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Acceptability of Group Visits for ADHD in Pediatric Clinics

Nerissa S. Bauer, MD, MPH[1,2], **Nina Azer, MD**[3], **Paula D. Sullivan, PhD**[4], **Dorota Szczepaniak, MD**[4], **Sarah M. Stelzner, MD**[5], **Stephen M. Downs, MD, MS**[1,2], and **Aaron E. Carroll, MD, MS**[6,2]

[1]Department of Pediatrics, Indiana University School of Medicine, Section of Children's Health Services Research, Indianapolis, IN

[2]Center for Health Services Research, Regenstrief Institute Inc., Indianapolis, IN

[3]Department of Pediatrics, University of Kentucky, Lexington, KY

[4]Department of Pediatrics, Indiana University School of Medicine, Indianapolis, IN

[5]Eskenazi Medical Group, Indianapolis, IN

[6]Department of Pediatrics, Indiana University School of Medicine, Section of Pediatric and Adolescent Comparative Effectiveness Research, Indianapolis, IN

Abstract

Background—Children with attention deficit hyperactivity disorder (ADHD) have ongoing needs that impair home and school functioning. Group visit models are a promising way to deliver timely parenting support but family and provider acceptance has not previously been examined.

Objective—To describe the acceptability of ADHD group visits in busy pediatric clinics based on caregivers, child participants and facilitators.

Methods—Data were analyzed from school age children and caregivers who participated in one of two 12-month long randomized controlled studies of the ADHD group visit model from 2012 to 2013 or 2014 to 2015. Feedback was obtained using semi-structured questions at each study end, by telephone or at the last group visit. Sessions were audio-recorded, transcribed and themes were extracted by participant type.

Results—A total of 34 caregivers, 41 children and 9 facilitators offered feedback. Caregivers enjoyed the "support group" aspect and learning new things from others. Caregivers reported improved understanding of ADHD and positive changes in the relationship with their child. Children were able to recall specific skills learned including how skills helped at home or school. Facilitators acknowledged systems-level challenges to offering group visits but felt the group format helped increase understanding of families' needs, improved overall care, and provided innovative ways to engage with families.

Corresponding Author: Nerissa S. Bauer, MD, MPH, nsbauer@iu.edu, Mailing Address: 410 W. 10th Street, Suite 2000, Indianapolis, IN 46202, Office: 317-27-0552, Fax: 317-278-0456.

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Conclusion—The majority of comments from families and facilitators highlighted a variety of benefits to the use of a group visit model for ADHD chronic care. Despite systems-level barriers to implementation, families and facilitators felt the benefits outweighed the challenges.

Key Terms

ADHD; Group Visits; Primary Care; Intervention

INTRODUCTION

Pediatric Attention Deficit Hyperactivity Disorder (ADHD) causes considerable family stress, despite adequate pharmacological treatment.[1,2] A majority of parents struggle, regardless of culture or background.[3,4] Even though stimulants can lessen some core symptoms of ADHD, caregivers report ongoing stress and strain within the context of parent-child and sibling relationships and worrying about their child's academic progress.[5] Moreover, it is not uncommon for caregivers to have lingering concerns regarding the use of medication, including whether it should be continued as their child matures.[2–56] Families report wanting more ADHD education and support to cope with the behavioral and life challenges associated with parenting a child with ADHD.[5,7] Yet, general parenting support, behavior management and educational supports may be more difficult to access in the community.[8]

An increasing number of pediatricians are identifying and managing ADHD.[9,10] Therefore, it is important to have tools or supports in place for use in the medical home to meet the ongoing unmet needs of families affected by ADHD.[11,12] However, most visits are brief and often insufficient to address all concerns or offer adequate support.[13]

Group visits (also known as shared medical appointment) models for ADHD chronic care management can offer support to families but the acceptability of this model for medical providers and families, is not yet known.[14] While group visit models have been examined for well child visits and other pediatric chronic diseases, such as asthma and diabetes,[15–20] they have yet to become part of mainstream practice.

