



## Attention-Deficit / Hyperactivity Disorder (ADHD)

### OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations for the treatment of ADHD. The CPG discusses the symptoms, diagnosis, treatment and behavioral health implications. In addition, the CPG outlines the organizations that WellCare aligns with regarding ADHD and Measureable Health Outcomes.

### OVERVIEW

Attention Deficit Hyperactivity Disorder (ADHD) is a neurobehavioral disorder of children, adolescents and adults characterized by persistent pattern of difficulty paying attention, excessive activity, and impulsivity that interferes with or reduces the quality of cognitive, academic, social, emotional, behavioral or occupational functioning. The percentage of children estimated to have ADHD has changed over time. The American Psychiatric Association states in the Diagnostic and Statistical Manual of Mental Disorders ( ) that 5% of children have ADHD. On the other hand, Center of Disease Control and Prevention's surveys studies estimated the prevalence of children 4-17 years of age diagnosed with ADHD in 2011 as approximately 11% (6.4 million).<sup>1</sup>

*Core Symptoms of ADHD<sup>2</sup>*

<i>Inattention Dimension</i>	<i>Hyperactivity-Impulsivity Dimension</i>	
	<i>Hyperactivity</i>	<i>Impulsivity</i>
Careless mistakes Difficulty sustaining attention Seems not to listen Fails to finish tasks Difficulty organizing Avoid tasks that require sustained attention Loses things Easily distracted Forgetful	Fidgety Unable to stay seated Moves excessively (restless) "On the go" Talks excessively Difficulty engaging in leisure activities quietly	Blurts answers before questions are completed Difficulty awaiting turn Interrupts on others

Based on the types of symptoms, three presentations of ADHD can occur: predominantly inattentive presentation; predominantly hyperactive-impulsive presentation; and combined presentation. The presentation of ADHD in a given patient can change from one to another, depending on symptom changes over time.<sup>2</sup>

Disorders that commonly co-exist with ADHD in children and adolescents include: <sup>3</sup>

1. **Behavioral and Conduct Problems.** This can include conduct disorders, anxiety disorders, depression, bipolar affective disorder, disruptive behavior disorders and oppositional defiant disorders.
2. **Developmental Disorders** such as learning disabilities, speech and language disorders or other neurodevelopmental disorders.
3. **Anxiety and Depression.** Almost 1 in 5 children with ADHD have a diagnosed anxiety disorder and around 1 in 7 children with ADHD have a diagnosis of depression. Extreme depression can lead to thoughts of suicide which

is a leading form of death among those ages 10-24.

4. **Peer Relationships.** Children who have difficulty making friends might also more likely have anxiety, behavioral and mood disorders, substance abuse, or delinquency as teenagers.
5. **Risk of Injuries.** Children with ADHD are more likely to suffer injuries while walking or riding a bicycle, including head injuries. They're also more likely to injure more than one part of their body, be hospitalized for unintentional poisoning, and be admitted to intensive care units or have an injury resulting in disability.
6. **Substance Abuse** such as higher incident in adolescents and adults.

## Hierarchy of Support

### GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the American Academy of Child and Adolescent Psychiatry (AACAP), American Psychiatric Association (APA), and the American Academy of Pediatrics (AAP). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to ADHD, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with the AACAP, APA, and AAP on the topic of ADHD. Highlights from their respective publications are below.

### AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY (AACAP)

The American Academy of Child and Adolescent Psychiatry (AACAP) published a practice parameter describing the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder (ADHD) based on the current scientific evidence and clinical consensus of experts in the field. The parameter discusses the clinical evaluation for ADHD, comorbid conditions associated with ADHD, research on the etiology of the disorder, and psychopharmacological and psychosocial interventions for ADHD.

