Episodes of Care
Oppositional Defiant Disorder (ODD):
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.

Behavior disorders are, by far, the most common reason for referrals to mental health services for children and adolescents. Oppositional defiant disorder is reported to affect 1% to 16% of the school-age population. ODD is more common in boys than in girls. The AHCPII ODD episode of care addresses many issues within the behavioral health system by creating accountability for all services related to a specific BH condition and increase effective care.

This toolkit, “Episodes of Care Oppositional Defiant Disorder (ODD): 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 ODD 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.
- Reward high-quality providers while creating financial incentive for ineffective providers to improve.
- Encourage providers to coordinate their patients’ care, leading to better health outcomes for Arkansans.
- Acknowledges that poor performance is a reality and should not be rewarded.
- Improve how care is currently delivered while avoiding third party care management systems.

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
- Allowing both medical and behavioral professionals to get the “full picture” about the clients they’re treating.
- Identification of co-occurring disorders, such as chronic medical conditions, developmental delays or other mental health diagnosis.

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
• 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
• 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

- 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 are intended 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 presentation of comorbidities and age exclusions

- Where appropriate, remaining cases are risk-adjusted based on age, comorbidities, and other factors
Oppositional Defiant Disorder (ODD) Episode of Care

In children with Oppositional Defiant Disorder (ODD), there is a pattern of uncooperative, defiant, and hostile behavior toward authority figures that seriously interferes with the youngster's day to day functioning.

All children are oppositional from time to time and they may argue, talk back, disobey, and defy parents, teachers, and other adults. Oppositional behavior is a normal part of development for two to three year olds and early adolescents. However, openly uncooperative and hostile behavior becomes a serious concern when it is so frequent and consistent that it stands out when compared with other children of the same age and developmental level and when it affects the child's social, family, and academic life.

Key features of the ODD episode include:

**Episode definition:** This 90-day episode includes any ODD treatment (defined by primary diagnosis ICD-9 code), excluding initial assessment is included in the episode. The episode begins on the first date of treatment. In the case of recurring clients, new episode starts on date of first treatment after previous episode ends (e.g., office visit or therapy.)

**Principal Accountable Provider:** The Principal Accountable Provider (PAP) for the ODD episode is the provider who delivers the majority of care. The primary care physician, psychiatrist or licensed clinical psychologist may be the PAP. Behavioral health provider organization will be official PAP when listed as billing provider.

**Quality Measures:** Medications excluded from episode, but utilization will be monitored as a quality measure to determine gain-share eligibility.

**Adjustments and exclusions:** Beneficiaries not continuously enrolled in Medicaid during the 90-day episode and those with any behavioral health comorbidity will be excluded from this episode. Beneficiaries must be between the ages of 5 and 18 at the time of the initial claim to be included in the episode.
## ODD Episode of Care Summary Tables

Specific triggers and exclusion determine the beginning and end of each episode of care.

### ODD algorithm summary (1/2)

<table>
<thead>
<tr>
<th>Triggers</th>
<th>ODD episodes are triggered by three medical claims with a primary diagnosis of ODD.</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. The provider responsible for the largest number of claims 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. Providers eligible to be PAPs include primary care physicians, psychiatrists, clinical psychologists, and RSPMI provider organizations.</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Episodes meeting one or more of the following criteria will be excluded: A. Beneficiaries not continuously enrolled in Medicaid during the 90-day episode B. Beneficiaries with any behavioral health comorbid condition C. Beneficiaries age 5 or younger and beneficiaries age 18 or older at the time of the initial claim</td>
</tr>
<tr>
<td>Episode time window</td>
<td>The standard episode duration is a 90-day period beginning at the time of the first trigger claim. Claims for a beneficiary are tracked for 180 days following the closure of the 90-day standard episode to determine the episode remission rate quality metric.</td>
</tr>
<tr>
<td>Claims included</td>
<td>All claims with a primary diagnosis of ODD. Behavioral health medications will be excluded from the episode, but utilization of medications will be tracked as a quality metric for providers “to pass.”</td>
</tr>
<tr>
<td>Quality measures</td>
<td><strong>Quality measures &quot;to pass&quot;:</strong> 1. Percentage of episodes with completion of either Continuing Care or Quality Assessment certification – must meet minimum threshold of 90% of episodes. 2. Percentage of new episodes (i.e., a PAP’s first ODD episode for this beneficiary) in which the beneficiary received behavioral health medications – must be under maximum threshold of 20%. 3. Percentage of repeat episodes (i.e., all episodes other than a PAP’s first ODD episode for this beneficiary) for which the beneficiary received behavioral health medications – must be equal to 0%. 4. Percentage of episodes resulting in beneficiary remission (no repeat ODD episode for this beneficiary within 180 days after the end of the episode) – must meet minimum threshold of 40%. If a PAP has &lt;5 episodes used for the calculation in a performance period, the metric becomes a quality measure “to track” – not “to pass.” <strong>Quality measures &quot;to track&quot;:</strong> 1. Percentage of episodes with completion of either Continuing Care or Quality Assessment certification – must meet minimum threshold of 90% of episodes. 2. Percentage of new episodes (i.e., a PAP’s first ODD episode for this beneficiary) in which the beneficiary received behavioral health medications – must be under maximum threshold of 20%. 3. Percentage of repeat episodes (i.e., all episodes other than a PAP’s first ODD episode for this beneficiary) for which the beneficiary received behavioral health medications – must be equal to 0%. 4. Percentage of episodes resulting in beneficiary remission (no repeat ODD episode for this beneficiary within 180 days after the end of the episode) – must meet minimum threshold of 40%. If a PAP has &lt;5 episodes used for the calculation in a performance period, the metric becomes a quality measure “to track” – not “to pass.”</td>
</tr>
</tbody>
</table>
# ODD algorithm summary (2/2)

