February 16, 2018

The Honorable Orrin Hatch Chair, Senate Committee on Finance U.S. Senate Washington, DC 20510

The Honorable Ron Wyden Ranking Member, Senate Committee on Finance U.S. Senate Washington, DC 20510

Submitted electronically to: opioids@senate.finance.gov

Re: Response to Request for Policy Recommendations Around the Opioid Use Disorder (OUD)

Dear Chairman Hatch and Ranking Member Wyden:

The College of Healthcare Information Management Executives (CHIME) is pleased to respond to the Senate Committee on Finance's request for feedback on policy recommendations to improve access and quality of treatment by addressing the root causes that lead to, or fail to prevent, opioid use disorder (OUD) and other substance use disorders (SUDs).

CHIME is an executive organization serving more than 2,500 chief information officers (CIOs) and other senior health information technology leaders at hospitals and clinics across the nation. CHIME members are responsible for the selection and implementation of clinical and business technology systems that are facilitating healthcare transformation.

We appreciate the committee's interest in stemming the opioid epidemic that claimed more than 42,249 people in 2016, more than any year on record and five times higher than they were in 1999, according to the Centers for Disease Control (CDC).[1] CHIME welcomes the opportunity to offer the perspective of our nation's healthcare chief information officers (CIOs) and senior health IT leaders on how technology can be leveraged to curb this devastating epidemic. Recently, CHIME launched a new Opioid Task Force with the intention of doing just that – lending the collective expertise of our members and "foundation firms" (vendor partners) to identify ways to use technology and data to promote

[1] https://www.cdc.gov/drugoverdose/data/statedeaths.html

solutions. To that end, we are pleased to offer our responses to three of the Committee's questions.

We are pleased to offer several policy suggestions and feedback to the Committee which, rather than impose unfunded mandates on providers, instead builds off existing technology systems. In many cases, the infrastructure already exists among many healthcare providers, thanks to the nearly ubiquitous adoption of electronic health records (EHRs) among hospitals and clinicians stemming from the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Question 3: How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment of for OUD and other SUDs to improve patient outcomes?

- **Improvement Activities under the Medicare Incentive-based Program (MIPS):** MIPS contains Improvement Activities aimed at opioids, however, more activities should be added. Specifically, we recommend the Committee request the Centers for Medicare and Medicaid Services (CMS) consider for payment in 2019 the following activities:
    - Use of the new CDC opioid guidelines, including use of their mobile app.[2]
    - Use of electronic prescribing for controlled substances (EPCS).
- **Focusing on interoperability:** CMS and the Office of the National Coordinator (ONC) should continue to focus on ways to improve the state of interoperability while minimizing requirements that burden clinicians. Clinicians still report that Continuity of Care Documents (CCD) are still too bulky and are not easily ingested by a receiving provider's EHR. Clinical decision support (CDS) may contain information needed to treat patients with SUDs and OUDs; however, without a way to seamlessly integrate the information into the EHR, clinicians cannot get a holistic picture of a patient's health. Unfortunately, CMS requirements in MIPS and the Meaningful Use program still operate under the assumption that sending and receiving CCD's drives interoperability.

Question 5: How can Medicare or Medicaid better prevent, identify and educate health professionals who have high prescribing patterns of opioids?

Since nearly half of all opioid overdose deaths involve a prescription opioid, CHIME believes there is an important role for technology to play in helping prevent, identify and educate those prescribing opioids and other substances. Examples of ways this can occur are described below.

- **Better integration of EHRs with prescription drug monitoring programs (PDMPs):** Today, oftentimes the information offered to a clinician in a PDMP is presented in a disjointed manner, requiring the prescriber to take additional steps to review past scripts from other healthcare providers. This creates a fragmented picture for clinicians and results in data that is not integrated seamlessly within an EHR. It also creates an additional barrier to interoperability. According to the CDC, "Clinicians do not consistently use practices intended to decrease the risk for misuse, such as PDMPs, urine drug testing, and opioid treatment agreements. This is likely due in part to challenges related to registering for PDMP access and logging into the PDMP (which can interrupt normal clinical workflow if data are not integrated into electronic health record systems)."[3]
- **Data-driven reports to identify scribing patterns can be used:** Data collection efforts should be encouraged among healthcare providers to help ascertain who the highest prescribers are and to deduce patterns and abuse concerns.
- **Using CDS to offer evidence-based treatment:** CDS should offer appropriate evidence-based treatment options, which may or may not involve the scripting of an opioid or controlled substance. Properly developed and used CDS can help those treating patients on opioids and those for whom they are considering prescribing them. For example, CDS can help prescribers determine how many doses are included every time a prescription is ordered. It can also help with offering other treatment options. Furthermore, it can be used to promote use guidelines. The CDC's opioid toolkit (referenced above) published in 2016, represents guidelines for prescribing opioids for chronic pain. CDC has said, "Activities such as development of clinical decision support in electronic health records to assist clinicians' treatment

[2] Guideline Resources: CDC Opioid Guideline Mobile App, https://www.cdc.gov/drugoverdose/prescribing/app.html.
[3] CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016, Recommendations and Reports / March 18, 2016 / 65(1);1–49, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

decisions at the point of care; identification of mechanisms that insurers and pharmacy benefit plan managers can use to promote safer prescribing within plans; and development of clinical quality improvement measures and initiatives to improve prescribing and patient care within health systems have promise for increasing guideline adoption and improving practice."[4] In addition, CDS is one piece of the EHRs; these systems overall need to be able to better support a more holistic approach to managing and treating addiction as a disease.