The AACAP notes that the key to effective long-term management of the patient with ADHD is continuity of care with a clinician experienced in the treatment of ADHD. The frequency and duration of follow-up sessions should be individualized for each family and patient, depending on the severity of ADHD symptoms; the degree of comorbidity of other psychiatric illness; the response to treatment; and the degree of impairment in home, school, work, or peer-related activities. The clinician should establish an effective mechanism for receiving feedback from the family and other important informants in the patient's environment to be sure symptoms are well controlled and side effects are minimal. Although this parameter does not seek to set a formula for the method of follow-up, significant contact with the clinician should typically occur two to four times per year in cases of uncomplicated ADHD and up to weekly sessions at times of severe dysfunction or complications of treatment. To access the full guideline, click [here](#).<sup>4</sup>

### AMERICAN PSYCHIATRIC ASSOCIATION (APA)

WellCare adheres to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5)*, published in 2013 by the American Psychiatric Association (APA) to make diagnosis of ADHD. Primary care physicians and behavioral health practitioners should adhere to the DSM-5 criteria when diagnosing ADHD. Adherence to the DSM-5 criteria can help to minimize over- and underdiagnoses of ADHD. The DSM-5 diagnosis of ADHD requires:<sup>1</sup>

- For children <17 years: ≥6 symptoms of hyperactivity and impulsivity or ≥6 symptoms of inattention.
- For adolescents ≥17 years and adults: ≥5 symptoms of hyperactivity and impulsivity or ≥5 symptoms of inattention

- Symptoms of hyperactivity/impulsivity or inattention must:
  - Be present before the age of 12 years
  - Be persistent for at least 6 months
  - Be present in two or more settings (e.g., at home, school or work)
  - Have clear evidence that the symptoms interfere with, or reduce the quality of, academic, social, or occupational activities
  - Show a persistent pattern that interferes with functioning or development
  - Other physical, situational, or mental health conditions that could account for the symptoms must be excluded (e.g., mood disorder, anxiety disorder, dissociative disorder, a personality disorder)
- Specify ADHD presentations that have been present for the past 6 months.
- Specify if in partial remission; when full criteria were previously met, fewer than the full criteria have been met for the past 6 months, and the symptoms still result in impairment in social, academic, or occupational functioning.
- Specify current symptom severity:
  - **Mild.** Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairments in social or occupational functioning.
  - **Moderate.** Symptoms or functional impairment between “mild” and “severe” are present.
  - **Severe.** Symptoms are in excess of those required to make a diagnosis; or several particularly severe symptoms are present; or symptoms result in marked impairment in social or occupational functioning.

#### AMERICAN ACADEMY OF PEDIATRICS (AAP)

WellCare adheres to 2011 clinical practice guidelines on ADHD by American Academy of Pediatrics (AAP) regarding treatment of ADHD in children and adolescents which vary depending on the patient's age:<sup>5</sup>

- **For preschool-aged children (4–5 years of age)**, the primary care clinician should prescribe evidence-based parent- and/or teacher-administered behavior therapy as the first line of treatment. Methylphenidate may also be prescribed if the behavior interventions do not provide significant improvement and there is moderate to severe continuing disturbance in the child's function. Medication should only be prescribed to preschool aged children with moderate-to-severe ADHD. In areas where evidence-based behavioral treatments are not available, the clinician should weigh the risks of starting medication at an early age against harm of delaying diagnosis and treatment.<sup>1,6</sup>

NOTE: Although the AAP recommends Methylphenidate for preschool aged children, Methylphenidate is not FDA approved for this age group. Dextroamphetamine is the only FDA approved product for preschool-aged children and is available on the WellCare Preferred Drug List; however, the AAP does not suggest as first-line therapy.

- **For elementary school-aged children (6–11 years of age)**, the primary care clinician should prescribe FDA approved medications for ADHD and/or evidence-based parent- and/or teacher-administered behavior therapy as treatment for ADHD (preferably both). Evidence is particularly strong for stimulant medications and sufficient however, evidence is less favorable for atomoxetine, extended-release guanfacine, and extended-release clonidine, respectively. The child's school environment, program, or placement is a part of any treatment plan.
- **For adolescents (12–18 years of age)**, the primary care clinician should prescribe FDA approved medications for ADHD with the agreement of the adolescent and may prescribe behavior therapy as treatment for ADHD (quality of evidence /recommendation) (preferably both).

The primary care clinician should titrate doses of medication for ADHD to achieve maximum benefit with minimum adverse effects. Treatment progress can be assessed by clinical observations and interviews, as well as rating scales completed by parents and teachers. The hallmark of treatment planning in children is a firm alliance with the parents, patient and teachers to make sure that consistent, coordinated efforts are applied across settings.