Before larger scale implementation and dissemination efforts should be undertaken, it is important to understand whether families and providers find the group visit model acceptable for ADHD chronic care management. Preliminary evidence suggested that group visits may facilitate ADHD chronic care management because families attended more follow-up clinic visits over the course of a year and reported improved child functioning in the home.[14] Therefore, our objectives were: (1) to understand what parts of the group visit ADHD model were most beneficial from the participant and provider point of view; (2) to solicit ideas that would improve efficacy and attendance; and (3) to assess the overall acceptability of the group visit model.

METHODS

ADHD Group Visit Intervention

The ADHD group visit intervention consists of 5 sessions for caregivers and children.[14] Each participating clinic offered the intervention over 15 months with each session offered monthly for 3 consecutive months until all 5 sessions were offered. Caregiver and child groups occurred in separate, adjacent rooms. Group discussion lasted 60–75 minutes, followed by brief medication and growth parameter checks. Families were allowed to enroll on a rolling basis until the 6th month when the third session was offered. In our pilot RCT, the parent and child groups were led by two general pediatricians.[14] For the second RCT, two clinic sites participated. In one clinic, a general pediatrician led the parent group and a child psychologist led the child group. The second clinic had a co-located community health agency working closely with the pediatrics practice. Therefore, the second clinic elected to utilize a co-leader structure: a general pediatrician and pediatric advanced nurse practitioner with mental health specialization led the parent group and two masters' level social workers co-led the child group.

Subject Population

Data for this paper come from two prior randomized controlled trials (RCTs) examining the effectiveness of the ADHD group visit intervention conducted in 2012–2013 and 2014–2015.[14,21] All children and families assigned to receive the ADHD group visit intervention, along with the providers who facilitated the ADHD group visits were included. To be eligible to participate, children 6 –12 years of age with ADHD must have received primary care at a participating clinic and deemed stable on medication verbally by their primary care provider and/or as noted in the electronic health record. Children with conduct disorder, autism, moderate to severe mental retardation/mental handicap or other neurodevelopmental disorder were excluded.

Study Design

Data were collected from families and facilitators during each RCT as a way to understand barriers and facilitators to implementation of the intervention in busy pediatric clinics, and as a way to solicit iterative feedback to inform and revise the ADHD group visit curriculum. At the end of each session, families provided feedback regarding overall satisfaction, preparedness and style of facilitators, and suggestions for improvement. Facilitators participated in monthly phone calls with the study team to review logistics and provide feedback on the curriculum. Three telephone calls to each eligible family was attempted before classification as lost to follow up.

Data Collection

Demographics and characteristics of caregivers, children and facilitators included gender, age, race (white/black/other) and ethnicity were collected at the beginning of each RCT. Caregivers also reported marital status (single/married/divorced/widowed), highest level of educational attainment, preferred language (English/Spanish), low health literacy via the single item literacy screener, if parent had diagnosis of ADHD themselves, and total number

of children in the home. Facilitator training background and years at the clinic was also obtained.

Data regarding perceptions of session content, logistics and perceived benefits and challenges to attendance were collected via semi-structured interviews. Open-ended questions such as “What did you like about the group visits and why?” or “Did you talk with your children about what they learned in their group visits?” were used. Additional probes such as “tell me more” were often used as a way to draw out additional details. Caregivers and children were asked to comment on the curriculum (topics they liked or wanted more of), logistics (timing, frequency and perceived importance of having closed or open groups), takeaways or lessons learned and general suggestions or comments. Reading level of the probes was at Flesch Kincaid grade level equivalent of halfway through 3rd grade for ease of understanding across all participants. See Supplementary material for examples of probes used for caregivers and children.

Provider feedback was obtained during monthly conference calls and at the conclusion of each study. At the end of the second RCT, provider feedback was collected via an electronic survey created and stored in REDCap electronic data capture tools hosted at Indiana University.[22] All other data were collected and managed by trained research assistants. The study protocol was reviewed and approved by the Office of Research Administration before each RCT.

