OSU Oregon State University College of Pharmacy
Drug Use Research & Management Program
OHA Division of Medical Assistance Programs
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DIVISION OF MEDICAL ASSISTANCE PROGRAMS
Policy & Planning Section
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Follow Up Care for Children Prescribed Their First ADHD Medication

Recommendations

- Fax reports biweekly to promote follow up care for children prescribed their first ADHD medication as defined by the Healthcare Effectiveness Data and Information Set (HEDIS®) 2013 specification
- Reports to contain:
    - Dashboard comparing the target provider to other Medicaid providers and providers within their specialty
    - Provide list of patient with their first ADHD prescription within the last 2 weeks
    - Form indicating the status of a scheduled follow up visit for each patient for the provider to complete and return to the Medical Assistance Program
    - Educational materials highlighting recommendations for monitoring and management of ADHD pharmacotherapy in children

Background

According to the Center for Disease Control's report on the results of the National Health Interview Survey from 2004-2006, 8.4% of American children 6-17 had at one point been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD).[1] The report also indicated the diagnosis of ADHD was more prevalent in children covered by a Medicaid program (11.6%). Given the observed annual increase of the percentage of children with the diagnosis of ADHD (3%), this figure is likely even higher now. Additionally the study does not capture the rate of undiagnosed ADHD. A CDC report indicated that 4.3% of children 4-17 years old had both a diagnosis of ADHD and were receiving pharmacologic treatment. Of all children 6-17 enrolled in the Oregon Medicaid program in January 2013, 10.6% had a prior claims history of ADHD (ICD-9 314.XX).

Phenylethylamine central nervous system (CNS) stimulants have been used for over half a century for the treatment of ADHD and hyperkinetic disorders. These drug products are chemical variants of amphetamine or methylphenidate, with various formulations to control the release rate of the active agents. The primary mechanism of action is the increase of synaptic dopamine and norepinephrine.[2,3] Safety monitoring should include assessments of cardiovascular risk and elevations in heart rate (HR) and blood pressure (BP), height and weight reductions and sleep disturbances. [4,5]All of these medications are Drug Enforcement Agency (DEA) schedule II substances, indicating a high risk of physical dependence, misuse and abuse.[6]

The non-traditional CNS stimulant modafinil has been studied for the treatment of ADHD.[5,7] Modafinil's mechanism of action is unclear. Both modafinil and the R-isomer armodafinil are FDA approved to "improve wakefulness in patients with excessive sleepiness associated with obstructive sleep apnea, narcolepsy and shift work disorder."[7,8] The safety and efficacy of these agents in children is unclear and neither agent is approved for use in children.[7,8] Monitoring parameters are similar to traditional stimulants (amphetamine and methylphenidate derivatives). Both of these medications are DEA Schedule IV controlled substances, indicating a lower risk of dependence and misuse when compared to traditional stimulants.[6–8]

Several alternatives to stimulants have been used for the treatment of ADHD. Immediate and extended release formulations of clonidine and guanfacine (alpha-2 adrenergic agonists) have been used in the treatment of ADHD, either as monotherapy or adjunctive therapy.[4,5,9] Developed initially as antihypertensives, cardiovascular symptoms generally present as reduced, rather than increased blood pressure.[2] Other common side effects include somnolence, fatigue and dizziness. Atomoxetine is a selective norepinephrine reuptake inhibitor indicated for the treatment of ADHD in children over six years old.[10] Atomoxetine has an FDA black box warning for an increased risk of suicidal ideation and must therefore be monitored closely. Cautions should be used in prescribing atomoxetine with comorbid bipolar disorder due to concerns of precipitating manic episodes. Atomoxetine has been shown to cause sleep disturbances manifesting as either somnolence or insomnia. Other side effects include increases in HR and BP, slowing of growth of height and weight, and aggressive behavior.

