March 15, 2018

Kevin Brady, Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Peter J. Roskam, Chairman
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

Richard Neal, Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, DC 20515

Sander Levin, Ranking Member
Committee on Ways and Means
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

Submitted electronically to:
WMOpioidSubmissions@mail.house.gov

Re: Response to Request for Policy Recommendations Around the Opioid Crisis

Dear Chairman Brady, Chairman Roskam, Ranking Member Neal, and Ranking Member Levin:

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to respond to the Committee's request for feedback from stakeholders intended to inform its efforts to address the opioid crisis. We appreciate the Committee's interest in stemming the opioid epidemic that claimed the lives of 42,249 Americans in 2016, a number five times higher than in 1999.[1]

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

[1] https://www.cdc.gov/drugoverdose/epidemic/index.html

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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 CIOs and senior health IT leaders on how technology can be leveraged to curb this devastating epidemic. Recently, CHIME launched an Opioid Task Force with the intention of identifying ways to use technology and data analytics to promote solutions. We are pleased to offer the following ideas for your consideration.

Overprescribing / Data Tracking

Prescription Drug Monitoring Programs (PDMPs) data-sharing (Question 6):

As the Committee request for information observes, CMS currently does not have access to state PDMPs. The Committee seeks input regarding state PDMP data sharing with CMS and other healthcare entities, and on potential barriers to implementation.

CHIME sees two areas where data sharing between state PDMPs and other healthcare entities could be improved. First, the lack of a consistent patient identity matching strategy is the most significant challenge inhibiting the safe and secure electronic exchange of health information. To address this, we continue to recommend the removal of the [funding] 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 would improve a patient's ability to manage consent privileges (for others to access their records) and diminish privacy concerns related to the digitization of personal health information (PHI).

Second, clinicians' access to PDMP information must be streamlined. Prescribers need seamless access to data in order to facilitate better patient outcomes. Unfortunately, there continue to be challenges integrating electronic health records (EHRs) with PDMPs. State rules can be barriers to facilitating data sharing and interoperability. For example, some state laws restrict access to prescribing data such that clinicians may be able to view prescribing data but are prohibited from truly accessing it and sharing it. Sometimes in these cases, clinicians are given a "snapshot" in time of a patient's prescription history, but are prohibited from taking screenshots of this information, hampering their ability to incorporate it into the medical record. Removing these types of restrictions around sharing information contained in PDMPs is critical to quality care. Unless the barriers at the local level can be overcome, prescribers will continue to have an incomplete picture of a patient's opioid use history and current prescriptions. These obstacles create a serious patient safety risk; until resolved, they will degrade the ability of all clinicians caring for a patient to provide fully informed and appropriate opioid treatment.

Also, even where information is made available to clinicians through a PDMP, it oftentimes is presented in a disjointed manner, requiring them to take additional steps to review past prescriptions from other healthcare providers. Healthcare providers working in partnership with developers can address the work flow barriers by creating more user-friendly tools. Fragmented records cause an incoherent picture for clinicians, resulting in data not appropriately integrated within an EHR which creates an additional barrier to interoperability.

Finally, 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 prescription monitoring programs (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. Complete data capture of a patient's opioid history may require data acquisition from nontraditional sources of PHI (e.g., transitional housing, emergency medical services records), further complicating data exchange.

Best practices and policies that can modify prescribing behavior (Question 1):

Improving interoperability in general: The degree to which our healthcare system is interoperable and healthcare providers are able to seamlessly send and receive patient information electronically is integral to helping curb the opioid crisis. CHIME appreciates the Administration has committed to streamlining the requirements in the Merit-based Incentive Payment System (MIPS) and the Medicare EHR Incentive Payment Programs ("Meaningful Use") and will focus on putting patients at the center of their care. The Meaningful Use requirements still operate under the assumption that sending and receiving Continuity of Care Documents (CCDs) drives interoperability. We agree that application programming interfaces (APIs) hold promise, however, interoperability will only be achieved if there are uniform standards used across the industry.

Using Clinical Decision Support (CDS) and Data-Driven Prescribing Reports: CHIME believes that if properly developed and used, CDS can help those treating patients on opioids and those for whom clinicians are considering prescribing opioids. However, without a way to seamlessly integrate the information into the EHR, clinicians cannot get a complete picture of a patient's health. CDS should offer appropriate evidence-based treatment options, which may or may not involve the prescribing of an opioid or controlled substance. For example, CDS can help prescribers determine how many doses are included every time a prescription is ordered. It can also help with offering alternative treatment options. Furthermore, it can be used to promote guidelines for opioid use, such as the CDC's opioid toolkit referenced above. However, CDS and EHRs need to function together more effectively in support of a more holistic approach to preventing, managing and treating addiction as a disease.

In addition, data collection efforts should be encouraged among healthcare plans and providers to help identify pattern and abuse concerns and to target provider education at high volume prescribers. CMS should strongly consider urging data collection and sharing by healthcare plans and providers to identify patterns of potential abuse and inappropriate prescribing.

Increasing Use of Telehealth for Opioid Treatment: 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 opioid use disorder and other substance use disorders. A logical next step could be to ensure that federally qualified health centers (FQHCs) are permitted to bill Medicare for telehealth visits in addition to in-person visits. Doing so could expand access to Medicare beneficiaries in underserved areas who could benefit from opioid addiction treatment as well as other healthcare services.

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. There are persisting challenges with separating out mental disorders and substance abuse issues from the rest of the electronic record. For example, a Continuity of Care Document (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, yet the PDF can only be incorporated in its entirety into the EHR. As a result, unintended access may be provided to sensitive information or important other PHI may not be incorporated into the EHR. 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. For instance, the 42CFR Part 2 rules prevent caregivers from sharing treatment data with very specific written consent from the patient.

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 already in play. CHIME, through its Opioid Task Force, is seeking out those in our community who are employing models to

reduce opioid addiction and mortality and we are raising awareness of the epidemic. One example can be found at Geisinger Health System[2] 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.

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

[2] See https://www.healthdatamanagement.com/news/geisinger-slashes-opioid-prescriptions-in-half-using-dashboard-for-docs, December 2017.