<table>
<thead>
<tr>
<th>Adjustments</th>
<th>An episode with fewer than 10 therapy visits over 30+ days will not be applied to reduce a PAP's average episode cost but may count toward risk sharing. PAPs who in an entire performance period have no episodes with 10 or more visits over 30+ days will not be eligible for gain sharing.</th>
</tr>
</thead>
</table>
| Trigger codes | Diagnosis or medication that would trigger the episode  
**ICD-9 codes (on Professional claim):** 313.81  
**CPT codes for assessment:** 90801, 96101, 96118, T1023 |
| Exclusion codes | The following ICD-9 diagnoses exclude an episode. The same diagnosis must appear at least twice within the year to qualify for exclusion.  
These codes represent the set of business and clinical exclusions described previously |
| Included claim codes | Any claim with a primary diagnosis of ODD—defined by the following ICD-9 codes—is included.  
**ICD-9-CM code:** 313.81  
Further, all pharmacy claims for medications with the following HIC3 classification are tracked for quality metrics but not included in episode cost calculation.  
List of CPT codes for behavioral therapy claims within the episode  
**Behavioral therapy visits:** 90846, 90847, 90849, 90853, 90887, 97110, 97150, 97530, 97532, 97535, H0004, H0046, H2011, H2015, H2017, H2012 |
How to Read Your Principal Accountable Provider (PAP) Reports

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 average costs in outpatient professional claims and pharmacy claims.

### Quality and utilization detail – ODD

<table>
<thead>
<tr>
<th>Metric</th>
<th>You</th>
<th>Percentile 25th</th>
<th>Percentile 50th</th>
<th>Percentile 75th</th>
<th>Percentile 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>% with compliant certification (PBO)</td>
<td>6%</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>+</td>
</tr>
<tr>
<td>% episodes w/ remission (based on episodes w/ 180 day run-out)</td>
<td>6%</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>+</td>
</tr>
<tr>
<td>% new episodes w/ medication</td>
<td>15%</td>
<td>10%</td>
<td>29%</td>
<td>30%</td>
<td>+</td>
</tr>
<tr>
<td>% repeat episodes w/ medication</td>
<td>6%</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>+</td>
</tr>
<tr>
<td>% episodes w/ &gt; 9 visits</td>
<td>49%</td>
<td>25%</td>
<td>62%</td>
<td>75%</td>
<td>=</td>
</tr>
<tr>
<td>% non-guideline concordance (TBD)</td>
<td>6%</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>+</td>
</tr>
<tr>
<td>% episodes w/ &gt; 7 family visits</td>
<td>49%</td>
<td>25%</td>
<td>62%</td>
<td>75%</td>
<td>=</td>
</tr>
</tbody>
</table>

You achieved selected quality metrics.

### Utilization metrics: Performance compared to provider distribution

<table>
<thead>
<tr>
<th>Metric</th>
<th>You</th>
<th>Percentile 25th</th>
<th>Percentile 50th</th>
<th>Percentile 75th</th>
<th>Percentile 100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of visits per episode</td>
<td>4.1</td>
<td>2.9</td>
<td>3.9</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Average number of behavioral visits per episode</td>
<td>62</td>
<td>15</td>
<td>38</td>
<td>74</td>
<td></td>
</tr>
</tbody>
</table>

### Cost detail – Oppositional Defiant Disorder (ODD)

<table>
<thead>
<tr>
<th>Care category</th>
<th># and % of episodes with claims in care category</th>
<th>Average cost per episode when care category utilized, $</th>
<th>Total vs. expected cost in care category, $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient professional</td>
<td>233 100%</td>
<td>550</td>
<td>128,150</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>220 99%</td>
<td>500</td>
<td>116,500</td>
</tr>
<tr>
<td>Emergency department</td>
<td>221 95%</td>
<td>2,415</td>
<td>555,450</td>
</tr>
<tr>
<td>Outpatient lab</td>
<td>184 79%</td>
<td>2,400</td>
<td>552,000</td>
</tr>
<tr>
<td>Outpatient radiology / procedures</td>
<td>21 75%</td>
<td>76</td>
<td>16,786</td>
</tr>
<tr>
<td>Inpatient professional</td>
<td>18 78%</td>
<td>76</td>
<td>7,040</td>
</tr>
<tr>
<td>Inpatient facility</td>
<td>12 78%</td>
<td>76</td>
<td>6,120</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>1 1%</td>
<td>97</td>
<td>169</td>
</tr>
<tr>
<td>Other</td>
<td>7 3%</td>
<td>26</td>
<td>189</td>
</tr>
</tbody>
</table>

Metrics that can prevent the receipt of gain share are highlighted.

