



Alaska Prescription Drug Monitoring Program Report to the 30th Alaska State Legislature (2018)

Prepared for the 30th Alaska Legislature on (date adopted by board)

Senator Pete Kelly, Senate President
Representative Bryce Edgmon, Speaker of the House

I. Introduction

The passage of Senate Bill 196 by the Twenty-Sixth Alaska State Legislature in 2008 established a controlled substance prescription database and operates under the name of “Alaska Prescription Drug Monitoring Program” (PDMP) in the Board of Pharmacy (the Board) within the Department of Commerce, Community, and Economic Development (DCCED), Division of Corporations, Business and Professional Licensing (CBPL). Since the inception of the database, multiple statutory changes have taken place impacting the Board of Pharmacy and the Prescription Drug Monitoring Program.

Alaska Statute 17.30.200. Controlled substance prescription database.

(a) The controlled substance prescription database is established in the Board of Pharmacy. The purpose of the database is to contain data as described in this section regarding every prescription for a schedule II, III, or IV controlled substance under federal law dispensed in the state to a person other than under the circumstances described in (u) of this section.

The purpose of the PDMP is multifactorial. It is used to:

- contain data regarding every prescription for a Schedule II, III, or IV controlled substance under federal law dispensed in the state, with few detailed exceptions noted in AS 17.30.200(u) and explained further in this report.
- improve patient care by providing prescribers and pharmacists with a detailed and current controlled substance dispensing history of their patients.
- assist practitioners in prescribing clinically appropriate controlled substance medications.
- reduce drug diversion.

- reduce the prescribing of inappropriate controlled substance medications.
- assist in the investigation of specific cases pursuant to legal requests.
- generate and send unsolicited reports to practitioners to compare their trends to other practitioners in their respective specialty.
- allow the following users access to data:
 - Dentists, physicians, nurse practitioners, optometrists, pharmacists, and veterinarians

II. Appriss Health and AWARe

Appriss Health is the current contractor providing prescription drug monitoring database services. Appriss Health uses the prescription drug monitoring interface, AWARe. The term “PDMP” may be used interchangeably with “AWARe” as these terms both refer to the controlled substance prescription drug monitoring database. AWARe provides staff the following capabilities:

- Approve practitioners, pharmacists and delegates registering for PDMP access.
- Manage PDMP accounts.
- Maintain a list of data submitters from pharmacies or licensed practitioners who dispense schedule II, III or IV control substances.
- Approve data submissions from pharmacies or licensed practitioners who dispense Schedule II, III, or IV controlled substances under federal law.
- Conduct analysis of pharmacies that have not reported or are delayed in reporting.
- Create dashboard announcements accessible to registered users.
- Consolidate patient information for patients reported to the database with differences in name, DOB, gender, or SSN.
- Generate patient prescription history reports.
- Generate dispensary activity reports.

III. 30th Legislative Report and Previous Legislative Reports

In 2017, mandatory registering, reviewing, and/or reporting with the PDMP database were enacted under AS 17.30.200 for practitioners and pharmacists. These expanded requirements have resulted in the state’s ability to collect, analyze, and report on controlled substance usage on a level that is both qualitatively and quantitatively more detailed than in previous years.

This report includes new information on:

- **Mandatory Interactions** – Practitioners licensed under AS 08.36 (dentists), AS 08.64 (physicians), AS 08.68 (nurses), AS 08.72 (optometrists), AS 08.80 (pharmacists), and AS

08.98 (veterinarians) are required to interact with the PDMP through registration, review, and/or reporting controlled substance data (Table 1).

- **Unsolicited Reports** – This report expounds on information previously discussed in the 29th legislative report relating to unsolicited reports “report cards” authorized under AS 17.30.200(t). New information on report cards include confidentiality, DEA # display, and specialty comparison measures.
- **Solicited Reports** – This report adds 2017 information on solicited reporting for patient prescription history reports and prescriber activity reports. The number of solicited reports by requestor type has been reported since 2013 and is reflected in the 27th, 28th, and 29th legislative report.
- **PDMP Fees** – The report for the 29th legislature provided brief information on the ability for DCCED to set fees for registering with the database.
- **Required Performance Measures** – Security of the PDMP and reductions in inappropriate use or prescription of controlled substances as a result of the PDMP are performance measures specifically required by AS 17.30.200(m)(2) to be reported on an annual basis to the legislature.
- **Optional Performance Measures** - Coordination among prescription drug monitoring program partners and involving stakeholders in planning processes are optional performance measures that may be reported to the legislature under AS 17.30.200(m)(1).
- **PDMP Data** – Updated numbers reflecting registration, patient prescription history requests, number of patients receiving an opioid prescription, number of total prescriptions and dispensations, top drugs dispensed, and the number of patients receiving high levels of morphine milligram equivalent (MMEs) opioids will be reported.
- **Interstate Data Sharing** – The Alaska PDMP shares data with seven other states.

IV. Mandatory Interactions with the PDMP

Table 1. Mandatory interactions for practitioners and pharmacists licensed under AS 08.36 (dentists), AS 08.64 (physicians), AS 08.68 (nurses), AS 08.72 (optometrists), AS 08.80 (pharmacists), and AS 08.98 (veterinarians).