The primary care physician should also stress the importance of a weekend “holiday” with methylphenidate, when appropriate, to treat ADHD. A randomized clinical trial showed significant reduction in side effects of insomnia and appetite suppression without a significant increase in symptoms, either on weekends or on the next school day, in the 5-day per week MPH regimen with weekend holidays compared to the 7-day per week MPH regimen.

## Evidence Based Practice

### AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

The Agency for Healthcare Research and Quality (AHRQ) is developing the following report:<sup>7</sup>

- **Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents**

The AHRQ web site will be monitored and the WellCare CPG on *ADHD* will be updated accordingly.

### MEASUREMENT OF COMPLIANCE

WellCare is committed to adhering to the measures and standards published by the Centers for Medicare and Medicaid Services (CMS) and the National Committee for Quality Assurance (NCQA). Please reference WellCare's Clinical Policy Guiding Document titled *Quality Improvement*.

NOTE: To access Clinical Policy Guiding Documents visit [www.wellcare.com](http://www.wellcare.com) – select the Provider tab, then “Tools” and “Clinical Guidelines”.

## Care Management

*Evaluation of ADHD.* The primary care clinician should initiate an evaluation for ADHD for any child 4 through 18 years of age who presents with academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity. The evaluation for possible ADHD includes comprehensive medical, developmental, educational, psychosocial, and ancillary evaluation. Comprehensive evaluation is necessary to confirm the presence, persistence, pervasiveness, and functional compliance of core symptoms. The evaluation should include review of the medical, social, and family histories; clinical interviews with the parent and patient; review of information about functioning in school or day care; and evaluation for coexisting emotional or behavioral disorders. Regular vital signs with height and weight are indicated at first visit and regularly at follow-up. Electrocardiogram and cardiology consults are recommended if cardiac history is known or suspected. The necessary information may be obtained through in-person discussions, questionnaires, and web-based tools. ADHD rating scales are recommended at diagnosis and for follow-up to track treatment response. These include the Conners Parent and Teacher Rating Scales or the equivalent and may also include the Continuous Performance Test. Neither Psychological Testing nor Neuropsychological Testing is considered medically necessary to establish the diagnosis of ADHD.<sup>2</sup>

*Indications for Referral.* Evaluation by a pediatric specialist (e.g., psychologist, psychiatrist, neurologist, educational specialist, or developmental-behavioral pediatrician) is indicated for children where the following are of concern:<sup>2</sup>

- Intellectual disability (mental retardation)
- Developmental disorder (e.g., speech or motor delay)
- Learning disability
- Visual or hearing impairment
- History of abuse
- Severe aggression
- Seizure disorder
- Coexisting learning and/or emotional problems
- Chronic illness that requires treatment with a medication that interferes with learning
- Children who continue to have problems in functioning despite ADHD treatment

### MEASURABLE HEALTH OUTCOMES

Targeted Case Management outcomes (**Extended Program Goals**) result from successful self-management (see Case Management Objectives).

- **Symptoms:** Member will be able to increase attention and concentration on a task by 10 minutes within 90 days as evidenced by behavior log or member guardian report
- **Symptoms:** Member will complete homework on time at least 80% of the time within 90 days as evidenced by member guardian or school report
- **Symptoms:** Member's sleep will increase by at least 20 minutes a night within 90 days as evidenced by member

guardian written sleep log

- **Symptoms:** Member's school attendance will improve by at least 20% within 90 days due to reduced amount of suspensions as evidenced by member guardian, provider, or school report
- **Symptoms:** Incidences of member's guardian having to be called at home for member's behavior problems will reduce by 20% within 90 days as evidenced by member guardian report
- **Engagement:** Member will engage in at least 60 minutes of exercise or active play a day at least 80% of the time by 90 days as evidenced by member guardian report
- **Adherence:** Member will take prescribed medications >90% of the time within 90 days as evidenced by pharmacy claims or provider report
- **Utilization:** Member and guardian will be engaged in community-based treatment and attend >80% of appointments within 90 days

### **CASE MANAGEMENT GOALS**

Goals should target specific care gaps and/or adherence issues, and measure the member's progress towards self-management and adherence which lead to the targeted health outcomes above.

