



DENVER HEALTH MEDICAL PLAN INC.™

CLINICAL PRACTICE GUIDELINE

Guideline Number: DHMP_DHMC_CG1000

Effective Date: 11/1/2022

Guideline Subject: ADHD Clinical Practice Guideline for the
Diagnosis, Evaluation and Treatment of Attention-
Deficit/Hyperactivity Disorder in Children and Adolescents

Revision Date: 11/1/2023

Pages: 1 of 4

Christine Seals Messersmith MD

11/1/22

Quality Management Committee Chair

Date

- I. **PURPOSE:** Attention-deficit hyperactivity disorder (ADHD) is the most common neurobehavioral disorder of childhood and can profoundly affect the academic achievement, well-being and social relationships of children. The purpose of this guideline is to provide guidance with diagnosis and treatment of ADHD.
- II. **POPULATION:** Members aged 4-18 years of age who present with academic or behavioral problems combined with symptoms of inattention, hyperactivity, or impulsivity.
- III. **GUIDELINE:**
 - A. Evaluation and Diagnosis (based on AAP guideline):
 - Evaluation is initiated by pediatrician/primary care physician for children aged 4-18 who present with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity
 - To make an ADHD diagnosis, the primary care clinician should determine that diagnostic criteria have been met based on the Diagnostic and Statistical Manual of Mental Disorders –Fifth Edition (DSM-5). Making a diagnosis includes documenting the child had difficulties in more than 1 major setting (in school and at home). Information is collected from parents, teachers, caregivers, and mental health professionals, etc. who are involved in the child’s care
 - Alternative Causes should be considered and ruled out such as: emotional and behavioral conditions, developmental disorders, and physical conditions
 - ADHD is classified as a chronic (long-standing) condition. The clinician should therefore recognize children and adolescents with ADHD as children and youth with special health care needs. Care for these youth should follow the principles of the chronic care model and the medical home
 - B. Screening Tools: (Attached)
 - Vanderbilt Assessment Scale
 - Conners Teacher and Parent Scale- Revised
 - DMS 5 Criteria
 - C. Treatment:

Treatment Recommendations are based on age:

 1. Pre-School (4-5 years):
 - Evidence-based parent or teacher administered behavioral intervention should be the first line of treatment
 - Medication (methylphenidate) may be considered if first line treatments are not available or insufficient
 - Weigh the risk of starting medication at an early age against harm of delaying diagnosis and treatment
 - Rate of metabolizing stimulant medication is slower in children 4-5 years old, they should start with lowest dose possible and it can be increased in increments as indicated

2. Elementary School-aged (6-11 years):

NOTE:

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- Combination of US FDA approved medication and evidence based behavioral interventions has been shown to have the best outcome. Preferably, both medication and behavior therapy should be used together
- Stimulant medications have been shown to be beneficial. In some instances, atomoxetine, extended-release guanfacine, and extended-release clonidine (in that order) may be used, but may not be as effective
- The school environment, program, or placement is part of any treatment plan. School modifications such as preferred seating, classroom adaptations, test modifications, behavior plans, organizational training, or special education should be encouraged

3. Adolescents (12-18 years):

- FDA-approved medications for ADHD with the assent of the adolescent and may prescribe behavior therapy as treatment for ADHD. Preferably, both medication and behavior therapy should be used together
- Clinicians should assess adolescent patients for signs and symptoms of substance abuse, particularly in those with a new diagnosis of ADHD. If signs and symptoms of substance abuse are found, evaluation and treatment for addictions should precede treatment for ADHD, if possible
- If medication is prescribed, it should be titrated to ensure the child receives the maximum benefit with the least degree of adverse side effects
- Mood disorders such as depression have co-morbid influences general function and school performance. Objective screening is recommended

D. Medication Evaluation/Re-evaluation:

- Initial exam should include history and physical exam
- Blood pressure, pulse, height and weight measures are completed before medication is initiated and monitored regularly, as ADHD medications may affect these measures
- The primary care clinician should monitor and alter, as needed, the dose of medication given to the child for ADHD in order to achieve the maximum benefit while minimizing any problems from taking the medication

E. Follow-Up Care

Children who are newly prescribed ADHD medication should receive follow-up care visits as follows:

- **Initiation Phase:**
Upon initiation of prescription medication, members should be re-evaluated by the prescribing physician in a face to face visit occurring on a monthly basis until consistent and optimal response is met. Once met, Members then should be seen every 3 months for the first year of treatment.
- **Continuation and Maintenance Phase:**

Subsequent visits should continue to occur at minimum of two times per year until goals are progressing and stable.

F: Goals for Treatment:

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The optimal goals for treatment of ADHD are to improve functioning and behavior of the child/adolescent. Behavioral interventions teach skill sets to help manage and control behavior and to improve social skills, peer interactions, and coping skills.

- To achieve optimal results with behavioral therapy, parents and teachers are recommended to be active participants, supporting the child/adolescent in learning and using behavioral interventions

The goals of medication treatment for individuals with ADHD are to reduce symptoms and help with maintaining a functional life style related to school, home, social interactions, and well-being.

G. Educational Resources:

Educating patients and their families/caregivers about ADHD and resources can positively support treatment and stabilization.

Patient/family educational materials are found at:

- The National Initiative for Children's Healthcare Quality at <https://www.nichq.org/resource/caring-children-adhd-resource-toolkit-clinicians>
- National Institute of Mental Health: What is Attention Deficit Hyperactivity Disorder (ADHD/ADD) <http://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml>
- Attention-Deficit/Hyperactivity Disorder (ADHD) Homepage <http://www.cdc.gov/ncbddd/adhd/index.html>

III. ATTACHMENTS:

DSM V Criteria

Fact Sheet

Conners Parent Scale

Conners Teachers Scale

Vanderbilt Assessment

V. REFERENCES:

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Signature: Christine Seals Messersmith MD

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ADHD Guidelines 2022 - Needs Signature

Final Audit Report

2022-11-10

Created:	2022-11-10
By:	Jacqueline De La Torre (Jacqueline.DeLaTorre@dhha.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAALPI9-OEQnGKTHFY0I4iMsFCgh3bBf8ou

"ADHD Guidelines 2022 - Needs Signature" History

-  Document created by Jacqueline De La Torre (Jacqueline.DeLaTorre@dhha.org)
2022-11-10 - 4:35:58 PM GMT
-  Document emailed to christine.seals@dhha.org for signature
2022-11-10 - 4:36:41 PM GMT
-  Email viewed by christine.seals@dhha.org
2022-11-10 - 5:55:57 PM GMT
-  Signer christine.seals@dhha.org entered name at signing as Christine Seals Messersmith MD
2022-11-10 - 5:56:15 PM GMT
-  Document e-signed by Christine Seals Messersmith MD (christine.seals@dhha.org)
Signature Date: 2022-11-10 - 5:56:17 PM GMT - Time Source: server
-  Agreement completed.
2022-11-10 - 5:56:17 PM GMT