Metrics with a +/- given are meant to encourage movement toward the plus. Some metrics are intentionally unmarked and are of a purely informational nature.
Provider Portal – Quality Metric Data and ODD Severity Certifications

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
  - New users follow enrollment process detailed online
Entering Certification

Arkansas Health Care Payment Improvement Initiative

Clinical Data Entry - ODD Episode

*Payer: Choose One

*Facility name

*Provider:

*Patient first: Patient middle: *Patient last:

*Member ID *Patient DOB: Date of service:
Quality assessment certification
I hereby certify and attest that I diagnosed the client with ODD and have completed and documented the following in my diagnosis:

1. I diagnosed the client through in-person assessment.  
   - Yes  
   - No

2. I evaluated the client for ODD in accordance with the DSM criteria (listed below).  
   - Yes  
   - No

3. I found [ ] of the ODD symptoms present for at least six months.  
   - Yes  
   - No

Please refer to these guidelines to determine the number of symptoms identified:

- At least 4 symptoms from any of the following categories over a 6 month period at least weekly (if age over 5) or almost daily (under 5):
  - **Angry/impatient mood**
    - Loses temper
    - Is touchy or easily annoyed
    - Is angry and resentful
  - **Argumentative/defiant behavior**
    - Argues with authority figures/adults
    - Actively defies or refuses to comply with requests from authority figures or rules
    - Deliberately annoys others
    - Blames others for mistake, excess behavior
  - **Vindictiveness**
    - Has been spiteful, vengeful twice in 6 months

- Symptoms must cause clinically significant impairment in social, educational, or vocational activities
- Disturbance is not solely due to another diagnosis (e.g., psychotic, substance abuse, or depressive)
- Criteria are not met for Conduct Disorder, and, if the individual is 18 years or older, criteria are not met for Antisocial Personality Disorder

4. I screened the client for common comorbidities using comprehensive assessment, broadband diagnostic or similar tool and client family history.  
   - Yes  
   - No

5. I informed the parent/guardian of the diagnosis, informed him/her of the importance of family involvement, and provided a chance for him/her to express comments about the treatment plan OR I have documented barriers to providing this information.  
   - Yes  
   - No

6. I have initiated obtaining information that a screen or assessment for learning disability and language impairment was performed in the last two years by communicating with client, parents, caregivers, teachers, doctors or reviewing school or medical records OR I completed or arranged for and documented a screen for learning disabilities and language impairments.  
   - Yes  
   - No
Continuing care certification

I hereby certify and attest that I have completed and documented the following in my care of the client with ODD:

I evaluated client's ongoing symptoms, impairment, and activities to determine continued necessity of treatment for ODD using reports from at least two settings.

I have re-screened for comorbid behavioral health conditions using comprehensive assessment, broadband diagnostic or similar tool.

I informed the parent/guardian of need for ongoing treatment, informed him/her of the continued importance of family involvement, and provided a chance for him/her to express comments about the treatment plan OR I have documented the barriers to providing this information.

I have obtained information that a screen or assessment for learning disability and language impairment was performed in the last two years by communicating with client parents, caregivers, teachers, doctors or reviewing school or medical records OR I completed or arranged for and documented a screen for learning disabilities and language impairments.

I am providing guideline concordant behavioral therapy management OR...

I have documented rationale for care outside of guidelines (e.g. in the client chart).
### Episode Checklist

**PREPARATION FOR FIRST PERFORMANCE PERIOD**

<table>
<thead>
<tr>
<th>To-Do:</th>
<th>When?</th>
</tr>
</thead>
</table>
| ✔ REVIEW and analyze October 2013 and January 2014 ODD Informational Reports:  
  - DETERMINE which, if any, current beneficiaries need to be reassessed and/or screened for comorbidities  
  - ANALYZE and compare medication utilization against ODD Episode quality measures  
  - ANALYZE and compare number of individual and family therapy visits against ODD Episode quality measures and thresholds | Now (October 2013 Report)  
End of January (January 2014 Report) |
| ✔ CONDUCT re-assessments of current beneficiaries  
  - INITIATE screening for learning/language impairments  
  - TALK with parents/guardians about involvement | Now through end of March 2014 |

The ODD Episode Toolkit has “Tools for Families” Tip Sheets that you can copy and give to parents/guardians during the Child’s Appointment.
## NEW ODD EPISODE – FIRST PERFORMANCE PERIOD (April 1, 2014 – March 31, 2015)

<table>
<thead>
<tr>
<th>To-Do</th>
<th>When?</th>
<th>Measure</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ CONDUCT initial assessment of new beneficiaries</td>
<td>Ongoing (starting April 1, 2014)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INITIATE screening for learning/language impairments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TALK with parents about involvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✅ COMPLETE quality assessment certification on AHIN</td>
<td>April 1, 2014 (or ASAP thereafter) for current population; after initial assessment for all new beneficiaries</td>
<td>90% of episodes must include this certification</td>
<td>Provider input</td>
</tr>
<tr>
<td>✅ ANALYZE and monitor medication utilization</td>
<td>Ongoing</td>
<td>Utilization of medications across all episodes must be under 20%</td>
<td>Claims</td>
</tr>
<tr>
<td>✅ ANALYZE and monitor number of individual and family therapy visits</td>
<td>Ongoing</td>
<td>If there are no episodes with at least 10 therapy visits during a 90-day episode, the PAP will not be eligible for gain sharing.*</td>
<td>Claims</td>
</tr>
<tr>
<td>✅ ANTICIPATE closure of episodes. If beneficiary continues treatment, follow next checklist.</td>
<td>90 days from the trigger claim date</td>
<td>At least 40% of all episodes must result in remission (no repeat episode within 180 days after episode ends)</td>
<td>Claims</td>
</tr>
</tbody>
</table>

The PAP report identifies the trigger claim date in the detail section as the “Episode Start Date”.