- **Symptoms:** Member's guardian will be able to verbalize 3 positive coping skills member can utilize to deal with anger or stress within 60 days
- **Symptoms:** Member will be able to stay on task for at least 10 minutes at a time without needing reminders within 90 days
- **Symptoms:** Member's guardian will verbalize 2 behavioral strategies that can be used to prevent verbal or physical altercations between member and siblings within 60 days
- **Symptoms:** Member's guardian will verbalize at least 3 symptoms of ADHD and 3 ways to help member manage symptoms within 60 days
- **Engagement:** Member's guardian verbalize plan to use a reward chart or other method for keeping track of and encourage and reward member's good behavior within 60 days
- **Engagement:** Member's guardian will create a chore chart for member to use and list at least 3 chores for member to complete weekly within 60 days
- **Engagement:** Member's guardian will attend at least one parenting training through community-based treatment, parenting classes or ADHD education programs within 90 days
- **Engagement:** Member's guardian will list 3 healthy snack options for member and 3 food items that should be avoided within 60 days
- **Engagement:** Member will be signed up for at least one organized sport or activity a month within 60 days
- **Engagement:** Member's guardian will attend at least one meeting with member's teacher to discuss IEP or 504 plan and modifications to reduce distractions and increase on-task behavior within 90 days
- **Engagement:** Member's guardian will verbalize a plan to get an organizational system in place to help with getting ready in the morning, completing chores and homework within 30 days
- **Adherence:** Member will be connected to behavioral therapy, psychoeducation and medication management and adhere to treatment plan >80% of the time within 90 days

### **CASE MANAGEMENT OBJECTIVES**

- Assist member's guardian in working with the member's school to ensure an appropriate IEP or 504 plan is in place
- Refer member's guardian to parent support and advocacy programs for children with disabilities such as Parent 2 Parent
- Refer member's guardian to online or in person support and educational groups for parents of children with ADHD such as CHADD
- Refer member to community-based services that can be provided in the home, school or community for psychotherapy, behavior therapy and social skills training
- Refer member to Targeted Case Management (TCM) as appropriate and where available
- Refer member to individual therapy, psychiatric evaluation and/or psychological testing if needed
- Educate member's guardian on coping skills for anger and stress that can be taught to member
- Educate member's guardian on the importance of setting a daily routine for the member and using a timer or

“countdown” to transition from one activity to another

- Educate member’s guardian on offering limited choices to the member instead of implicit directives or ultimatums and using reminders to keep member on track
- Educate member’s guardian on setting up rewards, consequences and expectations for behaviors that are clearly and specifically stated and consistently followed
- Educate member’s guardian on using timeouts to help member calm down and prevent overstimulation
- Educate member’s guardian on the importance of limiting screen time for the member and offering options of more outdoor play and activities
- Educate member’s guardian on the importance of a healthy diet for the member and staying away from processed foods, foods high in sugar, and foods with artificial dyes
- Educate member’s guardian on stimulant medications including side effects
- Refer member to afterschool program, tutoring program or mentoring program such as Boys and Girls Club or Big Brothers, Big Sisters
- Educate member’s guardian that stimulant medications can be abused and that it is important that the medications are not given to or sold to others
- Educate member’s guardian on monitoring member’s behavior on and off medications and that observations of behaviors can be documented in a journal or a behavior rating scale
- Educate member’s guardian on creating calendars, charts, planners and other organizational systems to help members stay on task
- Encourage regular communication between guardian and school
- Educate member’s guardian on how to assist member with communication and assertiveness to be able to express feelings and needs appropriately

#### MEDICAL BEHAVIORAL INTEGRATION

*Psychosocial Interventions for ADHD.* Psychosocial interventions should be implemented to offset the debilitating effects of the condition on academic/vocational performance as well as interpersonal relationships. It is indicated for all patients/families. Parental education and social skills training should be addressed with parents who are dealing with a child who repeatedly fails to meet expectations. Collaboration with schools is critical for children with academic and interpersonal difficulties which should be accessed at each visit for all students. Cognitive-Behavioral Therapy (CBT) and/or coaching by a specific ADHD coach can be very useful for college students and adults. It is appropriate to encourage an Individualized Educational Plan (IEP) or to support informal school modifications. Appropriate documentation, including crucial details, is required from the health care provider to the school system.<sup>2</sup>

#### MEMBER EDUCATIONAL RESOURCES

There are currently no Krames educational materials available for this topic.