Requirement	Interaction	Applicable to
Mandatory Registration	Create a PDMP account by completing an online registration through AWA RxE	<ul style="list-style-type: none"> • Practitioners who hold an active Alaska professional license under AS 08 AND have a valid DEA registration: <ul style="list-style-type: none"> ○ advanced practice registered nurses, dentists, optometrists, physicians, physician assistants, and veterinarians • Pharmacists who dispense federally scheduled II - IV controlled substances.
Mandatory Review	Conduct a patient prescription history query before prescribing, administering, or	<ul style="list-style-type: none"> • Practitioners who prescribe, administer, or directly dispense federally scheduled II – IV controlled substances:

	dispensing federally scheduled II – IV controlled substances	<ul style="list-style-type: none"> ○ advanced practice registered nurses, dentists, optometrists, physicians, physician assistants, and veterinarians.
Mandatory Reporting	Submit data to the PDMP via PMP Clearinghouse	<ul style="list-style-type: none"> ● Practitioners who prescribe, administer, or directly dispense federally scheduled II – IV controlled substances: <ul style="list-style-type: none"> ○ advanced practice registered nurses, dentists, optometrists, physicians, physician assistants, and veterinarians ● Pharmacists-in-charge (PIC) of a licensed or registered pharmacy, or pharmacist if the PIC is not present, if they dispense federally scheduled II – IV controlled substances.

In addition to mandatory interactions, SB74 expanded PDMP access to individuals who are licensed or registered by AS 08 and are acting as an agent or employee of the practitioner or pharmacist. These individuals apply as delegates and can perform reviewing or reporting actions on behalf of a provider already registered in the database.

V. Interaction Exemptions and Other Changes

Exemptions:

AS 17.30.200 provided for specific exemptions for registering, reviewing, and reporting requirements and are detailed in Table 2 below:

Practitioners:	Prescriptions:
<ul style="list-style-type: none"> ● Dispensing less than a 24-hour supply of controlled substances at an inpatient pharmacy for use after discharge. ● Dispensing less than a 24-hour supply of controlled substances in an emergency department. ● Dispensing, prescribing, or administering at a hospice or nursing home that has an inpatient pharmacy. ● Writing a non-refillable prescription for a controlled substance in a quantity intended to last for not more than three days. 	<ul style="list-style-type: none"> ● Administered to an inpatient admitted to a health care facility. ● Administered at the scene of an emergency, in an ambulance, or in an emergency department. ● Provided immediately before, during, or within the first 48 hours after surgery or a medical procedure.

Table 2.) Exemptions to mandatory interaction with the PDMP. Generally, exemptions relate to emergency or immediate inpatient care. AS 17.30.200(u).

Other Changes in AS 17.30.200:

- Mandated controlled substance data reporting frequency to be done on a weekly basis.
- Beginning July 1, 2018, reporting frequency will change to daily.

VI. Unsolicited Reports - “Prescriber Report Cards”

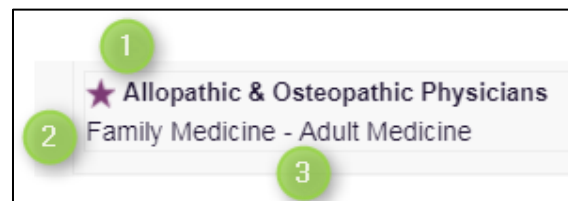
Report Card Background:

Changes to AS 17.30.200 in House Bill 159, effective July 17, 2017, authorized the Board to issue unsolicited prescriber reports, also known as “report cards”, to licensed practitioners holding an active registration with the PDMP. Report cards are reflective of all opioid, anxiolytic, sedative, and hypnotic medications reported to the database and are unique to individual prescribers. AS 17.30.200(t) allows the PDMP to generate and send these report cards to practitioners on a quarterly basis. The first round of report cards were sent to practitioners on December 6, 2017.

Report Card Purpose:

The intent of report cards is to give practitioners the opportunity to review their prescription activity and to see how their prescribing practices compare to similar practitioners within the same occupation and within a specific specialty. For example, a practitioner who holds a license under the medical board and is registered in the PDMP with the user role “physician” will see on their prescriber report the number of prescriptions written as compared to other physicians registered in the PDMP within the same occupation. Practitioners will also see the number of prescriptions written as compared to other physicians who practice in the same occupational specialty. For example, a practitioner whose specialty is family medicine will see how prescribing practices compared to other physicians whose specialties are family medicine.

Graphic 1. A practitioner must indicate a specialty to be associated with their PDMP registration, however, only the secondary specialty will be used as a comparison measure on a prescriber report card.



Additional Metrics:

Report cards also detail some of the following information:

- Top three medications prescribed.
- Number of patients receiving a dangerous combination therapy.
- Number of patient prescription history queries.

Additional descriptions and guidelines on how to interpret prescription metrics are sent to providers along with their report card.

Receiving a Report Card:


Only practitioners who hold a current DEA registration number and have registered with the PDMP will receive a prescriber report card. Delegate users do not receive report cards. Report cards are sent confidentially from Appriss Health via email on behalf of the PDMP, ensuring the report cards will only be accessed by the practitioner associated with a particular email address.

