Episodes of Care
Attention Deficit/Hyperactivity Disorder (ADHD): A Step by Step Guide
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**Introduction**

The Arkansas Health Care Payment Improvement Initiative (AHCPII) is moving the state’s entire health care system away from a fragmented fee-for-service approach to a more coordinated, incentive-based system that promotes the prevention and management of chronic conditions and the delivery of high-quality, efficient care. The initiative is led by the Arkansas Department of Human Services and the largest private insurers in the state (Arkansas Blue Cross Blue Shield and Arkansas QualChoice), with strong support from the federal Centers for Medicare and Medicaid Services (CMS). Arkansas is the first to use this approach statewide and with both public and private payers.

We are deeply appreciative of the feedback and assistance we have received from a wide range of stakeholders, most notably from the many workgroup discussions that have occurred from around the state during the first year of the design and implementation phases of the initiative. We have received clear and constructive input on the opportunities to improve quality, patient experience, and cost effectiveness for each priority treatment area.

The initiative continues to be guided by the core principle of designing a 21st century health care payment system for Arkansas that is patient-centered, clinically appropriate, practical and data-driven. We continue to believe that “episodes based payment” best addresses these goals for most situations, particularly acute and post-acute care. We also continue to endorse development of medical homes and post-acute care that apply a “population-based approach” to the prevention and management of chronic conditions through care coordination. We recognize that some important types of care, such as for people with developmental disabilities and long-term care support, may combine elements of both approaches to better provide ongoing support that meets individual needs.

For behavioral health (BH) services, Attention Deficit/Hyperactivity Disorder (ADHD) is the most common behavioral disorder of childhood. Given that ADHD often co-occurs with other behavioral health conditions, treatment occurs in a wide array of settings which causes treatment fragmentation and duplicative costly services. The AHCPII ADHD episode of care addresses many issues within the behavioral health system by creating accountability for all services related to a specific BH condition and increasing the adoption of evidence-informed practices.

This toolkit, “Episodes of Care Attention Deficit/Hyperactivity Disorder (ADHD): A Step by Step Guide” has been developed to assist providers, consumers, general public, and other interested parties to educate and raise awareness of the state’s implementation strategies and outcomes for AHCPII, more specifically the ADHD episode of care.

The material and exhibits presented in this toolkit represent examples of how providers can successfully meet the responsibilities of a Principle Accountable Provider (PAP) and potentially achieve gain-share. The toolkit is not intended to be all-inclusive, but to serve as a resource for providers, organizations, community-leaders, and individuals.
The Arkansas Healthcare Payment Improvement Initiative (AHCPII)

Medicaid programs in every state have the growing challenge of providing quality care with limited resources. In the face of immediate financial crises, many states are making or considering a variety of dramatic changes, including across the board rate cuts, elimination of vital services, shifting risk to large managed care companies and even requesting federal permission to eliminate many beneficiaries.

States are also testing new care and payment models, many based on the growing consensus that the predominant fee-for-service model of reimbursement creates tremendous inefficiencies. Unfortunately, most of these efforts are small scale and not expected to yield significant quality or cost impacts in the near future. There is not enough time for small-scale demonstration projects to evaluate new approaches over several years. Rather, it is essential to take broad action now based on the best available evidence of what steps will truly transform Medicaid for the better.

Arkansas has outlined an aggressive plan through the Arkansas Health Care Payment Improvement Initiative (AHCPII) to transform the Medicaid program from an inefficient fee-for-service system to one focused on providing quality care via “health homes” and “episodes of care”. The primary goal is to make more effective use of health care resources by:

- emphasizing wellness and prevention;
- paying for effective, coordinated episodes of care rather than for individual services;
- helping people live as independently as possible; and
- aligning financial incentives to achieve a transformed system.

The transition to such a system will not be easy or occur overnight. Medicaid will simultaneously work with providers and others to:

1. identify best practices for different diagnostic episodes,
2. create the reimbursement structure for those episodes, and
3. design and support the development of health home partnerships to assist seniors and people with disabilities to live as independently as possible and to ensure that people with long term care needs can be served in the most independent and cost-effective settings.

Reimbursement will then begin to transition from fee-for-service to payments for episodes of care, building off of the bundled payment strategies now employed for prenatal and obstetric services.
The initiative IS designed to:

- Focus on improving care -- not just saving money.
- Protect provider discretion and keep clinical decision-making with providers.
- Rewards high-quality providers while also creating a financial incentive for ineffective providers to improve.
- Encourages providers to coordinate their patients’ care, which should lead to better health outcomes for Arkansans.
- Acknowledges that poor performance is a reality and should not be rewarded.
- Aims to improve the status quo and protect Arkansans from alternatives such as intrusive managed care.

The initiative IS NOT designed to:

- Reduce patient benefits
- Cut provider rates
- Restrict patient eligibility for services/treatment
- Outsource managed care
- Require providers to join a single “accountable care organization”
- Limit providers ability to diagnose and treat patients

The transformation outlined above builds on strengths in Arkansas’ existing system and draws on the ongoing efforts around the country to stabilize and improve both Medicaid and broader health systems.
Coordinated and Integrated Behavioral Health Care

Despite recommendations and support for better coordination and integration of mental health care services, our delivery and care systems remain fragmented and are falling short of providing adequate prevention and treatment for children’s mental needs. Children with mental health disorders are served in multiple systems which often fail to communicate, share information and resources, and transition care smoothly from one system to the next. The result is overemphasis on intensive service providers and reactive, crisis-oriented interventions (sometimes resulting in the child’s removal from the home, school or child care setting) and insufficient focus on prevention, early identification, and timely treatment.

The potential benefits of a better coordinated and integrated approach to delivery of mental health services include:

- Early identification of emotional and behavioral problems
- Enhanced resources available to children and families
- Improved monitoring, and a collaborative approach to crisis management
- Both medical and behavioral professionals can get the “full picture” about the clients they’re treating.
- Many mental and physical disorders are co-occurring, especially depression and chronic medical conditions.

Research Suggests

- Coordinated and integrated care allows for a whole person approach for treatment.
- Addressing psychosocial aspects often results in lower overall health costs.
- Improving mental status and functioning often positively impacts physical conditions.
- Underlying behavioral or emotional conditions can increase unnecessary medical utilization and inappropriate referrals.
- Management of emotional/behavioral disorders may positively impact adherence to treatment of physical disorders.
- Coordinated and integrated care leads to a reduction of inappropriate use of medical services and a cost-savings in big-ticket items like emergency room visits and hospitalization.
Behavioral Health System: Opportunities to improve quality, patient, experience, and cost

In Arkansas, there are numerous challenges within the behavioral health system that fall within five (5) categories:

1. **Prevention**

   **Awareness of available services can be improved**
   - Discrimination and stigma associated with behavioral health creates challenges for clients
   - Need to improve public communications around the services that are available

   **Gaps in services for behavioral health needs (mental health and substance abuse)**
   - Lack of funding for comprehensive array of prevention programs and support services
   - Need to provide options for behavioral health prevention in different settings (e.g., shelters, hospitals, long term care settings, schools, job centers, justice system, DHS) includes RSPMI, PBIS, PBSS, coordinated school health services, anti-bullying
   - Limited utilization of peer, family/significant others, and community involvement services and supports for prevention
   - Need to improve identification of high risk populations, including those with BH needs among clients with physical or developmental disabilities

   **Need for additional training programs**
   - Prevention services need to be client centered
   - Lack of prevention training with clients (e.g., individuals and families) and key stakeholders (e.g., BH and DD providers, general practitioners, hospitals, job centers, shelters, teachers and other direct care staff)

2. **Early Intervention**

   **Gaps in early intervention services, including crisis intervention**
   - Access to crisis intervention and stabilization services is limited, especially after-hours and on weekends
Lack of mobile crises services across the state
Additional early intervention tools can potentially be incorporated (e.g., SBIRT, Ages and Stages, Conscious Discipline)

Existing early intervention can be enhanced

Limited consistency in early intervention across the state, e.g., EPSDT, juvenile drug and mental health courts, diversion, infant mental health
Lack of coordination with primary care providers and other direct care providers

Areas for improvement in current referral and awareness programs

Education about referral options could be better coordinated by early intervention providers
Limited utilization of peer and family/guardian supports, including family/significant other education
There are gaps in significant others/family/guardian oriented early intervention services

3. Treatment

Gaps in current treatment delivery system

Need to create the Center of Excellence program to ensure centralized access to training resources for serving special populations
Need training for specialties (e.g., ID/MH, MH/SA)
Limited pharmacological training for PCPs writing prescriptions for behavioral health clients
Individuals do not always have access to appropriate types of care (e.g., telemedicine, intensive outpatient, transportation) due to limitations in current set of offerings and workforce challenges, resulting in increased utilization of high intensity services
Lack of integrated mental health, physical health and substance abuse treatment.

