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The Barriers to the Timely Diagnosis and Treatment
of ADHD by Advanced Practice Nurses in the Pediatric Primary Care Setting

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Abstract

Introduction: This purpose of the study was to identify barriers to diagnosing and treating attention-deficit-hyperactivity-disorder (ADHD) in pediatric primary care.

Method: This study utilized a survey tool sent to Advanced Practice Nurse members of the Pediatric Nursing Certification Board in March of 2020 and gathered information from 415 participants.

Results: In a linear regression analysis, participants who received ADHD specific training showed a significantly increased level of comfort in overall ADHD management ($p \leq 0.001$). Providers who are screening, diagnosing and managing ADHD most often, are also the most comfortable in doing so.

Discussion: Barriers to the treatment and diagnosis of ADHD include the lack of training as it relates to varying levels of decreased provider comfort, absence of schedule II prescribing authority for APNs in some states and provider bias towards treating and managing ADHD.

Key Words:

Attention-deficit-hyperactivity-disorder, ADHD, ADHD treatment barriers, ADHD diagnosis barriers, ADHD training, provider comfort, provider bias

Identifying Barriers that Prevent Timely Diagnosis and Treatment of ADHD in Pediatric Primary Setting Primary Care

Current ADHD Management Recommendations

Attention-deficit-hyperactivity-disorder (ADHD) is the third most common, chronic childhood diagnosis affecting 6.1 million children, 2-to-17-years-of-age (Markowitz, 2020; Sultan, Pastrana & Pajer, 2018). The American Academy of Pediatrics maintains ADHD clinical practice guidelines that describe how ADHD should be diagnosed and managed in pediatric patients by their primary care providers. The guidelines recommend that any child ages 4 through 18 who have behavioral or academic concerns and symptoms of ADHD should have an evaluation initiated by the Primary Care Provider (PCP; Wolraich et al., 2020). Lack of initial ADHD specific training on utilization of the guidelines and tools was reported in 75% of the studies reviewed by French, Sayal & Daly (2019). They found that this lack of training resulted in providers that expressed a lack of confidence in treating and managing ADHD. Imboden & Fehr (2018) conclude that more research is needed to support building practice models that would include ADHD specific training on screening, diagnosing and treatment, to providers in primary care.

Barriers Identified in Literature

There is a wide range of barriers reported in the literature, including stigma, lack of training, and long wait times for patient referrals. Some providers have reported that they do not believe in the existence of ADHD (French et al., 2020; French, Sayal & Daly, 2019; Saul, 2014), which suggests that stigma may be a barrier to addressing ADHD. A lack of ADHD specific training, screening, diagnosis and management, that resulted in low levels of provider confidence

in managing ADHD has been identified as a barrier by French, Sayal & Daly (2019). In some cases, providers have not been trained in how to properly manage ADHD. Additionally, these providers reported they were unsure as to what their role should be in ADHD screening, diagnosis and management, even if they had the proper training (French et al., 2020).

According to Moore et al. (2018), often PCPs refer patients to a psychologist or psychiatrist for treatment, but there are concerns regarding the long wait times from the point an appointment is scheduled until the time a patient can be seen. According to Kates et al. (2011), a lack of standardized collaborative models leads to long wait times for patients to see a behavioral health specialist. A collaborative care model is shared management between a PCP and a behavioral health specialist and could reduce the time from initial consult regarding symptoms to diagnosis and treatment (Kates et al., 2011; Moore et al., 2018).

Study Purpose

Prior to this study, there has been some research done (French et al., 2020; Imboden & Fehr, 2018; Kates et al., 2011; Tatlow-Golden et al., 2016) that has identified barriers, but few studies were implemented to specifically seek out the barriers to ADHD screening and management within the pediatric primary care setting. The purpose of this study was to examine barriers that prevent children with ADHD or symptoms of ADHD from being screened, treated and managed in a timely manner within a pediatric primary care setting. One of the initial intentions was to identify and compare barriers between provider types (e.g. MA, DO, PA, APN).

Methods

Sample and Design

A survey instrument was utilized to identify possible barriers to the diagnosis and treatment of ADHD. The survey was completed anonymously by study participants. To be

eligible for this study, providers had to speak English and select “yes” to the question, “Are you a licensed healthcare provider who works with pediatric patients in a primary care setting?”