- **Consent policy:** The exchange of data among providers in various locations and settings will require the harmonization of state and federal privacy laws. As an example, consent policy varies by jurisdiction and personal health information (PHI) type, and like most privacy policies, there is no national consent policy. Aligning privacy and consent policies that enable cross border exchange of health information in a secure manner would be very helpful in coordinating care. Also, there are persisting challenges with separating out mental disorders and substance abuse issues from the rest of the electronic record. For example, a CCD is often imported as a PDF and may include elements of substance abuse or mental health in the past medical history section or medication or problem list. Often it is insufficiently granular and not easy to take out or leave in; as one clinician explained, "It can be all or none." Finally, incongruencies between the Substance Abuse and Mental Health Services Administration (SAMHSA) rules around 42 CFR Part 2 and the Health Insurance Portability and Accountability Act (HIPAA) rules must be ironed out if information is to flow more seamlessly.
- **Look to best practices in the provider community:** CMS should be encouraged to work collaboratively with the provider community and other stakeholders to learn from best practices in play. CHIME, through its Opioid Task Force, is seeking out those in our community who are employing models that are working and will work to raise awareness. One example can be found at Geisinger Health System[5] where they:
    - Have cut in half the number of opioid prescriptions ordered each month over the past three years by pioneering solutions that rely on technology;
    - Are using an electronic dashboard that helps track electronic prescriptions of controlled substances;
    - Require prescribers to consult their state PDMP and document in the EHR; and
    - Are exploring the use of wearable technology to measure pain through the use of a mobile app.
- **Increasing Use of Telehealth:** We are very pleased that the Bipartisan Budget Act of 2018 includes support for teledialysis, telestroke and telehealth use in Medicare managed care. We believe that extending telehealth services even further could benefit those afflicted with OUD and SUD. A logical next step could be to ensure that federally qualified health centers (FQHCs) are permitted to bill for telehealth visits rather than being restricted to in-person ones. Doing so could expand access to patients in underserved areas who could benefit from opioid addiction treatment.

Question 6: What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as the Prescription Drug Monitoring Programs?

There are two areas where we think data sharing could be improved between Medicare, Medicaid and state initiatives.

First, CHIME has long contended that without the ability to accurately match patients with their records, that this will continue to serve as a threat to patient safety and will continue to hinder interoperability. We believe that the lack of a consistent patient identity matching strategy is the most significant challenge inhibiting the safe and secure electronic exchange of health information, and we continue to recommend the removal of the prohibition barring federal regulators from identifying standards to improve positive patient identification. Without a consistent patient identity matching strategy, the creation of a longitudinal care record is simply not feasible. A longitudinal healthcare record, supported by widely adopted standards, also should improve a patient's ability to manage consent privileges and diminish privacy concerns related to the digitization of personal health information (PHI).

Second, the ease with which clinicians can refer to PDMPs must be streamlined. Prescribers need seamless access to data to facilitate better patient outcomes. Unfortunately, as noted above, there continues to be challenges integrating EHRs with PDMPs. Some state laws restrict access to prescribing data; clinicians in some cases may be able to view prescribing data but are prohibited from truly accessing it and sharing it. Therefore, some clinicians, while given a "snapshot" in time of a patient's prescription history, are even prohibited from taking

[4] CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016, Recommendations and Reports / March 18, 2016 / 65(1);1–49, https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

[5] https://www.healthdatamanagement.com/news/geisinger-slashes-opioid-prescriptions-in-half-using-dashboard-for-docs

screen shots, further hampering their ability to incorporate the information into the medical record. Therefore, removing restrictions around sharing information contained in PDMPs is critical to quality care. State governance rules can therefore be barriers to facilitating data sharing and a barrier to interoperability. Unless the barriers at the local level can be overcome, prescribers will continue to have an incomplete picture of a patient. These obstacles amount to a serious patient safety issue and until corrected will plague prescribers' ability to treat patients holistically.

Conclusion

CHIME commends the committee for its leadership and willingness to engage stakeholder on this critical public health issue facing our country. Should you have questions about our remarks or require additional information, please contact us at policy@chimecentral.org.

Sincerely,

Russell Branzell, FCHIME, CHCIO
CEO & President, CHIME

Cletis Earle
Chair, CHIME Board of Trustees
Vice President and CIO Information Technology
Kaleida Health