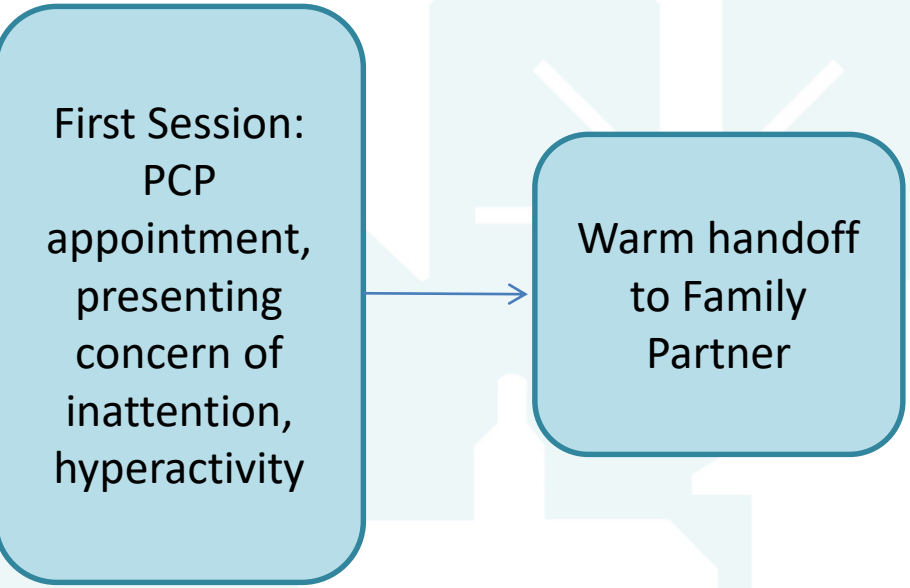

- Presenting concern: inattention, hyperactivity
- Warm handoff (ideally to Family Partner)
  - Goals: Family Partner or PIC
    - Distribute/Complete Vanderbilts
    - Explain ADHD diagnosis process
    - Obtain ROI for school, other providers
    - Clarify existing education services (IEP, 504)
      - Scan to chart when copies are received
    - Schedule parent follow-up visit with PIC

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Role Play

First Session: PCP Visit (Cold handoff)

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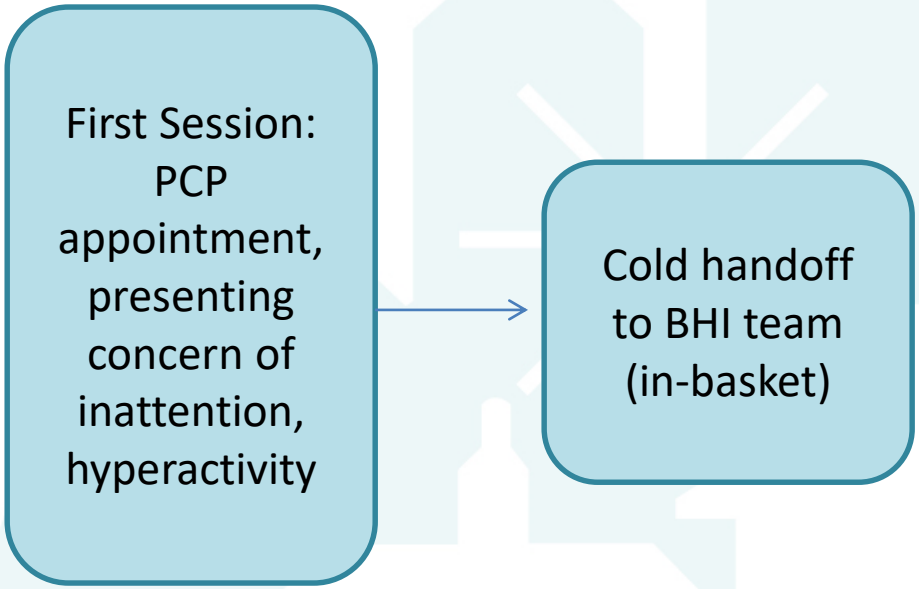

- PCP:
  - Distributes/Completes Vanderbilts
  - Confirms issues in at least two settings (home and school)
  - Primarily issues of inattention or hyperactivity or both
  - Sends inbasket to BHI team to schedule follow-up

