Measure: Attention Deficit Hyperactivity Disorder (ADHD) – Measure of Chronic Care Followup

Measure Developer: Pediatric Measurement Center of Excellence (PMCoE)

Numerator	Denominator	Exclusions	Data Source(s)
Patients who attended at least one ADHD followup care visit within the calendar year.	All patients aged 4 through 18 years with a diagnosis of ADHD.	(1) Documentation of medical reason(s) for not providing followup care (e.g., patient with multiple psychiatric conditions referred to other provider), (2) Documentation of system reason(s) for not providing followup care (e.g., patient for whom the followup visits were not all with the same practice).	Administrative Data

Measure Importance

- According to the Centers for Disease Control and Prevention (CDC), 5 million children ages 4–17 have been diagnosed with ADHD.[1] ADHD continues to cause symptoms and dysfunction over long periods of time for many children who have the condition. Current treatments address symptoms and functions but are usually not curative.[2]
- Longitudinal studies have found that, frequently, treatments are not sustained despite the fact that long-term outcomes for children with ADHD indicate they are at greater risk of significant problems if treatment is discontinued.[3]
- ADHD followup care and treatment adherence can be enhanced by improving the relationship between parents and health care providers so parents feel both involved and knowledgeable about their child's health condition and treatment regimen. The medical home and chronic care models both emphasize patient and family involvement in care, and thus, treating ADHD as a chronic care condition within a medical home is guideline-recommended care.[2,4]

Evidence Base for Focus of the Measure

- The American Academy of Pediatrics (AAP) ADHD clinical practice guideline[2,4] recommends that:
  - Primary care clinicians recognize ADHD as a chronic condition and consider children and adolescents with ADHD as children and youth with special health care needs.
  - Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home.
  - Followup for ADHD chronic care management should occur at least twice during the first year following diagnosis and annually thereafter.

Advantages of the Measure

- May hasten diffusion of best practices in ADHD care.
- May encourage the most effective treatment for this population.
- Data for this measure are reliably available in administrative claims data.
- This measure is publicly available for noncommercial use.

Levels of Aggregation Applicable to the Measure

The measure is intended for aggregation and comparison at the State, regional, payment model type, and health plan levels.

Reliability and Validity of the Measure

- Measure reliability was assessed by implementing the measure in a large, administrative claims database that included administrative claims data from both Medicaid and commercial payment model types.
- The face validity of the measure was assessed using expert and public opinion and was determined to have both understandability and face validity for key ADHD stakeholders.[5]

Measure Development and Testing

- Feasibility and reliability testing were performed in the Truven MarketScan Database, which includes administrative data from both Medicaid/Children's Health Insurance Program (CHIP) and commercial claims. The measure was tested iteratively, results were reviewed, and the measure was re-specified as needed resulting in the current specifications of a measure that is feasible, valid, and reliable.

Selected Results from Tests of the Measure

- Approximately 63 percent of Medicaid enrollees and 49 percent of commercial enrollees who were in the denominator met the criteria for the measure. This performance was consistent with performance in the literature as well as expert opinion.
- Children in the Medicaid population were much more likely to meet the measure criteria than children in the commercial population.

Caveats

- The measure uses administrative claims data and is therefore subject to all issues related to administrative claims-based measures, including long continuous coverage requirements, lack of sufficient clinical detail, and incomplete documentation of all diagnosis codes.
- State programs that do not reimburse for mental health diagnosis codes may have trouble using this measure if physicians are not incentivized to mark ADHD in a primary field and include relevant diagnostic and visit codes.
- Because the measure uses administrative claims data, it is impossible to attribute children to specific physicians or practices, which means that the measure can only be used to evaluate performance at the State, region, payment model type, and health plan levels.

More Information:

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- PMCOE: Lisa Krams, lkrams@aap.org, and Ramesh Sachdeva, rsachdeva@aap.org
- Coming soon: Link to measure details on the AHRQ Web site.

Notes

[1]Centers for Disease Control and Prevention (CDC), Vital and Health Statistics (PDF; December 2010; Series 10, Number 247).

[2]Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. ADHD: clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. Pediatrics. 2011; 128(5):1-16.

[3]Ingram S, Hechtman L, Morgenstern G. Outcome issues in ADHD: adolescent and adult long-term outcome. Ment Retard Dev Disabil Res Rev. 1999;5(3):243-50.

[4]Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. ADHD: clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents: process of care supplemental appendix. Pediatrics. 2011;SI1-SI21.

[5]The topic, language, specifications, and results were reviewed by a 24-member Expert Workgroup comprising a wide range of stakeholders including consumers, pediatricians, family physicians, adolescent medicine physicians, psychiatrists, teachers, State Medicaid agencies, and researchers. The Expert Workgroup technical panel was solicited for feedback on importance, relevance, understandability, and usability throughout the development process. Further, using the networks of Expert Workgroup members, this measure was put through a public comment period, and feedback on the variables above and general feedback were requested.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) called for establishment of a Pediatric Quality Measures Program (PQMP) as a followup to identifying the initial core set of children's health care quality measures. This measure fact sheet was produced by the Agency for Healthcare Research and Quality, based on information provided by the AHRQ-CMS CHIPRA Pediatric Measurement Center of Excellence (PMCOE) at the Medical College of Wisconsin, which was funded by an AHRQ-CMS award. A listing of all submitted CHIPRA Centers of Excellence measures can be found at www.ahrq.gov/chipra. All CHIPRA COE-developed measures are publicly available for noncommercial use.

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