Community Care
OF NORTH CAROLINA

Child/Adolescent ADHD Resource Guide

Introduction

In the Fall of 2017, in response to requests from our CCNC Primary Care Clinicians (PCCs), a Community Care of North Carolina (CCNC) workgroup formed to create a resource guide designed to assist PCCs in screening and treating child/adolescent Attention-Deficit/Hyperactivity Disorder (ADHD) in the primary care setting. This workgroup was comprised of the CCNC Central Office Pediatrics and Behavioral Health Teams.

This resource guide is designed to assist busy PCCs in accessing practical, evidence-based tools to help them successfully screen for and treat ADHD in children/adolescents. It includes an algorithm to aid in the initial assessment and corresponding treatment approach (of child/adolescent ADHD), rating scales, a psychopharmacology guide, and billing and coding guidance. In addition, the resource guide highlights multimodal interventions for child/adolescent ADHD based on available best-evidence, gives clinicians example materials for communication with schools, and provides guidance related to the transitioning of patients from the pediatric to the adult setting.

Our hope is that this resource guide proves useful, and we greatly look forward to continuing to work together on achieving the highest attainable levels of patient care across our wonderful state of North Carolina.

If you have any questions, or would like assistance in connecting with your local CCNC Network and its resources, please contact a member of the Central Office Behavioral Health Team:
(Current as of Summer 2018)

Central Office Pediatrics Team:

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Core Process

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Pre-ADHD Algorithm Assumptions/ Suggested Actions

- PCCs are conducting age-appropriate psychosocial evaluations at all well visits, as per *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition: https://brightfutures.aap.org/materials-and-tools/guidelines-and-pocket-guide/Pages/default.aspx

Social-Emotional Screens:	
Description:	**Code:**
0-5 Year Olds (ASQ-SE, ECSA, Baby PSC, Preschool PSC) 6-10 Year Olds (PSC)	96127
Adolescent Risk & Strength Screening:	
Description:	**Code:**
Bright Futures Supplemental Adolescent Questionnaires, GAPS	96160

- Practice clinicians have reviewed the AAP Guidelines for diagnosis and management of ADHD: http://pediatrics.aappublications.org/content/128/5/1007
  [2019 AAP Guidelines in press]

- Practice clinicians have met with the local school system Exceptional Children leadership or lead psychologist to review school processes and the practice process for ADHD assessment. At this meeting, agreement on communication and sharing assessment information has been reached, and the parties understand referral and request for services (lunch or evening meeting at the practice is suggested).

- The practice has designated a contact person for communication with the school.

- The practice has a standard process for responding to a parent's request for assessment and explaining the process for pre-visit preparation and scheduling.

- The practice has a standard way to request rating scales and other records from the school, (for example – a letter requesting such materials signed by the parent and clinician).

- The practice has a system to assure that a two-way release form is signed by the parent in order to share information with the school.

- The practice has a system to request rating scales, etc. in advance of the scheduled initial or follow-up visit.

- The practice has a reminder system for q 3 months follow-up visits.

Overview of the Child/Adolescent ADHD Assessment and Process of Care [1,2]

Derived from the AAP 2018 *Mental Health Care of Children and Adolescents: A Guide for Primary Care Clinicians* and the AAP 2011 ADHD Guidelines Supplement *Implementing the Key Action Statements: An Algorithm and Explaination for Process of Care for the Evaluation, Diagnosis, Treatment, and Monitoring of ADHD in Children and Adolescents* (see references below)

Introduction:

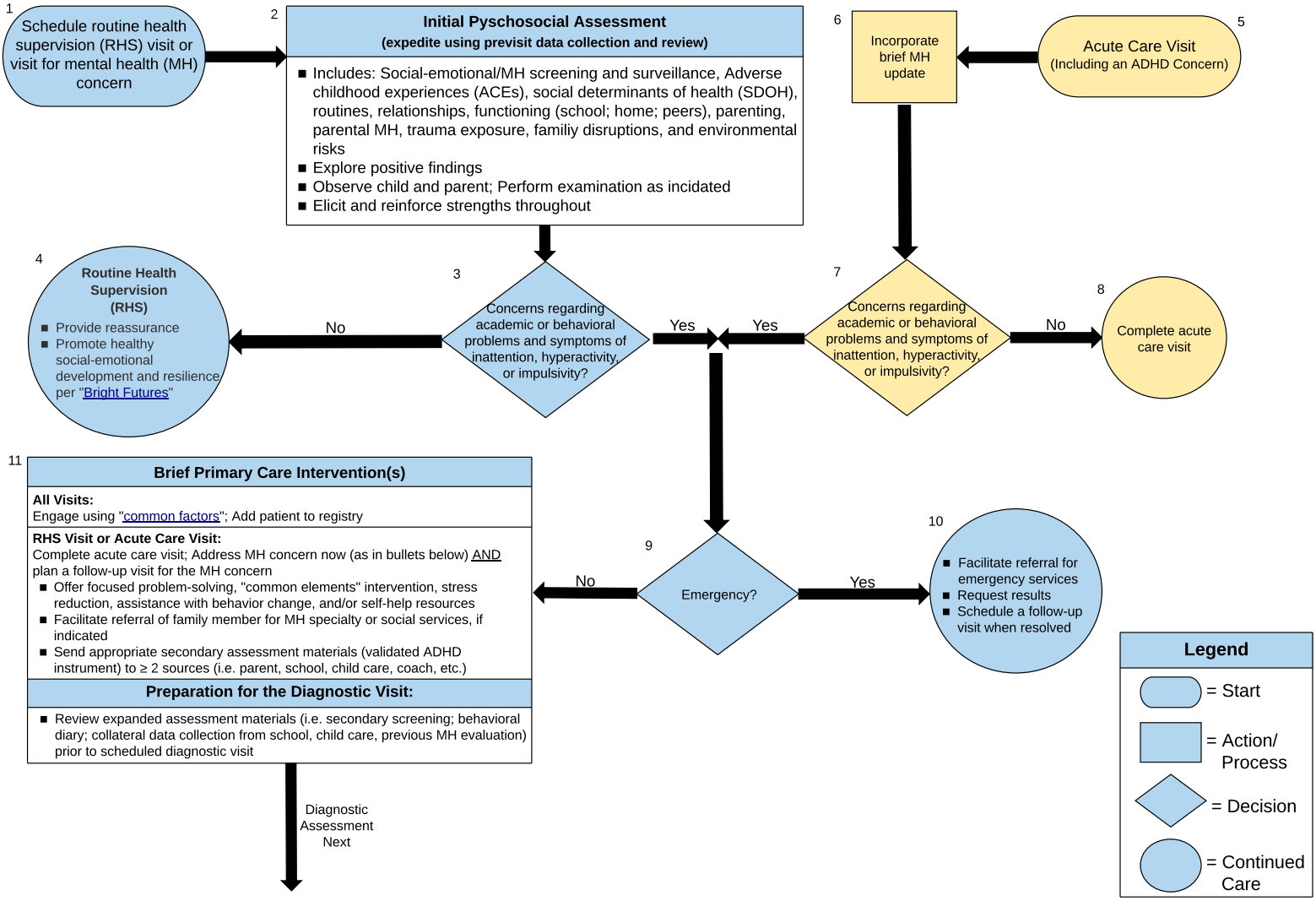
The American Academy of Pediatrics (AAP) recommends that when a child or adolescent (ages 4-18 years) presents with academic or behavioral concerns and symptoms of inattention or impulsivity, the Primary Care Clinician (PCC) should assess for ADHD. These concerns present when:

- Elicited during the psychosocial assessment at a routine health supervision visit (commonly the PSC-35);
- Elicited during a brief mental health update during an acute visit; or
- The reason for the visit is based on a family request/school concern.

PCCs should also be aware of factors that confer greater risk of ADHD (prematurity, extremely low birth weight (ELBW), maternal smoking during pregnancy) as part of routine care and monitoring. PCCs should also be aware that a child who has experienced trauma may present with impulsivity or inattention.