VII. PDMP Fees (AS 17.30.200(s)(2))

The PDMP is currently a grant-funded program that needs financial stability to support these augmented operational functions. SB 74 authorized the department to set fees for registration with the PDMP such that the fees are equal to the total operational costs of the database minus all federal funds acquired for its operational cost. In January 2018, DCCED proposed a \$50.00 initial and \$50.00 biennial registration renewal fee. This fee is charged to each licensee of the Board of Medicine, Nursing, Optometry, Pharmacy, Veterinary, and Dentists who are required to interact with PDMP.

VIII. Performance Measures (AS 17.30.200(m))

On an annual basis, the Board of Pharmacy is required to report performance measures to the legislature. Required performance measures include information pertaining to security of the database and reductions in inappropriate use or prescribing of controlled substances as a result of using the PDMP (AS 17.30.200(m)(2)). Optional performance measures suggested in AS 17.30.200(m)(1) that will be reported here include increasing coordination among prescription drug monitoring program partners and involving stakeholders in the planning process.

 = Required Measure  = Optional Measure

1.) [Maintain] security of the database (AS 17.30.200(m)(2))

The Prescription Drug Monitoring Program complies with confidentiality requirements set out under AS 17.30.200(d) and ensures confidentiality when the database and information contained in the database is used by practitioners, delegates, and other authorized users.

- *Security for PDMP administrators:*

The PDMP manager and the Board of Pharmacy Investigator are the only board personnel authorized to access the database for operational and review purposes in accordance with AS 17.30.200(d)(1). The PDMP vendor, Appriss Health, has issued unique administrative log-in credentials to these individuals; credentials are not used or shared by any other employee of the department.

- *Security for practitioners:*

In accordance with AS 17.30.200(d)(3), the PDMP manager ensures that individuals submitting registration requests to AWA Rx E for PDMP credentials are screened for requisite information, which include holding an active professional license in Alaska and a valid DEA registration. Professional licenses are reviewed using a primary verification source. The primary verification source used by the PDMP is the professional licensing database, CBP Portal. CBP Portal serves as a primary source verification because it is the system used to issue licenses and is used regularly as a necessary component of everyday CBP operations. Individual PDMP accounts are manually approved only after the requisite criteria has been demonstrated by the applying practitioner. Once approved, practitioners are only given user rights to certain functions of the database, including the ability to conduct patient prescription history requests, approve delegate requests, access dashboard announcements, and update profile information including specialty designations. Practitioners cannot update their own permissions, which may otherwise allow access to other functions of the database intended only for administrative use, such as reviewing registration requests, resetting practitioner passwords, or posting announcements on the dashboard. Passwords expire every three months to support continued confidentiality for each user authorized to access the database.

- *Security for delegates:*

In accordance with AS 17.30.200(d)(3) and 12 AAC 52.860, the PDMP manager ensures that individuals submitting registration requests as delegates to AWA Rx E for PDMP credentials are screened for requisite information, which include holding an active professional license in Alaska. Delegate registrations are not approved by the PDMP manager until the authorizing practitioner under whom the delegate is requesting access for has also approved that delegate. If delegates have indicated multiple supervising practitioners, delegate registration will not be approved until all practitioners have approved the individual.

- *Security for law enforcement:*

In accordance with AS 17.30.200(d)(5), the PDMP manager screens requests for patient, prescriber, and dispenser history for requisite documentation that demonstrate good cause to access confidential information. Information contained within the database are not released to federal, state, or local law enforcement unless a court-ordered subpoena or search warrant is presented with the request. Law enforcement is only given documentation of prescriber, dispenser, or patient history rather than login credentials to access the database directly. All requests processed are logged and a transmittal receipt letter is generated to document when reports are submitted to these agencies.

- *Security for data purposes:*

The Board of Pharmacy has drafted regulations to add language clarifying data access for individuals employed under the Alaska Department of Health and Social Services, who have limited access per AS 17.30.200(d)(10). The board will review public comment pertaining to these regulations at their February 28 – March 2, 2018 meeting.

2.) Reduce the inappropriate use or prescription of controlled substances resulting from the use of the database (AS 17.30.200(m)(2)).

- Inappropriate use or prescribing:*

The PDMP serves as a tool to assist authorized law enforcement in detecting drug diversion, misuse, and abuse. Patient prescription histories detailing prescription information for up to two years can be generated in response to investigative requests demonstrating good cause for data access. Prescribing history detailing patient information and dispenser reports can also be generated for federal, state, and local law enforcement. Unsolicited prescriber reports described in section IX of this report also provide feedback that allow providers to reflect on their prescribing practice. Since practitioners can only generate patient prescription history reports when using unique PDMP credentials, the number of patient prescription history queries conducted corresponds to the frequency with which practitioners are using the database (Figure 1):