Data Analysis

Descriptive statistics of the participants were analyzed using Stata 11(StataCorp. 2009. *Stata Statistical Software: Release 11*. College Station, TX: StataCorp LP). Feedback obtained at group feedback sessions and telephone interviews were audio recorded and transcribed. Feedback after other group sessions was collected on paper without personal identifiers. Two research assistants independently read and re-read the transcripts several times and recordings were listened to ensure accuracy of transcription, a process called “repeated reading” that results in data immersion.[23] Provider surveys were analyzed separately. A thematic analysis of all feedback and comments was performed and organized according to participant type.[24,25] Themes within each participant category were identified and specific quotes from participants were extracted. Coding discrepancies were resolved through discussion. Any remaining discrepancies were resolved with input from a third investigator (NB). Discrepancies between investigators were minimal and easily resolved.

RESULTS

Feedback came from 4 caregivers and 7 children from the first RCT and from 30 caregivers and 34 children from the second RCT. Therefore, a total of 84 participants (34 caregivers, 41 school age children with ADHD representing 34 families and 9 pediatric facilitators) representing family and clinician stakeholders contributed feedback for analysis. All eligible to participate at the last group session did so. All but one of the caregiver participants was female; most child participants were male (72%); and all providers were female. A third of participating families were self-reported as black (33%) or other race (40%); and 20% were self-reported as white. Almost half of the caregivers reported ethnicity to be either Hispanic

or Latino; half were married. Seventy-seven percent of caregivers reported a high school education or less. Almost half of the child participants were between 9 to 14 years of age; the rest were 6 to 8 years of age.

Half of the providers were pediatricians. Other provider types included a psychologist, and community mental health staff (1 pediatric nurse practitioner and remainder were therapists). Providers worked at the clinic site a mean of 9.4 years (range 2–28 years). See Table 1.

Several themes emerged by participant type and are explored in depth below.

Caregivers realized they were not alone in their feelings or experiences

One of the most consistent responses was about how much support the caregivers received from the providers and other participants. One mother enjoyed being around others who were going through the same parenting struggles: “I like that parents can get together and compare notes.” Others commented on how productive it was to be around others who understood what they were going through (“just knowing that there are other mothers that have the same experiences and you’re not doing it by yourself”). Group visits provided a vehicle to normalize caregivers’ feelings and experiences and helped them overcome feelings of isolation. For example, one caregiver stated she had been to the point of desperation and feeling “ready to give up. [However] if it weren’t for these groups, I might have given up on my daughter.” Another caregiver commented, “I was talking to my sister and best friend, but they just don’t know. They just don’t understand like you all do, because you know, you’re all going through the same things. So this is wonderful.” Single parents were especially vocal about the usefulness of the groups: “I’m a single parent and I only have one child at home, but it’s like you’re out there all by yourself, and you know there are other people out there, but…it’s like no one has this problem but me. No one will understand or no one’s kid is as bad as this.”

Groups helped parents gain new insights into ADHD

Caregivers felt that the group visits were a place where they could learn more about what ADHD was and work out new solutions to recurrent challenges: “I learned a lot. You know, when we started group visits it was taboo for me. All of these situations about ADHD, so every single time we’ve been here, I’ve learned a lot.” Rather than feeling overwhelmed by their circumstances, they reported gaining a new perspective from other parents (“it encourages better self-esteem that..hey, I’m not doing as bad as what I thought. And it’s helped, you know, just hearing what each one of us has done. It gives us different insight on how to handle a situation”). Moreover, caregivers were motivated to try again or to try an alternate approach based on what others shared. One mother noted that the session on time-in and praise was especially valuable since she had never heard about the need to do this with her child: “I learned that it was important for my child, and now he is closer to me and more open.” She, and others, agreed that the sessions covering positive parenting techniques were helpful, (time in and time out) even if the focus was not on specific challenges to a particular parent-child dyad: “I think a lot of people don’t understand. I’m not a person who uses corporal punishment, and a lot of people are like, ‘just whoop him, that is the problem, you don’t spank him.’ Parents all agreed that conflicting advice had been given to them

about discipline but the groups provided a forum to learn acceptable positive parenting techniques from trustworthy sources of information.