## REPEAT ODD EPISODES

<table>
<thead>
<tr>
<th>To-Do</th>
<th>When?</th>
<th>Measure</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ CONDUCT re-evaluation</td>
<td>Every 90 days</td>
<td>Quality measures outlined in Continuing Care Certification</td>
<td>Provider input</td>
</tr>
<tr>
<td>FINALIZE learning/language impairment screen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>INFORM parents of need for ongoing treatment and continued involvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✅ COMPLETE continuing care certification on AHIN</td>
<td>Every 90 days (or ASAP thereafter)</td>
<td>90% of episodes must include this certification</td>
<td>Provider input</td>
</tr>
<tr>
<td>✅ ANALYZE and monitor medication utilization</td>
<td>Ongoing</td>
<td>Utilization of medications across repeat episodes must be equal to 0%</td>
<td>Claims</td>
</tr>
<tr>
<td>✅ ANALYZE and monitor number of individual and family therapy visits</td>
<td>Ongoing</td>
<td>If there are no episodes with at least 10 therapy visits during a 90-day episode, the PAP will not be eligible for gain sharing.*</td>
<td>Claims</td>
</tr>
<tr>
<td>✅ ANTICIPATE closure of repeat episodes. If treatment continues, repeat.</td>
<td>90 days from the trigger claim date</td>
<td>At least 40% of the episodes must result in remission</td>
<td>Claims</td>
</tr>
</tbody>
</table>

If the parents have access to a computer, you can give them a list of helpful online resources from the Odd Episode Toolkit.
AHCPII 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**
The following websites provide information designed to assist clinicians and families in caring for children diagnosed with ODD.

Tips to Promote Social-Emotional Health Among Young Children

A Primer on Oppositional and Aggressive Behaviors

A Brief Overview on ODD by the Mayo Clinic

Preparing for the Appointment - Another Tool from the Mayo Clinic that Clinicians can Share with Parents Prior to the First Appointment

The American Academy of Child & Adolescent Psychiatry’s Oppositional Defiant Disorder Resource Center
Charting Positive Behavior

Some parents and children ages 2 and older find it helpful to post a chart that serves to praise and reinforce desired behaviors.

- Make a short list of the behaviors you want to promote, and share it with your child.
- Make a large chart with your child, using simple words or pictures to represent the behaviors you want to promote.
- Place a mark or a sticker on the chart each time your child engages in a desired behavior, while thanking her or telling her what you like about that behavior.
- Give marks for whatever period each day you can watch your child closely. Anything from 15 minutes to all day will work. At the end of the period, add up the marks and give a small reward (e.g., read your child an extra book, give her a special sticker, give her a penny).
- Give extra marks or special stickers for especially good behaviors such as spontaneous helpful actions, even if they are not on the list.
- If your child asks for a mark for something he did, give him one. His request reflects his understanding and his pride in cooperating.
- Siblings may want to participate by receiving marks themselves. This method also works well in a class or child care group.
- Continue this method for several weeks until praise alone is enough to maintain your child’s positive behaviors. You can begin using the chart again if your child’s behavior slips.

Here is an example of what a positive-behavior chart might look like.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Stars</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picking up toys</td>
<td>⭐⭐⭐⭐⭐</td>
</tr>
<tr>
<td>Saying thank you</td>
<td>⭐⭐⭐⭐⭐⭐</td>
</tr>
</tbody>
</table>

Principles of Limit Setting

The most important thing to your child is your love and approval. Because of this need for your love, your child will want to respond to and meet your expectations. By keeping your expectations consistent, reasonable, and predictable you can help your child gain control over his or her behavior.

- Reasonable limits make your child feel protected by someone who understands the world better than he does. Knowing the rules helps him relax.
- Most children do not need an abundance of rules. Your child will understand and accept limits better when she helps make the rules through a process of discussion that includes the reasons for the rules (e.g., safety). If you are having to make rules all the time or having to discipline often, consult your primary care health professional.
- When you make a request, get your child’s attention, then only ask once. If he does not follow your instructions, take him with you while you complete the task.

Praise any cooperation. This is called “One request and then move.”

- Although it is best when all caregivers use rules consistently, your child can also adapt to different rules used consistently by different people or in different settings. It is better to expect your child to adapt than to openly clash with others over differences.

- Sometimes rules should be enforced flexibly to meet the needs of a “special occasion” (e.g., staying up later for a special event). This is best done before your child demands such a change to avoid the appearance that you were manipulated. Instead of weakness, this demonstrates a desirable amount of flexibility.