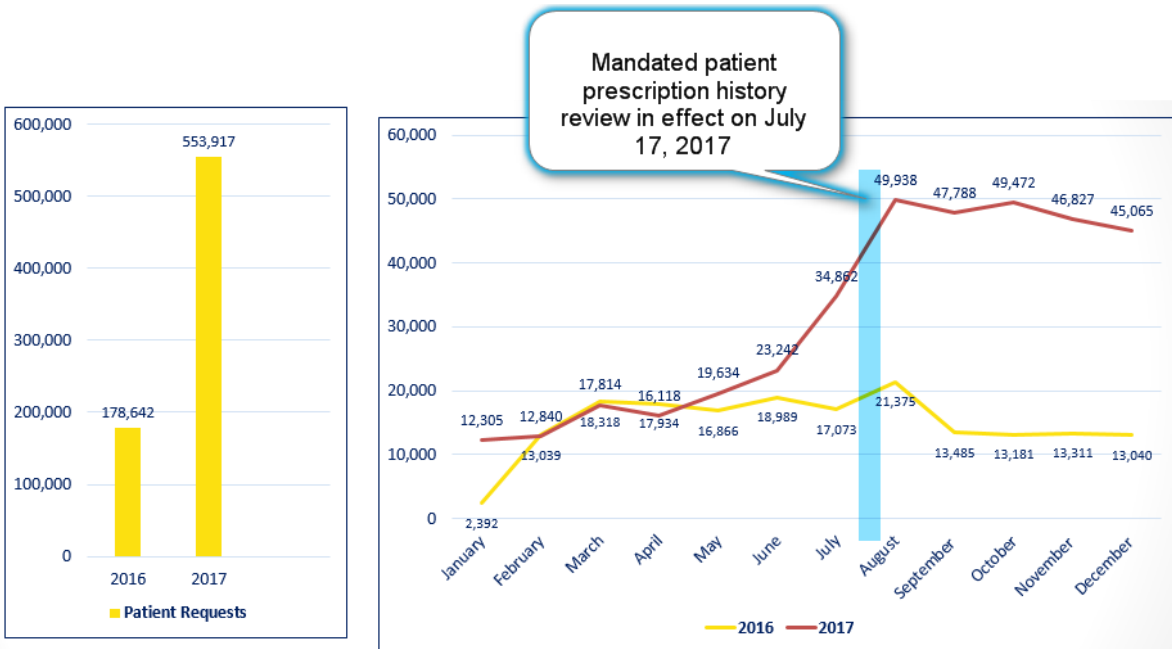


Figure 1. The bar graph on the left shows the number of patient prescription history requests conducted by practitioners in 2016 versus the number of requests conducted in 2017. The line graph indicates patient prescription history request trends over a two-year period. Source: Alaska Prescription Drug Monitoring Program, AWARxE.

The above graph shows an increase of 210% in practitioners conducting one or more patient prescription history requests from 2016 to 2017. This indicates recognition by providers and pharmacists of the mandatory interactions effective July 2017. In August 2017, nearly 50,000 patient prescription history requests were conducted, corresponding with the date in which the mandated review provision went into effect. The exponential increase of patient prescription history requests may also be positively correlated with the increase of registered users (Figure 3), which increased by over 230% from 2016 to 2017.

3.) Increase coordination among prescription drug monitoring program partners (AS 17.30.200(m)(1))

The Alaska PDMP manager attended the National Association of Controlled Substance Authorities Annual Meeting in October 2017, which provided an opportunity to meet with other PDMP administrators. In participating at this annual meeting, the PDMP manager established relationships with state PDMP administrators that have resulted in efficiencies and improvements in Alaska’s program.

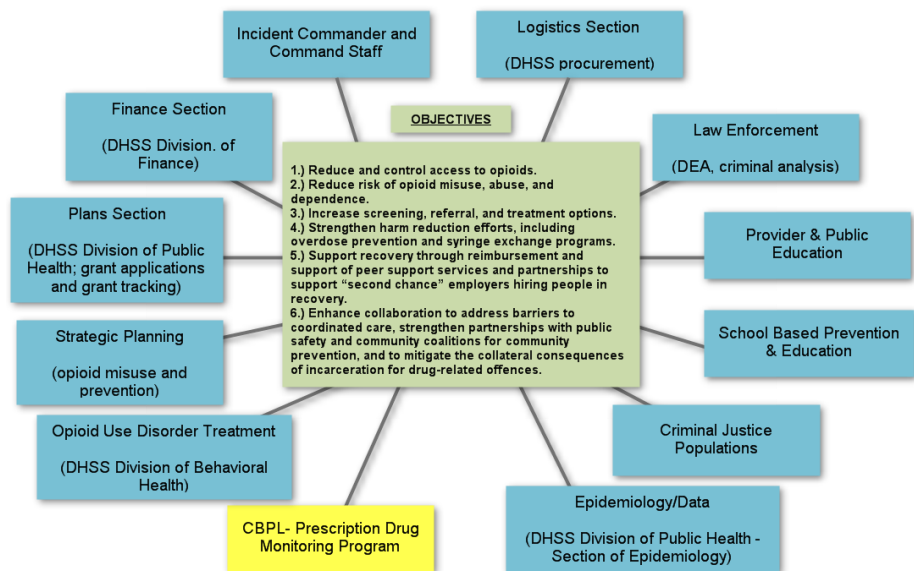
Alaska’s PDMP also benefitted by participating in a peer networking call with the Association of State and Territorial Health Officials (ASTHO) in September 2017, which Alaska Department of Health and Social Services partners also attended. At this meeting, rural population challenges, prevention, and policy initiatives and perspectives were shared with attendees.