Treatment is not always delivered in an evidence-informed manner

Treatment for some conditions across the state does not always accord with clinical practice guidelines (includes polypharmacy use)
The use of paraprofessionals is not always aligned with the level of care need
Unspecified diagnoses are used too frequently and for too long
Evidence-based standards (e.g., patient- and family-centered, trauma informed, gender sensitive, culturally informed, age appropriate) are not widely practiced
- Client engagement in plan development and treatment is difficult and inconsistent
- Standards for single point of entry providers need development and monitoring

**Care integration and coordination is limited**

- Some clients have multiple, separate behavioral health treatment plans and treatment plans in multiple areas (e.g., BH with DD and LTSS) and often not including plans for recovery
- BH care is not well coordinated with other care types and systems (e.g., primary, DD, LTSS)
- Includes poor coordination of treatment throughout the continuum of care (e.g., emergency room care and discharge coordination)
- Extends to gaps in pharmacy (e.g., medication management, polypharmacy)
- Covers data and information sharing between providers
- Substance abuse treatment is not integrated with mental or physical healthcare

**Outcomes are not tracked effectively**

- Data and findings are currently not tracked and used effectively to inform program design and practice
- Lack of integrated system for data transfer between providers/state agencies
- Low participation rates in the YOQ

4. **Recovery/Resiliency**

**There are gaps in the ways providers address recovery and resilience today**

- Clients do not always have clinical support after they leave high intensity levels of service (including community-based supports such as a 1915i, case management/care coordination and ACT teams)
- Limited support for clients in finding/maintaining housing and supportive employment (includes transportation, respite and specialized childcare)
- There is lack of funding for evidence-based recovery services

**Opportunity to improve consistency in existing recovery / resilience efforts**

- Providers and individuals may not always have a recovery based orientation
- Medical care for patients in recovery is often high cost and is not always well managed
Consumer, peer, family, and community supports are not always leveraged most effectively

- There is a lack of peer support in recovery
- Lack of integrated, state-wide structure for engaging and communicating with consumers in recovery

5. Screenings and Assessments

Inconsistent screening and assessment process

- Medical providers may not routinely screen for behavioral health issues (e.g., children during Well Child checkups, EPSDT, and post-partum depression screenings)
- There are inconsistent evaluations of need for determining the most appropriate level of care
- Need to ensure that people get the right screenings irrespective of where they enter the system
- Screening and assessment process is not coordinated, meaning some clients receive redundant assessments
- Training on administering assessments can be improved to ensure results accurately reflect client circumstances

Need to improve the use of data

- Can improve collection of information from multiple sources (including other departments, RSPMIs)
- Can increase availability of data to providers and stakeholders
- Support providers in accessing information through electronic systems

Arkansas has a high prevalence of SED/SMI designations

- There may be premature diagnoses of severe mental health conditions, resulting in some over-identification
- Definitions need to be enhanced to include functional needs
AHCPII Episode Based Care Delivery

The AHCPII episode-based care delivery and payment model rewards providers who deliver high-quality, patient-centered, and cost-effective care for a clinical episode. Providers are incented to make early investments in diagnosis, patient education and treatment; to effectively coordinate care minimizing preventable complications, duplications and inefficient use of services; and to refer patients to the highest-value providers. Providers share in the savings or excess costs of an episode depending on their performance for each episode.

During the first phase of the payment initiative, Medicaid and the private insurers initially introduced five episodes of care: upper respiratory infections (URI), total hip and knee replacements, congestive heart failure (CHF), attention deficit/hyperactivity disorder (ADHD), and perinatal.

How it Works

Patients experiencing one of the episodes will schedule office visits and be seen by their physician or mental health provider just as they are today. Providers will submit claims to payers as they do now and will continue to receive reimbursement based on each payer’s established fee schedules. The change comes as physician practices, hospitals, behavioral health organizations and providers and other qualifying providers submit a small amount of information not currently available through the billing system and view quality metrics reports through the Provider Portal. Quality Metric reports show the overall quality of care delivered during a set time period -- typically one year -- and at what average cost.

In addition, Medicaid and private payers will use these clinical metrics to track and monitor the content and quality of care for each episode and determine which physician practice, hospital or other provider is most responsible for the quality and cost of care. This “quarterback” of care, called the Principal Accountable Provider (PAP), leads and coordinates the episode’s team of providers and helps drive improvement.

The following page shows an illustrative example of this process.
1. Outliers are removed and adjusted for risk and hospital per diems.
2. Appropriate cost and quality metrics based on latest and best clinical evidence, nationally recognized clinical guidelines and local considerations.

Only PAPs are eligible to share in savings or excess costs of episodes based on the average quality and cost of care over all episodes for a given time period. At the end of the set time period, each PAP’s average cost per episode will be calculated and compared to “acceptable” and “commendable” levels of costs. If the average cost is above the acceptable level, the provider will pay a portion of the “excess” costs. If the average cost is acceptable but not commendable, there will be no payment changes. If the provider offers high-quality care below the commendable level, then he or she will be eligible to share in the savings with the payer.
Episodes of Care Risk/Gain Share

The guiding principles that payers use to determine cost levels (‘commendable’ and ‘acceptable’ thresholds) and incentive payments is to:

1. **Reward high quality, efficient** delivery of clinical care
2. **Promote fairness** by considering patient access, provider economics, and changes required for improvement
3. **Acknowledge that poor performance is a reality** and should not be rewarded
4. **Protect quality and access by setting a gain sharing limit** at a reasonable, achievable level
5. **Sustain thresholds for reasonable period** to allow for adjustment and learning

Each payer designates one or more providers as the Principal Accountable Provider (PAP). The PAP is responsible for the overall quality and cost of care in the episode. The PAP’s average costs and care quality across all episodes delivered during a specific time period is calculated and compared against performance thresholds independently preset by each payer. If a PAP achieves an average episode cost below a “commendable” threshold and meets quality requirements, savings beneath the commendable threshold are divided between the PAP(s) and the payer or plan sponsor. Conversely, if a PAP’s performance reflects an average cost exceeding an “acceptable” threshold, the PAP is responsible for a share of costs in excess of the threshold. PAPs not meeting quality targets are not eligible for shared savings.
What does this mean for you as a provider?

**There can be many winners!**

- The aim is to have as many providers receive rewards as possible
- Risk/reward levels are set so as to make this a reality

**Key things to remember, in addition to your normal payments…**

- **Commendable** - If your average costs are below the commendable threshold and quality standards are met, you share in the savings

- **Acceptable** - If your average costs are above this threshold, you will have to share the additional costs

- **Gain sharing limit** - If your average costs are below the gain sharing limit and quality standards are met you will receive a share of the savings up to this limit

- Average costs are what count!!

- Extraordinary cases that exceed cost outlier thresholds are excluded

- Other atypical cases are removed, including cases of comorbidities and age exclusions

- Where appropriate, remaining cases risk-adjusted based on age, comorbidities, and other factors
Attention deficit/hyperactivity disorder (ADHD) is the most common behavioral disorder of childhood. Given that ADHD often co-occurs with other behavioral health conditions, treatment occurs in a wide array of settings. Today, the care delivered across these multiple settings varies tremendously by provider. The initial version of the ADHD episode encourages stronger use of evidence-based care in the treatment of ADHD, specifically addressing those patients without co-occurring behavioral health conditions.