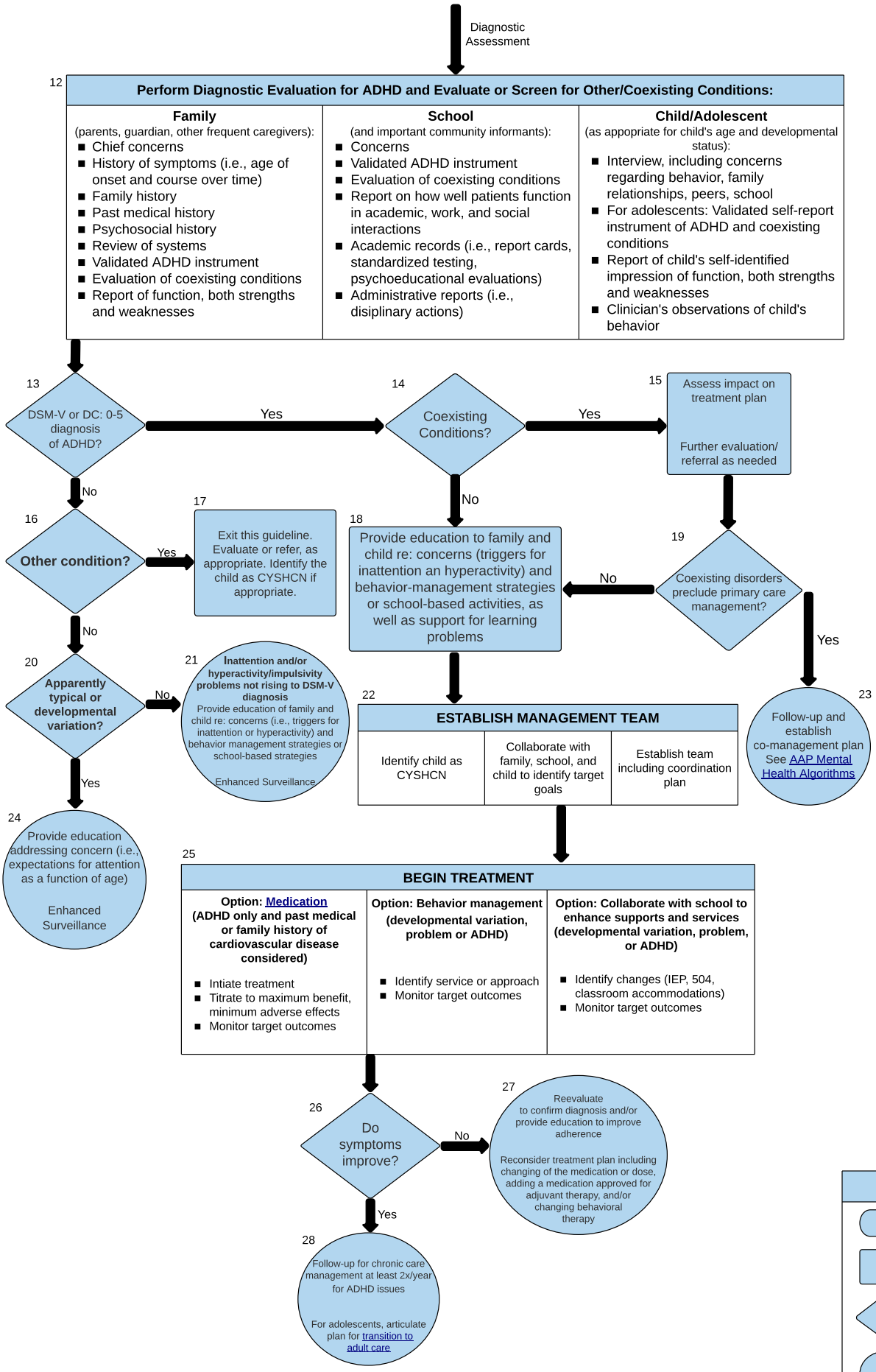
The algorithm below moves through the steps of presentation with concerns, brief primary care intervention, secondary assessment and diagnostic evaluation, and intervention/treatment. The PCC should be familiar with, and use, validated ADHD instruments such as the Vanderbilt (age 6 years and above) and Conners (age 3 years and above). For further information on validated ADHD instruments, please refer to the accompanying section elsewhere in this resource guide.

The care team for children diagnosed with ADHD includes the PCC, family, school, the adolescent, and, if appropriate, co-management with a developmental and behavioral pediatrician or psychiatrist.



Overview of the Child/Adolescent ADHD Assessment and Process of Care (Cont.) [1,2]

CYSHCN = Child/Youth with Special Health Care Needs



References:

1. Foy JM, ed. Mental Health Care of Children and Adolescents: A Guide for Primary Care Clinicians. Itasca: American Academy of Pediatrics (AAP); 2018. https://shop.aap.org/mental-health-care-of-children-and-adolescents-a-guide-for-primary-care-clinicians-paperback/.

2. American Academy of Pediatrics (AAP). Implementing the key action statements: an algorithm and explanation for process of care for the evaluation, diagnosis, treatment, and monitoring of ADHD in children and adolescents.*Pediatr*. 2011;128(5):S11-S21. http://pediatrics.aappublications.org/content/suppl/2011/10/11/peds.2011-2654.DC1/zpe611117822p.pdf. Accessed February 24, 2018.

NICHQ Vanderbilt Assessment Scales

Used for diagnosing ADHD

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

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NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

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Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

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D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant, continued

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the last assessment scale was filled out. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1	2	3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following direction	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

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HE0353

D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Side Effects: Has the child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score: _____

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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Scoring Instructions for the NICHQ Vanderbilt Assessment Scales

These scales should NOT be used alone to make any diagnosis. You must take into consideration information from multiple sources. Scores of 2 or 3 on a single Symptom question reflect *often-occurring* behaviors. Scores of 4 or 5 on Performance questions reflect problems in performance.

The initial assessment scales, parent and teacher, have 2 components: symptom assessment and impairment in performance. On both the parent and teacher initial scales, the symptom assessment screens for symptoms that meet criteria for both inattentive (items 1–9) and hyperactive ADHD (items 10–18).

To meet *DSM-IV* criteria for the diagnosis, one must have at least 6 positive responses to either the inattentive 9 or hyperactive 9 core symptoms, or both. A positive response is a 2 or 3 (often, very often) (you could draw a line straight down the page and count the positive answers in each subsegment). There is a place to record the number of positives in each subsegment, and a place for total score for the first 18 symptoms (just add them up).

The initial scales also have symptom screens for 3 other co-morbidities—oppositional-defiant, conduct, and anxiety/depression. These are screened by the number of positive responses in each of the segments separated by the "squares." The specific item sets and numbers of positives required for each co-morbid symptom screen set are detailed below.

The second section of the scale has a set of performance measures, scored 1 to 5, with 4 and 5 being somewhat of a problem/problematic. To meet criteria for ADHD there must be at least one item of the Performance set in which the child scores a 4 or 5; ie, there must be impairment, not just symptoms to meet diagnostic criteria. The sheet has a place to record the number of positives (4s, 5s) and an Average Performance Score—add them up and divide by number of Performance criteria answered.

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Predominantly Inattentive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Predominantly Hyperactive/Impulsive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Predominantly Hyperactive/Impulsive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
ADHD Combined Inattention/Hyperactivity ■ Requires the above criteria on both inattention and hyperactivity/impulsivity	**ADHD Combined Inattention/Hyperactivity** ■ Requires the above criteria on both inattention and hyperactivity/impulsivity
Oppositional-Defiant Disorder Screen ■ Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Oppositional-Defiant/Conduct Disorder Screen** ■ Must score a 2 or 3 on 3 out of 10 items on questions 19–28 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Conduct Disorder Screen ■ Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Anxiety/Depression Screen** ■ Must score a 2 or 3 on 3 out of 7 items on questions 29–35 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Anxiety/Depression Screen ■ Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	

The parent and teacher follow-up scales have the first 18 core ADHD symptoms, not the co-morbid symptoms. The section segment has the same Performance items and impairment assessment as the initial scales, and then has a side-effect reporting scale that can be used to both assess and monitor the presence of adverse reactions to medications prescribed, if any.

Scoring the follow-up scales involves only calculating a total symptom score for items 1–18 that can be tracked over time, and the average of the Performance items answered as measures of improvement over time with treatment.

