MOLINA HEALTHCARE OF CALIFORNIA

ADHD:
CLINICAL PRACTICE GUIDELINE FOR THE DIAGNOSIS, EVALUATION, AND TREATMENT OF ATTENTION-DEFICIT/HYPERACTIVITY DISORDER IN CHILDREN AND ADOLESCENTS


The Clinical Practice Guideline may be accessed from:
http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654.full.pdf+html
Key Points from ADHD Guidelines

Summary of Key Action Statements:

1. The primary care clinician (PCP) should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral health problems and symptoms of inattention, hyperactivity, or impulsivity.
2. To make a diagnosis of ADHD, the PCP should determine that Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, have been met (including documentation of impairment in more than 1 major setting); 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 PCP should also rule out any alternative cause.
3. In the evaluation of a child for ADHD, the PCP should include assessment for other conditions that might coexist with ADHD, including emotional, behavioral, or developmental conditions.
4. The PCP 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.
5. Recommendations for treatment of children and youth with ADHD vary depending on the patient’s age:

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<th>Recommendations</th>
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| Preschool-aged children (4-5 years of age) | First line of treatment: PCP should prescribe evidence-based parent and/or teacher-administered behavior therapy.  
  - 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 where evidence-based behavioral treatments are not available, the clinician needs to weigh the risks of starting medication at an early age against the harm of delaying diagnosis and treatment. |
| Elementary school-aged children (6-11 years of age) | PCP should prescribe, preferably both, US Food and Drug Administration (FDA)-approved medications for ADHD and/or evidence-based parent and/or teacher-administered behavior therapy.  
  - 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).  
  - The school environment, program, or placement is a part of any treatment plan. |
| Adolescents (12-18 years of age) | PCP should prescribe, preferably both, FDA-approved medications for ADHD with the assent of the adolescent and may prescribe behavior therapy as treatment for ADHD. |

6. The PCP should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects.
Overview of the ADHD Care Process

1. Perform Diagnostic Evaluation for ADHD and Evaluate or Screen for Other Coexisting Conditions:
   - See action statements 2–3

2. DSM-IV diagnosis of ADHD?
   - Yes
   - No

3. Other condition?
   - Yes
   - No

4. Inattention and/or hyperactivity/impulsivity problems not rising to DSM-IV diagnosis?
   - Yes
   - No

5. Coexisting conditions?
   - Yes
   - No

6. Other condition?
   - Yes
   - No

7. Apparently typical or developmental variation?
   - Yes
   - No

8. Option: Medication (ADHD only and past medical or family history of cardiovascular disease considered)
   - Initiate treatment
   - Tolerate to maximum benefit, minimum adverse effects
   - Monitor target outcomes

9. Follow-up for chronic care management at least 2x/year for ADHD issues

10. Other condition? (as appropriate for child’s age and developmental status)
    - Interview, including concerns regarding behavior, family relationships, peers, school
    - For adolescents: validated self-report instrument of ADHD and coexisting conditions
    - Report of child’s self-identified impression of function, both strengths and weaknesses
    - Clinician’s observations of child’s behavior
    - Physical and neurologic examination

11. Option: Behavior management (developmental variation, problem on ADHD)
    - Identify service or approach
    - Monitor target outcomes

12. Option: Collaborate with school to enhance supports and services (developmental variation, problem, or ADHD)
    - Identify changes
    - Monitor target outcomes

13. Follow-up and establish co-management plan
    - See TFOMH Algorithms

14. Derive impact on treatment plan

15. Assess impact on treatment plan

16. Do symptoms improve?
   - Yes
   - No

17. Recompose treatment plan including any needed medication or dose changes, behavioral therapy, and/or

18. Follow-up for chronic care management at least 2x/year for ADHD issues

SUPPLEMENTAL APPENDIX FIGURE 2
ADHD process-of-care algorithm. TFOMH indicates Task Force on Mental Health; CYSHCN, child/youth with special health care needs.1


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