In Arkansas, ADHD:

- **Impacts large number of children:** ~13% of 4-17 year olds in Arkansas have been diagnosed with ADHD; about 25,000 Medicaid patients are affected
- **Significant spend:** over $100M Medicaid dollars spent on ADHD-related primary diagnoses in state fiscal year 2010
- **Impacts a large number of diverse providers:** over 1,000 providers in Arkansas assess or treat ADHD, including primary care physicians, mental health professionals, hospitals, and Rehabilitative Services for Persons with Mental Illness (RSPMI) providers
- **Clear guidelines:** there are well-established guidelines for important aspects of ADHD

Key features of the ADHD episode include:

- **Episode definition:** The episode includes all ADHD-related care provided during the 12-month duration: (shorter durations for partial episodes), excluding initial assessment. This includes the full range of services provided (e.g., physician visits, psychosocial therapy) as well as all medication used to treat ADHD. If a patient continues treatment after the end of the initial 12-month episode, a new episode is triggered.
- **Episode levels:** There are two progressive levels to the ADHD episode. New patients begin in Level I, and will remain there as long as they respond positively to medication management and other first-line treatments. For patients who experience an inadequate treatment response, providers will certify the severity or rationale in order to begin a Level II episode. Each type of episode will have its own cost thresholds.
- **Principal Accountable Provider:** The Principal Accountable Provider (PAP) for the ADHD episode is the provider who delivers the majority of care, determined by number of visits and cost of services delivered. When physicians or Rehabilitative Services for Persons with Mental Illness (RSPMI) provider organizations deliver the majority of care, they will be the sole PAP. When a licensed clinical psychologist not associated with an RSPMI delivers the majority of care, he or she will require a co-PAP with the ability to write a prescription for medication.
- **Quality measures:** Providers will use a user-friendly Provider Portal to certify that their assessment and treatment are delivered according to relevant clinical guidelines. Providers will receive reports highlighting their performance on a number of cost and quality measures.
- **Adjustments and exclusions:** The initial ADHD episode excludes all patients with co-morbid behavioral health conditions.
## ADHD Episode of Care Triggers and Exclusions Summary Tables

Specific triggers and exclusion determine the beginning and end of each episode of care. Codes are in the process of being updated.

<table>
<thead>
<tr>
<th>Triggers</th>
<th>Level I subtype episodes are triggered by either two medical claims with a primary diagnosis of ADHD or a medical claim with a primary diagnosis of ADHD as well as a pharmacy claim for medication used to treat ADHD. Level II subtype episodes are triggered by a completed Severity Certification followed by either two medical claims with a primary diagnosis of ADHD or a medical claim with a primary diagnosis of ADHD as well as a pharmacy claim for medication used to treat ADHD.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAP assignment</td>
<td>Determination of the Principal Accountable Provider (PAP) is based upon which provider is responsible for the largest number of claims within the episode. If the provider responsible for the largest number of claims is a physician or an RSPMI provider organization, that provider is designated the PAP. In instances in which two providers are responsible for an equal number of claims within the episode, the provider whose claims accounted for a greater proportion of total reimbursement will be designated PAP. If the provider responsible for the largest number of claims is a licensed clinical psychologist operating outside of an RSPMI provider organization, that provider is a co-PAP with the physician or RSPMI provider providing the next largest number of claims within the episode. In instances in which two providers are responsible for an equal number of claims within the episode, the provider whose claims accounted for a greater proportion of total reimbursement will be designated co-PAP. Where there are co-PAPs for an episode, the positive or negative supplemental payments are divided equally between the co-PAPs.</td>
</tr>
</tbody>
</table>
| Exclusions | Episodes meeting one or more of the following criteria will be excluded:  
A. Duration of less than 4 months  
B. Small number of medical and/or pharmacy claims during the episode  
C. Beneficiaries with any behavioral health comorbid condition  
D. Beneficiaries age 5 or younger and beneficiaries age 18 or older at the time of the initial claim |
| Episode time window | The standard episode duration is a 12-month period beginning at the time of the first trigger claim. A Level I episode will conclude at the initiation of a new Level II episode if a Severity Certification is completed during the 12-month period. |
| Claims included | All claims with a primary diagnosis of ADHD as well as all medications indicated for ADHD or used in the treatment of ADHD. |
| Quality measures | *Quality measures “to pass”:*  
1. Percentage of episodes with completion of either Continuing Care or Quality Assessment certification – must meet minimum threshold of 90% of episodes  
*Quality measures “to track”:*  
1. In order to track and evaluate selected quality measures, providers are asked to complete a “Quality Assessment” certification (for beneficiaries new to the provider) and a “Continuing Care” certification (for beneficiaries previously receiving services from the provider)  
2. Percentage of episodes classified as Level II  
3. Average number of physician visits/episode  
4. Percentage of episodes with medication  
5. Percentage of episodes certified as non-guideline concordant  
6. Percentage of episodes certified as non-guideline concordant with no rationale |
<p>| Adjustments | Total reimbursement attributable to the PAP for episodes with a duration of less than 12 months will be scaled linearly to determine a reimbursement per 12-months for the purpose of calculating the PAP’s performance. |</p>
<table>
<thead>
<tr>
<th>Trigger codes</th>
<th>Diagnosis or medication that would trigger the episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9 codes (on Professional claim):</td>
<td>314.xx</td>
</tr>
<tr>
<td>HIC3:</td>
<td>H7Y, H8M, H2V, J5B</td>
</tr>
<tr>
<td>CPT codes for assessment:</td>
<td>90801, 96101, 96118, T1023</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion codes</th>
<th>The following ICD-9 diagnoses exclude an episode. The same diagnosis must appear at least twice within the year to qualify for exclusion.</th>
</tr>
</thead>
</table>

These codes represent the set of business and clinical exclusions described previously.

<table>
<thead>
<tr>
<th>Included claim codes</th>
<th>Any claim with a primary diagnosis of ADHD – defined by the following ICD-9 codes – is included.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9-CM code:</td>
<td>314.xx</td>
</tr>
</tbody>
</table>

Further, all pharmacy claims for medications with the following HIC3 classification are included.


List of CPT codes for psychosocial therapy claims within the episode

'OFFICE' codes: | 01, 02, 03, 04 |

Periodically, each payer will provide a performance report with details on quality, cost and utilization for episodes where you are designated as Principal Accountable Provider (PAP).

Reports provide performance information for PAP’s episode(s):

- Overview of **quality** across a PAP’s episodes
- Overview of **cost effectiveness** (how a PAP is doing relative to cost thresholds and relative to other providers)
- Overview of **utilization** and drivers of a PAP’s average episode cost
- First time PAPs receive detailed analysis on costs and quality for their patients increasing performance transparency
- Guide to Reading Your Reports available online via the provider portal
  - Valuable to both PAPs and non-PAPs to understand the reports
- Reports are issued quarterly
Below is an illustrative example and may help you:

- Understand the cost and quality of care given to patients where you are the PAP
- Identify where there is potential for practice changes, care coordination and documenting best practices

The guide assumes knowledge of the design of payment episodes. To find out more, please go to: www.paymentinitiative.org.
Variations from average are the key to this page. In this example the PAP has roughly average cost in outpatient professional claims but well above average cost in pharmacy claims.

Metrics with a +/- given are meant to encourage movement toward the plus. Some metrics are intentionally unmarked and are of a purely informational nature.

Metrics that can prevent the receipt of gain share are highlighted.
PAPs will submit several pieces of quality data for each episode and receive periodic reports through the portal detailing their quality, cost and utilization. PAPs may choose to invest in further coordination of care and are encouraged to take a holistic view of their patients' care.

The provider portal is:

- A way for providers to:
  - Enter additional quality metrics for select episodes (Hip, Knee, CHF and ADHD with potential for other episodes in the future)
  - Access current and past performance reports for all payers where designated the PAP

- Accessible to all PAPs via the payment initiative website at www.paymentinitiative.org
- Login with existing username/password

Included episodes and their total costs are listed on the left side.

The right side breaks down the episode total cost into 9 categories.