Following through consistently, yet flexibly, on expectations for behavior is a difficult balance for any parent to achieve. The following factors can make this even harder:

- Feeling reluctant to enforce consistent rules or limits because of concerns about causing your child extra stress, or feeling uncomfortable handling your child’s anger when a limit is set
- Widely differing expectations for behavior among your child’s caregivers
- Stress in other areas of your life
- Too many or too rigid rules
- A history of being exposed to anger in your own life, which can make it more difficult to handle angry responses from your child
- Not having as much fun time together with your child as you would like

If you feel any of these factors are relevant to your family, consider discussing them with your child’s primary care health professional or another supportive professional (e.g., religious leader, social worker, counselor).


www.brightfutures.org
How to Handle Anger

Whenever our body signals and behavior let us know we are feeling angry, we need to find a way to be angry without fighting or being mean to other people. What can we do?

When you notice you are getting angry, you might try one of the following:

- Say to yourself,

  "I am starting to feel angry and I need to go to a place where I can calm down."

  Tell an adult that you are feeling angry and need a place to calm down. Think of a place ahead of time where you can go if you need to be by yourself. Arrange ahead of time to talk with a trusted friend or adult when you start to feel angry. Stay in this place or with this person until you feel you are in control and calm again.

- Do an activity that helps you relax and that gets the anger out in a safe way, such as throwing a ball or running in the gym. Continue doing this activity until you feel you are in control and calm again.

- Try some of the following actions you can do anytime or in any place when you feel angry:
  - Take some deep breaths
  - Count to 10
  - Rub your feet on the floor
  - Think of a “calm” picture

Check in with your parent or another adult when you are feeling less angry, and let them know what it was that made you angry.


www.brightfutures.org
Disruptive and aggressive behaviors are common among children from toddlerhood through adolescence. They may be transient, influenced by temperament and environmental factors, or they may be persistent, rising to the level of oppositional-defiant disorder (ODD) or conduct disorder (CD) and causing significant impairment in the child’s and family’s functioning. ODD affects 1% to 16% of children, depending on the population studied; CD affects 1.5% to 3.4%. Male-to-female ratio varies with age and diagnosis from 3.2:1 to 5:1. Many children progress from ODD to CD. They can be extremely challenging to manage and, if untreated, experience an increased risk of school failure, underemployment, difficulty with legal authorities, substance abuse, and antisocial personality disorder; furthermore, those with CD may be dangerous to themselves and others and, in some instances, require emergent treatment. All children manifesting disruptive or aggressive behaviors require intervention, education and support of parents and teachers, and careful monitoring.

**Screening Results Suggesting Disruptive Behavior or Aggression**

**Pediatric Symptom Checklist (PSC)-35:** Total score $\geq 24$ for children 5 years and younger; $\geq 28$ for those 6 to 16 years; and $\geq 30$ for those 17 years and older AND further discussion of items related to disruptive behavior and aggression confirms a concern in that area.

**PSC-17:** Externalizing subscale is $\geq 7$ AND further discussion of items related to disruptive behavior and aggression confirms a concern in that area.

**Strengths and Difficulties Questionnaire (SDQ):** Total symptom score of $\geq 19$; conduct problem score of 5 to 10 (see instructions at www.sdqinfo.com/ScoreSheets/e2.pdf); impact scale (back of form) score $\geq 2$ indicates some degree of impairment; AND further discussion of items related to disruptive behavior and aggression confirms a concern in that area.

**Symptoms and Clinical Findings Suggesting Disruptive Behavior or Aggression**

- In younger children, marked tantrums, defiance, fighting, and bullying.
- In older children and adolescents, serious law breaking such as stealing, damage to property, or assault.
- Repetitive, persistent, excessive aggression or defiance; behaviors out of keeping with the child’s development level, norms of peer group behavior, and cultural context indicating a disorder rather than a phase or transitional disruption.
- Aggression may be impulsive and associated with intense emotional states, or it may be predatory and premeditated. It is important to distinguish which pattern of aggression the child is showing.
- Behaviors characteristic of ODD: angry outbursts, loss of temper, refusal to obey commands and rules, destructiveness, hitting, and intentional annoyance of others, but without the presence of serious lawbreaking. Symptoms can be confined only to school, home, or the community.
- Behaviors characteristic of CD: vandalism, cruelty to people and animals (including sexual and physical violence), bullying, lying, stealing, truancy, drug and alcohol misuse, and criminal acts, plus all the features of ODD.

**Conditions That May Mimic or Co-occur With Disruptive Behavior and Aggression**

**Differentiate From Normal Behavior**

All children are defiant at times and it is a normal part of adolescence to do the opposite of what one is told; a problem or disorder may be present if the behaviors interfere with family life, school, or peer relationships, or put the child or others in danger.
Attention-deficit/hyperactivity disorder (ADHD). This is a common co-morbidity. Association of ODD and ADHD confers a poorer prognosis, and children tend to be more aggressive, have more behavior problems that are more persistent, suffer peer rejection at higher levels, and have more significant academic underachievement. See Inattention and Impulsivity guidance.

Sleep deprivation. Sleep problems can cause irritability and contribute to outbursts of anger and poor impulse control.

Learning problems or disabilities. Unidentified learning difficulties can contribute to frustration and oppositionality. If disruptive or aggressive behavior is associated with problems of school performance, the child may have a learning disability. See Learning Difficulties guidance to explore this possibility.

Developmental problems. Children with overall intellectual or social limitations may experience frustration and poor impulse control.