In addition, the Alaska PDMP manager is a working member of the Opioid Working Group created by the state’s Chief Medical Officer, Dr. Jay Butler, and managed by Chief of Epidemiology, Merry Carlson. This working group meets periodically to discuss data relating to prescription drug issues in our state, including neonatal health surveillance, drug arrests, seizures, therapeutic court referrals, naloxone overdose kits, and data related to drug disposal.

4.) Team with multi-agency representatives to combat the opioid crisis in Alaska [(AS 17.30.200(m)(1))

Opioid Command System - In response to Governor Walker signing Administrative Order 283 on February 14, 2017 declaring a state-wide opioid crisis, the Department of Health and Social Services identified key players to help address prescription drug issues affecting our state. These key players were called on to convene as the Incident Command System, unifying unique niches of government to provide a robust strategy to combating the opioid crisis (Figure 2). This multi-agency team is led by the Incident Commander and Chief Medical Officer, Dr. Jay Butler and by Command Lead and Chief of Rural and Community Health Systems, Andy Jones. On a bi-weekly basis, the team meets to discuss various updates with the ultimate goal of improving health

Figure 2. This stakeholder/organization assignment map shows the various agencies involved in a combined initiative to combat the opioid crisis. The PDMP (highlighted in yellow) is an important contributor to this state-wide effort.

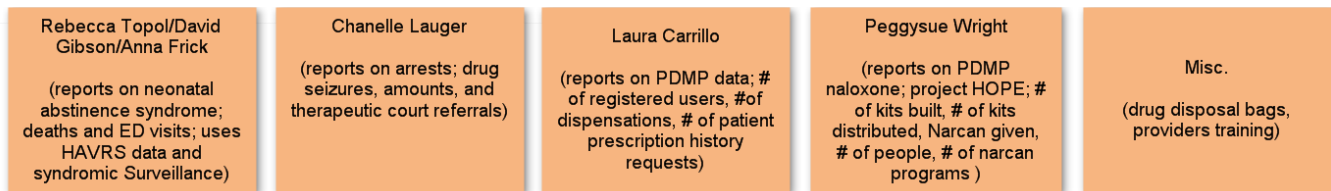


Opioid Dashboard Team - The PDMP Manager works collaboratively with key stakeholders from the Department of Health & Social Services (DHSS) - Vital Statistics, DHSS – Central Nursing Office, DHSS – Behavioral Health, and the Department of Public Safety. The shared vision and objectives of this team are to issue situational awareness reports of the opioid crisis, receive more timely and accurate data, share data with other data stewards, and to gauge if transparency of data is making a difference. The team was created by Dr. Jay Butler, is managed by DHSS – Division of Public Health’s Operations Manager, Merry Carlson, and is led by OSMAP’s Behavioral Health Fellow, Jessica Filley. On a monthly basis, the Alaska PDMP manager reports on the number of newly registered PDMP users, the number of patient prescriptions written, and the number of patient prescription history requests conducted. Using a public Tableau dashboard, information provided by data stewards (Graphic 2) are displayed for several opioid data points (Graphic 3).



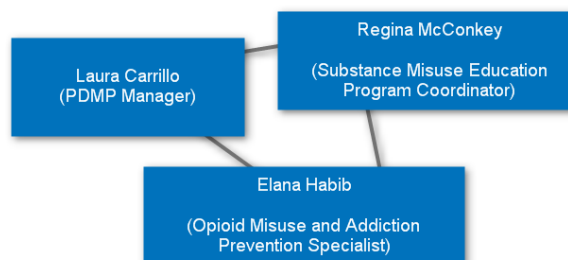
Graphic 2. Data stewards provide opioid data to be displayed on the Alaska Opioid Data Dashboard. The website is maintained by DHSS Office of Substance Misuse and Addiction Prevention (OSMAP).

Graphic 3. Data stewards contributing to opioid dashboard data.



PDMP Awareness and Feedback Questionnaire Team - This partnership is comprised of the PDMP Manager and OSMAP’s Regina McConkey and Elana Habib (Graphic 4). The team was established in December 2017 and is working to create an online questionnaire to satisfy CDC grant deliverable activities, which requires that the team 1.) solicit input to determine awareness levels of providers; 2.) solicit feedback to identify system limitations and improvement needs to enhance use of PDMP, and 3.) gauge client satisfaction and identify areas for quality improvement. The team is in the design phase and aims to launch the survey by Spring, 2018.

Graphic 4. The awareness and feedback questionnaire team will develop an online survey to solicit input from practitioners on interacting with the PDMP.



IX. PDMP Data

Number of Registered Users:

The graph below (Figure 3) shows the number of total users by profession since 2014. Information on profession-specific registration in 2014 and 2015 are not available and is presented below as the number of total registered users only. Figure 5 shows the number of registered users by professions or user role type not previously recorded in the database.

