AMERICAN ACADEMY OF
CHILD & ADOLESCENT
PSYCHIATRY

March 15, 2010

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–0033–P
P.O. Box 8013
Baltimore, MD 21244–8013.

To Whom It May Concern:

On behalf of the American Academy of Child and Adolescent Psychiatry (AACAP), I am submitting comments to the Centers for Medicare and Medicaid Services (CMS) regarding the public notice for comment on the proposed rule for the Electronic Health Record Incentive Program under CMS (42 CFR Parts 412, et al.).

AACAP is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 8,000 members strong, AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7-12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders. AACAP's members actively research, evaluate, diagnose, and treat psychiatric disorders and pride themselves on giving direction to and responding quickly to new developments in addressing the health care needs of children and their families.

Implementation of an electronic health record (EHR) into a practice must be a seamless process and its primary goal should be to improve access to, and efficiency and quality of our healthcare delivery system. The regulations address the large hospital systems and institutions but may be problematic for the solo or small group practitioner, where many child and adolescent psychiatrists practice. Despite living in the wealthiest nation in the world, many of our children in need of help lack access to appropriate mental health care. While almost one in five children in the Unites States suffers from a diagnosable mental disorder, only 20 to 25 percent of these children receive treatment. With the severe shortage of child and adolescent psychiatrists, many children are not being treated, and those who are, are often treated by their pediatrician or nonmedical mental health provider in consultation with a child and adolescent psychiatrists. This coordination of treatment makes EHRs most important to this very vulnerable population of children and adolescents suffering from mental illnesses.

The comments below reflect some concerns about the regulations and how they can be improved to provide a higher certainty of access to, and efficiency and quality of care for children and adolescent suffering from mental illness.

Diagnosis Classification Systems (Section II, A, 2, d, (1) Objectives – page 1855)
You have proposed using ICD-9 or SNOMED CT as the diagnosis classification systems for EHR. Most child and adolescent psychiatrists and other mental health professionals use the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) and we recommend this be included as an additional classification system to maintain the up-to-date problem list.

Proposed Clinical Quality Measures Specialty Groups (Section II, A, 3, d – page 1873)
The list of specialties outlined includes pediatrics and psychiatry but not child and adolescent psychiatry. While pediatrics and psychiatry both have some measurements relevant to our specialty, a table of measures, central to the work of child and adolescent psychiatrists, selected from those two groups would help focus the process of quality improvement and build a foundation for the development of additional measures directly relevant to the clinical world of our specialty. We recommend that the new Child and Adolescent Psychiatry table include:
From Pediatrics:

- NQF 0106 Diagnosis of ADHD
- NQF 0107 Management of ADHD
- NQF 0108 Follow up care for children on ADHD medication
- NQF 0024 Measurement of BMI on children ages 2 to 18 who are taking medication

From Psychiatry:

- NQF 0103 Major Depressive Disorder diagnostic evaluation
- NQF 0104 Major Depressive Disorder suicidal risk assessment
- NQF 0105 Major Depressive Disorder optimal contacts for medication treatment follow up

If a table for a child and adolescent psychiatry measure group is not possible, then we recommend adding NQF 0106, NQF 107, NQF 108, and NQF 0024 to the Psychiatry Measure group in addition to their inclusion in the Pediatrics Measure group.

Definition of Children's Hospital (Section II, D, 3, b, 2 – page 1930)
The proposed rule asks for comments on the definition of a children's hospital. Although many children with mental illnesses can be treated in the community and remain with their families, the goal of treatment is to alleviate the acute symptoms as quickly as possible, and sometimes hospitalization is required. The number of psychiatric beds in children's hospitals has been decreasing at a steady rate in the last 10 years. There are some freestanding child and adolescent psychiatric hospitals in the United States that provide intense services for children who need hospitalization. AACAP would like to ensure that 1): free standing child and adolescent psychiatric hospitals are included as part of the definition, therefore we support the alternative proposed definition; and 2) that medically supervised residential treatment centers are also included under such definition.

