Statement of the College of Healthcare Information Management Executives

Senate Committee on Health, Education, Labor & Pensions

Hearing on "The Opioid Crisis Response Act of 2018"

320 Dirksen Senate Office Building

April 11, 2018

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to lend our voice to the important national dialogue concerning 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] To that end, we are pleased to offer our perspective on H.R. 3528, Every Prescription Conveyed Securely Act, as well as, the Committee's discussion draft on prescription drug monitoring programs (PDMPs).

CHIME is an executive organization dedicated to serving chief information officers (CIOs), chief medical information officers (CMIOs), chief nursing information officers (CNIOs) and other senior healthcare IT leaders. With more than 2,600 members in 51 countries and over 150 healthcare IT business partners, CHIME provides a highly interactive, trusted environment enabling senior professional and industry leaders to collaborate; exchange best practices; address professional development needs; and advocate the effective use of information management to improve the health and healthcare in the communities they serve.

CHIME's Opioid Task Force is undertaking several initiatives aimed at curbing the pattern of addiction, including reviewing the impact of technology and data driven solutions. As the Committee deliberates the myriad ideas, bills and options for reducing the devastating effect of this national epidemic, we offer the following input for your consideration.

Sec. 505. Preventing overdoses of controlled substances.

CHIME appreciates the Committee's focus on prevention activities and Section 505 which calls for authorizing the Centers for Disease Control and Prevention (CDC) to execute prevention activities such as offering grants to states, localities and Indian tribes to carry out prevention activities. As described in this provision, this would include activities, "to improve the efficiency and use of a new or currently operating prescription drug monitoring program."

Our members believe there is tremendous value in leveraging PDMPs. We applaud the Committee for their focus on improving PDMPs and increasing use of these systems. Our

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

members believe that better integration with electronic health records will facilitate more use of PDMPs. According to the Pew Charitable Trusts, 24 states have no access to integration solution. To that end, we believe better integration is possible if:

1. States make available to providers open application programming interfaces (APIs) to allow a more seamless integration with providers' electronic health records (EHRs);
2. Minimum data sharing standards are established;
3. More consistency around when prescription data is loaded into PDMPs and thus available to prescribers – a good first step is reviewing trending data to determine the extent of variations;
4. Data contained in PDMPs is available to be imported into EHRs in granular detail. Integration with clinical decision support is needed to help facilitate prescribers' ability to run reports (i.e. lists in the PDMP view lists and running analytics). It could also help address concerns prescribers have around acting on decisions (and thus possible downstream liability issues) based on data that was available only to be "viewed" but never able to be incorporated into the medical record;
5. Proxy access for medical staff to access PDMPs to flag issues prior to a visit, as well as, allowing clinicians to have the data in a time efficient manner;
6. Transparency around how PDMP software scoring (i.e. algorithms that predict the potential for addiction);
7. Funding is available to help offset connection costs for providers; and
8. Alerts sent to prescribers flagging patients with a history of opioid use / dependence could also be helpful. However, this could run afoul of 42 CFR Part 2 (consent rules for sharing mental health and substance abuse information). Further, until 42 CFR Part 2 and Health Insurance Portability and Accountability Act (HIPAA) are aligned, sharing patient's information on opioid use will present challenges.

We thus agree with the Committee's discussion draft language which encourages the analysis of PDMP data for the purposes of engaging in prevention activities including:

- Awarding grants to localities;
- Encouraging "authorized users" to register with and use these systems;
- Enabling users to receive data updates as close to real-time as possible;
- Providing reports to localities and licensing boards to prevent inappropriate prescribing / misuse / drug diversion provided such agencies and boards maintain data use agreements with programs;
- Enhancing interoperability between the program and any health information technology (including certified health information technology), including by integrating program data into such technology;

- Updating program capabilities to respond to technological innovation to address the occurrence and evolution of controlled substance overdoses; and
- Facilitating and encouraging data exchange between the program and the prescription drug monitoring programs of other States.

We also appreciate that the discussion draft calls for allowing the CDC to carry out innovative projects for grantees to, "rapidly respond to controlled substance misuse, abuse, and overdoses, including changes in patterns of controlled substance use," and for any other evidence-based activities deemed appropriate by the CDC. We believe two such areas that could be considered appropriate for inclusions are grants that support:

- Providers' use of PDMPs by helping defray some of the costs providers experience in connecting with PDMPs. For example, Ohio has offered these types of grants;
- Providers' use of technology to correctly match patients with their records. The lack of a consistent patient identity matching strategy is the most significant challenge inhibiting the safe and secure electronic exchange of health information. The ability to do so continues to be hampered by the funding prohibition barring federal regulators from identifying standards to improve positive patient identification. Therefore, evidence-based grants could be a critical driver to ensuring that we consistently identify and respond appropriately to the right patient and the right drug use patterns.

Section 507: Jessie's Law

CHIME is pleased to see the Committee moving to codify "Jessie's law." We are supportive that it was included as report language in the 2018 Omnibus bill, however, we believe codifying is important to ensuring Congress' intent is indeed met.

Section 507 would codify Jessie's Law with the objective of ensuring prescribers have the information they need on a patient's opioid addiction history to avert situations where prescribing more opioids could lead to overdose and possible death. Named after Jessie Grub, a patient who died after being prescribed opioids by a clinician who did not have access to her opioid history, this provision marks an important step forward in furthering important information sharing at the point of care. The provision would call for the information to be "prominently displayed in the medical records (including electronic health records) of such patient" if the patient consented to sharing this information.

Specifically, we support the language included in this provision that calls for the U.S. Department of Health & Human Services (HHS) to consult with various stakeholders such as EHR experts and healthcare providers to develop best practices including:

- The circumstances under which information that a patient has provided to a healthcare provider regarding such patient's history of opioid use disorder should,

only at the patient's request, be prominently displayed in the medical records (including electronic health records) of such patient; and

- What constitutes the patient's request for sharing that information; and
- The process and methods by which the information should be so displayed.

While we support the language in Section 507 and appreciate this provision marks an important step forward for sharing a patients' opioid addiction history, we still worry that inconsistencies around how consent is managed – as noted earlier – between 42 CRF Part 2 and HIPAA will continue to present challenges for information sharing.

Conclusion

CHIME commends the Committee for its leadership and willingness to engage stakeholders 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.