Groups helped establish parent-child two-way communication and with other caregivers

Caregivers provided examples of how participation led to increased communication between caregivers at home or after they shared information and handouts with other family members. Many parents also reflected that communication with their children improved after attending these groups. One parent said she gained a better understanding of ADHD, which in turn allowed her to explain concepts to her son that he did not previously understand, “I’ve gotten to understand more with him. To be patient with him…I have gotten tools to use or handouts to share with him to say, ‘this is why.’” Parents reflected on how sharing the experience of going to group visits with their child spurred more conversations: “I think it makes her feel like she can talk and be more open since she is attending the meetings like me. I think she feels like she’s really interested in what I’m saying and how I feel about the situation. I think that’s good.” Another parent added, “I noticed that when they’re not paying attention and we don’t think they’re listening, they really are, you know, in their own way. It may not be the way we want them to be doing it, but I think we’ve gotten closer. He’s willing …to talk, before he was the one who you couldn’t get him to talk about anything.” Multiple caregivers reported that their children were usually very excited to share what they had learned after group visits, which spontaneously led to conversations during the drive home.

Caregivers had additional suggestions to improve the model

Suggestions were made to have more sessions on additional topics (sibling relationships or sleep) or ways to improve ADHD follow-up care (offering groups monthly instead of quarterly). While caregivers enjoyed participating in separate groups from their children, occasional joint sessions or integrating time towards the end of each session for caregivers and children to learn together was viewed as beneficial. Scheduling was difficult when trying to maintain a cohort of caregivers in groups together; yet while they agreed it was nice to see the same faces at each group visit, it was not the most important factor to families. One mother said, “Groups are a safe place and I know all the parents here have a child with ADHD. So they all can understand what I am going through.” Another parent added, “on the other hand, since I was able to see the same people in the group it made me feel more comfortable asking them to meet outside of group…like at a park.” Families also suggested considering inviting parents after diagnosis to participate “because others are dealing with these feelings too.” One mother asked whether she could bring additional family members to the group visits because arguments or conflicts related to the care of the child with ADHD were frequent. A suggestion was made that clinics set a recurring day or two during the month to offer group visits to allow families time to plan ahead and adjust their own work and home commitments so to attend more consistently.

Children felt groups were a good place to meet others like them

Children reported feeling they realized that they could “be themselves and feel comfortable,” given that they were with others “just like me.” Children recognized the groups were “a safe place.” One child felt he could share his feelings because he came to trust the people in the

group ("I wasn't the only one who had ADHD. It's like there's more people to know how it feels. It was comfortable because I really don't talk to anybody about my stuff I have to go through, so it was fun to tell people about it"). Several children finished the study with new friendships that developed over the course of the group visits.

Group curriculum fostered children's knowledge about ADHD, self-awareness and self-esteem

While all children participating had ADHD, not all struggled with the same aspects of the disorder.[15] Some children were more hyperactive and others were more inattentive. Children were taught to recognize their individual type of ADHD at the first session and think about their strengths and challenges. Under the guidance of the child facilitators, children came to realize that there were similiarities in their feelings and challenges. The children reported a sense of responsibility and acceptance of their feelings with one child mentioning that the best part of groups was talking about how he felt. At the end of the study, one child remarked, "I'm sad. I want to come back. This group really helped me."