Exposure to adverse childhood experiences (ACE). Children who have experienced or witnessed trauma, violence, a natural disaster, separation from a parent, parental divorce or separation, parental substance use, neglect, or physical, emotional, or sexual abuse are at high risk of developing emotional difficulties such as adjustment disorder or post-traumatic stress disorder (PTSD) and may manifest outbursts of disruptive or aggressive behavior; this possibility should always be borne in mind because PTSD requires specific trauma-focused interventions. The clinician should tactfully explore the possibility that harsh physical or emotional punishment is related to the child’s behavior problem, or that tensions might escalate to that point. Denial of trauma symptoms does not mean trauma did not occur; questions about ACE should be repeated as a trusting relationship is established. See Anxiety guidance.

Bereavement. The vast majority of children will experience the death of a family member or friend sometime in their childhood. Other losses may also trigger grief responses—separation or divorce of parents, relocation, change of school, deployment of a parent in military service, breakup with a girlfriend or boyfriend, or remarriage of parent. Such losses are traumatic. They may result in feelings of sadness, despair, insecurity, anger, or anxiety immediately following the loss and in some instances, more persistent anxiety or mood problems, including PTSD or depression. In some children, such losses trigger aggressive or disruptive behavior. See also Depression guidance and the discussion of PTSD in Anxiety guidance.

Anxiety: Many children with disruptive or aggressive behaviors have anxiety. When faced with demands that make them anxious, they use oppositional behavior to manage their anxiety or avoid the expectations that triggered their anxiety. See Anxiety guidance.

Depression or bipolar disorder: Marked sleep disturbance, disturbed appetite, irritability, low mood, or tearfulness could indicate that a child is depressed. Symptoms of depression rapidly alternating with episodes of agitation may suggest bipolar mood disorder. Common symptoms of pediatric bipolar disorder include explosive or destructive tantrums, dangerous or hypersexual behavior, aggression, irritability, belligerence with adults, driven creativity (sometimes depicting graphic violence), excessive talking, separation anxiety, chronic depression, sleep disturbance, delusions, hallucinations, psychosis, and talk of homicide or suicide.

Substance use. All children exhibiting disruptive or aggressive behavior should be screened for substance use and abuse because drug effects, or withdrawal from drugs, may cause irritability and reduced self-control.

Autism spectrum disorders. Children with this developmental pattern also have problems with social relatedness (eg, poor eye contact, preference for solitary activities), language (often stilted), and range of interest (persistent and intense interest in a particular activity or subject). They often will have very rigid expectations for routine or parent promises and become anxious or angry if these expectations are not met.
Tools for Further Assessment of
Disruptive Behavior and Aggression

Vanderbilt ADHD Rating Scale (teacher and parent scales): This tool has been developed for children 6 to 12 years of age.

Modified Overt Aggression Scale (MOAS): This tool was developed for adults but has been used with adolescents.

Evidence-Based and Evidence-Informed Interventions for Disruptive Behavior and Aggression (as of October 2011)
Updates are available at www.aap.org/mentalhealth.

Psychosocial Interventions for Disruptive Behavior

• Level 1 (best support): anger control, assertiveness training, cognitive behavior therapy (CBT), multisystemic therapy, parent management training, parent management training and problem solving, social skills

• Level 2 (good support): communication skills, contingency management, functional family therapy, parent management training and classroom management, problem solving, rational emotive therapy, relaxation, therapeutic foster care, transactional analysis

Psychopharmacologic Interventions

The US Food and Drug Administration (FDA) has no approved indications for aggression in children and adolescents, apart from irritability-associated aggression in children with autism. In other populations, recent federally supported evidence-based reviews suggest efficacy for some psychotherapeutic agents, but primary care clinicians are urged to consult with mental health specialists before prescribing medications for aggression.4–5

Selected Informational Links

• American Academy of Pediatrics Children’s Mental Health in Primary Care Web site (www.aap.org/mentalhealth)

• American Academy of Child & Adolescent Psychiatry (www.aacap.org)

• US FDA Web site (www.fda.gov)
Plan of Care for Children With Disruptive Behavior or Aggression
Engage child and family in care.

Engaging Children and Families in Mental Health Care: A Process for Pediatric Primary Care Clinicians*
Reinforce strengths of child and family. Follow the mnemonic HELP to
- Build trust and optimism.
- Reach agreement on incremental next steps and, ultimately, therapeutic goals.
- Develop plan of care (see the following clinical guidance).
- Collaboratively determine role of primary care clinician, eg, provide intervention(s); provide initial intervention while awaiting family’s readiness for or access to specialty care; coordinate with specialist(s); child care, school, or agencies; monitor progress; encourage child and family’s positive view of treatment.

*Without engagement, most families will not seek or persist in care. Process may require multiple primary care visits.

Encourage healthy habits.
Encourage exercise, outdoor play, balanced and consistent diet, sleep (critically important to mental health), avoidance of exposure to frightening or violent media, positive and consistent (not punitive) experiences with parents (see the following), praise for good behavior, and reinforcement of strengths.

Reduce stress: consider the environment
(eg, family social history, parental depression screening, results of any family assessment tools administered, reports from child care or school).

Is stress on the parent(s) leading to parental irritability or low mood, drinking, or greater demands for the child to behave? Are there ways for parents to get more support for themselves? Explore parent’s readiness to seek and accept help.