Parent Assessment Follow-up
- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

Teacher Assessment Follow-up
- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ National Institute for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

Multilingual Vanderbilt Assessment Scales & Other Alternative ADHD Rating Scales (Secondary)

The National Initiative for Children's Healthcare Quality (NICHQ) Vanderbilt Assessment Scales can be used by healthcare professionals to help diagnosis ADHD in children between the ages of 6 and 12.[1]

In addition to the 1st Edition (2002) NICHQ Vanderbilt Assessment Scales provided above there is a 2nd (2011) Edition available for free to AAP members through the AAP web page, or for purchase through the AAP bookstore: https://shop.aap.org/Caring-for-Children-with-ADHD-A-Resource-Toolkit-for-Clinicians/

1st Edition (2002) Vanderbilt Assessment Scale Multilingual (Parent Initial and Parent Follow-Up): https://www.med.unc.edu/pediatrics/education/current-residents/resources/clinical/unc-general-pediatric-clinic-documents/adhd

Note:** The above link provides ***translations of the 1st Edition (2002) Vanderbilt Assessment Scale screening tool. Please note that these translations may **NOT** be validated, and that translation without validation can lead to false test results due to poor interpretability [translation ≠ interpretation]. As such, an interpreter/interpretation services is/are always recommended over translated materials.

Other pediatric screening tools to aid in the clinical assessment of potential pediatric ADHD include the **Conners Comprehensive Behavior Rating Scales™ (Conners CBRS®)**, a multi-informant assessment designed to provide a complete overview of child and adolescent (ages 3-17 for parent/teacher; ages 12-17 for self) concerns and disorders.[2,3] A full description of the assessment tool and ordering/pricing information can be found here: https://www.mhs.com/MHS-Assessment?prodname=cbrs

***Note:** Available in Spanish via link above. Please note translation versus interpretation concerns as listed above.

References:

1. National Institute for Children's Health Quality (NICHQ). NICHQ Vanderbilt assessment scales. National Institute for Children's Health Quality (NICHQ). https://www.nichq.org/resource/nichq-vanderbilt-assessment-scales#. Published 2002. Accessed February 20, 2018.
2. MHS Assessments. Conners CBRS®: Conners Comprehensive Behavior Rating Scales™. MHS Assessments . https://www.mhs.com/MHS-Assessment?prodname=cbrs. Published 2015. Accessed February 20, 2018.
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ADHD Multimodal Intervention Grid (for Children/Adolescents)

***Please Note:** No single treatment is best for all children/adolescents with ADHD. Side effects of medications should be considered, as well as other circumstances that might render certain treatments inappropriate for the child/adolescent.[1–3] A combination of both medication and behavior therapy is typically recommended.[2,4,5]

	Pre-School:	School-Age:	Adolescent:
Treatment: 	▪ Parent/teacher administered behavioral therapy [Evidence Level A][4] **Examples:** ▪ Incredible Years Intervention[6,7] ▪ Parent-Child Interaction Therapy (PCIT) [Parent Live-Action Coaching][8] ▪ Medication: Methylphenidate [Evidence Level B][4]	▪ Medication: Stimulant First Line [Evidence Level A][4] ▪ Behavioral Therapy [Evidence Level B][4]	▪ Medication: Stimulant First Line [Evidence Level A][4] ▪ Behavioral Therapy [Evidence Level C][4]
Academic/School: 	▪ Early Education Settings CSEFEL Incorporation[9] ▪ Predictable Routine	▪ Organizational Skills Support and Development: ▪ Homework/Schedule Organizer[4] ▪ Written Output Bypass Strategies: ▪ Note-Taking[4] ▪ Testing[4] ▪ Reminder Systems[4] ▪ IEP/504/Goodwill Accommodations[4]	▪ Organizational Skills Support and Development: ▪ Homework/Schedule Organizer[4] ▪ Written Output Bypass Strategies: ▪ Note-Taking[4] ▪ Testing[4] ▪ Reminder Systems[4] ▪ IEP/504/Goodwill Accommodations[4]
Home/Community 	▪ Sleep[4] ▪ Outdoor Play[4] ▪ Special Time with Parents[4] ▪ Limited Screen/Media Time[4] ▪ Promotion of Strengths/Positive Feedback[4]	▪ Sleep[4] ▪ Exercise[4] ▪ Limited Screen/Media Time[4] ▪ Promotion of Strengths/Positive Feedback[4]	▪ Sleep[4] ▪ Exercise[4] ▪ Limited Screen/Media Time[4] ▪ Promotion of Strengths/Positive Feedback[4]

***Please Note:** For the full set of American Academy of Pediatrics (AAP) ADHD practice guidelines, please see: http://pediatrics.aappublications.org/content/128/5/1007 [2019 AAP Guidelines in press]

References:

1. National Institute of Mental Health (NIMH). The multimodal treatment of attention deficit hyperactivity disorder study (MTA):Questions and answers (2009 MTA revision). National Institute of Mental Health (NIMH). https://www.nimh.nih.gov/funding/clinical-research/practical/mta/the-multimodal-treatment-of-attention-deficit-hyperactivity-disorder-study-mta-questions-and-answers.shtml. Published 2009. Accessed February 13, 2018.
2. Jensen PS, Hinshaw SP, Swanson JM, et al. Findings from the NIMH Multimodal Treatment Study of ADHD. *J Dev Behav Pediatr*. 2001;22(1):60-73. https://journals.lww.com/jrnldbp/Abstract/2001/02000/Findings_from_the_NIMH_Multimodal_Treatment_Study.8.aspx. Accessed February 13, 2018.
3. Molina BSG, Hinshaw SP, Swanson JM, et al. The MTA at 8 Years: Prospective Follow-up of Children Treated for Combined-Type ADHD in a Multisite Study. *J Am Acad Child Adolesc Psychiatry*. 2009;48(5):484-500. doi:10.1097/CHI.0b013e31819c23d0.
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8. PCIT International. What is PCIT? PCIT International. http://www.pcit.org/what-is-pcit1.html. Accessed April 30, 2018.
9. CSEFEL. CSEFEL: Center on the Social and Emotional Foundations for Early Learning. CSEFEL. http://csefel.vanderbilt.edu/. Accessed April 30, 2018.

Billing/Diagnostic Codes and Other Guidance: ADHD Visits (Child/Adolescent)

Coding and Description:

	Initial Assessment:	Follow-Up:
Time:	45-60 minutes	25-40 minutes (at least Q3 months)
Rating Scales:	Social-Emotional Screening Code: 96127 *Limit 2 units per visit* At least 2 settings required, home and school (school setting, good to get from multiple teachers, coaches, etc.) *4-5 year olds: Conners CBRS®	Social-Emotional Screening Code: 96127 *Limit 2 units per visit* At least 2 settings required, home and school (school setting, good to get from multiple teachers, coaches, etc.) *4-5 year olds: Conners CBRS®
Pre-Visit:	Review records and rating scales.	Review rating scales. Review records as needed.
CPT:	Consult Code: 99244/99245 Appropriate if requested by school/teacher/colleague.[1] Must send report. *See sample report form for school.* **Otherwise office visit E&M code: 99214/99215** **Use prolonged visit code if needed based on time beyond E&M: 99354-99355[2]**	Office Visit Code: 99214/99215 If done at well visit, use well visit code plus E&M (based on additional time) with 25 modifier. **Use prolonged visit code if needed based on time beyond E&M: 99354-99355[2]**
ICD-10:	F90.0 ADHD, inattentive type (DSM-V) F90.1 ADHD, hyperactive/impulsive type (DSM-V) F90.1 ADHD (DC 0-5) F90.1 Overactivity disorder of toddlerhood (DC 0-5) F90.2 ADHD, combined type F90.8 ADHD with developmental delay R45.87 Hyperactive/impulsive behavior problem R41.840 Inattention problem F81.9 Learning problem R27.8 Graphomotor problems/dysgraphia Z55.3 Academic underachievement Z55.9 Education/academic problem	F90.0 ADHD, inattentive type (DSM-V) F90.1 ADHD, hyperactive/impulsive type (DSM-V) F90.1 ADHD (DC 0-5) F90.1 Overactivity disorder of toddlerhood (DC 0-5) F90.2 ADHD, combined type F90.8 ADHD with developmental delay R45.87 Hyperactive/impulsive behavior problem R41.840 Inattention problem F81.9 Learning problem R27.8 Graphomotor problems/dysgraphia Z55.3 Academic underachievement Z55.9 Education/academic problem