Second Session: Parent/PIC

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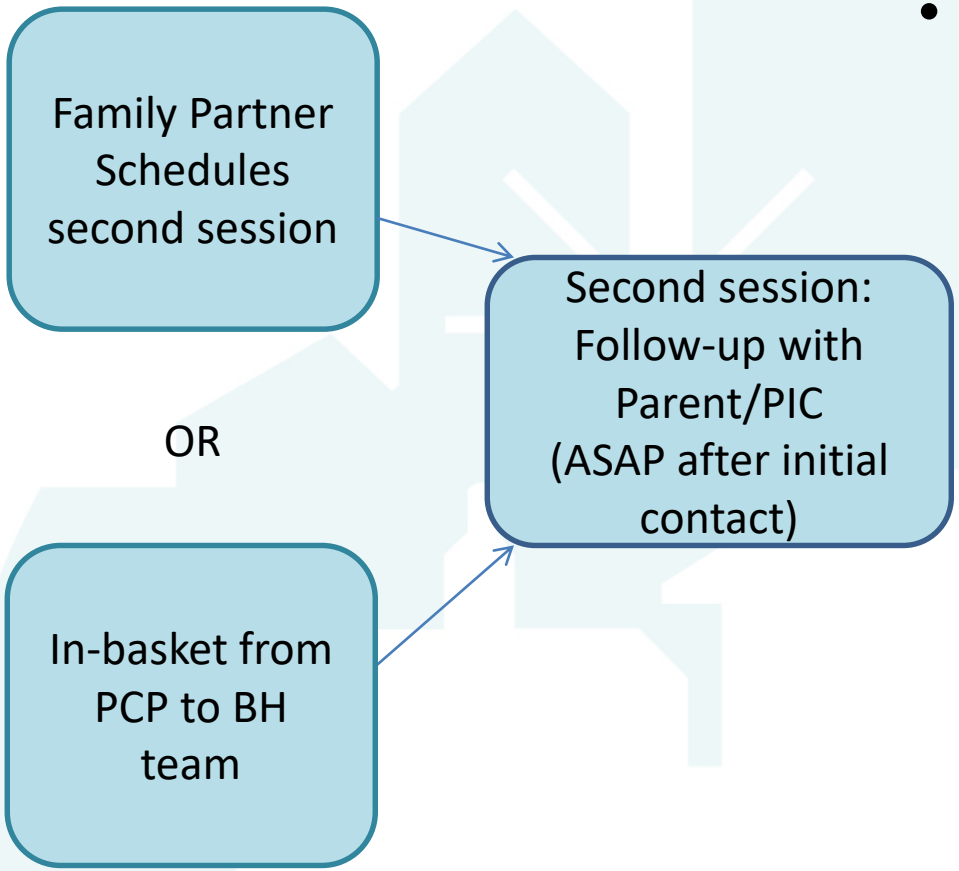

- ASAP after Warm-handoff, without PCP
  - Differential diagnosis: rule out mood, trauma, adjustment issues (any additional screeners to use?)
  - Get Vanderbilts back, address barriers
  - Introduce behavioral strategies
    - Positive praise
    - Identify appropriate and sustainable consequences
    - Creation of behavioral chart
  - Administer PSC

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Role Play

Third Session: Joint PCP/BHI appt. with parent and child

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Third session: Joint PCP/BHI appointment with parent and child (two weeks after first session)

Ongoing follow-up with BH and PCP as appropriate

- Two week f/u from 1st session
  - Goals:
    - PCP – Confirm tx plan (med, therapy, or both
      - Complete med, family, development history as needed
    - PIC check in on behavior plan
    - Set timeline, frequency of visits, when and how would we know to hand off to more permanent provider
    - Administer PSC at each subsequent visit

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Role Play

FP role

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- Provide education around ADHD and externalizing behaviors
- Support parents and encourage problem solving and positive parenting techniques
- Coordinate and navigate medical and community based systems – including completion of screeners and school accommodations
- Explain diagnosis process to parents – address barriers and concerns

PIC role

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- Behavioral techniques with parents
  - Use of praise
  - Use of consistent reinforcement and consequences
  - Creation of behavioral plans or charts
- Identify issues in school, at home, in social sphere
- Work with kid
  - Social skills
  - CBT
  - Externalizing issue to prevent exacerbated mood issues
  - Suggested areas to consider: homework routines, sleep, school communication

PCP role

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- Address initial concern with parent, connect family to integrated BH staff through warm handoff or cold handoff
- Complete and distribute Vanderbilts if cold hand-off necessary
- Collaborate with BH team to determine treatment plan
- Prescribe medication as necessary
- Provide ongoing follow-up support in collaboration with BH staff