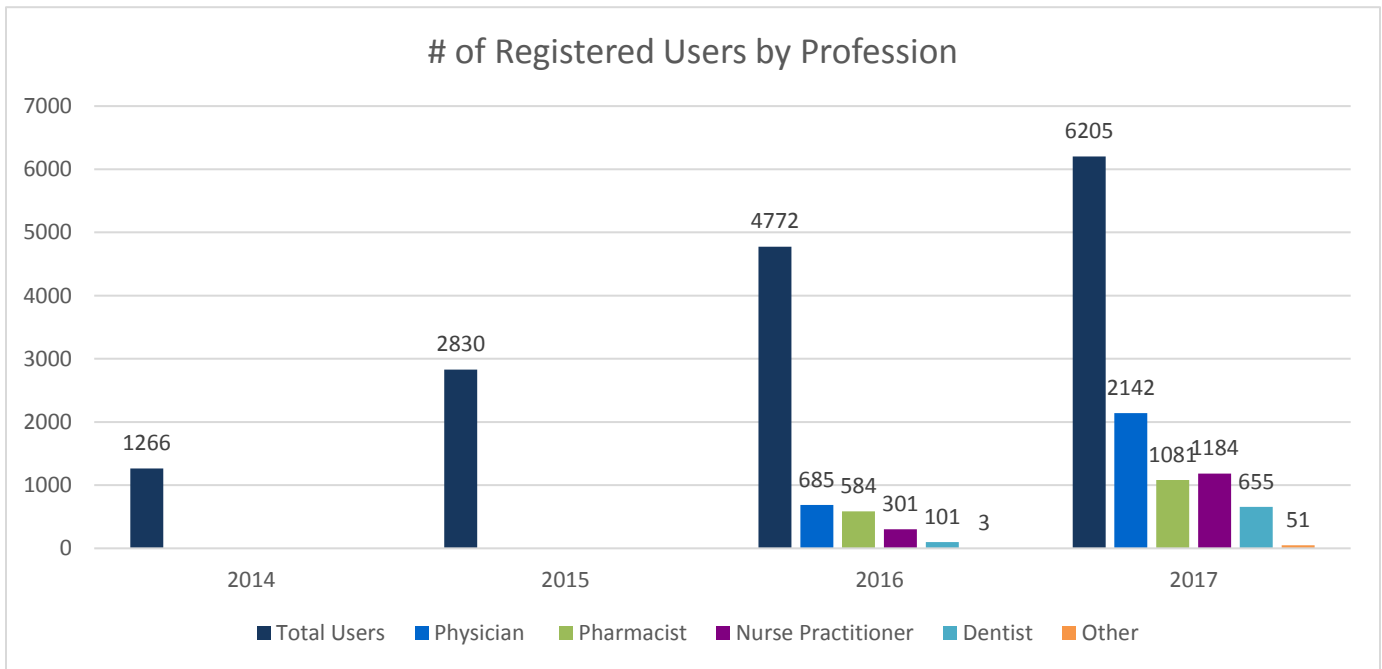


Figure 3. The cumulative number of registered users has increased since 2014. Practitioners in the “Other” category include Indian health service prescribers, Indian health service dispensers, veteran administration prescribers, and veteran administration dispensers and are only reported in 2016 and 2017. Physician assistants, optometrists, and veterinarians are not included in this graph as they were not reported until 2017 and represent new registration types. See figure 4 below.

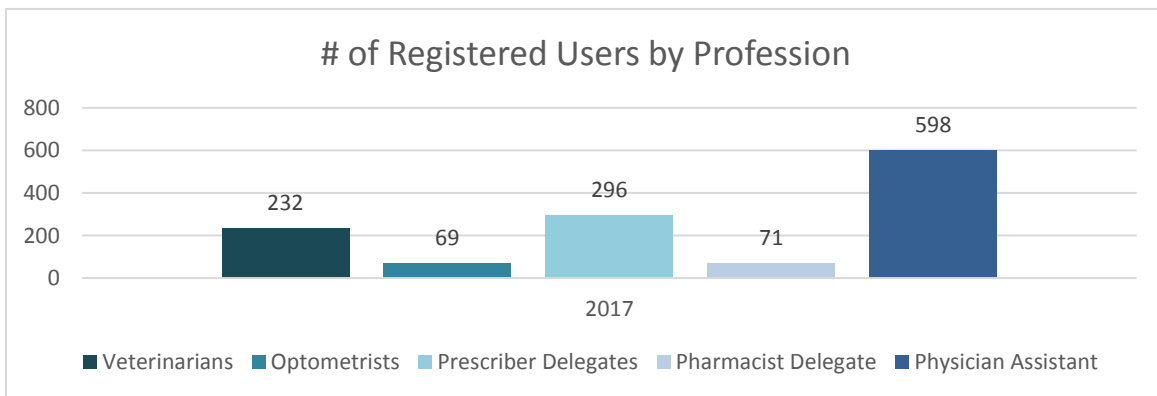


Figure 4. The total number of registered users in 2017 for profession types or user roles not previously reported is the baseline measurement for these specific professions.

Total Prescriptions:

Table 4 and Figure 5 shows the number of total prescriptions written in 2016 and 2017. Monitoring the percent of opioids versus non-opioids over time allows us to see changes in clinical decision making with regards to prescribing opiates.