There was no compensation provided to the participants. Although there were 475 total participants, 60 surveys were less than 15% complete, and were excluded from the analysis. SPSS 27 was utilized for data analysis. This study was approved by DePaul University’s Institutional Review Board (IRB).

Measures

Survey Development

The ADHD characteristics and comfort assessment survey was designed to collect data from pediatric primary care providers about characteristics regarding their current practice, assess their level of comfort in various aspects of ADHD management and collaboration with behavioral health specialists, and solicit opinion regarding what provider types they believe should be managing ADHD. The survey used in this study was adapted from a non-published survey previously utilized at a children’s hospital. This 18-question survey was utilized to assess provider data related to treatment and diagnosis of anxiety and depression in pediatric patients (A. Soble, personal communication, April 9, 2019). The previous survey addressed similar provider characteristics and comfort of providers in the management of anxiety and depression in pediatric patients.

Three content experts assisted in the adaptation and validation of the survey tool used for this study’s purpose. See Appendix A for selected survey excerpts. The initial adaptation included 22 survey items which were electronically sent to the content experts who were asked to rank each survey item for validity on a scale of 1-4. A survey item with a ranking of 1 would indicate low relevance to the goal of the study, and a survey item with a ranking of 4 would

indicate high relevance. Next to each survey item there was a space to for each content expert to provide suggestions to either improve a question or remove it entirely. After feedback was received from the experts, four questions were removed based on low ranking and a recommendation to remove them. The remaining questions were revised based on feedback from the content experts.

The final adapted survey instrument included 36 items, and 18 of the questions were relevant to the management of ADHD in the pediatric primary care setting. The remaining 18 survey items related to the characteristics of the study participants. The five-point Likert scale was retained from the survey tool given its ease for participants' navigation through items while still producing valid results (Preston & Coleman, 2000). The questions related to provider comfort (11 items; $\alpha = .70$) and provider time utilization and frequency (14 items; $\alpha = .82$) were analyzed in SPSS and found to be consistent and reliable.

Comfort Measures

In this study, there were a total of ten questions that sought to measure the level of comfort in managing ADHD, as well as the comfort level of referring patients out to other providers to manage. This study included five questions with the goal of measuring the level of comfort participants had in their patients being seen within a reasonable amount of time when referred to a psychiatrist for medication management, a psychologist for a neuropsychological evaluation, a psychologist for psychotherapy, a licensed clinical social worker (LCSW) for therapy, or a nurse practitioner who provides ADHD medication management and/or other ADHD behavioral management techniques. Additionally, this study included five questions with the goal of assessing the level of comfort providers have in various aspects of ADHD treatment and management. The first question in this set aims to identify comfort in knowledge of

diagnosing and treating ADHD. The second question aims to identify comfort in managing medications for their patients with ADHD. The remaining questions aim to identify comfort in ADHD management overall, in ADHD management if a patient had received their diagnosis from a specialist, and ADHD management if the respondent was first able to have a phone conversation with a child and adolescent psychiatrist regarding ADHD.

Results

Participant Characteristics

Data was collected from March 2020 through September 2020 with 475 recorded responses. Following exclusion of surveys with less than 15% completion, subsequent analyses was completed with the remaining 87% of valid survey responses (N = 415). Patterns in missing data mechanism were analyzed and determined to be missing completely at random (MCAR), as determined by Little's MCAR test, $X^2(56) = 66.71, p \leq .155$. There were no particular questions or set of questions consistently left unanswered by the participants. The study sample of 415 APNs included providers from 41 states. No sociodemographic (age, race, gender, etc.) characteristics were collected in this survey. See Table 1 for participant characteristics including practice location type, percentage of time spent in primary care, if ADHD training was received, and if so, the type of training. Other characteristics regarding clinical experience including number of years worked in primary care, average number of patients see per week, minutes spent on ADHD during well child checks (WCC) or sick visits, and number of patients referred to a specialist for ADHD management are shown in Table 2.