<table>
<thead>
<tr>
<th>Episode ID</th>
<th>Patient Name</th>
<th>Enter quality standard start &amp; end date</th>
<th>Non-admitted</th>
<th>Cost</th>
<th>Inpatient - Non-PAP</th>
<th>Inpatient - PAP</th>
<th>Non-Non-PAP</th>
<th>Revenue</th>
<th>PAP</th>
<th>Pharmacy</th>
<th>Emergency</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456</td>
<td>John Doe</td>
<td>01/01/2013 - 01/31/2013</td>
<td>$10,000</td>
<td>$750</td>
<td>$2,000</td>
<td>$500</td>
<td>$500</td>
<td>$3,500</td>
<td>$800</td>
<td>$1,000</td>
<td>$500</td>
<td>$200</td>
</tr>
<tr>
<td>78901</td>
<td>Jane Smith</td>
<td>02/01/2013 - 02/28/2013</td>
<td>$8,000</td>
<td>$600</td>
<td>$1,500</td>
<td>$400</td>
<td>$400</td>
<td>$2,800</td>
<td>$600</td>
<td>$800</td>
<td>$400</td>
<td>$300</td>
</tr>
<tr>
<td>26789</td>
<td>Bill Jones</td>
<td>03/01/2013 - 03/31/2013</td>
<td>$12,000</td>
<td>$900</td>
<td>$2,250</td>
<td>$600</td>
<td>$600</td>
<td>$4,500</td>
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<td>$1,200</td>
<td>$600</td>
<td>$400</td>
</tr>
<tr>
<td>34567</td>
<td>Mary Brown</td>
<td>04/01/2013 - 04/30/2013</td>
<td>$15,000</td>
<td>$1,200</td>
<td>$3,000</td>
<td>$800</td>
<td>$800</td>
<td>$6,000</td>
<td>$1,200</td>
<td>$2,000</td>
<td>$800</td>
<td>$500</td>
</tr>
</tbody>
</table>
Provider Portal – Quality Metric and ADHD Severity Certifications

The provider portal is a multi-payer tool that allows providers to enter quality metrics for certain episodes and access their PAP reports.

Details on the provider portal include:

- Accessible to all PAPs
  - Login with existing username/ password
  - New users follow enrollment process detailed online
- Key components of the portal are to provide a way for providers to
  - Enter additional quality metrics for select episodes (Hip, Knee, CHF and ADHD with potential for other episodes in the future)
  - Access current and past performance reports for all payers where designated the PAP

Login to portal from payment initiative website
<table>
<thead>
<tr>
<th>Login</th>
<th>Questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>User ID</td>
<td>Read/Forgot Your Password?</td>
</tr>
<tr>
<td>Password</td>
<td>Learn More About Login?</td>
</tr>
<tr>
<td></td>
<td>How do I register as a new user?</td>
</tr>
</tbody>
</table>

**Links**

- Arkansas Blue Cross and Blue Shield
- Health Advantage
- Health Advantage Customer Service
- Arkansas Medicare
- Arkansas Medicaid
- Arkansas Department of Human Services
- Arkansas Department of Correction
- MedPak Advantage PMPM
- Arkansas Payment Improvement Initiative

**AHIN Alerts**

**Mandatory** Medicare Advantage Compliance and Code of Conduct Training - Must Complete by 12/31/2013

Arkansas Blue Cross and Blue Shield is required by the Centers for Medicare & Medicaid Services (CMS) to develop and maintain a compliance program and to provide annual training to all provider, downstream, and related entities. Providers are considered to be entities because there is a direct contract for Medicare Services between Arkansas Blue Cross and each provider. As a contractor with CMS, we provide Medicare Advantage (MA) and Prescription Drug Plans (PDP) plans, we are required to provide compliance and Code of Conduct training.

Please complete the online training at the following link: [AHIN Training](#). This training is available online and can be completed at any time. If you have any questions, contact the Arkansas Blue Cross Blue Shield Medicare C & L Compliance Office at 865-676-3251, or email us at medicarecompliance@arkansascare.com.
ADHD Episode of Care Severity Certifications

There are two progressive levels to the ADHD episode. New patients begin in Level I, and will remain there as long as they respond positively to medication management and other first-line treatments. For patients who experience an inadequate treatment response to guideline concordant medication management and parent/teacher administered behavioral supports, providers will certify the severity or rationale in order to begin a Level II episode. Each type of episode will have its own cost thresholds. The cost threshold for Level II was developed to allow provider flexibility in service provision for those beneficiaries who have had an inadequate response to guideline concordant medication management, severe side effects of medications, major environmental or familial complication, or other severe clinical indicators requiring additional psychosocial therapy.

Providers who fail to complete the Severity Certification upon determination that Level I care will not be sufficient, will be accountable for episode risk sharing due to these beneficiaries exceeding the cost threshold at the lower level and being included toward the episode average cost for the Level I (refer to Risk/Gain Share section for more details). In addition, providers who fail to enter Quality Metrics into the portal will not be eligible for gain sharing, even if they would have otherwise qualified for gain sharing based on average episode costs.

The following pages (3 – 18) provides illustrative examples of the severity certification within the portal and treatment pathway scenarios for certifications.

For ADHD Training webinars please visit:

Entering Severity Certification

Provider Portal

Clinical Data Entry - ADHD Episode

have you previously treated this patient for ADHD? is this a severe patient who requires Level II care? Yes No

continuing care certification:

I hereby certify and attest that I have completed and documented the following in the care of my patient with ADHD. This certification should be completed for any patient you have treated previously for ADHD. Please select "Yes" or "No" to each question:

- evaluated patient's ongoing symptoms, impairment, and activities to determine continued necessity of treatment for ADHD; screening for comorbidities if appropriate
- provided psychoeducation to the parent and/or guardian of the patient regarding diagnosis and treatment of ADHD
- am providing guideline-concordant medication management, or...
- have documented complete rationale for care outside of guidelines, if not the PCP, I alerted the PCP to any changes in treatment regimen and side effects of medication.

*Please enter your e-signature here: 09/28/2012

Submit Episode Data  Submit Data and Add Another Episode

Provider Portal

Have you previously treated this patient for ADHD? Is this a severe patient who requires Level II care? Yes No

Quality Assessment Certification:

I hereby certify and attest that I diagnosed the patient with ADHD and have completed and documented the following in my diagnosis. This certification should be completed for any patient you have not treated previously for ADHD. Please select "Yes" or "No" to each question:

- completed and documented a vision and hearing test OR I confirmed the test was completed within the year by a qualified provider
- evaluated the patient for ADHD in accordance with the DSM-IV criteria. (see below)
- screened the patient for common comorbidities, using a broadband diagnostic or similar tool.
- obtained the patient's family history, including any incidence of the disorder in parents or guardians which might influence treatment pathway OR I attempted to collect a family history but was unable to obtain.
- alerted the PCP to my diagnosis and any initial treatment I have prescribed. (If not the PCP)

*Please enter your e-signature here: 09/28/2012
Provider Portal

Severity Certification:

This certification should only be completed for severe patients who require Level II care. I hereby certify that I diagnose the patient with ADHD, have screened for and not found comorbid conditions, that the patient has an inadequate response to guideline concordant medication management, and that further treatment is clinically necessary for one or more of the following rationale (select one or multiple reasons):

- Inadequate response to medication management.
- Severe side effects of medication.
- Major environmental or familial complications (e.g. trauma, homelessness, high likelihood of medication diversion).
- Other reason patient is more severe (please enter explanation below).

*Please enter your e-signature here: 09/26/2012

Clinical Data Entry - ADHD Episode

- *Payer: Medicaid
- *Provider:
- *Patient first: John
- *Patient middle: 
- *Patient last: 
- *DOB: 09/20/1979
- *Date of service: 09/20/2012

Have you previously treated this patient for ADHD? Yes No
Is this a severe patient who requires Level II care? Yes No

Continuing Care Certification:

I hereby certify and attest that I have completed and documented the following in the care of my patient with ADHD. This certification should be completed for any patient you have treated previously for ADHD. Please select "Yes" or "No" to each question:

- I evaluated patient’s ongoing symptoms, impairment, and activities to determine continued necessity of treatment for ADHD, screening for comorbidities if appropriate.
- I provided psychoeducation to the parent and/or guardian of the patient regarding the diagnosis and treatment of ADHD.
- I am providing guideline concordant medication management, or.
- I have documented complete rationale for care outside of guidelines.
- (If not the PCP) I alerted the PCP to any changes in treatment regimen and side effects of medication.