Coding and Payment:

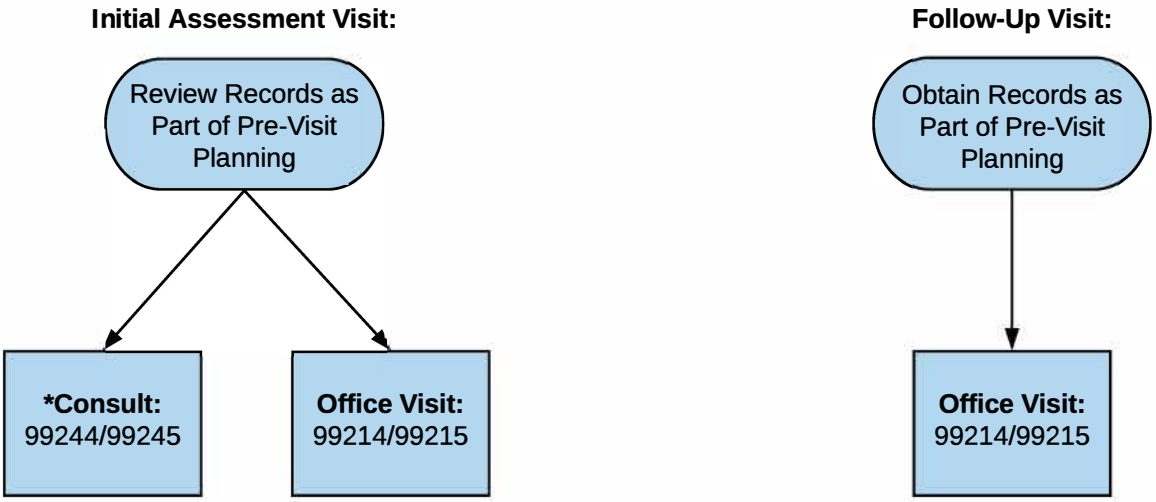
Code Type:	Code:	Payment (Medicaid 2018):
Rating Scales:	96127	$4.25
Consults:	99244/99245	$148.40/$182.39
E&M:	99214/99215	$81.76/$110.58
Prolonged Visits:	99354/99355	$82.03/$81.21

To access the most up-to-date information on North Carolina Medicaid CPT codes, please view the most recent Physician Fee Schedule: https://medicaid.ncdhhs.gov/providers/fee-schedule/physician-services-fee-schedule

For North Carolina Division of Health Benefits support, contact the Medical Assistance Operations Section at (919) 855-4050.
If you have a billing or credentialing concern, you may contact CSRA (NCTracks) at (800) 688-6696

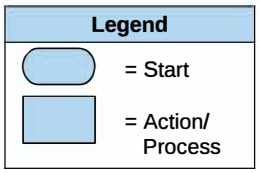
[1] Referral from school or colleague: ***Must*** indicate referral source and send a report only usable for initial visit
[2] **99354:** 31-75 minutes beyond E&M; **99355:** 16-30 minutes beyond 99354

Billing/Diagnostic Codes Supplemental Flow Chart (Child/Adolescent ADHD Visits)



Use Prolonged Visit Codes if Needed for Time: 99354/99355
99354: 31-75 minutes beyond E&M; **99355:** 16-30 minutes beyond 99354

CPT CODES:	
■ Rating Scales (Social-Emotional Screening Code): 96127	
ICD-10 CODES:	
F90.0	ADHD, Inattentive Type (DSM-V)
F90.1	ADHD, Hyperactive/Impulsive Type (DSM-V)
F90.1	ADHD (DC 0-5)
F90.1	Overactivity Disorder of Childhood (DC 0-5)
F90.2	ADHD, Combined Type
F90.8	ADHD with Developmental Delay
R45.87	Hyperactivity/Impulsive Behavior Problem
R41.840	Inattention Problem
F81.9	Learning Problem
R27.8	Graphomotor Problems/Dysgraphia
Z55.3	Academic Underachievement
Z55.9	Education/Academic Problem



*Assumes a referral from school or colleague: ***Must*** indicate referral source and send a report only usable for initial visit

Psychopharmacology

Community Care
OF NORTH CAROLINA

ADHD Medication Guide*

Revised: May 2018

Methylphenidate Derivatives – Long Acting/Extended Release**

(Capsules and tablets in this section are shown at 90% of actual size)

Cotempla XR-ODT™¶ (grape flavor)	6-17 Yrs: 8.6–51.8mg; SD: 17.3mg	8.6mg	T1			17.3mg	T2	25.9mg	T3	34.6mg	T2 + T2			51.8mg	T3 + T3				
Aptensio® XR‡	6 Yrs–Adult: 10–60mg; SD: 10mg	10mg	Aptensio 10 mg	15mg	Aptensio 15 mg	20mg	Aptensio 20 mg	30mg	Aptensio 30 mg	40mg	Aptensio 40 mg	50mg	Aptensio 50 mg	60mg	Aptensio 60 mg				
Concerta®†	6-12 Yrs: 18-54mg; SD: 18mg 13-17 Yrs: 18-72mg; SD: 18mg ≥18 Yrs: 18-72mg; SD: 18mg or 36mg	G 18mg	alza 18	G 27mg	alza 27	G 36mg	alza 36	G 54mg	alza 54	G 72mg	alza 36 + alza 36								
Quillivant XR® 25mg/5mL (5mg/mL) (banana flavor)	6 Yrs–Adult: 20–60mg; SD: 20mg	10mg 2mL	1 Bottle: 300mg 60mL			20mg 4mL	1 Bottle: 600mg 120mL	30mg 6mL	1 Bottle: 900mg 180mL	40mg 8mL	2 Bottles: 600mg 120mL	50mg 10mL	2 Bottles: 750mg 150mL	60mg 12mL	2 Bottles: 900mg 180mL				
Quillichew ER™§ (cherry flavor)	6 Yrs–Adult: 20–60mg; SD: 20mg					20mg		30mg		40mg									
Focalin® XR‡ (dexmethylphenidate)	6-17 Yrs: 5–30mg; SD: 5mg 18 Yrs-Adult: 5–30mg; SD: 5mg	G 5mg	NVR D5			G 10mg	NVR D10	G 15mg	NVR D15	G 20mg	NVR D20	G 25mg	NVR D25	G 30mg	NVR D30	G 35mg	NVR D35	G 40mg	NVR D40
Ritalin® LA‡	6-12 Yrs: 10–60mg; SD: 20mg	G 10mg	NVR R10			G 20mg	NVR R20	G 30mg	NVR R30	G 40mg	NVR R40			G◆ 60mg	NVR R60				
Metadate® CD‡	6-17 Yrs: 10–60mg; SD: 20mg	G 10mg	UCB 579 10mg			G 20mg	UCB 580 20mg	G 30mg	UCB 581 30mg	G◆ 40mg	UCB 582 40 mg	G 50mg	UCB 583 50 mg	G◆ 60mg	UCB 584 60 mg				
Metadate® ER†	6 Yrs-Adult: 20–60mg; SD: 20mg	G◆ 10mg	MD 561			G 20mg	MD 562												

Daytrana®

6-17 Yrs: 10–30mg; SD: 10mg

(Patches are shown at 60% of actual size)

Administration Key:

¶ Orally disintegrating tablet
† Must be swallowed whole
§ Chewable
¥ Can be mixed with yogurt, orange juice, or water
‡ Can open capsule and sprinkle medication on applesauce

****Important Information:** The age-specific dosing information listed for each medication reflects the FDA-approved prescribing information. "SD" refers to the FDA-recommended starting dose, which sometimes varies by age. Practitioners should refer to the full prescribing information for each medication.

Please note: medications have been arranged on the ADHD Medication Guide for ease of display and comparison; dosing equivalence cannot be assumed.