Groups helped them learn new ways to handle their own behavior

When asked about what they learned, children were able to report specific things and gave specific examples. For instance, children valued learning different ways of handling negative emotions: "I learned how to walk away from arguments when I was upset" or "I asked to take a break so I could have time to take a few moments to calm down by taking my deep breaths." Children found the time spent to learn organizational and social skills valuable: "It's a group that helps me learn how to stay focused and organized…because some people lose stuff and their desk at school is messed up and they lose papers and get in trouble for it, so we learned how to keep stuff organized." Children were also taught about friendships: one child talked about how he was "proud of learning how to make friends" and "that if it's a new person don't just be mean, if they do something wrong, just help them out," "you can make a lot of friends if you be nice."

Comments from caregivers corroborated children's reports of increasing organizational and social skills. One mother felt "it was unique that both children got something different out of the group visits" describing how one son grew in terms of talking with her about his experience with the medication and her other son took to using the techniques to calm down. Others stated, "they [the children] learned skills to handle situations better," "they think, they listen and they take it in. They'll say, 'Granny, I remembered to use this, I remembered to do this or do that. For example, how to handle a situation, instead of being angry and retaliate, they learned how to walk away or count to 10."

Providers saw parents become more confident

Providers were coached to facilitate and encourage active discussion rather than lecturing and, in doing so, providers reported learning from parents in the process. During the groups, providers reported another advantage was being able to observe social interactions between parents. For example, they noted how easily the families related to each other's situations and how quickly they stepped in to encourage one another, regardless of culture or racial/ethnic background thus creating an "inviting environment."

Pediatricians were surprised at the ease of interacting with families in a group model

One pediatrician expressed concern about the facilitator guides upon seeing them for the first time. Having not had prior experience in observing group therapy or a group visit in her own residency training, she expressed feelings of doubt as to whether she had the skill set to facilitate the group. However, with minimal coaching, she was surprised at how "easy" it was to sit back, observe and listen rather than having the burden of needing to "always know the answers." Providers noted that they often times found themselves "learning alongside families" as they listened to the stories exchanged between the group participants. As a result, providers also gained appreciation of families' plights: "Leading the groups allowed me to gain a better understanding on how stressful and time demanding parenting a child with ADHD can be. During each visit, I gained more and more respect for the devoted parents who best to their abilities try to work on improving children's performance, encourage good behaviors and boost their kid's confidence. The supportive environment of the group visits encouraged parents to feel comfortable sharing their difficult struggles and efforts as well as allowed productive criticism of each parent's child-rearing techniques and [self-reflection on my] own counseling techniques. This relaxed and empathetic atmosphere allowed for easy feedback and ongoing improvement to make sessions more practical and pertinent to parents."

Groups allowed providers to observe child behavior and medication effects

Providers facilitating child groups were given the opportunity to directly observe social interactions with peers during group. They also noted that the extended time and time of day the groups were offered (such as after school) provided a unique ability to see whether medications were lasting or when they wore off.

ADHD group visits presented logistical challenges

The most challenging aspect of group visits from the providers' perspective was related to scheduling and space. Group visits were offered twice a month at both study clinics; however, one clinic offered the visits between the morning and afternoon sessions and the other site offered them after school. Providers considered whether to change when group visits were offered when schools administered standardized testing. One clinic offered group visits over the lunch hour, which required caregivers to consider how much school children could miss in the middle of the school day. Regardless of when groups were offered, caregivers had difficulty with consistent attendance, especially if the next group visit date was decided upon a few weeks before. Both clinics served a large proportion of families on Medicaid with limited access to transportation and little flexibility to request time off from work, which presented challenges to last minute scheduling. Families often relied upon public transportation or the assistance of friends or family members to drive them to the clinic. Another cited a challenge related to staffing. If the provider facilitating a group was sick or running late, a back up provider was not always available. This was identified as a source of provider stress. However, providers felt benefits outweighed identified challenges. One pediatrician shared the sentiment that "group visits are a great value for both children and group leaders. It is humbling to hear what children will share and observations of the group process. Having groups helps to normalize the experience of ADHD." Lastly, billing

for the service was a continual concern. Pediatricians billed using E/M visit codes as time was dedicated to individualized brief medication review, vital signs and growth monitoring and refills of prescriptions given. Non-physician facilitators did not bill for their time during the study period, given the unique climate of organizational support for the innovation and desire to implement a needed service.