Do inconsistencies or differing beliefs about parenting among caregivers (eg, parents, grandparents) undermine attempts to create rules, limits, or consequences? Can caregivers agree on priority behavioral problems and how to address them? Explore conflicts; seek agreement on common beliefs and achievable steps to help the child.

If problems are mainly or exclusively at school, parents should request that the school assess the child for special educational needs and develop a plan to monitor behavior while at school; primary care clinicians can often provide support in these situations by communicating to the school the degree to which the parents are actively engaged in finding help for their child’s problems.

Acknowledge and reinforce protective factors, eg, good relationships with at least one parent or important adult, pro-social peers, concerned or caring family, help-seeking, connection to positive organization(s).

Offer initial intervention(s).
Promote daily positive joint activities between parents and child or teen.
- Reinforce compliant, pro-social behavior using parental attention (“Catch ‘em being good” [Ed Christopherson]).
- Encourage praise and rewards for specific, agreed, and desired (target) behaviors. If appropriate, monitor with a chart. Negotiate rewards with the child. Change target behaviors every 2 to 6 weeks; change rewards more frequently. The choice of target behaviors and the time intervals for rewards should be developmentally appropriate.
- Some minor unwanted behaviors can be ignored and will then stop; others could increase if they are ignored. Pick battles and focus discipline on priority areas.

Encourage parents to focus on prevention in the following ways:
- Reduce positive reinforcement of disruptive behavior.
- When possible, reorganize the child’s day to prevent trouble by avoiding situations in which the child cannot control himself or herself. Examples include asking a neighbor to look after the child while the parent goes shopping, ensuring that activities are available for long car journeys, and arranging activities in separate rooms for siblings who are prone to fight.


**DISRUPTIVE BEHAVIOR AND AGGRESSION**

- Monitor the whereabouts of adolescents. Telephone the parents of friends whom they say they are visiting. See if there are ways to limit contact with friends who have behavior problems and promote contact with friends who are a positive influence.

- Talk to the school and suggest similar principles are applied. Request the school evaluate the child for learning problems if you suspect this is a possibility because the frustration experienced by the child with a learning problem may be intolerable for him or her.

**Encourage parents to be calm and consistent. Suggest that parents**

- Set clear house rules and give short, specific commands about the desired behavior, not prohibitions about undesired behavior (eg, “Please walk slowly,” rather than “Don’t run”).

- Provide consistent and calm consequences for misbehavior. Consequences should not be drastic or, in the case of young children, go on for so long that the child is likely to forget what he or she originally did wrong.

- Find a way for children to make reparation for a negative behavior (eg, doing something nice for a sibling they have struck, cleaning up a mess they made while in a tantrum).

- When enforcing a rule, avoid getting into arguments or explanations because this merely provides additional attention for the misbehavior; defer negotiations until periods of calm.

- Consider parenting classes.

- See also suggestions in Inattention and Impulsivity guidance.

**Create a safety and emergency plan.**

- Care plan developed jointly with family should include listing of telephone numbers to call in the event that the child’s behavior causes a threat to his or her own safety or the safety of others.

- Instruct family to proactively remove weapons from the home.

- Instruct family to monitor for situations that trigger outbursts.

- Provide number for hotline, on-call telephone number for the practice, or area mental health crisis response team contact information according to community protocol.

**Offer child and parents resources to educate and assist them with self-management.**

**Brochures**

Your Child’s Mental Health: When to Seek Help and Where to Get Help

How to Handle Anger

Parent’s Role in Teaching Respect

**Web Sites**

The Incredible Years (www.incredibleyears.com). Accessed April 29, 2010


**Monitor child’s progress toward therapeutic goals.**

- See report “Enhancing Pediatric Mental Health Care: Strategies for Preparing a Primary Care Practice” for monitoring methods.

- Child care, preschool, or school reports can be helpful in monitoring progress.

- SDQ (parent, teacher) and PSC can be helpful in monitoring progress with symptoms and functioning.

- Provide contact numbers and resources in case of emergency (see “Create a safety and emergency plan”).

**Involve specialist(s) if child does not respond to initial interventions or if indicated by the following clinical circumstances:**

- Child is younger than 5 years.

- Child’s problems do not respond to primary care intervention.

- Family is not able to maintain calm, consistent, or safe environment.

- Child’s behaviors are injurious to other children or animals.

- Child has comorbid depression.

- Child is experiencing severe dysfunction in any domain.
• Child has comorbid anxiety. (The combination of shyness, anxiety, and behavior problems is thought to be particularly risky for future behavior problems of a more serious nature.)
• Problems at school are interfering with academic achievement or relationships.
• Child or adolescent is involved with legal authorities. (This situation requires coordination with probation officers and understanding the terms of probation; simply reminding the adolescent and family of the consequences of violating probation can help promote participation in treatment or changes to lifestyle.)

✓ Primary care tasks may include the following:
  q Monitoring response to treatment through use of parent and teacher reports and communication with referral sources or agencies involved in care
  q Engaging and encouraging child’s positive view of treatment
  q Coordinating care provided by parents, school, medical home, and specialists
  q Observing for comorbidities

Resources for Clinicians

Toolkits


Web Sites


SAMHSA is a public health agency within the Department of Health and Human Services. SAMHSA is responsible for improving accountability, capacity, and effectiveness of the nation’s substance abuse prevention, addictions treatment, and mental health delivery system.