Methylphenidate Derivatives – Short Acting/Immediate Release**

(Medications in this section are shown at actual size)

Focalin® (dexmethylphenidate)	6–17 Yrs: Daily: 5–20mg, divided BID; SD: 2.5mg BID		G 2.5mg	2.5	G 5mg	5	G 10mg	10
Ritalin®	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID		G 5mg	7	G 10mg	3	G◆ 20mg	34
Methylphenidate Chewable§ (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID	G◆ 2.5mg	2.5 CHEW	G◆ 5mg	5 CHEW	G◆ 10mg	10 CHEW		
Methylin® Solution (grape flavor)	6–12 Yrs: Daily: 10–60mg; divided BID or TID; SD: 5mg BID Adults: Daily: 10–60mg, divided BID or TID		G 5mg/5mL		G 10mg/5mL				

G indicates a generic formulation is also available; generic products are not shown

G indicates a generic (but NOT a branded) formulation is available

*Disclaimer: The ADHD Medication Guide was created by Dr. Andrew Adesman of Northwell Health, Inc. Northwell Health is not affiliated with the owner of any of the brands referenced in this Guide.

The ADHD Medication Guide is a visual aid for professionals caring for individuals with ADHD. The Guide includes only medications indicated by the FDA for the treatment of ADHD. In clinical practice, this guide may be used to assist patients in identifying medications previously tried, and may allow clinicians to identify ADHD medication options for the future. Medications have been arranged on the card for ease of display and comparison, but dosing equivalence cannot be assumed. Practitioners should refer to the FDA-approved product information to learn more about each medication. Although every effort has been made to depict the size and color of each medication, we cannot guarantee that there are not minor distortions in the final image.

This Guide should not be used as an exclusive basis for decision-making. The user understands and accepts that if Northwell Health were to accept the risk of harm to the user from use of this Guide, it would not be able to make the Guide available because the cost to cover the risk of harm to all users would be too great. Thus, use of this ADHD Medication Guide is strictly voluntary and at the user's sole risk.

This Guide is accurate as of April 26, 2018.

Cohen Children's Medical Center
Northwell Health℠

ADHD Medication Guide*

Revised: May 2018

Amphetamine Derivatives – Long Acting/Extended Release**

(Medications in this section are shown at actual size)

Adzenys XR-ODT®¶ (d- & l-amphetamine) (orange flavor)	6–12 Yrs: 3.1–18.8mg; SD: 6.3mg 12–17 Yrs: 3.1–12.5mg; SD: 6.3mg Adults: 12.5mg		3.1mg	6.3mg	9.4mg	12.5mg	15.7mg	18.8mg	
Adzenys ER® (d- & l-amphetamine) 1.25mg/mL (orange flavor)	6–12 Yrs: 6.3–18.8mg; SD: 6.3mg 12–17 Yrs: 6.3–12.5mg; SD: 6.3mg Adults: 12.5mg		3.1mg 2.5mL	6.3mg 5mL	9.4mg 7.5mL	12.5mg 10mL	15.7mg 12.5mL	18.8mg 15mL	
Adderall XR®‡ (mixed amphetamine salts)	6–17 Yrs: 5–30mg; SD: 10mg Adults: 5-30mg; SD: 20mg		G 5mg	G 10mg	G 15mg	G 20mg	G 25mg	G 30mg	
Vyvanse®¥ (capsules) (lisdexamfetamine)	6 Yrs–Adults: 10–70mg; SD: 30mg	10mg	20mg	30mg	40mg	50mg	60mg	70mg	
Vyvanse®§ (chewables) (lisdexamfetamine) (strawberry flavor)	6 Yrs–Adults: 10–60mg; SD: 30mg	10mg	20mg	30mg	40mg	50mg	60mg		
Dyanavel® XR (d- & l-amphetamine sulfate) 2.5mg/mL (bubblegum flavor)	6–17 Yrs: 2.5–20mg; SD: 2.5 or 5mg	2.5mg 1mL	5mg 2mL	7.5mg 3mL	10mg 4mL	12.5mg 5mL	15mg 6mL	17.5mg 7mL	20mg 8mL
Mydayis™‡ (mixed amphetamine salts)	13–17 Yrs: 12.5–25mg; SD: 12.5mg Adults: 12.5-50mg; SD: 12.5mg	12.5mg		25mg		37.5mg		50mg	
Dexedrine Spansule® (d-amphetamine sulfate)	6-17 Yrs: 10–60mg; SD: 5mg 1-2x/day		G♦ 5mg	G♦ 10mg	G 15mg				

Amphetamine Derivatives – Short Acting/Immediate Release**

(Medications in this section are shown at actual size)

Evekeo® (d- & l- amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		5mg		10mg				
Zenzedi® (d-amphetamine sulfate)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day	2.5mg	G 5mg	7.5mg	G 10mg		15mg	20mg	30mg
Adderall® (mixed amphetamine salts)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg	G 7.5mg	G 10mg	G 12.5mg	G 15mg	G 20mg	G 30mg
ProCentra® (d-amphetamine sulfate) (bubblegum flavor)	3–5 Yrs: SD: 2.5mg 1x/day 6–17 Yrs: 5-40mg divided BID; SD: 5mg 1-2x/day		G 5mg/5mL						

Non-Stimulants**

(Medications in this section are shown at actual size)

Intuniv®† (guanfacine, extended release)	6–12 Yrs: 1-4mg; SD: 1mg 13–17 Yrs: 1-7mg; SD: 1mg Target dose is weight-based: .05-0.12mg/kg/day	G 1mg	G 2mg	G 3mg	G 4mg				
Kapvay®† (clonidine, extended release)	6–17 Yrs: 0.1-0.2mg BID; SD: 0.1mg qHS	G 0.1mg	(only in dose pack) 0.2mg						
Strattera®† (atomoxetine)	<70kg: 0.5mg/kg x 3d, then 1.2mg/kg (max:1.4mg/kg, not to exceed 100mg) ≥70 kg: 40mg/kg x 3d, then 80mg (max:100mg)	G 10mg	G 18mg	G 25mg	G 40mg	G 60mg	G 80mg	G 100mg	

♦ **Discontinued ADHD Medications:** The following FDA-approved proprietary formulations are no longer available (though, in some cases, branded or generic equivalents are still available): Ritalin LA capsule (60mg); Metadate CD capsules (40mg, 60mg); Metadate ER tablet (10mg); Ritalin SR tablets (20mg); Methylin Chewable tablets (2.5mg, 5mg, 10mg); Dexedrine Spansules (5mg, 10mg); Dexedrine tablets (5mg, 10mg); DextroStat tablets (5mg, 10mg); LiquADD solution (5mg/5mL), and Cylert (pemoline).

- Updated versions of the ADHD Medication Guide can be viewed at www.ADHDMedicationGuide.com
- Laminated copies of the ADHD Medication Guide can be obtained at: www.ADDWarehouse.com
- Contact Dr. Andrew Adesman with any comments or suggestions: ADHDMedGuide@Northwell.edu

Cohen Children's Medical Center
Northwell Health™

ADHD Medication Guide Supplement (for Children/Adolescents): Formulation Type and Duration of Action

**NOTE: PRODUCTS LISTED IN THE FOLLOWING CHART ARE FDA APPROVED FOR THE MANAGEMENT OF CHILD/ADOLESCENT ADHD*[1-3]

STIMULANT: Please note that stimulants are considered first-line *medication* therapy.

Formulation Type:	Stimulant Type:	Duration of Action (In Hours):
Short Acting/Immediate Release:		
Tablet	Methylphenidate (Ritalin®; Focalin®)	3-5
	Amphetamine (Adderall®; Evekeo®; Zenzedi®)	4-8
Liquid	Methylphenidate (Methylin® Solution; Quillivant XR®)	3-5
	Amphetamine (ProCentra®)	≤ 8
Chewable	Methylin (Methylin Chewable)	3-5
Long Acting/Extended Release:		
Pulse Capsules*	Methylphenidate (Ritalin SR®; Metadate ER; Methylin ER®)	7-8
	Amphetamine (Dexedrine Spansule®)	6-9
Pearl Capsules	Methylphenidate (Metadate CD®; Ritalin LA®; Focalin XR®)	8-12
	Amphetamine (Adderall XR®)	8-12
Pump	Methylphenidate (Concerta®)	≤ 12
Transdermal	Methylphenidate (Daytrana®)	≤ 12
Pro-Drug	Amphetamine (Vyvanse®)	8-12

NON-STIMULANT:

Please note time to initial effect for these non-stimulants can take as long as 1-2 weeks

Formulation Type:	Stimulant Type:	Duration of Action (In Hours):
Short Acting/Immediate Release: (α-adrenergic)		
Tablet	Clonidine (Kapvay®)	3-5
	Guanfacine (Intuniv®)	4-8
Long Acting/Extended Release: (α-adrenergic)		
Tablet	Clonidine (Kapvay®)	12-24
	Guanfacine (Intuniv®)	≤ 24
SNRI (Continuous):		
Capsule	Atomoxetine (Strattera®)	Continuous After: 2-4 weeks on a stable, therapeutic dose

*Pulse Capsule: Pulse preparations are capsules containing a mixture of immediate-release beads and delayed-release beads. For children who cannot swallow capsules, they can be opened and the beads can be sprinkled into food such as applesauce.

