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Readers Write: Will PDMPs Remain a Vital Tool in the Opioid Response, or a Costly Burden?

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Will PDMPs Remain a Vital Tool in the Opioid Response, or a Costly Burden?
By David Finney

David Finney is a partner with Leap Orbit of Columbia, MD.

New battle lines are being drawn in an important corner of the nation's broad fight to control the opioid epidemic. Health IT professionals should sit up and take notice.

Much quiet maneuvering has been taking place for months, particularly among a number of large and well-connected technology vendors sensing a windfall. But with the recent signing into law of the $1.3 trillion federal omnibus spending package, the debate about what the future should look like for prescription drug monitoring programs (PDMPs) has burst into the open.

PDMPs — which are state-based systems for tracking and analyzing the prescribing and dispensing of controlled substances — have existed in some form for a century. Over the last 10 years, they have become more technologically sophisticated and are frequently pointed to as a critical (and mostly non-controversial) tool in the opioid response. Today, 49 states, the District of Columbia, Puerto Rico, and Guam have established PDMPs, while in Missouri, a PDMP instituted by St. Louis County serves most of the state's population.

In an increasing number of states—over 30—clinicians and pharmacists are required by law to check their PDMP prior to prescribing or dispensing any controlled substance. Though enforcement is so far minimal, failure to do so could result in suspension or loss of license. Among other emerging techniques, many states now also send unsolicited reports to prescribers, using PDMP data, demonstrating that their prescribing habits are outside the norms for their specialty.

The federal government has encouraged these policies with a steady and increasing stream of grant funding to states to cover software development, licenses, and IT staffing. Not surprisingly, the private sector recognized the opportunity. Appriss, a private equity-owned firm that got its start helping states monitor sex offenders, has been the chief beneficiary of this flow of government

dollars achieving a near monopoly in the state PDMP market by, among other things, acquiring its two largest competitors.

With 42 state contracts, Appriss has done what monopolists do, bidding up contract prices and seeking to monetize every aspect of the data it controls. Given the commitment by states and the federal government to "do whatever it takes" to address the opioid epidemic—including supporting PDMPs with ever-increasing grant funds—PDMP administrators may grumble, but otherwise few people have stopped and taken much notice.

Few, that is, except for several large healthcare and technology interests (increasingly those are one and the same) and the Washington lobbyists who work for them. Acting no doubt out of a genuine desire to positively impact the opioid epidemic, and also sensing a business opportunity, these interests have quietly been pushing Congress and the Trump administration to rethink the federal government's traditional support of PDMPs and "modernize" them.

How to do this? By awarding tens, if not hundreds, of millions of dollars in new federal contracts to one or a small number of firms to facilitate the flow of PDMP data at a national level. This new network would leverage existing prescription data feeds that support e-prescribing and third-party payment. Initially, this network might complement and enhance state PDMPs, but in the longer term, it seems likely to make them redundant.

By all indications, the federal omnibus spending bill and subsequent signals from federal officials and lobbyists seem poised to deliver on this new model. Not surprisingly, Appriss is worried. In recent weeks, it has launched a marketing campaign of its own to highlight the benefits of the current state-based approach to PDMPs and the interstate gateway it developed in collaboration with the National Association of Boards of Pharmacy.

Why should health IT professionals care? Frankly (and functionally), whether the nation continues with a states-based model for PDMPs or a federal one probably won't make a big difference to end users at hospitals, ambulatory practices, retail pharmacies, or other healthcare facilities. The more timely data offered by the federal model may offer some marginal benefit, but states have already been moving in that direction. In either case, though, the outcome is likely to hit the bottom lines of these organizations in a big way.

Already, as prescribers and dispensers are required by law to consult PDMP data, their IT departments face pressure to deliver the data to them in more workflow-friendly ways. Appriss has gladly obliged by presenting hospitals and health systems across the country with steep per-user, per-month fees to access the data it controls via its state contracts via APIs or single sign-on. These fees can reach seven figures per year for some health systems. A federally facilitated approach is likely to look no different—it would use established e-prescribing networks, whose business models are well known, to deliver PDMP data into the workflow. What all of these businesses likely understand is that the last mile into the prescriber and dispensers' workflow could be the most lucrative aspect of PDMPs.

A few states are attempting to buck these powerful forces. They take the view that PDMPs are a public utility, and as such, PDMP data should be widely and democratically made available to anyone who has an appropriate use for it. In Maryland, Nebraska, and Washington, this has meant collaborating with a statewide health information exchange to publish open APIs and support a range of standards-based integration techniques for bringing PDMP data into the workflow. California's PDMP, with support from the legislature, is also in the midst of an ambitious initiative to make open APIs available to all of the state's healthcare institutions.

These states support a nascent ecosystem of third-party technology providers and system integrators that are inventing new ways to present PDMP data to those who need it, when they need it. Companies—and I count my own among them—are demonstrating real innovation that can make a difference in fighting the opioid epidemic. The earnest competition also keeps us honest and hungry and should ultimately drive down cost. If more take notice, these states may present an alternative to the models being pitched by more powerful interests.
