State Policymaking and Prescription Drug–Monitoring Programs: A Look Ahead

See also Holmgren et al., p. 1191.

"A History of Prescription Drug Monitoring Programs in the United States" by Holmgren et al. in this issue of *AJPH* (p. 1191) describes the past, present, and potential future of prescription drug–monitoring program (PDMP) use our nation. The article valuably chronicles the tension confronting public health practitioners, health care providers, and state policymakers in the adoption and implementation of a significant tool for understanding and addressing the opioid crisis in the states and territories. This tension results from policy debates concerning whether a PDMP should be used as a tool for public health surveillance and community health promotion ("preventative") or as a tool for law enforcement or licensing boards to identify and punish criminal behavior, including aberrant prescribing and patient doctor shopping ("punitive").

Having lobbied for the modernization of Pennsylvania's PDMP while serving as executive vice-president of that state's medical society (2013–2016), I can attest firsthand to how the preventative versus punitive tension surrounded PDMP policymaking in the second to last of the 50 states to update and upgrade its PDMP. This included taking friendly and unfriendly fire in legislative battles over moving PDMP administration from the Office of the Attorney General to the Department of Health as well as considering its voluntary versus compulsory use, who gets access to what is in the PDMP and when, who pays for the PDMP, what training is required of prescribers to use it, how to sanction aberrant prescribing behavior, and how to address patient "doctor shopping." Holmgren et al. suggest that there has been less critical review of or controversy over national PDMP policymaking than other facets of the opioid crisis such as syringe services programs or safe injection sites. Agreed. But state and territorial level debates over PDMPs have been, and are, fierce. Walt Whitman wrote, "The real war will never get in the books."[1] This is certainly true of many contentious and controversial legislative fights over PDMPs.

How can we use the helpful history of Holmgren et al. to inform the future of PDMPs? If the past is prologue, the future will be characterized by a continued evolution of policies that attempt to balance the preventative versus punitive tension they describe. Future research questions worthy of mention in an update to their history might include which states have what kinds of restrictions on PDMP use and what might explain that variation. That could include state-specific politics, the other legislative or policy battles raging in the state during PDMP reform efforts, narratives about the role of the state and federal government in decision making, and the never to be ignored role of lobbying groups in influencing policy outcomes, including patient groups, privacy advocates, medical associations, independent physicians, pharmacists, technology companies, and others with valid stakeholder interests in PDMP policy.

Several factors will affect the future of PDMPs in significant ways. First, the market for state PDMPs is consolidating quickly toward a single supplier. Appriss Health now runs 30 PDMPs,[2] and states have the choice of just two dominant systems to promote cross-jurisdictional sharing of data (RxCheck and PMP Interconnect). What this means for future state policymaking is not clear, but less choice often brings higher prices. That could mean potential constraints to future functionality or customizations to address state-specific contextual or community needs, as they might be prohibitively expensive or unworkable for a multistate platform.

Second, every state legislature and governor ultimately decides the specific administrative agency home for its PDMP, the schedules of drugs covered, the frequency of data collection and periodicity of reporting, who has to enroll in the system, and whether enrollment in the system is mandatory or voluntary.[3] State policymaking on these issues, especially the question of voluntary or mandatory prescriber use and timeliness of reporting, may have a profound impact on a PDMP's utility as both a state and national tool for public health surveillance, clinical decision making, and law enforcement.

Most of the 53 state and territorial PDMPs are operated by state or territorial boards of pharmacy (n = 20) and departments of health (n = 18), followed by professional licensing agencies (n = 6), law enforcement agencies (n = 4), substance abuse agencies (n = 4), and a state consumer protection agency

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(n = 1).[3] There is no one-size-fits-all PDMP, and every state and territorial has developed the system it believes will work for its specific context. Continued heterogeneity in approach can be assumed as states continue to administer, retool, and reform their PDMPs. But as more states link and share their PDMP data, this diversity will need to be addressed by creating uniform standards for reporting between states. Are we moving toward a new, centralized federal PDMP or a more robust integrated national system of connected state and territorial PDMPs? Time will tell, but both approaches have their advantages and disadvantages (and their supporters and opposers).

Further integration of state PDMPs with electronic health records may suggest a coming coalescence around the preventative approach to PMPDs. A barrier to PDMP use has been prescriber utilization, primarily because many state PDMPs require accessing Web sites or portals outside of individual providers' or health plans' electronic health record systems. Working PDMPs into the clinical workflow may increase prescriber utilization but can also increase the risk of unintentional data sharing, raise questions about the costs of system upgrades and enhancements, and conflict with how and why the PDMP in a particular state might have been established in the first place.

Ultimately, I believe the next history of PDMPs will show that we expected far too much from them. Expecting PDMPs to control prescriber behavior and help prescribers become better stewards of a potentially addictive substance is reasonable (by the way, why haven't we tried this with antibiotic stewardship?)[4]; expecting PDMPs to prevent opioid addiction and overdose is not. Are PDMPs one of several different clinical tools to assess and screen patients for substance misuse risk and to encourage referral to treatment?[5] Absolutely. Are they an effective means for the primary prevention of addiction? Most likely not.[6]

Just as a carpenter may view most problems as solvable with a hammer, many policymakers have viewed PDMPs as a primary solution to the complex problem of addiction. Systems thinkers know that complex problems require complex solutions.[7] The opioid misuse crisis has been years in the making for reasons that go far beyond the health care and public health systems creation of PDMPs in the United States. Attention to PDMPs as a principal tool for the prevention of opioid misuse and overdose is misplaced. Instead, it would be wiser to focus on policies that expand evidence-based, community-led efforts to create the vital, vibrant local conditions for community health and wellness. These efforts, and their robust evaluation, will be excellent and complementary additions to future histories of PDMPs and our national effort to end the opioid epidemic. AJPH

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CONFLICTS OF INTEREST

The author has no conflicts of interest to declare.

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