*Please enter your e-signature here: 09/26/2012
DSM-IV guidelines:

**DSM-IV Criteria**

I. Either A or B:

A. Six or more of the following symptoms of inattention have been present for at least 6 months to a point that is inappropriate for developmental level:

1. Often does not give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
2. Often has trouble keeping attention on tasks or play activities.
3. Often does not seem to listen when spoken to directly.
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
5. Often has trouble organizing activities.
6. Often avoids, dislikes, or doesn’t want to do things that take a lot of mental effort for a long period of time (such as schoolwork or homework).
7. Often loses things needed for tasks and activities (e.g., toys, school assignments, pencils, books, or tools).
8. Is often easily distracted.
9. Is often forgetful in daily activities.

B. Six or more of the following symptoms of hyperactivity-impulsivity have been present for at least 6 months to an extent that is disruptive and inappropriate for developmental level:

**Hyperactivity**

1. Often fidgets with hands or feet or squirms in seat when sitting still is expected.
2. Often gets up from seat when remaining in seat is expected.
3. Often excessively runs about or climbs when and where it is not appropriate (adolescents or adults may feel very restless).
4. Often has trouble playing or doing leisure activities quietly.
5. Is often “on the go” or often acts as if “driven by a motor”.

6. Often talks excessively.

**Impulsivity**

7. Often blurts out answers before questions have been finished.
8. Often has trouble waiting one’s turn.
9. Often interrupts or intrudes on others (e.g., butts into conversations or games).

II. Some symptoms that cause impairment were present before age 7 years.
III. Some impairment from the symptoms is present in two or more settings (e.g., at school/work and at home).
IV. There must be clear evidence of clinically significant impairment in social, school, or work functioning.
V. The symptoms do not happen only during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder. The symptoms are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).
AHCPPII Contacts

Website:
More information on the Payment Improvement Initiative can be found at www.paymentinitiative.org.
- Further detail on the initiative, PAP and portal
- Printable flyers for bulletin boards, staff offices, etc.
- Specific details on all episodes
- Contact information for each payer’s support staff
- All previous workgroup materials

Direct Contact:
Medicaid: 1-866-322-4696 (in-state) or 1-501-301-8311 (local and out-of state)
ARKPII@hp.com
Blue Cross Blue Shield: Providers 1-800-827-4814, direct to EBI 1-888-800-3283
APIICustomerSupport@arkbluecross.com
QualChoice: 1-501-228-7111
providerrelations@qualchoice.com
Resource Guide

The ADHD episode of care encourages the use of evidence-based care. Therefore, the PAP is required to perform specific services for each client. These services include an in-person evaluation and completion of reports.

This toolkit includes samples of two rating scales: the Vanderbilt ADHD Diagnostic Rating Scale and the SNAP-IV Rating Scale-Revised (SNAP-IV-R). These reports can be used to provide information about the child’s performance in school and at home. The ADHD episode also requires that the PAP provide psych education to the patient’s parent and/or guardian. This toolkit contains samples of the following resources to assist the PAP in educating parents/guardians about the child’s diagnosis and treatment:

The Clinical Resources outlines online links for ADHD clinical resources for everything from a free PsychTLC consultation with a child and adolescent psychiatrist to a primary care initial evaluation form.

Finally, Resources for Parents is a reference list of online resources for parents who want to learn more about ADHD on their own. Clinicians may find some of these resources helpful as well.

These resources may all be printed and provided in the clinic, given to parents for reference or in any educational manner you see fit.
Clinical Resources

- The Psych TLC program at UAMS offers free psychiatric consultations with a child and adolescent psychiatrist to pediatricians, family practice physicians and general psychiatrists 24 hours a day, 7 days a week. To learn more about this program, click here PsychTLC.

- Two rating scales which can be used by clinicians to help identify ADHD and monitor symptoms are the Vanderbilt ADHD Diagnostic Rating Scale and the SNAP-IV Rating Scale-Revised (SNAP-IV-R). These scales are completed separately by a parent and a teacher. For additional screening tools and rating scales, please visit: Table of Screening Tools and Rating Scales

  The Vanderbilt Scale, for use with children ages 6-12, is widely used to provide information about system presence and severity, and performance in the classroom, home and school settings. The Vanderbilt Scale takes 10 minutes to complete (parent form has 55 items; teacher form has 43 items.)
  
  - The Parent Form is free and available online at Parent Rating Scale and Instructions
  - The Teacher Form is free and available online in PDF format at: Teacher Rating Scale and Instructions

  The SNAP-IV Rating Scale, for use with children and adolescents ages 6-18, contains 90 items, and takes about 10 minutes to administer. The SNAP-IV includes symptoms of ADHD and also oppositional defiant disorders (ODD) and aggression. It was developed by Swanson, Nolan, and Pelham.

  - SNAP-IV Form
  - SNAP-IV Instructions

- NICHQ (the National Initiative for Children’s Healthcare Quality) is an independent, nonprofit organization working for more than a decade to make children’s health and healthcare better through quality improvement. Please click here to access the ADHD-focused content: NICHQ ADHD. Clinicians can download Caring for Children with ADHD: A Resource Toolkit for Clinicians (1st Edition) with a free one-time on-line registration. The toolkit includes: Primary Care Initial Evaluation Form; a complete set of Vanderbilt scales and instructions; and a Sample Cover Letter to teachers that can be used when sending them the Vanderbilt scale.

- For a list of Arkansas Medicaid preferred and non-preferred ADHD medications, including the cost attributed to the Episode Principal Accountable Provider, please click here: Arkansas Medicaid ADHD Medication List

- The Bright Futures Tool and Resource Kit includes forms to streamline health supervision visits and practice management tools. The Bright Futures website also includes a section focused on children’s mental health: Bright Futures in Practice: Mental Health. The two volume set includes a practice guide, a toolkit and an ADHD Guide for Primary Care Professionals.
Resources for Parents

- The ADHD Parents Medication Guide was developed by a consensus group of medical professionals and parent advocacy groups and published by the American Academy of Child and Adolescent Psychiatry (AACAP) and the American Psychiatric Association (APA). The guide provides information on symptoms, treatment options, types of medications, side effects, and co-occurring disorders. (No pharmaceutical funding or editorial support was used in the preparation or development for the guide.) The guide can be found at: Parents Medication Guide.

- The American Academy of Child and Adolescent Psychiatry Resource Centers empower consumers through patient education. Each AACAP Resource Center contains consumer-friendly definitions, answers to frequently asked questions, clinical resources, expert videos, and abstracts from the JAACAP, Scientific Proceedings and Facts for Families relevant to each disorder. The ADHD Resource Center can be found at ADHD Resource Center.

- The National Resource Center on ADHD (NRC): A Program of CHADD (Children and Adults with Attention-Deficit / Hyperactivity Disorder), was established in 2002 to be the national clearinghouse for the latest evidence-based information on ADHD. The NRC provides comprehensive information and support to individuals with ADHD, their families and friends, and the professionals involved in their lives. www.help4adhd.org.

- The National Institutes of Health (NIH), a part of the U.S. Department of Health and Human Services, is the nation’s medical research agency—making important discoveries that improve health and save lives. Within NIH is the National Institute of Mental Health which maintains a site devoted to ADHD at: http://www.nimh.nih.gov/health/topics/attention-deficit-hyperactivity-disorder-adhd/index.shtml

- MedlinePlus is the National Institutes of Health's Web site for patients and their families and friends. Produced by the National Library of Medicine, has information about diseases, conditions, and wellness issues in language anyone can understand. Click here for the MedlinePlus ADHD page.
TEN TIPS for Educating Parents in the Clinical Setting:

Managing ADHD Behaviors at Home

1. Explain that rules should be clear and brief. The child should know exactly what the parent expects.

2. Discuss giving the child age-appropriate chores. This will encourage a sense of responsibility and boost self-esteem.

3. Encourage parents to establish routines for their child or adolescent to help her learn organizational skills. It may be useful for parents to have a daily calendar at home for the child to see and use. A good example is building a visual calendar with pictures and drawings explaining the daily and/or weekly schedule.