Behavioral and environmental interventions have been investigated for the treatment of ADHD. The 2011 Agency for Healthcare Research and Quality (AHRQ) systematic review of ADHD treatments found high quality evidence supporting effectiveness of parent behavior training for the management of ADHD symptoms in preschoolers.[9] A recent Oregon Health Evidence Review Commission (HERC) draft guidance recommended the coverage of patient behavior training in preschool age children and behavioral treatment in children over the age of six.[11] The American Academy of Pediatrics (AAP) systematic review and clinical practice guidelines agree with the AHRQ findings for preschool children.[4] The AHRQ report assessed the data for behavioral interventions in other age groups as either low quality or insufficient to support treatment recommendations. The AAP cites the same evidence as the AHRQ, but deemed the evidence sufficient to recommend the use of behavioral interventions in elementary school age children and adolescents with or without the use of pharmacotherapy.

Regular monitoring of ADHD pharmacotherapy is essential for efficacy and safety. In 2009 the Children's Health Insurance Program Reauthorization Act (CHIPRA) identified 25 core health care quality measures including "Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication."[12,13] Measures were taken from 121 public submissions. These were narrowed to 25 based on expert opinion on validity, feasibility, and importance. This ADHD measure was ranked 13th by the expert panel. This metric identifies both initiation and continuation phases. The initiation phase identifies patients 6-12 with at least one follow up visit within 30 days in pharmacotherapy naïve patients upon issuing of the first ADHD medication. The continuation phase monitors these patients for at least two additional follow up appointments over the following 270 days. As part of Oregon's Medicaid Demonstration project, the Oregon Health Authority Metrics and Scoring Committee adopted the ADHD metrics as a performance measure for all Coordinated Care Organizations (CCO).[14,15] The Metrics and Scoring Committee reported that Statewide monitoring rates were 52.3% for initial follow up and 61% for continuation phase follow up.[16] The AAP guidelines recommend a patient-specific follow up schedule, with frequent telephone and face-to-face evaluations during titration and follow up at least every three months for the first year.[17] Neither the AHRQ or DERP reports discuss monitoring or follow up schedules in detail.[5,9] Despite limited evidence supporting the HEDIS® specification, it provides a standard which can be compared to other programs both locally and nationally.[18]

RetroDUR Intervention

As part of the efforts of the Division of Medical Assistance Programs (DMAP) to improve the use of psychotropics in foster children, a dashboard was created for CCOs to monitor newly started ADHD medication which are paid for by the FFS program (i.e. carve-out medications).[18] This FFS RetroDUR proposal adapts the CCO dashboard to target fee for service patients. The new program will send a fax reminder to providers to schedule appointments for the initiation phase and continuation phase consistent with the HEDIS® measure and AAP guideline recommendations (Appendix A).[19] These notifications will contain a list of patients recently started on ADHD medications, educational material describing AAP guidelines and monitoring parameters. Faxes will be sent every two weeks containing all new starts since the previous notification.

Provider feedback will also be solicited on:

1. Action Taken
    - Already scheduled follow within 30 days
    - Already scheduled quarterly follow up
    - Will schedule appointments
    - Will not schedule the appointments
        - Explain_____
    - Not my patient/ no longer my patient
    - Patient Deceased
    - Neither clinician or patient associated with this office
    - Other_____
2. Provider Satisfaction
    - This information was useful
    - I agree with the recommendation in general
    - This information will change my future practice
    - Please do not send further notifications

Biweekly messages will not be sent to providers exceeding 75% of either initiation or continuation phase follow up. For these outstanding providers, a “Thank you” message will be sent quarterly (Appendix B).