Correlations Between Provider Comfort as it Relates to ADHD Screening and ADHD

Diagnosis

Results of the Kendall's tau-b correlation indicated that there is a positive and significant correlation between the comfort measure questions, providers with ADHD specific training and

the frequency of screening and diagnosing ADHD ($p \leq 0.01$). All data in the correlation was found to be significant. See Table 3 (Appendix B) for correlation data, means and standard deviations. The percentage of participants that reported being “Extremely comfortable” and “Somewhat comfortable” with their knowledge of ADHD was 25.1% (N = 104) and 28% (N=116) respectively. The percentage that reported being “Extremely comfortable” and “Somewhat comfortable” with diagnosing ADHD was 32% (N = 133) and 22.9% (N=95) respectively. The percentage that reported being “Extremely comfortable” and “Somewhat comfortable” with ADHD medication management was 27.6% (N= 114) and 27% (N=112) respectively. The percentage that reported being “Extremely comfortable” and “Somewhat comfortable” with ADHD medication management, but after an outside diagnosis of ADHD, changed to 41.9% (n = 174) and 20.7% (N=86) respectively. The percentage that reported being “Extremely comfortable” and “Somewhat comfortable” with ADHD medication management, but after consulting with a child and adolescent psychologist, changed to 20.5% (N=85) and 21.9% (N=91) respectively. Participants were asked how often they screen for ADHD when appropriate. The most common responses were “Always” (42.4%, N=175) and “Sometimes” (19%, N=79). They were asked how often they diagnose patients with ADHD when appropriate. The most common responses were “Sometimes” (55%, N=232) and “Never” (17.3%, N=72).

Specialized Training and its Role in Diagnosing and Treating ADHD

Table 4 shows the results of the linear regression as a series of 4 unadjusted models and one fully adjusted model, each of which was statistically significant ($p \leq 0.001$). Linear regression analyses were conducted to determine the relationship between provider level of comfort and the frequency in which ADHD is diagnosed, the frequency in which ADHD is screened for, the number of ADHD chief complaints a provider sees weekly, or whether the participant received

training. The dependent variable in this analysis is the participant's level of comfort in ADHD management. Model 1 is the frequency of diagnosing ADHD when appropriate, Model 2 is the frequency of screening for ADHD when appropriate and Model 3 is the number of ADHD chief complaints seen weekly. Models 1, 2 and 3 significantly predicted whether or not a provider is comfortable managing ADHD ($p \leq 0.001$.) Additionally, the control group, which included only providers who received specialized ADHD training, significantly predicted that a provider who receives specialized ADHD training is more comfortable managing ADHD ($p \leq 0.001$).

Discussion

Chief Purpose and Findings

The purpose of this study was to explore the barriers that prevent the timely diagnoses and treatment of ADHD in a pediatric primary care setting. How often providers screen for, diagnose and manage ADHD was predicted by their own level of comfort in ADHD management (Table 4). Participant comfort levels showed a strong correlation to whether or not a provider received ADHD specific training ($p \leq 0.001$, Table 3). Another area that showed a positive correlation in participant level of comfort in ADHD screening, diagnosing and treatment is having access to a child and adolescent psychologist for a phone consultation ($p \leq 0.001$; Table 3). Finally, an incidental finding included the barrier of negative stigma associated with provider perception of ADHD. Participant #73 stated the following:

I do not believe in ADHD. It is way over-diagnosed. I find parents are too lazy or unmotivated to discipline and grow their children. [They] want an immediate fix with medication and they are unwilling to invest the time in therapy; 98% want [an] easy medication fix even if it is truly unwarranted and I cannot in good conscience diagnose or medically treat ADHD.

Study Support and Conclusions

This study supports the conclusion that providers who receive training specific to ADHD are more likely to diagnose and manage ADHD. The French, Sayal & Daly (2019) study which identified that many primary care providers are not confident in diagnosing or managing ADHD, with a lack of ADHD specific training being identified as the key component negatively impacting their confidence. Tatlow-Golden et al. (2016) reported that providers did not feel they received education about treatment and management of ADHD, while subsequently being educated far more on far less common diagnoses. The current study additionally supports the findings of Sultan, Pastrana, & Pajer (2018) in which the telephone consultation model of a PCP consulting with a mental health specialist was effective in increasing the comfort level of PCPs managing ADHD. Additionally, the finding of negative provider perceptions and stigma supports the conclusion of Tatlow-Golden et al. (2016) that a majority of general practitioners did not believe in ADHD and believed symptoms of ADHD were a result of poor parenting, ineffective discipline, or family stressors. The French, Sayal & Daly (2019) study also observed that some PCPs simply do not believe in ADHD.