4. Suggest that parents encourage the child or adolescent to participate in activities that improve his self-esteem and sense of mastery (e.g., encourage a child or adolescent who likes to draw to take an art class).

5. Discuss the importance of a healthy lifestyle (e.g., participating in regular physical activity, eating healthy foods) in maintaining a sense of well-being.

6. Discuss ways that the parent can encourage the child or adolescent to interact with peers in a supportive environment (e.g., during after-school activities, in clubs or sports, at play dates [for younger children], through faith-based activities, etc.).

7. Discuss whether appropriate modifications should be made for a child or adolescent in the school setting.

8. Talk about the importance of establishing a routine and schedule for homework.

9. Parents often get angry at their ADHD child’s behavior and may resort to physical punishment. Talk about why spanking, slapping or hitting is not advisable.

10. Encourage parents to praise and compliment the child when he or she puts forth good effort and completes tasks.

Sources

Psych TLC Guidelines: ADHD in Children and Adolescents, Department of Psychiatry, Division of Child & Adolescent Psychiatry, UAMS. www.psychiatry.uams.edu/upload/docs/PRI/PsychTLC/ADHD.pdf

American Academy of Pediatrics; National Initiative for Children's Healthcare Quality, Caring for Children With ADHD: A Resource Toolkit for Clinicians. www.nichq.org/adhd_tools.html (First time visitors must create a free account to access the toolkit.)
TEN TIPS for Parents:
Learning About and Managing Your Child’s ADHD Medication

1. Understand when and how your child should take the medication.
2. Ask the doctor what you should do if your child misses a dose.
3. Ask the doctor what changes you should expect to see in behavior and when those changes should take place.
4. Learn about the most common side effects of the medication.
5. Finding the correct medication and dose takes time. Doctors often need to try more than one medication or adjust the dose to find what works best.
6. Keeping a written record of symptoms and side effects can help the doctor find the right medication and dosage.
7. Over-the-counter, herbal supplements and vitamins can interfere with ADHD medication. Be sure to tell your doctor about all of these that your child is taking.
8. Medication is an effective way to treat ADHD, but it only works when it is taken as prescribed.
9. Store all medications in the home in a safe location where children cannot get into it on their own.
10. ADHD medication does not control behavior; it is used to improve symptoms.

Sources


TEN TIPS for Teachers:

Managing ADHD Behaviors in the Classroom

1. Make rules clear and concise and review rule regularly with the student. Post rules in classroom and tape to the student’s desk if possible.

2. Seat student near teacher and away from distractions such as doors, windows, areas of high traffic (pencil sharpener, cubbies, etc.)

3. Give the student frequent and immediate feedback and consequences including use of immediate praise when they are doing well. Ignore small behaviors that are not disruptive to the class.

4. Use rewards and incentives more frequently than punishment to motivate student and create more positive attitude toward school environment.

5. Allow some restlessness at desk, including frequent physical breaks so student can move around.

6. Limit classroom distraction by limiting excessive noise, visual stimuli, clutter, etc. Prepare child for any changes in routine (visitors, field trips, etc.) in advance.

7. Break school work into smaller sections that require shorter periods of sustained attention.

8. Give concise one or two step instructions. Don’t overload student with too much information.

9. Do not use loss of recess as a consequence for negative behaviors. Physical movement can help students with ADHD focus better.

10. Use timers, verbal cues, schedules, and other means to show how much time the student has to complete a task or activity.

Sources


American Academy of Pediatrics; National Initiative for Children's Healthcare Quality, Caring for Children With ADHD: A Resource Toolkit for Clinicians. www.nichq.org/adhd_tools.html (First time visitors must create a free account to access the toolkit.)
TEN TIPS for Parents:
How to Help your Child Complete Homework

1. Develop a schedule and routine for completing homework including specific time and place in the home and stick to this routine as closely as possible each day.

2. Reduce and limit other distractions during homework time. (turn off the TV, games, unnecessary noises and activities)

3. Help your child break up assignments into smaller parts that are more manageable.

4. Help your child in getting started with assignments by reading directions, making sure they understand yet then leave them alone to complete the assignment.

5. Monitor and provide feedback for your child while allowing them to work independently.

6. Provide frequent praise and encouragement for your child’s effort and tasks completed.

7. Develop a plan for larger incentives/reinforcement to reward your child’s persistence and following through with homework over a period of time. (“If you have no late or missing homework assignments for the next 5 days, you can earn…”)

8. To decrease any frustration or struggle with reading, help by reading the material/assignments together.

9. Arrange for your child to have the phone number of a “study buddy”-at least one classmate who can be called to clarify homework assignments.

10. Set up a routine in the morning for double-checking that homework assignments have made it to the backpack/notebooks before leaving the house to go to school.

Source:
(First time visitors must create a free account to access the toolkit.)
FIVE TIPS for Completing a Mental Health Evaluation/Diagnosis

The Mental Health Evaluation Should:

11. Establish a baseline measurement of the beneficiary’s symptoms, behaviors, strengths, skills, abilities, and limitations.

12. Document how these symptoms impact the beneficiary’s ability to function in the community/family including their effects on activities of daily living and social functioning. Document the concentration, persistence, and pace of the impairments and the specific episodes of decompensating, etc. (functional impairments)

13. Communicate clear, pertinent information about the beneficiary and their mental health status to colleagues for treatment planning and referral purposes.

14. Establish in writing “where the beneficiary is” at a particular moment in time; the psychosocial assessment offers baseline information about the beneficiary, so progress may be both measured and demonstrated in the medical record.

15. Be of sufficient quality, complexity, and depth to provide a solid foundation from which to implement and evaluate treatment and recovery based on measurable outcomes.

Suggested elements of a quality assessment might include:

- Identifying information
- Reason for referral/ presenting problem(s)
- History of presenting problem (onset, duration, course and severity)
- General descriptions of beneficiary during the interview (mental status, clinical observations, and impressions)
- Family composition and history
- Developmental history
- Substance use or abuse (including prescription medications)
- Education and employment
- Religious and spiritual involvement
- Physical functioning, health conditions and medical background.
- Psychological and psychiatric functioning and treatment history, including response to past treatment
- Family psychiatric history
- Medications including effectiveness of medications in the past and the medication dosages and durations of past treatment to determine the adequacy of past treatment.
- Social, community, and recreational activities
- Basic life necessities (food, housing, income, etc.)
- Forensic and legal history (probation, juvenile court, FINS, DCFS, current or past charges)
• Other environmental and psychosocial factors (sexuality issues, relevant cultural issues, etc.)
• Strengths, capacities, resources and natural supports
• Clinical summary, impressions, formulation, and assessment
• Diagnostic impression based on current DSM/ICD
• Treatment recommendations (goals) based on needs identified and prioritized during the assessment
VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

Child’s Name: ___________________________  Today’s Date: ___________
Date of Birth: ___________________________  Age: _________________
Grade: _________________________________

Circle the number on the scale that corresponds to how you would rate your child’s behavior.

0 = Never  1 = Occasionally  2 = Often  3 = Very Often

1. Does not pay attention to details or makes careless mistakes, for example homework
   
2. Has difficulty attending to what needs to be done
   
3. Does not seem to listen when spoken to directly
   
4. Does not follow through when given directions and fails to finish things
   
5. Has difficulty organizing tasks and activities
   
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort
   
7. Loses things needed for tasks or activities (assignments, pencils, books)
   
8. Is easily distracted by noises or other things
   
9. Is forgetful in daily activities
   
10. Fidgets with hands or feet or squirms in seat

11. Leaves seat when he is suppose to stay in his seat

12. Runs about or climbs too much when he is suppose to stay seated

13. Has difficulty playing or starting quiet games

14. Is “on the go” or often acts as if “driven by a motor”

15. Talks too much

16. Blurs out answers before questions have been completed

17. Has difficulty waiting his/her turn

18. Interrupts or bothers others when they are talking or playing games

19. Argues with adults

20. Loses temper

21. Actively disobeys or refuses to follow an adults’ requests or rules

22. Bothers people on purpose

23. Blames others for his or her mistakes or misbehaviors

24. Is touchy or easily annoyed by others

25. Is angry or bitter

26. Is hateful and wants to get even

27. Bullies, threatens, or scares others

28. Starts physical fights

Vanderbilt children’s hospital
Center for Child Development
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39
VANDERBILT ADHD DIAGNOSTIC PARENT RATING SCALE

Scoring Instructions for the ADTRS

*Predominately inattentive subtype requires 6 or 9 behaviors, (scores of 2 or 3 are positive) on items 1 through 9, and a performance problem (scores of 1 or 2) in any of the items on the performance section.

