Statement of the College of Healthcare Information Management Executives

Senate Committee on Health, Education, Labor & Pensions

Hearing on "The Opioid Crisis: The Role of Technology and Data in Preventing and Treating Addiction"

320 Dirksen Senate Office Building

February 27, 2018

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to submit a statement for the record for the February 27, 2018, hearing entitled, "**The Opioid Crisis: The Role of Technology and Data in Preventing and Treating Addiction**." 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] They are also the leading cause of death for people under 50.

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. 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 identifying ways to use technology and data analytics to promote solutions.

Some proactive providers have recognized that reducing the exposure of patients to addictive opioid drugs from the onset can help stem the tide of addiction. We are in the midst of gathering data and information on best practices around these types of interventions and hope to be able to make this information available soon. In the meantime, we are pleased to offer the below ideas for consideration.

1. **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. Healthcare providers working in partnership with developers can address this together to create more user-friendly tools. 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. 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 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.

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

PDMPs generally fall under the purview of state medical licensing or pharmacy governance boards. The National Association of the Boards of Pharmacy (NABP) oversees and manages "PMP Interconnect", the only existing national network for state-based PMPs. PMP Interconnect allows participating states to access PDMP data from other participants. Agreements between states and the NABP may place limits on how the states can provide access to PDMP data to entities outside PMP Interconnect yet maintain states' ability to access data via the PMP Interconnect network. Finally, -complete data capture of a patient's opioid history may extend outside traditional sources of PHI (e.g., transitional housing, emergency medical services records), further complicating data exchange.

2. **Focusing on interoperability:** ONC, together with the Centers for Medicare and Medicaid Services (CMS) 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 afflicted with an opioid addiction; 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. Application programming interfaces (APIs) hold promise, however, interoperability will only be achieved if there are uniform standards used by the industry.

3. **Using CDS to offer evidence-based treatment:** Clinical decision support (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.[2] 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.

4. **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. Finally, incongruencies between the Substance Abuse and Mental Health Services Administration (SAMHSA) rules around 42 CFR Part 2 and the Health Insurance

[2] 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.

Portability and Accountability Act (HIPAA) rules must be ironed out if information is to flow more seamlessly.

5. **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 expanding the use of telehealth can also help provide better access to care for those battling an opioid addiction. This can include, among other things, allowing federally qualified health centers (FQHCs) to be permitted to bill for telehealth visits rather than being restricted to in-person ones, and expanding the use of telehealth under the Federal Communications Commissions' (FCC) Rural Health Care (RHC) Program.

6. **Patient Identification:** 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. As a preliminary matter, it is critical that we identify and treat the correct patient. 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).