#### PHARMACOLOGY

The first line treatment of management of ADHD is stimulant medications such as methylphenidate (Concerta, Ritalin), dextromethylphenidate (Focalin), dextromethamphetamine (Desoxyn) and amphetamine-based stimulants such as Adderall. Nonstimulant medications may be prescribed if the member does not respond to stimulant medications or has unmanageable side effects. These medications include Strattera, nortriptyline, guanfacine and clonidine. Common side effects for medications for ADHD include headache, trouble sleeping, stomach upset, nervousness, irritability, weight loss and dry mouth. Rare, but serious side effects for stimulant medications include hallucinations, increased blood pressure, allergic reaction and suicidal thoughts or actions and for nonstimulants include seizures and suicidal thoughts or actions. Stimulant medications have the likelihood of being abused, so care should be taken to keep medications in a safe place to ensure that medications are not being given to or sold to others.<sup>8</sup>

### Related WellCare Guidelines

In addition to the information contained in this document, please reference the following CPG: *Child and Adolescent Behavioral Health (HS-1049)*. For the Georgia market, please reference *ADHD (HS-1020GA)*.

NOTE: Clinical Policies can be accessed by going to [www.wellcare.com](http://www.wellcare.com) – select the Provider tab, then “Tools” and “Clinical Guidelines”.

## References

1. American Psychiatric Association. Attention-deficit/hyperactivity disorder. In: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-5) American Psychiatric Association, Arlington, VA 2013. p.59.
2. Krull K, Augustyn M, et al. Attention deficit hyperactivity disorder in children and adolescents: clinical features and evaluation. Up To Date. 2015; 624. Accessed April 18, 2018.
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4. Pliszka S, AACAP Work Group on Quality Issues. Practice parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder. J Am Acad Child Adolesc Psychiatry. 2007 Jul;46(7):894-921. [http://www.aacap.org/App\\_Themes/AACAP/docs/practice\\_parameters/jaacap\\_adhd\\_2007.pdf](http://www.aacap.org/App_Themes/AACAP/docs/practice_parameters/jaacap_adhd_2007.pdf). Accessed April 18, 2018.
5. Wolraich M, et al. 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. American Academic of Pediatrics. 2011;128(5):1007-1022. <http://www.pediatrics.org/cgi/doi/10.1542/peds.2011-2654>. Accessed April 18, 2018.
6. Martins S, Tramontina S, et al. Weekend Holidays During Methylphenidate Use in ADHD Children: A Randomized Clinical Trial. Journal of Child and Adolescent Psychopharmacology. 2004;14: 195-205. [https://www.researchgate.net/publication/8392642\\_Weekend\\_Holidays\\_During\\_Methylphenidate\\_Use\\_in\\_ADHD\\_Children\\_A\\_Randomized\\_Clinical\\_Trial](https://www.researchgate.net/publication/8392642_Weekend_Holidays_During_Methylphenidate_Use_in_ADHD_Children_A_Randomized_Clinical_Trial). Accessed April 18, 2018.
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8. Robinson, L. Smith, M. Segal, J. Ramsey, D. ADHD Medications. <https://www.helpguide.org/articles/add-adhd/medication-for-attention-deficit-disorder-adhd.htm#resources>. Accessed April 18, 2018.

## Disclaimer

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*Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ 'Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona  
OneCare (Care1st Health Plan Arizona, Inc.) ~ Staywell of Florida ~ WellCare Prescription Insurance ~ WellCare Texan Plus (Medicare – Dallas and Houston markets)  
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)*

## Medical Policy Committee Approval History

Date	History and Revisions by the Medical Policy Committee
5/3/2018	<ul style="list-style-type: none"> <li>• Approved by MPC. No changes.</li> </ul>
7/24/2017	<ul style="list-style-type: none"> <li>• Approved by MPC. Includes sections on Care Management and Health Equity, Health Literacy, and Cultural Considerations.</li> </ul>
1/7/2016	<ul style="list-style-type: none"> <li>• Approved by MPC. Cross referenced Georgia specific CPG on Asthma. Inclusion of CPG Hierarchy.</li> </ul>
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