*Predominately hyperactive/Impulsive subtype requires 6 or 9 behaviors (scores of 2 or 3 are positive) on items 10 through 18 and a problem (scores of 1 or 2) in any of the items on the performance section.

*The Combined Subtype requires the above criteria on both inattention and hyperactivity/impulsivity.

*Oppositional-defiant disorder is screened by 4 of 8 behaviors, (scores of 2 or 3 are positive) (19 through 26)

*Conduct disorder is screened by 3 of 15 behaviors, (scores of 2 or 3 are positive) (27 through 40).

*Anxiety or depression are screened by behaviors 41 through 47, scores of 3 of 7 are required, (scores of 2 or 3 are positive).
The SNAP-IV Teacher and Parent Rating Scale
James M. Swanson, Ph.D., University of California, Irvine, CA 92715

<table>
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<tr>
<th>Name:</th>
<th>Gender:</th>
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<th>Grade:</th>
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<th>Ethnicity (circle one which best applies): African-American</th>
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<th>Hispanic</th>
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For each item, check the column which best describes this child:

<table>
<thead>
<tr>
<th>Item</th>
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<tbody>
<tr>
<td>1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks</td>
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<td>2. Often has difficulty sustaining attention in tasks or play activities</td>
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<tr>
<td>3. Often does not seem to listen when spoken to directly</td>
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<td>4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties</td>
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<td>5. Often has difficulty organizing tasks and activities</td>
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<td>6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort</td>
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<td>7. Often loses things necessary for activities (e.g., toys, school assignments, pencils, or books)</td>
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<td>8. Often is distracted by extraneous stimuli</td>
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<td>9. Often is forgetful in daily activities</td>
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<td>10. Often has difficulty maintaining attention, orienting to requests, or executing directions</td>
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<td>11. Often fidgets with hands or feet or taps on seat</td>
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<td>12. Often leaves seat in classroom or in other situations in which remaining seated is expected</td>
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<tr>
<td>13. Often runs about or climbs excessively in situations in which it is inappropriate</td>
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<td>14. Often has difficulty playing or engaging in leisure activities quietly</td>
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<td>15. Often is &quot;on the go&quot; or often acts as if &quot;driven by a motor&quot;</td>
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<td>16. Often talks excessively</td>
</tr>
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<td>17. Often blurts out answers before questions have been completed</td>
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<td>18. Often has difficulty waiting turn</td>
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<tr>
<td>19. Often interrupts or intrudes on others (e.g., butts into conversations/games)</td>
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<td>20. Often has difficulty sitting still, being quiet, or inhibiting impulses in the classroom or at home</td>
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<td>21. Often loses temper</td>
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<td>22. Often argues with adults</td>
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<td>23. Often actively defies orrefuses adult requests or rules</td>
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<td>24. Often deliberately does things that annoy other people</td>
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<td>25. Often blames others for his or her mistakes or misbehavior</td>
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<td>26. Often touches or easily annoyed by others</td>
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<td>27. Often is angry and resentful</td>
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<td>28. Often is spineless or vindictive</td>
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<td>29. Often is quarreling</td>
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<td>30. Often is negative, defiant, disobedient, or hostile toward authority figures</td>
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<td>31. Often makes noises (e.g., humming or odd sounds)</td>
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<td>32. Often is excitable, impulsive</td>
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<td>33. Often cries easily</td>
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<td>34. Often is uncooperative</td>
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<tr>
<td>35. Often acts &quot;smart&quot;</td>
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<tr>
<td>36. Often is restless or overactive</td>
</tr>
<tr>
<td>37. Often disturbs other children</td>
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<tr>
<td>38. Often changes mood quickly and drastically</td>
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<td>39. Often easily frustrated if demands are not met immediately</td>
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<td>40. Often teases other children and interferes with their activities</td>
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<th>Not At All</th>
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<th>Just A Little</th>
<th>Quite A Bit</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
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</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Scoring Instructions for the SNAP-IV-C Rating Scale

The SNAP-IV Rating Scale is a revision of the Swanson, Nolan and Pelham (SNAP) Questionnaire (Swanson et al, 1993). The items from the DSM-IV (1994) criteria for Attention-Deficit/Hyperactivity Disorder (ADHD) are included for the subtypes of symptoms: inattention (items #1-40) and hyperactivity/impulsivity (items #41-100). Also, items are included from the DSM-IV criteria for Oppositional Defiant Disorder (items #21-#28) since it often is present in children with ADHD. Items have been added to summarize the Inattention domain (#10) and the Hyperactivity/Impulsivity domain (#20) of ADHD. Two other items were added: an item from DSM-III-R (#29) that was not included in the DSM-IV list for ODD, and an item to summarize the ODD domain (#30).

In addition to the DSM-IV items for ADHD and ODD, the SNAP-IV contains items from the Connors Index Questionnaire (Connors, 1988) and the IOWA Conners Questionnaire (Loevey and Milich, 1983). The IOWA was developed using divergent validity to separate items which measures inattention/hyperactivity (I/O — items #4, #8, #11, #31, #32) from those items which measure aggression/defiance (A/D — items #21, #23, #29, #34, #35). The Connors Index (items #4, #8, #11, #21, #32, #33, #36, #37, #38, #39) was developed by selecting the items which loaded highest on the multiple factors of the Connors Questionnaire, and thus represents a general index of childhood problems.

The SNAP-IV is based on a 0 to 3 rating scale: Not at All = 0, Just a Little = 1, Quite a Bit = 2, and Very Much = 3. Subscale scores on the SNAP-IV are calculated by summing the scores on the items in the subscale and dividing by the number of items in the subscale. The score for any subscale is expressed as the Average Rating-Per-Item, as shown for ratings on the ADHD-Inattentive (ADHD-I) subscale:

```
Not At All Just A Little Quite A Bit Very Much Item Score
1. Makes careless mistakes X X X X 2
2. Can’t pay attention X X X 3
3. Doesn’t listen X X X 3
4. Fails to finish work X X 2
5. Disorganized X X X 1 ADHD-I Total = 18, Average = 18/9 = 2.0
6. Can’t concentrate X X X 3
7. Loose things X X X 3
8. Distractible X X X 3
9. Forgetful X X X X 0
```

A scoring template for the DSM-IV subtypes of ADHD (I/I and H/I), for ODD; for the dimensions of the CLAM (I/O and A/D); and for the Connors Index are presented below:

```
<table>
<thead>
<tr>
<th>ADHD-I</th>
<th>ADHD-H/I</th>
<th>ODD</th>
<th>I/O</th>
<th>A/D</th>
<th>Connect Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>#11</td>
<td>#21</td>
<td>#4</td>
<td>#21</td>
<td>#4</td>
</tr>
<tr>
<td>#2</td>
<td>#12</td>
<td>#22</td>
<td>#8</td>
<td>#23</td>
<td>#8</td>
</tr>
<tr>
<td>#3</td>
<td>#13</td>
<td>#23</td>
<td>#11</td>
<td>#20</td>
<td>#11</td>
</tr>
<tr>
<td>#4</td>
<td>#14</td>
<td>#24</td>
<td>#31</td>
<td>#31</td>
<td>#31</td>
</tr>
<tr>
<td>#5</td>
<td>#15</td>
<td>#25</td>
<td>#32</td>
<td>#35</td>
<td>#35</td>
</tr>
<tr>
<td>#6</td>
<td>#16</td>
<td>#26</td>
<td>#33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#7</td>
<td>#17</td>
<td>#27</td>
<td>#30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#8</td>
<td>#18</td>
<td>#28</td>
<td>#37</td>
<td></td>
<td></td>
</tr>
<tr>
<td>#9</td>
<td>#19</td>
<td></td>
<td>#38</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Total In = H/I = ODD = I/O = A/D = CI =
Average = C =
```

