Statement of the College of Healthcare Information Management Executives

Committee on Energy & Commerce Subcommittee on Health

Hearing on "Combating the Opioid Crisis: Improving the Ability of Medicare and Medicaid to Provide Care for Patients"

Rayburn House Office Building, Room 2322

April 11, 2018

The College of Healthcare Information Management Executives (CHIME) welcomes the opportunity to lend our voice to the important national dialogue addressing 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 provider 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 driving down the speed with which this disease is gripping our country, we offer the following input for your consideration.

H.R. 3528, Every Prescription Conveyed Securely Act

Our members recognize the value and importance of prescribing controlled substances electronically and *agree that f*acilitating more use of EPCS can help combat the opioid epidemic. As of 2015, all states now allow for EPCS, yet the number of non-controlled substances which are sent electronically as compared to controlled substances sent electronically, is far greater. According to SureScripts data, the rates of clinicians scripting controlled substances electronically range between widely between 3.6% to 73.4%.

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

Our members have invested heavily in certified electronic health records which are required to support electronic prescribing of controlled substances. We recognize, however, that some vendors may be better equipped at supporting a single workflow.

Based upon data shared some of our of members in New York State, the first state in the nation to require their prescribers to script controlled substances electronically, they found:

- 73% reduction in lost or stolen narcotics
- 70% reduction in paper scripts
- Ability to monitor opioid scripts by provider (authenticated/registered) and patient to monitor for "frequent flyers" and patterns of behaviors
- Providers can use portals to see patient uses of narcotics before prescribing
- Ability to monitor medical marijuana dispensing and use

Additionally, data conducted by the Pew Charitable Trusts found that, "After the implementation of use mandates, prescriber PDMP registrations increased in all three case study states (Kentucky, New York, and Ohio), as did requests for the controlled substance prescription histories of patients. For example, in New York, PDMP report requests increased from an average of 11,000 per month to 1.2 million per month in the six months after the mandate went into effect."[2]

While the bill calls for adoption of EPCS in less than two years by January 1, 2020, we appreciate that the H.R.3528 has eight different waivers, and that lawmakers have considered a variety of scenarios in which mandating e-prescribing of a controlled substance may not be appropriate or feasible.

Prescription Drug Monitoring Programs

Our members appreciate the Committee's attention to the importance of PDMPs and how they can be used to help address the opioid crisis. We furthermore appreciate that the Committee is looking to provider leaders in the space like Geisinger Health System in Pennsylvania. 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.

Our members believe that it is critical to facilitate more use of PDMPs that better integrate with electronic health records. According to the Pew Charitable Trusts, 24 states have no access to integration solutions.[3]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;

[2] http://www.pewtrusts.org/~/media/assets/2016/12/prescription_drug_monitoring_programs.pdf
[3] http://www.pdmpassist.org/pdf/PDMP_Integration_Status_20171205.pdf

3. More consistency around when prescription data is loaded into PDMPs and thus available to prescribers. A good first step is to review 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 only available 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. H.R. 3545, the Overdose Prevention and Patient Safety Act, if adopted, would address this situation by allowing substance abuse disorder information to be shared according to the same rules that govern HIPAA.

Discussion Draft to authorize CDC to conduct prevention activities related to controlled substances overdoses

The discussion draft aimed at authorizing, "the Centers for Disease Control and Prevention to carry out certain activities to prevent controlled substances overdoses, and for other purposes," takes aim at prevention and CHIME supports the notion of funding prevention through evidence-based grants, including activities designed to help states improve the efficiency of their PDMPs.

We are particularly pleased to see it would help support efforts to improve interoperability between PDMPs and EHRs to improve clinical decision-making. Furthermore, we believe the bill's support for evidence-based activities, which centers around facilitating information sharing between/among neighboring states, is also highly desirable. Finally, we are pleased to see the bill would also encourage the use of evidence-based grants in an effort to align controlled substances guidelines. We believe that more uniform use of the CDC's guidelines, especially through clinical decision-support and their mobile app, will be helpful. As the Committee considers grants, we hope they will also consider the utility of:

- Helping 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;
- Correctly matching 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.

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