Reporting follow up rates by practice site may be an alternative strategy to providing clinician-specific rates. Assigning practice sites is dependent on the accuracy of National Provider Identifier Standard data. This option may be considered based on the Pharmacy & Thera

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Appendix A: Provider Letter for ADHD Follow-Up Care

Date: mm/dd/yyyy

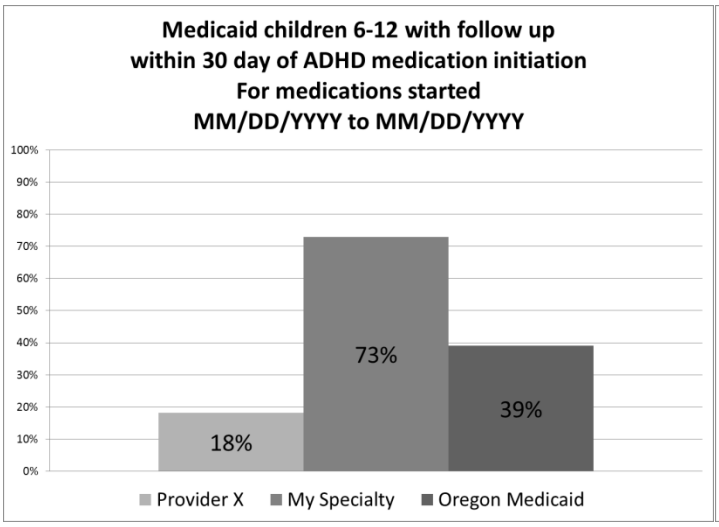
Attention: Provider X
Fax: 541-123-4567

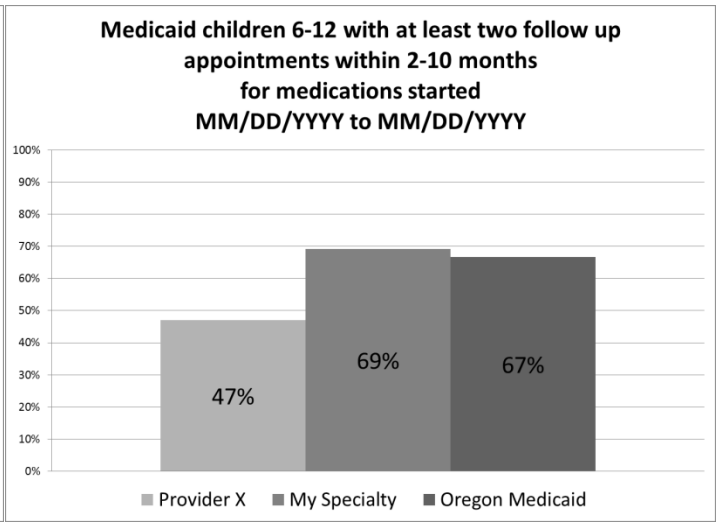
Re: Scheduled follow-up for children on ADHD medications

The Division of Medical Assistance Programs and all Coordinated Care Organizations encourage providers to follow the American Academy of Pediatrics and the Agency for Healthcare Research and Quality recommendations for follow up care in children receiving pharmacotherapy for the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

The following pages contain a list of Fee-For-Service (FFS) Medicaid patients that you are identified by the pharmacy claim as the prescriber of the first ADHD medication. We encourage you to schedule at least one follow up appointment within thirty days of initiation and at least 2 appointments 2-10 months after initiation.

The figures below reflect the proportion of patients for which you initiated ADHD medications with initial follow up and maintenance phase follow by any provider. Overall Medicaid rates and rates for your specialty are included for reference.





If you have any questions or comments regarding this policy, please call 503-945-6513 or fax 503-947-2596.

We thank you for your cooperation.

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Highlights of the American Academy of Pediatrics (AAP) 2011 Recommendations for Treatment and Management of Attention Deficit Hyperactivity Disorder (ADHD)

- Use rating scales for the diagnosis and monitoring of symptoms such as the Vanderbilt ADHD assessment tool available at: http://www.nichq.org/toolkits_publications/complete_adhd/03VanAssesScaleParent%20Infor.pdf
- The Conners' Parent and Teacher rating scales (CPRS & CTRS) may also be useful in screening for ADHD and comorbid conditions in select populations
- Review school records including report cards, suspensions, and progress reports
- Monitor for sleep disturbances at baseline and at each follow up visit
- Monitor height, weight, blood pressure (BP) and heart rate (HR) at baseline and at all follow up visits regardless of pharmacologic agent
    - Stimulants and atoxmoxetine may increase BP and HR and slow growth in height and weight
    - Clonidine and guanfacine may decrease BP and HR
- Stimulants may be titrated every 3-7 days
- Guanfacine and clonidine may take 2-4 weeks to see full therapeutic effects
- Atomoxetine may take 4-6 weeks to see full therapeutic effects and monitored for signs of suicidal ideation
- For non-response to a stimulant, consider switch to a CNS agent of a different chemical group (i.e. methylphenidate to amphetamine or vice versa).
- Poor symptom control should prompt neuropsychological and psychoeducational assessments, possibly by a psychologist or neuropsychologist