Tentative 5% Cutoffs:

<table>
<thead>
<tr>
<th>Teacher Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.50</td>
</tr>
<tr>
<td>1.78</td>
</tr>
<tr>
<td>1.78</td>
</tr>
<tr>
<td>1.44</td>
</tr>
<tr>
<td>2.00</td>
</tr>
<tr>
<td>1.67</td>
</tr>
<tr>
<td>1.38</td>
</tr>
<tr>
<td>1.88</td>
</tr>
</tbody>
</table>
Scoring Instructions for the SNAP-IV-C Rating Scale

The SNAP-IV Rating Scale is a revision of the Swanson, Nolan & Pelham (SNAP) Questionnaire (Swanson et al., 1983). The items from the DSM-IV (1994) criteria for Attention-Deficit/Hyperactivity Disorder (ADHD) are included for the two subsets of symptoms: inattention (items #1-#9) and hyperactivity/impulsivity (items #10-#18). Also, items are included from the DSM-IV criteria for Oppositional Defiant Disorder (items #19-#23) since it often is present in children with ADHD. Items have been added to summarize the Inattention domain (#10) and the Hyperactivity/Impulsivity domain (#20) of ADHD. Two other items were added: an item from DSM-III-R (#29) that was not included in the DSM-IV list for ODD, and an item to summarize the ODD domain (#30).

In addition to the DSM-IV items for ADHD and ODD, the SNAP-IV contains items from the Conner's Index Questionnaire (Conner, 1998) and the IOWA Conner's Index Questionnaire (Loney & Milich, 1983). The IOWA was developed using divergent validity to separate items which measure inattention/overactivity (U/O — items #4, #6, #11, #31, #32) from those items which measure aggression/defiance (A/D — items #21, #23, #29, #34, #35). The Conner's Index (items #4, #6, #11, #21, #23, #31, #33, #35, #37, #38, #39) was developed by selecting the items which loaded highest on the multiple factors of the Conner's Questionnaire, and thus represent a general index of childhood problems.

The SNAP-IV is based on a 0 to 3 rating scale: Not at All = 0, Just A Little = 1, Quite A Bit = 2, and Very Much = 3. Subscale scores on the SNAP-IV are calculated by summing the scores on the items in the subset and dividing by the number of items in the subset. The score for any subset is expressed as the Average Rating-Per-Item, as shown for ratings on the ADHD-Inattentive (ADHD-I) subset:

<table>
<thead>
<tr>
<th>Item</th>
<th>All</th>
<th>Little</th>
<th>A Bit</th>
<th>Much</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Makes careless mistakes</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>2. Can't pay attention</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>3. Doesn't listen</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>4. Fails to finish work</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>5. Disorganized</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>6. Can't concentrate</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>7. Loses things</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>8. Distractable</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>9. Forgetful</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

ADHD-I Total = 18, Average = 18/6 = 3.0

A scoring template for the DSM-IV subtypes of ADHD (In and H/In), for ODD; for the dimensions of the CLAM (U/O and A/D); and for the Conner's Index are presented below:

<table>
<thead>
<tr>
<th>DSM-IV Subtype</th>
<th>U/O</th>
<th>A/D</th>
<th>Conner's Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD-I</td>
<td>#1</td>
<td>#11</td>
<td>#21</td>
</tr>
<tr>
<td>ADHD-H/In</td>
<td>#2</td>
<td>#12</td>
<td>#22</td>
</tr>
<tr>
<td>ADHD-C</td>
<td>#3</td>
<td>#13</td>
<td>#23</td>
</tr>
<tr>
<td>ODD</td>
<td>#4</td>
<td>#14</td>
<td>#24</td>
</tr>
<tr>
<td>I/O</td>
<td>#5</td>
<td>#15</td>
<td>#25</td>
</tr>
<tr>
<td>A/D</td>
<td>#6</td>
<td>#16</td>
<td>#26</td>
</tr>
<tr>
<td>CI</td>
<td>#7</td>
<td>#17</td>
<td>#27</td>
</tr>
<tr>
<td></td>
<td>#8</td>
<td>#18</td>
<td>#28</td>
</tr>
<tr>
<td></td>
<td>#9</td>
<td>#19</td>
<td>#29</td>
</tr>
</tbody>
</table>

Total In = H/In = ODD = I/O = A/D = CI =
Average =

C =

Tentative % Cutoffs: ADHD-I 2.50 1.78
ADHD-H/In 1.78 1.44
ADHD-C 2.00 1.67
ODD 1.38 1.88
APII Provider Readiness Assessment

- Are you familiar with AHCPPII?
- Do you have internet access?
- Do you have access to AHIN? Who is the administrator? If no administrator, do you know who to contact for access?
- Do you know how to get onto the Medicaid portal and have you registered?
- Have you accessed your report?
- If you are missing your report, do you know who to contact?
- Do you know how to input data into the portal for the different episodes?
- Have you accessed the AHCPPII website? If yes, have you registered your email address to receive updates?

Strategic Issues

- Is there a framework in place for AHCPPII adherence?
- What are the practice’s plans regarding sharing and exchanging health information?
- Has the practice defined the type of relationship required with a vendor?

Staffing and Skill Sets

- Which staff members comprise the AHCPPII leadership?
- Is staff dedicated to change management and quality improvement?
- Does the practice currently have access to professional IT skills?
- What skills gaps must be addressed prior to implementation?

Current State of Workflow

- Has the practice identified and documented workflows for its major processes?
- Has staff identified the bottlenecks, workarounds, opportunities for errors, and rework in current processes? Will these be addressed prior to implementation or as part of the process?
- Has the practice identified the current information gaps in existing processes? Has it determined if current systems and resources can be optimized or leveraged to fill these gaps?
- Are the physicians/providers and staff ready to potentially change the workflow or processes that are currently in place?
- Are care coordination measures defined?
- What resources do you need to help successfully implement AHCPPII?

Training Issues

- Who could/should receive the appropriate support on your staff?
- Does staff use computers in their daily tasks? If not, which areas don’t use computers?
- Do all the physicians/providers in the practice currently use computers on a daily basis?
- Do the physicians and staff currently use an EHR? If not, what system do they use?
Arkansas Health Care Payment Improvement Initiative

Key Terms and Acronyms

APII – Arkansas Health Care Payment Improvement Initiative, which has two core components, Episodes of Care and Patient Centered Medical Homes, aimed at reducing or controlling health care costs while improving the quality of care.

BH – Behavioral Health

CMMI – Center for Medicare and Medicaid Innovation, which awarded Arkansas a $42 million federal grant in February 2013 to support the payment improvement initiative.

CPC – Comprehensive Primary Care Initiative, which is overseen by the Centers for Medicare and Medicaid Services. As part of the initiative, Medicare will work with commercial and State health insurance plans and offer bonus payments to primary care doctors who better coordinate care for their patients. Primary care practices that choose to participate in this initiative will be given resources to better coordinate primary care for their Medicare patients. There are currently 69 practices participating in Arkansas. The state’s Patient Centered Medical Home model builds on this program.

DD – Developmental Disabilities

Episodes of Care – The acute or post-acute medical conditions that are the focus of the payment improvement initiative.

LTSS – Long Term Services and Supports, which includes personal care services, nursing home care and home-based assistance in the ElderChoices, Independent Choices, Alternatives for Adults with Physical Disabilities and Living Choices programs.

PAP – Principle Accountable Provider

PCCM -- Medicaid Primary Care Case Management shared savings pilot program created by Act 1453 of 2013.

PCMH – Patient Centered Medical Home model, which focuses on prevention, screening and chronic disease management.

PMPM – Per member per month payment made to practices as part of the Patient Centered Medical Home model.

Quality Metrics – These are the measures payers track to ensure providers are providing quality care

Risk/Gain Share – The PAP shares gain or loss with the payer.

SPA – Medicaid State Plan Amendment

Total Cost of Care – The total cost of care provided across all service providers.