DISRUPTIVE BEHAVIOR AND AGGRESSION

Articles and Reports

- Conduct Disorders (Vol 36, October 1997 Supplement)


References


Children’s Mental Health Disorder Fact Sheet for the Classroom

Oppositional Defiant Disorder

About the Disorder

Students with oppositional defiant disorder (ODD) seem angry much of the time. They are quick to blame others for mistakes and act in negative, hostile, and vindictive ways. All students exhibit these behaviors at times, but in those with ODD, these behaviors occur more frequently than is typical in individuals of comparable age and level of development.

Students with ODD generally have poor peer relationships. They often display behaviors that alienate them from their peers. In addition, these students may have an unusual response to positive reinforcement or feedback. For instance, when given some type of praise they may respond by destroying or sabotaging the project that they were given recognition for.

Some students develop ODD as a result of stress and frustration from divorce, death, loss of family, or family disharmony. ODD may also be a way of dealing with depression or the result of inconsistent rules and behavior standards.

If not recognized and corrected early, oppositional and defiant behavior can become ingrained. Other mental health disorders may, when untreated, lead to ODD. For example, a student with AD/HD may exhibit signs of ODD due to the experience of constant failure at home and school.

Symptoms or Behaviors

- Sudden unprovoked anger
- Arguing with adults
- Defiance or refusal to comply with adults’ rules or requests
- Deliberately annoying others
- Blaming others for their misbehavior
- Easily annoyed by others
- Being resentful and angry
# Children's Mental Health Disorder Fact Sheet for the Classroom

## Oppositional Defiant Disorder

### Educational Implications

Students with ODD may consistently challenge class rules, refuse to do assignments, and argue or fight with other students. This behavior can cause significant impairment in both social and academic functioning. The constant testing of limits and arguing can create a stressful classroom environment.

### Instructional Strategies and Classroom Accommodations

- Remember that students with ODD tend to create power struggles. Try to avoid these verbal exchanges. State your position clearly and concisely.
- Choose your battles wisely.
- Give 2 choices when decisions are needed. State them briefly and clearly.
- Establish clear classroom rules. Be clear about what is non-negotiable.
- Post the daily schedule so students know what to expect.
- Praise students when they respond positively.
- Avoid making comments or bringing up situations that may be a source of argument for them.
- Make sure academic work is at the appropriate level. When work is too hard, students become frustrated. When it is too easy, they become bored. Both reactions lead to problems in the classroom.
- Avoid “infantile” materials to teach basic skills. Materials should be positive and relevant to students’ lives.
- Pace instruction. When students with ODD have completed a designated amount of a non-preferred activity, reinforce their cooperation by allowing them to do something they prefer or find more enjoyable or less difficult.
- Allow sharp demarcation to occur between academic periods, but hold transition times between periods to a minimum.
- Systematically teach social skills, including anger management, conflict resolution strategies, and how to be assertive in an appropriate manner. Discuss strategies that the students may use to calm themselves when they feel their anger escalating. Do this when students are calm.
- Praise students when they respond positively.
- Provide consistency, structure, and clear consequences for the student’s behavior.
- Select material that encourages student interaction. Students with ODD need to learn to talk to their peers and to adults in an appropriate manner. However, all cooperative learning activities must be carefully structured.
- Minimize downtime and plan transitions carefully. Students with ODD do best when kept busy.
- Maximize the performance of low-performing students through the use of individualized instruction, cues, prompting, the breaking down of academic tasks, debriefing, coaching, and providing positive incentives.
- Allow students to redo assignments to improve their score or final grade.
- Structure activities so the student with ODD is not always left out or is the last one picked.
- Ask parents what works at home.

### Resources

- **American Academy of Child and Adolescent Psychiatry**
  3615 Wisconsin Avenue NW
  Washington, DC 20016-3007
  800-333-7636
  [www.aacap.org](http://www.aacap.org)
- **Information on child and adolescent psychiatry, fact sheets, current research, practice guidelines**
- **Anxiety Disorders Association of America**
  8730 Georgia Avenue, Suite 600
  Silver Spring, MD 20910
  240-485-1001
  [www.adaa.org](http://www.adaa.org)
- **National Institute of Mental Health (NIMH)**
  Office of Communications
  6001 Executive Boulevard, Room 8184, MSC 9663
  Bethesda, MD 20892-9663
  866-615-6464
  [www.nimh.nih.gov](http://www.nimh.nih.gov)
- **Free educational materials for professionals and the public**
- **SAMHSA’s National Mental Health Information Center——Center for Mental Health Services**
  PO Box 42557
  Washington, DC 20015
  800/789-2647
  [www.mentalhealth.samhsa.gov](http://www.mentalhealth.samhsa.gov)

- The NIMH and the SAMHSA websites each have publications tabs that lead to several current and reliable publications. The other websites listed above also have extensive listings of resources.

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While it is important to respect a child’s need for confidentiality, if you work with children or families, you are legally required to report suspected child abuse or neglect. For more information, consult “Reporting Child Abuse and Neglect: A Resource Guide for Mandated Reporters,” available from the Minnesota Department of Human Services.

This fact sheet must not be used for the purpose of making a diagnosis. It is to be used only as a reference for your own understanding and to provide information about the different kinds of behaviors and mental health issues you may encounter in your classroom.
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.