CHILD/ADOLESCENT ADHD PSYCHOPHARMACOLOGY "PEARL":

In doing a trial on stimulants, please note that a patient may respond better to one formulation than another. For more information on the evidence-based treatment of child/adolescent ADHD, please see the "ADHD Multimodal Intervention Grid (for Children/Adolescents)" within this resource guide.

References:

1. Riddle MA. Chapter 4: Group 1 medications for Attention-Deficit/Hyperactivity Disorder. In: *Pediatric Psychopharmacology*. Elk Grove Village: American Academy of Pediatrics (AAP); 2016:65-101.
2. Adesman A. The ADHD medication guide. Northwell Health . http://www.adhdmedicationguide.com/. Published 2018. Accessed May 21, 2018.
3. Center TR. *Pharmacist's Letter/Prescriber's Letter: Comparison of ADHD Medications*.; 2016. http://rw.therapeuticresearch.com/pl/ArticlePDF.aspx?cs=&s=PRL&DocumentFileID=0&DetailID=271221&SegmentID=0.

Communication with Schools

Community Care
OF NORTH CAROLINA

TO: [IST COORDINATOR – INSERT NAME IF KNOWN]

FROM: [CLINICAN NAME AND PRACTICE]

RE: [INSERT CHILD NAME, NAME OF SCHOOL, AND CHILD GRADE]

DATE: [INSERT DATE]

[Insert child's name] is a patient at [insert name of practice]. [insert name of physician] and [insert child's name] parents are concerned about [insert child's name] ability to pay attention and its potential impact on their school success.

At this time, we are requesting the following information to assist in further evaluation:

- Teacher's classroom observations;
- Vanderbilt rating scale from *each* of the child's teachers;
- Results of any formal testing, if conducted; and
- Current academic strengths and weaknesses

Please send the above information within two-weeks from the date of this memo [re-insert date].

Sincerely,

[insert physician signature and printed name]

[insert parent signature(s) and printed name(s)]

[Insert practice address and contact information, including telephone and fax numbers]

[INSERT NAME OF COUNTY] COUNTY SCHOOL SYSTEM

TWO-WAY CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Information to be Released by:

Agencies/ Schools/ Persons _____

Address _____

Telephone _____ FAX _____

Name/ Position _____

Information to be Released to:

Agencies/ Schools/ Persons _____

Address _____

Telephone _____ FAX _____

Name/ Position _____

Specific Information to be released:

☐ Unlimited disclosure	☐ Vision testing/ reports	☐ Health evaluations
☐ Hearing/ Audiological	☐ Social/ developmental history	☐ ADHD/ ADD reports
☐ Academic records	☐ EC records	☐ Speech/ Language testing
☐ Psychoeducational evals	☐ Medical evaluations	☐ Current medications

☐ Other _____

☐ I give my permission for the information listed above regarding this student [insert full name] _____, _____ , [insert date of birth] _____, ___, to be released as indicated. I understand that the purpose of the released information is for the provision of appropriate educational services for my student. I understand that the released information is protected under the Family Educational Rights and Privacy Act (FERPA) and that the agency/ school/ person(s) receiving the information will be responsible for its continued confidentiality. This release is valid for one (1) calendar year and can be revoked, in writing, at any time.

☐ I also give my permission for the exchange of information (oral and/ or written) between the above named agencies/ schools/ persons.

Signed by _____ Date _____

Circle: Parent/ Legal Guardian/ Surrogate Parent/ Eligible Student

Witnessed by _____ Date _____

PERMANENTLY RETAIN ORIGINAL SIGNED COPY WITH STUDENT'S EC FILES

For EC students, permission can be given only by the student's parent, surrogate parent, or legal guardian. For non-EC students, permission can be given by the student's parent or DSS, if the student is in the custody of DSS. Eligible students can provide their own consent. Any information exchanged is to be shared only between the above listed agencies/ schools/ persons.

CONFIDENTIAL INFORMATION FOR PROFESSIONAL USE ONLY

Do not send this report to a third party (private practitioners or community agencies) without consent of the student's parent/legal guardian.

[Insert Name of School]
Professional Report of ADHD Evaluation

Student Name: _____	**Name of Medical Provider or Mental Health Provider:** _____
School: _____	**Address:** _____
Grade: _____	**Phone:** _____

Dear **[Insert Name of School]** IST Team:

This report is a summary of the ADHD evaluation for the above named student. Attached is a signed release from this student's parent/legal guardian which will allow you to share information with us to assist in providing this student appropriate educational services.

_____ _____

Name of Practice Contact Person Phone Number

ADHD Evaluation

1. List relevant findings from the evaluation (i.e., medical, physical, psychological, etc.):
   Date of exam:_____
2. List any significant birth and medical history:
3. List any significant developmental/behavioral history:
4. List any significant family history:

Behavior Rating Scales and Behavioral History

1. Name of teacher rating scale used:_____ When completed_____
   Results met criteria for being *clinically significant* for:
   - ☐ Inattentive subtype ☐ Hyperactive/Impulsive subtype ☐ Combined subtype
2. Name of parent rating scale used:_____ When completed_____
   Results met criteria for being *clinically significant* for:
   - ☐ Inattentive subtype ☐ Hyperactive/Impulsive subtype ☐ Combined subtype
3. Indicate if there is or was a consistent history of behavioral characteristics of ADHD in two or more settings for at least two years. _____

Evidence of Co-Existing Disorders

- ☐ Yes ☐ No Anxiety or Depression. Describe source of evidence and diagnosis:
- ☐ Yes ☐ No Learning Disorder, Reading Disorder, Language Disorder, Developmentally Disabled, Graphomotor problems, or Mentally Deficient. Describe the source of evidence and diagnosis:
- ☐ Yes ☐ No Oppositional-Defiant Disorder. Describe source of evidence and diagnosis:
- ☐ Yes ☐ No Conduct Disorder. Describe source of evidence and diagnosis
- ☐ Yes ☐ No Other medical disorders. Describe source of evidence and diagnosis:

Diagnosis of ADHD

- ☐ Does not meet criteria for ADHD
- ☐ ADHD Predominantly Inattentive subtype*
- ☐ ADHD Predominantly Hyperactive/Impulsive subtype*
- ☐ ADHD Combined subtype*

Describe how the symptoms which led to your diagnosis might adversely affect this student's educational performance and thus cause significant learning problems at school: _____
_____
_____

Date of most recent diagnosis of ADHD:_____

* A multi-disciplinary team at the school will consider the information from your report along with data collected by the school and other sources in determining if the student meets the eligibility guidelines for any EC services, 504 services, or other special services from the school. A diagnosis of ADHD in and of itself is not sufficient to automatically qualify a student for any special school services.

Treatment Plan

- Medication: ☐ Yes ☐ No If yes, list type and dosage:_____
- Referrals to other specialists: ☐ Yes ☐ No If yes, list to whom and why:_____
- Other treatment recommendations (list): _____
- Next follow-up office visit is scheduled for:_____

Signature

_____ _____
Signature of Medical Provider or Mental Health Provider Date

_____
License # from State Board of Examiners for Mental Health Provider

CONFIDENTIAL INFORMATION
FOR PROFESSIONAL USE ONLY

Do not send this information to a third party (private practitioners or community agencies) without consent of the student's parent/legal guardian.