2016	2017	Percent Change
1,053,999 (55.47% opioids; 44.53% non-opioids)	965,659 (54.26% opioids; 45.74% non-opioids)	<ul style="list-style-type: none"> • In total prescriptions: 12.87% decrease • In opioids: 10.38% decrease • In non-opioids: 5.89% decrease

Table 4. The number of total prescriptions written and the percent of opioids prescribed has decreased since 2016.

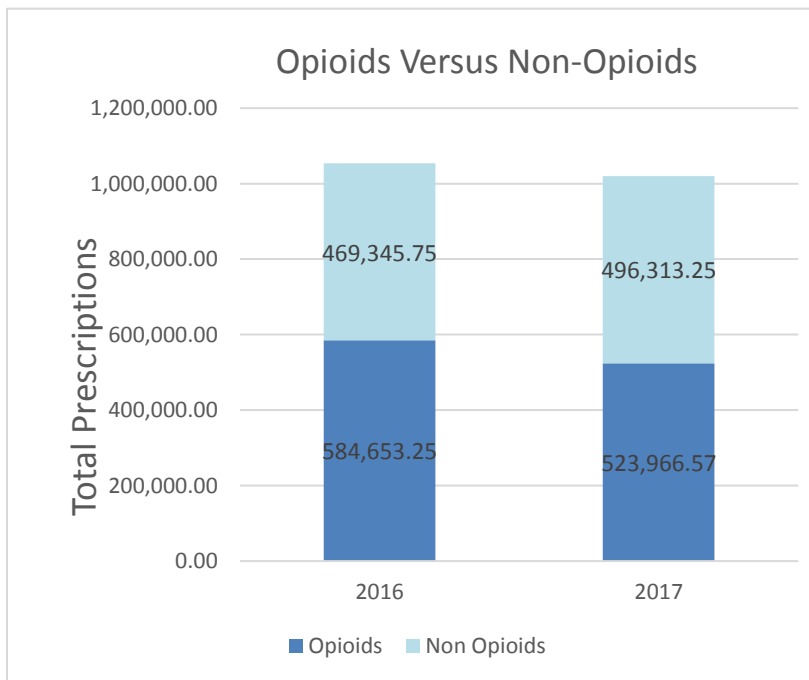


Figure 5. The number of opioid prescriptions has decreased since 2016.

Patient Prescriptions and Dependency Potential:

Individuals using opioid analgesics for extended periods of time are at increased risk of dependency, overdose and death. Patients using opioids in excess of 100mg of a total daily Morphine Milligram Equivalent (MME) are at significant risk of overdose. There is a continuous need to monitor the distribution of the most heavily abused drugs, including those prescribed over 100mg of painkillers with the same therapeutic effect as morphine. Table 5 demonstrates this change from 2016 to 2017.

Table 5. Opioid prescriptions and prescriptions exceeding 100mg MME per day.

	2016	2017	Percent Change
# of patients receiving an opioid prescription	150,600	135,362	10.12% (decrease)
# of opioid prescriptions greater than 100mg MME per day	79,654	79,288	.46% (decrease)

Top 3 Drugs Dispensed by Generic Name:

The top three drugs dispensed among all federally scheduled controlled substances and drug classes monitored in the PDMP provides insight into whether opioid prescribing is the most common clinical prescribing decision.

Table 6. Prescriptions for top drugs by generic name has decreased since 2016.

Generic Drug	Federal Schedule	Prescriptions in 2016	Prescriptions in 2017	Percent Change
Hydrocodone Bitartrate/Acetaminophen	Schedule II opioid	206,130	171,766	16.67% (decrease)
Oxycodone HCL/Acetaminophen	Schedule II opioid	105,743	91,267	13.70% (decrease)
Oxycodone HCL	Schedule II opioid	75,595	72,194	4.50% (decrease)

Solicited Reports:

A solicited report is when PDMP specified data on a practitioner’s prescribing activity, a patient’s prescription history, or a pharmacy’s dispensing activity over a specified period of time is provided to an authorized user. A solicited report is produced only after the requestor has provided adequate information justifying their legal ability to access the information contained in the database. Figure 6 shows the number of solicited reports by requestor type since 2012.

Federal, state, and local law enforcement and/or regulatory boards may receive this information. Additionally, a patient may also request a report of his or her own prescription information upon payment of a \$10.00 fee.