New Findings

This study found that providers who have ADHD specialized training are significantly more comfortable in diagnosing, managing and treating ADHD. In addition, this study found that if a provider is comfortable treating and managing ADHD, they are seeing more patients with ADHD as the chief complaint. Providers who are comfortable treating and managing ADHD still felt they would benefit from a consultation with a child and adolescent psychiatrist. Participants were overall still comfortable with management of ADHD if they have received training specific to ADHD screening, diagnosis and treatment. Some studies have found a positive connection

between providers who receive ADHD specialized training and an increase in their overall confidence, but not specifically the comfort of ADHD management (Imboden & Fehr, 2018; French, Sayal & Daly, 2019). A systematic review by Sultan, Pastrana, & Pajer, (2018) found that PCP collaboration with psychiatrists may correlate to an increased level of comfort, but there was not statistically significant data available specifically related to comfort.

Strengths & Limitations of Study

The limitations of this study include that a vast majority of the participants were APNs and therefore, an analysis between provider types (e.g. MA, DO, PA) was not possible. Initially the study had been intended to compare variances between provider types, but as the study progressed, the focus became APNs. Determining if there are different type of barriers between provider types may offer solutions based off of practice type or training received by one provider type of another. Another limitation of this study was that the study did not identify if providers who have higher levels of comfort have collaborative practice models in place, nor did it aim to identify if the reason(s) for this increased level of comfort was the result of a collaborative care model.

A strength of the study was the collaboration with Pediatric Nursing Certification Board, an ideal partner to reach the target audience, to send out the survey to their members. This allowed for a robust sample size that allowed for data collection from a majority of the US states. Survey responses were collected anonymously, which encouraged authentic comments. The results of the data analysis were statistically significant, and therefore beneficial in identifying and supporting the existence of barriers that need to be addressed in ADHD management.

Clinical Practice Implications

Understanding what barriers prevent providers from screening, diagnosing and managing ADHD is paramount in developing interventions to remove these barriers from practice. This study strongly emphasizes that barriers exist and are prevalent. This demonstrates the need for further research and interventions to improve opportunities for providers to receive ADHD specific training to improve provider comfort in ADHD management. Additionally, this demonstrates the need for education related to ADHD to assist in resolving stigma associated with ADHD that is preventing providers from addressing ADHD as a medical diagnosis. Finally, 19% of the participants, are living in states where APNs cannot prescribe Schedule II medications. Given that the majority of ADHD medications are classified as schedule II, this limits the ability of APNs to effectively treat & manage ADHD in a primary care setting. Policy change regarding prescriptive abilities for APNs is necessary to increase patient access to ADHD management within the seven states that APNs are unable to prescribe schedule II medications (AANP, n.d.).

Implications for Future Research

Comfort of providers was identified as a key factor in the providers who screened, diagnosed and managed ADHD consistently. Future studies that explore many possible variables to determine what most strongly influences high levels of comfort in ADHD management would be helpful in determining intervention models. Qualitative studies should be implemented to better understand the perspectives of providers who do not believe in ADHD. Implementation and evaluation of an ADHD specific training program and phone consultation models would be able to offer further evidence to benchmark provider needs to increase comfort in ADHD management. Given the challenge of limited pediatric mental health resources, barriers to APNs prescribing schedule II medications in all states should be explored in future research. This

research would provide additional data to support bills that could remove these restrictions in the future.

Conclusion

The purpose of this study was to identify barriers to the timely diagnosis and treatment of ADHD in a pediatric primary care setting. Low levels of comfort in managing ADHD, lack of ADHD specific training, negative provider stigma, and the lack of prescriptive abilities for APNs to prescribe schedule II medications were identified as barriers in this study. Despite the clear recommendations from the American Academy of Pediatrics for pediatric primary care providers to screen for, diagnose and treat ADHD, the recommendations are inconsistently followed. In the case of lack of prescriptive authority for APNs in some states, they are unable to be followed. This study has identified barriers that support existing research and has identified a new theme of lack provider comfort in ADHD management as a barrier to effective ADHD management in primary care. There is substantial opportunity to move forward with interventions and further research to remove these barriers from practice.

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Appendix A

How comfortable do you feel regarding your knowledge of the current treatments provided for ADHD?

- Extremely comfortable
- Somewhat comfortable
- Comfortable
- Somewhat uncomfortable
- Extremely uncomfortable

How comfortable do you feel in diagnosing ADHD in your patients?