[Insert Name of School]
Feedback Form to Medical Service Provider

Name of Student:		**Name of Physician:**	
Date of Birth:		**Street Address:**	
School:		**City:**	
Grade:		**Telephone:**	

This form is to be completed by the IST coordinator or designee at the request of the medical service provider. **If you have questions, please call the physician listed above.**

The above named student has been diagnosed as ADHD. Please indicate below the services now being provided for this student as a result of this diagnosis.

☐ The student is receiving services in the Exceptional Children's program under the classification Other Health Impaired (OHI). The Individualized Education Program (IEP) addresses the student's educational needs by offering classroom/testing accommodations and direct intervention services in the following areas:

_____ _____

_____ _____

☐ The student is receiving the following accommodations as part of a 504 plan.

_____ _____

_____ _____

☐ The student is receiving the following goodwill accommodations in the classroom.

_____ _____

_____ _____

☐ The student is receiving other services as indicated below.

_____ _____

_____ _____

_____ _____

Name of School Contact Telephone Number

_____ _____

Signature of School Contact Date

NICHQ Vanderbilt Assessment Scales

Used for diagnosing ADHD

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the beginning of the school year. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Fails to give attention to details or makes careless mistakes in schoolwork	0	1	2	3
2. Has difficulty sustaining attention to tasks or activities	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (school assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by extraneous stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
12. Runs about or climbs excessively in situations in which remaining seated is expected	0	1	2	3
13. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks excessively	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting in line	0	1	2	3
18. Interrupts or intrudes on others (eg, butts into conversations/games)	0	1	2	3
19. Loses temper	0	1	2	3
20. Actively defies or refuses to comply with adult's requests or rules	0	1	2	3
21. Is angry or resentful	0	1	2	3
22. Is spiteful and vindictive	0	1	2	3
23. Bullies, threatens, or intimidates others	0	1	2	3
24. Initiates physical fights	0	1	2	3
25. Lies to obtain goods for favors or to avoid obligations (eg, "cons" others)	0	1	2	3
26. Is physically cruel to people	0	1	2	3
27. Has stolen items of nontrivial value	0	1	2	3
28. Deliberately destroys others' property	0	1	2	3
29. Is fearful, anxious, or worried	0	1	2	3
30. Is self-conscious or easily embarrassed	0	1	2	3
31. Is afraid to try new things for fear of making mistakes	0	1	2	3

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

D4 NICHQ Vanderbilt Assessment Scale—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
32. Feels worthless or inferior	0	1	2	3
33. Blames self for problems; feels guilty	0	1	2	3
34. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
35. Is sad, unhappy, or depressed	0	1	2	3

Performance *Academic Performance*	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
36. Reading	1	2	3	4	5
37. Mathematics	1	2	3	4	5
38. Written expression	1	2	3	4	5

Classroom Behavioral Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
39. Relationship with peers	1	2	3	4	5
40. Following directions	1	2	3	4	5
41. Disrupting class	1	2	3	4	5
42. Assignment completion	1	2	3	4	5
43. Organizational skills	1	2	3	4	5

Comments:

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–28: _____

Total number of questions scored 2 or 3 in questions 29–35: _____

Total number of questions scored 4 or 5 in questions 36–43: _____

Average Performance Score: _____

American Academy of Pediatrics

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NICHQ National Institute for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

11-20/rev0303

D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of the child you are rating and should reflect that child's behavior since the last assessment scale was filled out. Please indicate the number of weeks or months you have been able to evaluate the behaviors: _____.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Reading	1	2	3	4	5
20. Mathematics	1	2	3	4	5
21. Written expression	1	2	3	4	5
22. Relationship with peers	1	2	3	4	5
23. Following direction	1	2	3	4	5
24. Disrupting class	1	2	3	4	5
25. Assignment completion	1	2	3	4	5
26. Organizational skills	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

D6 NICHQ Vanderbilt Assessment Follow-up—TEACHER Informant, continued

Teacher's Name: _____ Class Time: _____ Class Name/Period: _____

Today's Date: _____ Child's Name: _____ Grade Level: _____

Side Effects: Has the child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score: _____

Please return this form to: _____

Mailing address: _____

_____

Fax number: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

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11-22/rev0303

Scoring Instructions for the NICHQ Vanderbilt Assessment Scales

These scales should NOT be used alone to make any diagnosis. You must take into consideration information from multiple sources. Scores of 2 or 3 on a single Symptom question reflect *often-occurring* behaviors. Scores of 4 or 5 on Performance questions reflect problems in performance.

The initial assessment scales, parent and teacher, have 2 components: symptom assessment and impairment in performance. On both the parent and teacher initial scales, the symptom assessment screens for symptoms that meet criteria for both inattentive (items 1–9) and hyperactive ADHD (items 10–18).

To meet *DSM-IV* criteria for the diagnosis, one must have at least 6 positive responses to either the inattentive 9 or hyperactive 9 core symptoms, or both. A positive response is a 2 or 3 (often, very often) (you could draw a line straight down the page and count the positive answers in each subsegment). There is a place to record the number of positives in each subsegment, and a place for total score for the first 18 symptoms (just add them up).

The initial scales also have symptom screens for 3 other co-morbidities—oppositional-defiant, conduct, and anxiety/depression. These are screened by the number of positive responses in each of the segments separated by the "squares." The specific item sets and numbers of positives required for each co-morbid symptom screen set are detailed below.

The second section of the scale has a set of performance measures, scored 1 to 5, with 4 and 5 being somewhat of a problem/problematic. To meet criteria for ADHD there must be at least one item of the Performance set in which the child scores a 4 or 5; ie, there must be impairment, not just symptoms to meet diagnostic criteria. The sheet has a place to record the number of positives (4s, 5s) and an Average Performance Score—add them up and divide by number of Performance criteria answered.

Parent Assessment Scale	Teacher Assessment Scale
Predominantly Inattentive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Predominantly Inattentive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 1–9 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Predominantly Hyperactive/Impulsive subtype ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Predominantly Hyperactive/Impulsive subtype** ■ Must score a 2 or 3 on 6 out of 9 items on questions 10–18 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
ADHD Combined Inattention/Hyperactivity ■ Requires the above criteria on both inattention and hyperactivity/impulsivity	**ADHD Combined Inattention/Hyperactivity** ■ Requires the above criteria on both inattention and hyperactivity/impulsivity
Oppositional-Defiant Disorder Screen ■ Must score a 2 or 3 on 4 out of 8 behaviors on questions 19–26 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Oppositional-Defiant/Conduct Disorder Screen** ■ Must score a 2 or 3 on 3 out of 10 items on questions 19–28 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Conduct Disorder Screen ■ Must score a 2 or 3 on 3 out of 14 behaviors on questions 27–40 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	**Anxiety/Depression Screen** ■ Must score a 2 or 3 on 3 out of 7 items on questions 29–35 AND ■ Score a 4 or 5 on any of the Performance questions 36–43
Anxiety/Depression Screen ■ Must score a 2 or 3 on 3 out of 7 behaviors on questions 41–47 AND ■ Score a 4 or 5 on any of the Performance questions 48–55	

The parent and teacher follow-up scales have the first 18 core ADHD symptoms, not the co-morbid symptoms. The section segment has the same Performance items and impairment assessment as the initial scales, and then has a side-effect reporting scale that can be used to both assess and monitor the presence of adverse reactions to medications prescribed, if any.

Scoring the follow-up scales involves only calculating a total symptom score for items 1–18 that can be tracked over time, and the average of the Performance items answered as measures of improvement over time with treatment.

Parent Assessment Follow-up
- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

Teacher Assessment Follow-up
- Calculate Total Symptom Score for questions 1–18.
- Calculate Average Performance Score for questions 19–26.