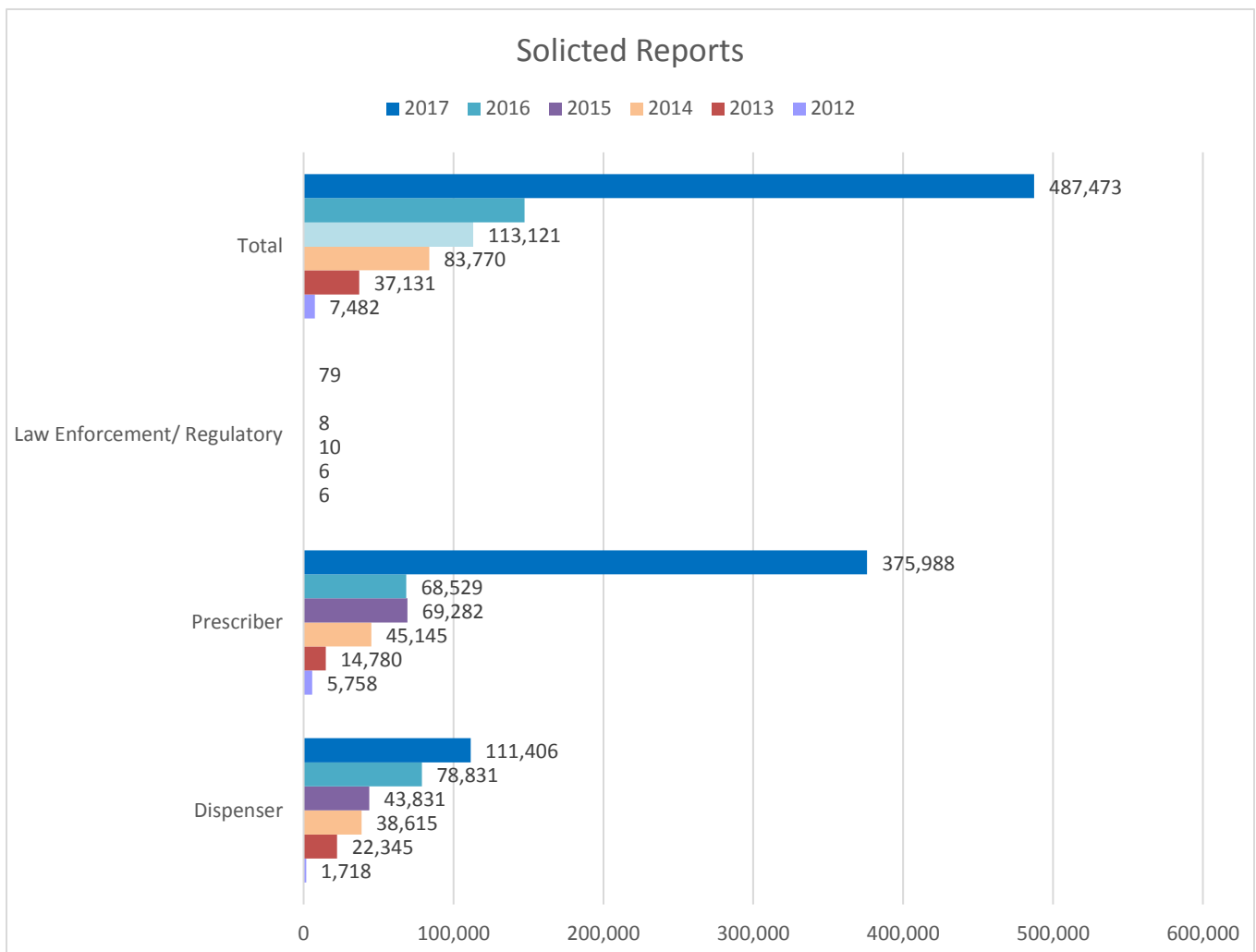


Figure 6. The number of solicited reports increased significantly from 2012 to 2017.

X. Interstate Data Sharing

The Alaska PDMP shares data with seven other states through the National Association of Boards of Pharmacy’s (NABP) PMP InterConnect program at no cost to the state under a partnership with the current PDMP vendor, Appriss Health. InterConnect provides a secure portal for which to share data between states, however, patient prescription information from other states cannot be stored in Alaska’s PDMP, and the Alaska PDMP cannot store such information from other state PDMPs. To execute this access, the division signed a memorandum of agreement in 2015 on the basis of 12 AAC 52.855(b)(1), which authorizes practitioners not licensed in Alaska to access patient prescription information from the Alaska PDMP. States currently authorized to access information include practitioners licensed in Idaho, Massachusetts, Minnesota, Montana, Louisiana, North Dakota, and Rhode Island.

Practitioners licensed in these states do not have full access to the Alaska PDMP; they do not register using the AWAxRxE platform in Alaska, however, they sign-in to the AWAxRxE platform for the jurisdiction under which they are currently licensed and when conducting a patient prescription history query are able to select states they are authorized to access. In return, practitioners licensed in Alaska may choose to include any or all of the seven states in a patient prescription history query (Graphic 4).

Important update:

At its February – March, 2018 meeting, the Alaska Board of Pharmacy entertained a regulation project to repeal a section of their regulations relating to PDMP access, including the section that would otherwise authorize interstate data sharing. The existing MOUs will be re-evaluated when this change takes effect.



The screenshot shows a web interface titled "PMP Interconnect Search". Below the title is a instruction: "To search in other states as well as your home state for patient information, select the states you wish to include in your search". There is a list of states with checkboxes next to them, all of which are checked. The states listed are: I (Idaho), L (Louisiana), M (Massachusetts), M (Minnesota), M (Montana), N (North Dakota), and R (Rhode Island). Below the list is a link that says "Please read the acknowledgement." and a "Search" button.

Graphic 4. A practitioner licensed in another state other than Alaska may include these seven states in a patient prescription history search. If these other states have prescription information on the patient, the practitioner will be able to consider this in making a clinical treatment decision.