Qualifying Patient Threshold (Section II, D, 3, d – page 1931)
The proposed rule lists physician requirements at 30% patient threshold and pediatricians at 20%. As child and adolescent psychiatry is a subspecialty of psychiatry not pediatrics, it would fall under the physician requirements. We recommend that child and adolescent psychiatrists, and general psychiatrists and certified nurse practitioners who see children under the age of 21 to be included in the 20% pediatric threshold. It is further important to include partial hospitalization program hours as allowable hours to track under the 20% threshold. Child and adolescent psychiatrist often work in multiple settings (private practice and community services) and allowing patients in the partial hospital setting or the numbers of hours in this setting to be counted towards the patient threshold is a better snap shot of this field. We recommend CMS count 1 hour worked at a partial hospital program equal to four visits in an office setting. We also recommend that additional incentives be provided to subspecialties, including child and adolescent psychiatry, where the demand for care of that specific patient population significantly outweighs the shortage with the profession. As the use of psychotropic medications, and particularly antipsychotic agents, are commonly and increasingly used as first-line treatments in children and adolescents with mental illnesses, there is an urgent need for child and adolescent psychiatrists to become or stay actively involved with the Medicaid population, which would be supported by the reduction in the qualifying patient threshold for pediatric subspecialties.

Criteria for meaningful use (non-clinical measures)
Meaningful Use Criteria
EP Objective: Generate and transmit permissible prescriptions electronically (Section II, A, 2, d – page 1860)
It would appear that most of the requirements for meeting the meaningful use criteria can be applied to child and adolescent psychiatrist practicing in outpatient settings. One barrier to adoption however, may be the problem that our membership writes a significant number of prescriptions for stimulants that at this time require an original signature on the prescription. Resolution of this issue by changes in regulations through the Justice Department will be necessary to get wide spread adoption of electronic prescribing by our members. While we are very concerned about the inappropriate use of stimulant medications, we are not persuaded that the requirement for an original prescription actually reduces diversion of stimulant medications. Never producing a printed prescription but sending all orders for stimulant medications directly to the pharmacy may provide better controls for all Schedule II medications. Another resolution would be to continue the original signature requirement for Schedule II pain medications but exempt stimulant medications that are sent directly to the pharmacy. This change would benefit both pediatricians and child and adolescent psychiatrists.

AACAP further recommends two items that are meant for implementation in Phase one to be deferred until Phase 2. The first is the requirement to provide 10% of the EP's patients with access to their records electronically. Where this may be feasible for larger hospital systems this is a serious burden to small practices. Our membership will need to be further educated on these systems and to require an additional reporting component would overwhelm them. Second, the requirement to report public health information to

state and local health departments is not customary for child and adolescent psychiatrists. For child and adolescent psychiatrists, adverse events are reported to the FDA rather than to state and local health departments and clarification is needed.

AACAP recommends CMS conduct outreach to all physician organizations to work together to ensure that appropriate access to and quality of care is maintained through the implementation of the EHR. While AACAP supports the use of EHR, we remain concerned about the difficulties many child and adolescent psychiatrists in solo and smaller practices will have in transferring their hard copy medical records to an EHR system. We will work with CMS to ensure that our membership is informed about the new incentives, and ask that CMS also conduct an outreach campaign to inform our subspecialty and others that this program is meaningful to them rather than just a challenge, it will only benefit our patients, providing effective and safe healthcare. Because of high barriers of entry into the EHR for many of our members, without such outreach and appropriate adjustment of incentives, we are deeply concerned that the unintended effect of this very positive initiative will be to further restrict access to child and adolescent psychiatrists for the many who need our care.

Thank you for the opportunity to comment. We would be happy to talk with you further about our comments. Please contact Kristin Kroeger Ptakowski, Director of Government Affairs and Clinical Practice at kkroeger@aacap.org, 202-966-7300, ext 108.

Sincerely,

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President