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February 16, 2018

United States Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden,

On behalf of the more than 30 members of the Electronic Health Record Association (EHRA), we are pleased to offer our input in relation to the Committee's February 2, 2018 request for feedback regarding policy options to address the opioid epidemic.

EHRA members serve the vast majority of hospitals and ambulatory care organizations that use electronic health records (EHRs) and other health information technology to deliver high quality, efficient care to their patients. The Association operates on the premise that the rapid, widespread adoption of health IT has and will continue to help improve the quality of patient care as well as the productivity and sustainability of the healthcare system.

We see many hopeful signs of progress in the fight against opioid abuse, particularly in the improved awareness of the medical community and the public, and in states taking thoughtful and proactive steps in issuing and enforcing guidelines. Information technology, such as EHRs, information exchange solutions and Prescription Drug Monitoring Programs (PDMPs), are already playing a key role in addressing the opioid crisis. To that end, the EHR Association recently formed an Opioid Crisis Task Force, which has begun looking into how EHRs can be part of the solution.

In the Committee's request for feedback, you provided eight questions for which you're seeking input. We believe that our association is well-positioned to speak to two of them.

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

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February 16, 2018

- Tracking patterns of opioids prescribed electronically at the organizational or individual provider level should already be feasible, given that those prescriptions are captured in EHRs (which can be used to run reports) and are increasingly transmitted through intermediaries (such as Surescripts) to the pharmacy. Prescriptions initiated within the EHR but printed (where electronic transmission is not legal or otherwise enabled) are also reportable from the EHR. Certainly, too, in states with PDMPs or Electronic Prescriptions for Controlled Substances (EPCS) systems already live, those centralized data warehouses are good resources to identify prescribing patterns.

- Encourage CMS to enable access to Medicaid and Medicare episode data, correlated with PDMP data, for both providers and public health entities. For example, correlating Medicaid Emergency Department visit behavior with pharmacy fill behavior, or elective surgery patterns with pharmacy fill behavior and Emergency Department visits related to post-surgery pain. Associating and reporting on those correlations, among others, would allow identification of patterns earlier than is currently taking place.

- Encourage the incorporation of pain management Clinical Decision Support (CDS) tools into the EHR, at the point at which prescribing decisions are being made. For example, CDS could be implemented to recommend a limited initial prescription of a few days, remind the clinician to discuss birth control with female patients taking opioids, and alert for potential medication interactions. Standardized e-specs for new CDS (similar to electronic Clinical Quality Measures) would be a powerful tool in enabling widespread adoption of best practices pain management guidelines and PDMP access within EHRs.

- Encourage the creation of a national clearinghouse for peer-reviewed best practices for pain management and addiction management. Providers currently do not feel they have easy access to evidence-based practices, even where they exist (e.g. DoD/VA opioid chronic pain management guidelines), and it is clear that such resources also need to be significantly expanded. Further, converting such content to e-specs (similar to the description above) would dramatically ease adoption by EHRs and allow us, as developers, to rapidly make them available to clinicians at the point of care.

- Almost 10 percent of drugs diverted for abuse are tied to fraud or forgery of paper prescriptions. We strongly suggest that Congress prioritize the removal of barriers to EPCS technology, such as disparate approaches to authentication and lagging adoption by small, independent pharmacies and, instead, pass a law requiring its adoption nationwide. EPCS technology is available within EHRs today and receivable by more than 90 percent of pharmacies, according to Surescripts, but provider utilization is just 17 percent.

- Create quality measures reportable to CMS related to opioid prescribing and general pain management practices. Such an item or items could be added easily to a dashboard in the EHR to encourage adherence to best practices for increased compliance score and increased accountability.

Standardized compliance metrics would give providers the appropriate target, and developers would also have the necessary guidance in developing the calculations and visualizations to display feedback to providers. Such consistent guidance and metrics are currently lacking.

- Monitor Medicare and Medicaid claims to identify post-surgical chronic pain (i.e. post-surgery pain lasting three months or longer and/or which is not expected to improve, per the International Association for the Study of Pain (IASP) definition) that is being managed by a surgeon instead of a pain specialist. If a surgeon continues to prescribe opioids after 90 days, by definition this is no longer acute pain being managed. The beneficiary should also have an active diagnosis of chronic pain and be on a pain management agreement.

- Encourage PDMP access through the EHR, within the clinical workflow. This requires integration steps taken by both EHR companies and PDMP vendors, but such information access within the workflow will minimize provider burden as this process becomes more commonplace.

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

- Currently, there is a notable and problematic lack of standardization among states when it comes to their approaches to combat the opioid epidemic. There are many sizes and shapes when evaluating the state-to-state landscape, including technical approaches, privacy and security rules, as well as both limitations and requirements associated with the data fields that are to be exchanged. This is rapidly leading to inconsistent workflows for providers, a higher cost to ensure compliance, and opportunities for drug seekers to cross state lines when they know that the state databases are not connected.

- We believe it would be very helpful to create a central hub of opioid prescribing data that could be "pinged" by the provider in place of individual state-level PDMPs, and we strongly suggest that unified standards for PDMP access be developed by standards development organizations and promulgated by regulators. Standardized regulations at the federal level will help drive down costs and improve clinical outcomes.

- Require that vendors for the PDMPs establish connections between the various PDMP databases. Some providers are concerned with the market dominance of a single PDMP vendor, believing it is limiting their negotiating power.

- Encourage or even require the states to take a more standardized approach to the exchange of opioid data so that neighboring and other states can check with one another to identify problematic behavior. Currently, many states intentionally do not allow such checks to take place, dramatically increasing the chances of cross-state drug purchases.

Thank you for this opportunity to share our expertise. We would be happy to discuss our recommendations with your staff. If you have any questions, please contact Leigh Burchell, Chair of the EHRA Opioid Crisis Task Force, at leigh.burchell@allscripts.com or Sarah Willis-Garcia, EHRA Program Manager, at swillis@himss.org.

Sincerely,

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