Public Policy Statement on Refocusing Prescription Drug Monitoring Programs (PDMPs) to Serve Public Health

Introduction

The American Society of Addiction Medicine supports a wide variety of effective measures to protect public and patient health and safety, which includes a proper role for Prescription Drug Monitoring Programs (PDMPs). PDMPs manage and collect data on dispensed prescription drugs with misuse potential in a state or territory. Now widely recognized public health tools, PDMPs provide insight into individual-level prescribing over time and epidemiological trends at the population-level.[1] Features of robust PDMPs reduce controlled substance prescribing associated with higher risk of adverse outcomes, and thus, can reduce substance-related harms, including misuse and overdose.[2–6] Without a public health focus, PDMPs may also have unintended consequences, such as shifting misuse of prescription opioids to more fatal heroin or fentanyl use.[7–10]

Background

PDMPs can promote safer prescribing and dispensing practices for controlled medications. States develop, operate, and manage PDMPs and house them among varying agencies – with different policy goals – that provide authorized individuals access to data, mainly prescribers and dispensers, as well as other requestors, such as treatment providers and drug courts.[11] Wide variation in state policy has created discrepancies in how PDMP data is accessed, provided, queried, and used.[12,13] Over time, many states have modified their PDMPs' features, and implemented individual features in clusters, possibly conflating the influence of single characteristics on prescribing and overdose.[14] Investigators, therefore, were prompted to characterize PDMPs' strength in scores of "robustness."[4] Despite this diversity, however, most states contract for PDMP services with one vendor.[15]

To reduce the administrative and other burdens on clinicians, PDMPs are commonly enhanced with data visualization tools, and aim to assist clinicians with drawing inferences from data for decision-making and patient communication.[16] For example, some states implement an algorithm provided by the vendor to represent patients' risk scores of overdose, and opioid, sedative, and stimulant misuse.[17] While that algorithm's complete list of weighted variables has not been published,[15] it is known that such risk scores increase with patients' rising numbers of prescribers, including within one system; pharmacies; overlapping prescriptions; and dosages of controlled medications and potentiating medications.[17] When assessed in the algorithm, however, such factors can be problematic for patients that consult numerous specialists or change residences through the continuum of medical care, including for SUD treatment.[15] Additional data that should be available to the algorithm, such as drug-related arrests, can

correlate with race, ethnicity, or socioeconomic status, and thus, may bias the algorithm's prediction of risk.[18] Without concurrent measures to mitigate algorithmic bias and ensure clinicians' awareness that risk scores not replace clinical judgement,[19] the common use of such algorithmic tools could compound existing barriers to accessing equitable care.[15,20,21]

PDMPs hold hundreds of millions of prescription records that allow authorized individuals to track medical information across clinicians and over time, and draw inferences about patients' highly sensitive medical conditions.[22] Importantly, the majority of states rely on relatively lenient legal mechanisms to protect significant privacy interests at stake, such as requiring law enforcement obtain only a subpoena to pursue evidence in an investigation.[22] The Fourth Amendment of the U.S. Constitution and relevant case law guarantee a reasonable expectation of privacy "against unreasonable searches and seizures" in electronic surveillance, and generally require law enforcement first obtain a search warrant to prevent arbitrary access or inappropriate use of sensitive medical data to target individuals for investigation.[23] Despite the importance of justification standards requiring demonstration of probable cause to obtain a search warrant, only nineteen states currently require one for evidence to be pursued in PDMPs,[24] and some courts have found patients have little or no reasonable expectation of privacy in their records held in PDMPs.[25]

Unraveling technological, legal, and political barriers to the establishment of uniform federal and state policies to enhance the effectiveness of PDMPs for research purposes can improve patient care and clinician utilization.[26] A critical factor to such uniformity is interstate data sharing, especially between programs among bordering states.[27] Education and peer-to-peer messaging may increase clinicians' PDMP utilization if accompanying PDMP registration or use mandates.[28] Improving data reporting timeliness, incorporating non-prescription related clinical data, and integrating PDMPs within the clinical workflow is in the interest of clinicians, patients, and public health.[29,30] Furthermore, the absence of methadone or buprenorphine dispensed by opioid treatment programs (OTPs) in the PDMP denies patients who seek care at OTPs and their medical teams the clinical benefits of PDMPs.

Recommendations

1) States' declared goals for PDMPs should be to promote public health, protect patients, and prevent overdose, for the purposes of legislation and regulations.[31]
    a. States should house PDMPs within public health agencies, rather than law enforcement agencies or justice departments, and should make PDMP data accessible to authorized clinicians and public health researchers.
2) Algorithms used by data visualization tools for patient risk scoring should be transparent, and such tools should be prospectively validated against clinical outcomes. They should not be used to replace clinical judgement or withhold appropriate treatment from patients, but to engage patients in care.
    a. Federal agencies should issue updated guidance on the use of patient risk scoring to clinicians, including, for patients classified as high risk, the use of additional screening and confirmation techniques, and initiation of evidence-based treatment, rather than reflexive termination of care.

3) States should prohibit law enforcement from accessing PDMP data, unless a search warrant supported by probable cause that an unlawful criminal act may have occurred has been obtained, and states should tightly regulate this process.
4) States should facilitate interstate data sharing, and at a minimum, have query and audit agreements with bordering states.[32]
5) States should establish universal integration of PDMP data with health information exchanges (HIE), electronic health records (EHR), and pharmacy dispensing systems (PDS).[32]
6) States should require and facilitate controlled medication prescribers' enrollment in and utilization of PDMPs, and allow their authorized delegates to query.
    a. States should provide educational feedback to prescribers with patterns that may be associated with a higher risk of adverse outcomes.
    b. States should fund and promote education for clinicians on effective patient engagement regarding potential substance misuse and SUD, including the risks of abrupt discontinuation of long-term prescribed medications (for example, opioid or benzodiazepine therapy).
    c. States should take educational, rather than punitive, approaches to support prescribers who do not enroll in or regularly query the PDMP as mandated.
7) States should optimize PDMPs for function, efficiency, data accuracy and timeliness, and clinical workflow integration.
8) States should require the inclusion of methadone and buprenorphine dispensed from OTPs in the medications reportable to PDMPs.
9) Methadone used for the treatment of addiction involving opioids, and buprenorphine, regardless of indication, should be explicitly excluded from morphine milligram equivalent (MME) calculations for the purposes of PDMPs that attempt to reduce overdose mortality by limiting or otherwise restriction MME.[33]

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