AAP Minimum Follow-Up Schedule for Patients Receiving ADHD Drugs

Initiation and Titration	At least once within 30 days of initiation
First Year of Therapy	Every 3 months
After First Year	Twice yearly, with telephone follow up with each refill

AAP ADHD Treatment Recommendations

Age	Strength	Therapy
Preschool 4-5 Years	Strong	Parental/Teacher Behavioral Therapy
	Recommended	Methylphenidate
Elementary School Age 6-11 Years	Strong	FDA Approved, Age Appropriate Medications +/- Behavioral & Environmental Therapy
Adolescents 12-18 years	Strong	FDA Approved, Age Appropriate Medications
	Recommended	Behavioral & Environmental Therapy

*Modafinil (Provigil®) and armodafinil (Nuvigil®) have not been demonstrated to be safe or effective in the treatment of ADHD in children and do not have FDA approval for ADHD

Other Useful References

- American Academy of Pediatrics 2011 ADHD Guideline Implementation Guide: http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654/suppl/DC1
- Parent's Guide to ADHD: http://www.effectivehealthcare.ahrq.gov/ehc/products/191/1148/adhd_con_fin_to_post.pdf
- CCO Incentive Measures and data specifications available at: http://www.oregon.gov/oha/Pages/CCO-Baseline-Data.aspx
- Brown RT, Freeman WS, Perrin JM, et al. Prevalence and Assessment of Attention-Deficit/Hyperactivity Disorder in Primary Care Settings. *PEDIATRICS*. 2001;107(3):e43–e43. doi:10.1542/peds.107.3.e43 http://pediatrics.aappublications.org/cgi/doi/10.1542/peds.107.3.e43

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The following is a list of FFS Medicaid patients that you are identified by the pharmacy claim as the prescriber of the first ADHD medication. We encourage you to schedule at least one follow up appointment within thirty days of initiation and at least 2 appointments 2-9 months after initiation.

Please complete the form below and fax back to 503-947-2596.

Member ID	Patient Name	Date of Birth	Drug Name	First Rx Fill Date	Action Taken
XYZ1234	Doe, Jane	MM/DD/YYYY	Guanfacine	MM/DD/YYYY	☐ Already scheduled follow within 30 days ☐ Already scheduled quarterly follow up ☐ Will schedule appointments ☐ Will not schedule the appointments Explain_____ ☐ Not my patient/ no longer my patient ☐ Patient Deceased ☐ Neither clinician or patient associated with this office ☐ Other_____
ABC9876	Doe, John	MM/DD/YYYY	Methylphenidate	MM/DD/YYYY	☐ Already scheduled follow within 30 days ☐ Already scheduled quarterly follow up ☐ Will schedule appointments ☐ Will not schedule the appointments Explain_____ ☐ Not my patient/ no longer my patient ☐ Patient Deceased ☐ Neither clinician or patient associated with this office ☐ Other_____

Please check all that apply:

- ☐ This information was useful
- ☐ I agree with the recommendation in general
- ☐ This information will change my future practice
- ☐ Please do not send further notifications

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Appendix B: Exceptional Provider Thank You Letter