- Extremely comfortable
- Somewhat comfortable
- Comfortable
- Somewhat uncomfortable
- Extremely uncomfortable

How comfortable do you feel in providing medication management for your patients with ADHD?

- Extremely comfortable
- Somewhat comfortable
- Comfortable
- Somewhat uncomfortable
- Extremely uncomfortable

How comfortable would you feel treating ADHD with medication management if you first had a confirmed diagnosis through a psychological or neuropsychological assessment?

- Extremely comfortable
- Somewhat comfortable
- Comfortable
- Somewhat uncomfortable
- Extremely uncomfortable

How comfortable would you feel in managing medications after a phone consultation with a Child & Adolescent Psychiatrist regarding ADHD (even) if that provider has not seen the patient?

- Extremely comfortable
- Somewhat comfortable
- Comfortable
- Somewhat uncomfortable
- Extremely uncomfortable

Appendix B

Table 1. Study Sample Characteristics

Variable	%	N
<i>Practice Location Type</i>		
1. Urban	29.6%	123
2. Rural	19.3%	80
3. Suburban	9.2%	38
<i>Percentage of Time Spent in Primary Care</i>		
1. <25%	1.4%	6
2. 30%-50%	6.9%	29
3. 60%-70%	3.1%	12
4. 80%-100%	79.9%	332
5. Not reported	9.9%	41
<i>ADHD Training Received</i>		
1. No Training Received	34.9%	145
2. Training Received	56.1%	233
3. Not reported	8.9%	37
<i>ADHD Type of Training Received</i>		
1. Graduate practicum	8.9%	37
2. Certificate training	11.8%	49
3. Webinar	8.4%	35
4. Graduate Course	9.6%	40
5. On-the-job training	4.3%	18
6. CMEs	3.6%	15
7. Conferences	1.7%	7
8. No training received	34.9%	145
9. Not reported	8.9%	37

Table 2. Study Sample Characteristics Continued

Variable	M	SD	Range
Years worked in pediatric primary care	12.9	7.22	21
Patients seen on average per week	64	25.76	94
Minutes spent on ADHD during a routine well child check or sick child visit	11	5.96	30
Patients referred per month for a specialist for ADHD management	6	4.41	19

Table 3.

Correlation of Provider Comfort with ADHD and Screening/Diagnostic Frequency

Variable	M	SD	1	2	3	4	5	6	7
1. Provider has had Training Specific to ADHD	1.62	.49	-						
2. Frequency of Screening for ADHD when appropriate	7.78	1.40	.207**	-					
3. Frequency of Diagnosing ADHD when appropriate	7.08	.81	.220**	.424**	-				
4. Comfort with ADHD knowledge	2.40	1.18	.311**	.324**	.391**	-			
5. Comfort with diagnosing ADHD	2.32	1.26	.277**	.342**	.414**	.730**	-		
6. Comfort with managing ADHD medication	2.45	1.33	.273**	.330**	.378**	.741**	.704**	-	
7. Comfort with managing ADHD medication after a patient has been diagnosed by an outside provider	2.04	1.20	.277**	.306**	.351**	.552**	.544**	.639**	-
8. Comfort with managing ADHD medication after a phone consultation with a child & adolescent psychologist	2.76	1.32	.148**	.219**	.317**	.365**	.345**	.368**	.451**

Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4. Multiple Linear Regression Analysis

Variable	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6
IV1: Frequency of Diagnosing ADHD when appropriate (Reference: Never)	.225***					.184***
IV2: Frequency of Screening for ADHD when appropriate (Reference: Always)		-.695***				-.308***
IV3: Number of ADHD CC Seen Weekly (Reference: 1-2)			.530***			.408***
IV4: Number of ADHD CC Seen Weekly (Reference: 3-5)				.068		.268
Control Group/Provider Characteristic: Provider has had training specific to ADHD (Reference: Yes)					-.712***	-.503***
Constant (standard error)	2.142*** (.052)	2.719*** (.070)	2.268*** (.061)	2.374*** (.066)	2.843*** (.082)	2.453*** (.104)
Adjusted R-squared	.252***	.107***	.044***	-.002	.107***	.364***

Note. * $p \leq 0.05$; ** $p \leq 0.01$; *** $p \leq 0.001$