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Other ADHD Care Support Resources

Community Care
OF NORTH CAROLINA

Side-by-Side Version

Six Core Elements of Health Care Transition 2.0

The ***Six Core Elements of Health Care Transition 2.0*** are intended for use by pediatric, family medicine, med-peds, and internal medicine practices to assist youth and young adults as they transition to adult-centered care. They are aligned with the AAP/AAFP/ACP Clinical Report on Transition.[i] Sample clinical tools and measurement resources are available for quality improvement purposes at **www.GotTransition.org** ■

Transitioning Youth to Adult Health Care Providers (Pediatric, Family Medicine, and Med-Peds Providers)	Transitioning to an Adult Approach to Health Care Without Changing Providers (Family Medicine and Med-Peds Providers)	Integrating Young Adults into Adult Health Care (Internal Medicine, Family Medicine, and Med-Peds Providers)
1. Transition Policy • Develop a transition policy/statement with input from youth and families that describes the practice's approach to transition, including privacy and consent information. • Educate all staff about the practice's approach to transition, the policy/statement, the ***Six Core Elements,*** and distinct roles of the youth, family, and pediatric and adult health care team in the transition process, taking into account cultural preferences. • Post policy and share/discuss with youth and families, beginning at age 12 to 14, and regularly review as part of ongoing care.	**1. Transition Policy** • Develop a transition policy/statement with input from youth/young adults and families that describes the practice's approach to transitioning to an adult approach to care at 18, including privacy and consent information. • Educate all staff about the practice's approach to transition, the policy/statement, the ***Six Core Elements,*** and distinct roles of the youth, family, and health care team in the transition process, taking into account cultural preferences. • Post policy and share/discuss with youth and families, beginning at age 12 to 14, and regularly review as part of ongoing care.	**1. Young Adult Transition and Care Policy** • Develop a transition policy/statement with input from young adults that describes the practice's approach to accepting and partnering with new young adults, including privacy and consent information. • Educate all staff about the practice's approach to transition, the policy/statement, the ***Six Core Elements*** and distinct roles of the young adult, family, and pediatric and adult health care team in the transition process, taking into account cultural preferences. • Post policy and share/discuss with young adults at first visit and regularly review as part of ongoing care.
2. Transition Tracking and Monitoring • Establish criteria and process for identifying transitioning youth and enter their data into a registry. • Utilize individual flow sheet or registry to track youth's transition progress with the ***Six Core Elements.*** • Incorporate the ***Six Core Elements*** into clinical care process, using EHR if possible.	**2. Transition Tracking and Monitoring** • Establish criteria and process for identifying transitioning youth/young adults and enter their data into a registry. • Utilize individual flow sheet or registry to track youth/young adults' transition progress with the ***Six Core Elements.*** • Incorporate the ***Six Core Elements*** into clinical care process, using EHR if possible.	**2. Young Adult Tracking and Monitoring** • Establish criteria and process for identifying transitioning young adults until age 26 and enter their data into a registry. • Utilize individual flow sheet or registry to track young adults' completion of the ***Six Core Elements.*** • Incorporate the ***Six Core Elements*** into clinical care process, using EHR if possible.
3. Transition Readiness • Conduct regular transition readiness assessments, beginning at age 14, to identify and discuss with youth and parent/caregiver their needs and goals in self-care. • Jointly develop goals and prioritized actions with youth and parent/caregiver, and document regularly in a plan of care.	**3. Transition Readiness** • Conduct regular transition readiness assessments, beginning at age 14, to identify and discuss with youth and parent/caregiver their needs and goals in self-care. • Jointly develop goals and prioritized actions with youth and parent/caregiver, and document regularly in a plan of care.	**3. Transition Readiness/Orientation to Adult Practice** • Identify and list adult providers within your practice interested in caring for young adults. • Establish a process to welcome and orient new young adults into practice, including a description of available services. • Provide youth-friendly online or written information about the practice and offer a "get-acquainted" appointment, if feasible.

[i] American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians. Transitions Clinical Report Authoring Group. Supporting the health care transition from adolescence to adulthood in the medical home. *Pediatrics.* 2011; 128:182.

Continued »

Side-by-Side Version (continued)

Six Core Elements of Health Care Transition 2.0

Transitioning Youth to Adult Health Care Providers (Pediatric, Family Medicine, and Med-Peds Providers)	Transitioning to an Adult Approach to Health Care Without Changing Providers (Family Medicine and Med-Peds Providers)	Integrating Young Adults into Adult Health Care (Internal Medicine, Family Medicine, and Med-Peds Providers)
4. Transition Planning • Develop and regularly update the plan of care, including readiness assessment findings, goals and prioritized actions, medical summary and emergency care plan, and, if needed, a condition fact sheet and legal documents. • Prepare youth and parent/caregiver for adult approach to care at age 18, including legal changes in decision-making and privacy and consent, self-advocacy, and access to information. • Determine level of need for decision-making supports for youth with intellectual challenges and make referrals to legal resources. • Plan with youth/parent/caregiver for optimal timing of transfer. If both primary and subspecialty care are involved, discuss optimal timing for each. • Obtain consent from youth/guardian for release of medical information. • Assist youth in identifying an adult provider and communicate with selected provider about pending transfer of care. • Provide linkages to insurance resources, self-care management information, and culturally appropriate community supports.	**4. Transition Planning/Integration into Adult Approach to Care** • Develop and regularly update a plan of care, including readiness assessment findings, goals and prioritized actions, medical summary and emergency care plan, and, if needed, legal documents. • Prepare youth and parent/caregiver for adult approach to care at age 18, including legal changes in decision-making and privacy and consent, self-advocacy, and access to information. • Determine of need for decision-making supports for youth with intellectual challenges and make referrals to legal resources. • Plan with youth and parent/caregiver for optimal timing of transfer from pediatric to adult specialty care • Obtain consent from youth/guardian for release of medical information. • Provide linkages to insurance resources, self-care management information, and culturally appropriate community supports.	**4. Transition Planning/Integration into Adult Practice** • Communicate with young adult's pediatric provider(s) and arrange for consultation assistance, if needed. • Prior to first visit, ensure receipt of transfer package (final transition readiness assessment, plan of care with transition goals and pending actions, medical summary and emergency care plan, and, if needed, legal documents, condition fact sheet, and additional provider records.) • Make pre-visit appointment reminder call welcoming new young adult and identifying any special needs and preferences. • Provide linkages to insurance resources, self-care management information, and culturally appropriate community supports.
5. Transfer of Care • Confirm date of first adult provider appointment. • Transfer young adult when his/her condition is stable. • Complete transfer package, including final transition readiness assessment, plan of care with transition goals and pending actions, medical summary and emergency care plan, and, if needed, legal documents, condition fact sheet, and additional provider records. • Prepare letter with transfer package, send to adult practice, and confirm adult practice's receipt of transfer package. • Confirm with adult provider the pediatric provider's responsibility for care until young adult is seen in adult setting.	**5. Transfer to Adult Approach to Care** • Address any concerns that young adult has about transferring to adult approach to care. Clarify adult approach to care, including shared decision-making, privacy and consent, access to information, adherence to care, and preferred methods of communication, including attending to health literacy needs. • Conduct self-care assessment (transition readiness assessment) if not recently completed and discuss needed self-care skills. • Review young adult's health priorities as part of ongoing plan of care. • Continue to update and share portable medical summary and emergency care plan.	**5. Transfer of Care/Initial Visit** • Prepare for initial visit by reviewing transfer package with appropriate team members. • Address any concerns that young adult has about transferring to adult approach to care. Clarify approach to adult care, including shared decision-making, privacy and consent, access to information, adherence to care, and preferred methods of communication, including attending to health literacy needs. • Conduct self-care assessment (transition readiness assessment) if not recently completed and discuss the young adult's needs and goals in self-care. • Review young adult's health priorities as part of their plan of care. • Update and share portable medical summary and emergency care plan.
6. Transfer Completion • Contact young adult and parent/caregiver 3 to 6 months after last pediatric visit to confirm transfer of responsibilities to adult practice and elicit feedback on experience with transition process. • Communicate with adult practice confirming completion of transfer and offer consultation assistance, as needed. • Build ongoing and collaborative partnerships with adult primary and specialty care providers.	**6. Transfer Completion/Ongoing Care** • Assist young adult to connect with adult specialists and other support services, as needed. • Continue with ongoing care management tailored to each young adult. • Elicit feedback from young adult to assess experience with adult health care. • Build ongoing and collaborative partnerships with specialty care providers.	**6. Transfer Completion/Ongoing Care** • Communicate with pediatric practice confirming transfer into adult practice and consult with pediatric provider(s), as needed. • Assist young adult to connect with adult specialists and other support services, as needed. • Continue with ongoing care management tailored to each young adult. • Elicit feedback from young adult to assess experience with adult health care. • Build ongoing and collaborative partnerships with pediatric primary and specialty care providers.