DISCUSSION

Our findings suggest that for families struggling with ADHD and their primary care providers, the ADHD group visit model is an acceptable way to provide follow up care in busy pediatric practices. While group visits have been used for other reasons in the pediatric medical home, this is the first paper to examine caregiver, child and provider perspectives of the group visit model for the chronic care management of ADHD. Our analyses revealed important insights into the value of the model for families in terms of learning new knowledge and willingness to try alternate strategies when managing ADHD, as well as getting support from other participants. Providers gained new insights into the daily challenges their families faced, a renewed energy in providing care for patients with ADHD and the ability to monitor peer interactions and medication wear-off. They also found new ways to engage children in the pediatric office.

The traditional model of care is for families to schedule follow-up appointments with individual providers. Providers reported enjoying having more time with a small group of patients. This is despite the fact that at first some pediatricians raised concern about having appropriate skills, thinking that therapists were at an advantage with prior training to facilitate groups. However, all providers in our study found their role shifted from the customarily providing “on the spot” expert opinion to facilitation of active discussion among a small group of families.[26] Providers reported their confidence grew with repeated exposure to session materials and with more group visits facilitated. They also reported the usefulness of ADHD group visit facilitator guides with suggested scripts and probes to start group discussions and resources for additional reading should the provider need more in-depth information. Over the course of the studies, clinics started exploring whether this model could be used with well child visits. Our findings are similar to those previously described for physicians who facilitated Centering Pregnancy groups: group visits allowed for greater information exchange, seeing women get to know and support each other, sharing ownership of care, having more time and garnering enjoyment and satisfaction in providing care.[27]

From a logistical and systems-level standpoint, group visit models take advance planning to implement given the need to identify appropriate space, rearrange scheduling and ensuring adequate staffing. Our ADHD group visit model were designed so that caregivers and children participated in their own groups in different conference rooms in the clinic.[28] Moreover, clinics considered when to offer group visits to minimize the impact it had on overall clinic workflow while ensuring a minimum of two pediatric providers were available to facilitate each of the caregiver and child groups. Despite this, our findings support the notion that benefits outweighed the challenges. Other studies have documented similar findings when measuring provider satisfaction with group visits to usual care, as well as leading to decreased provider burnout.[29,30] The use of group visits for pediatric conditions is

limited but slowly gaining renewed interest; however, the rigorous examination of the model in pediatric medicine has lagged behind studies in adult medicine and obstetrics.[31–36] Studies have shown that families receiving care in a patient-centered medical home have fewer unmet ADHD and other health-related needs.[19–20] Hinojosa et al. documented if parents of children with ADHD reported greater levels of social support or improved parental mental health, parental strain was lessened.[37] Our findings reflect this in terms of the qualitative data presented here but also quantitative data from a previous study.[14] Our findings add to the growing literature that group visits for pediatric ADHD chronic care management enhances the social support among all participants, but further study on implementation strategies and cost effectiveness are needed.[38,39]

Parents consistently endorsed the support they received as a critical factor for adherence to group visits. The group visits helped normalize parental feelings and highlight shared experiences among families dealing with ADHD. Families with children with ADHD often experience ongoing stress and strain. [22,40] This is often despite improvements in children's core symptoms with medication initiation.[17] As more general pediatricians are prescribing medications as part of the overall treatment of ADHD, there is a need to examine primary care-based models to improve the overall quality and care delivered to families.[40–42] Pediatricians can refer families to community-based family support organizations like Family Voices and Children and Adults with Attention-Deficit/Hyperacitvity Disorder/ CHADD. The group visit model builds upon the existing relationship between the family and the primary care provider. It keeps care coordinated within the medical home and ensures information provided is accurate and tailored to the needs of the family. Other studies have documented this phenomenon of satisfaction with shared medical appointments.[43] In both the pediatric and adult literature, patients rated their care as more sensitive to their needs and derived satisfaction from the accessibility of peer support and motivation, the ability to actively participate during the visit, and increased time to learn from others.[44]