Date: mm/dd/yyyy

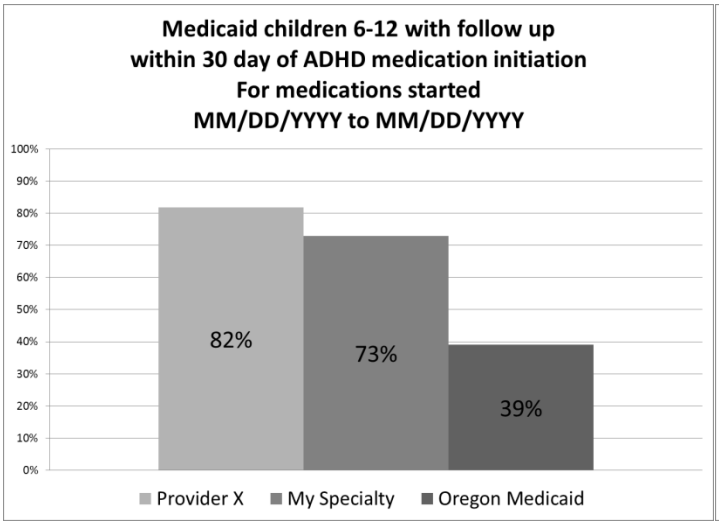
Attention: Provider X
Fax: 541-123-4567

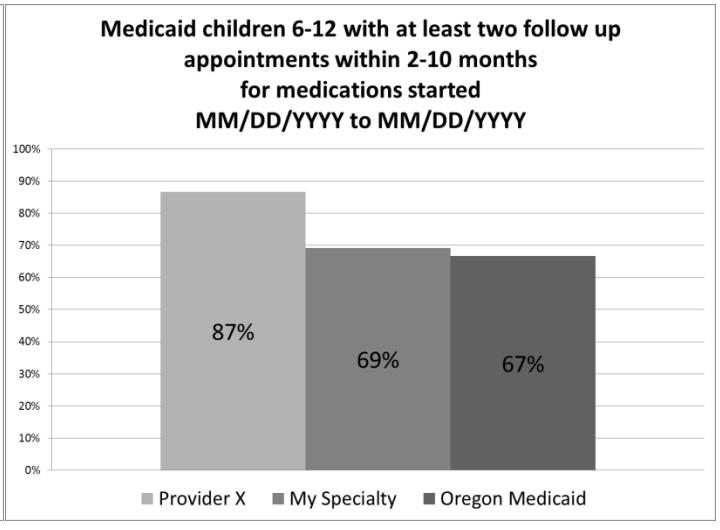
Re: Your excellence in follow up care for children receiving ADHD medications

You were identified as an exceptional provider based on the frequency of follow up care for children started on attention deficit hyperactivity disorder (ADHD) medications. For children 6-12 started on their first ADHD medication, at least one follow up visit was scheduled for XX% of your patients. Over the next 9 months, there were at least two follow up visits for XX% of those new starts.

The Division of Medical Assistance Programs and all Coordinated Care Organizations encourage providers to follow the American Academy of Pediatrics (AAP) and the Agency for Healthcare Research and Quality (AHRQ) recommendations for follow up care in children receiving pharmacotherapy for the treatment of Attention Deficit Hyperactivity Disorder (ADHD). We appreciate your efforts to follow the AAP guidelines and AHRQ recommendations and the delivery of exceptional care to our members.

The figures below reflect the proportion of patients for which you initiated ADHD medications with initial follow up and maintenance phase. Overall Medicaid rates and rates for your specialty are included for reference.





If you have any questions or comments regarding this policy, please call 503-945-6513 or fax 503-947-2596.

Please check all that apply:

- ☐ This information was useful
- ☐ I agree with the recommendation in general
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	Recommended	Methylphenidate
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Adolescents 12-18 years	Strong	FDA Approved, Age Appropriate Medications
	Recommended	Behavioral & Environmental Therapy

*Modafinil (Provigil®) and armodafinil (Nuvigil®) have not been demonstrated to be safe or effective in the treatment of ADHD in children and do not have FDA approval for ADHD

Other Useful References

- American Academy of Pediatrics 2011 ADHD Guideline Implementation Guide: http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654/suppl/DC1
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