Our study is the first to document children's involvement in and satisfaction with the group visit model in pediatric primary care. Our findings highlighted involving children with chronic conditions in their own care as early as 8 years of age is important for their self-awareness and self-esteem. Our ADHD child group visit curriculum focuses on improving children's awareness, knowledge and skills delivered in a child-friendly way, along with adequate time to practice through role plays, hands on activities and other group work. The constellation of these approaches translated to children expressing improved functioning at home and school via the specific examples of what they learned and how they used these skills in home and school. Our curriculum mirrors health promotion school-based curriculum in that it used "learning through playing" or experiential learning approaches to increase children's knowledge.[45–47] Others have explored the use of interactive video games to engage children in promoting healthy behaviors and chronic care management for diabetes, cancer, obesity and asthma.[48–54] While our ADHD group visits did not utilize technology or video games, children expressed enjoyment from "hands on" activities that occurred during group visits, such as the craft or icebreaker activities that encouraged children to move around or helped break up the time sitting in a circle. Programs with child

friendly materials and that reinforce opportunities to make positive connections with others improve the effectiveness of health education curricula for school aged children.[55,56]

There are certain limitations to consider when interpreting our findings, which may limit its generalizability. Our study samples came from two outpatient pediatric clinics in one urban city: one was affiliated with an academic center and the other was within a community-based health center. Both clinics served a large portion of uninsured or publically insured families. We acknowledge that some of the same providers who facilitated group visits also collected feedback during the last group visit session, which may have introduced an element of social desirability bias. However, caregivers shared suggestions and critique of the process (for example, need to provide group visits on a regular day and time for ease of family planning and attendance or the need to streamline the portion of the group visit appointment for medication review and refill of prescriptions). Moreover, by study end, providers and families had established an easy rapport, which allowed participants to freely share their thoughts and feelings, positive and negative. Lastly, not all families who participated in the group visit trials were included. Study personnel attempted to solicit opinions from those unable to attend the last group visit via telephone calls; fourteen additional families were reached.

CONCLUSION

Group visits were an acceptable way to provide critical parenting support, education and awareness about ADHD and has the potential to be implemented in large pediatric practices. Numerous benefits and some challenges were dependent on participant type, but all agreed that the group visit portion was fun and informative. In light of these findings, the group visit model for ADHD chronic care management shows promise for use in busy clinics because it leads to satisfaction among those involved; however, more study is needed.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
RCT	Randomized Controlled Trial

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Table 1

Participant characteristics, N=84

Characteristic		
PARENT (N=34)	**N**	**%**
Female gender	33	97
Age		
<40	18	53
40 or > years	9	23
Race		
White	7	20
Black	12	33
Other	13	40
Hispanic or Latino Ethnicity	15	47
Marital Status		
Single	7	17
Married	15	47
Divorced	7	23
Widowed	2	3
Educational Attainment		
High School/GED or less	25	77
2yr college or greater	8	20
Preferred Language Spanish	13	43
Low Health Literacy	13	43
Has ADHD themselves	2	3
	Mean	**Range**
Total Children in the Home	2.75	1 to 6
CHILD (N=41)	**N**	**%**
Female Gender	10	26
Age		
6–8 years	17	41
9–14 years	20	48
Race		
White	7	18
Black	15	32
Other	14	35
Hispanic or Latino Ethnicity	17	34
FACILITATORS (N=9)	**N**	%
Female Gender	9	100
Race		
White	9	100

Characteristic		
PARENT (N=34)	**N**	**%**
Black	0	0
Hispanic or Latino Ethnicity	1	11
Training Background		
Pediatrician	5	56
Psychologist	1	11
Social Worker	2	22
Nurse Practitioner	1	11
	Mean	**Range**
Years at Clinic	9.4	2 to 28