Alaska Prescription Drug Monitoring Program Report to the 31st Alaska State Legislature (2020)

Prepared for the 31st Alaska Legislature on February 26, 2020 (Adopted 02/28/2020)

Senator Cathy Giessel, Senate President
Representative Bryce Edgmon, Speaker of the House

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I. Introduction

The passage of Senate Bill 196 by the Twenty-Fifth Alaska State Legislature in 2008 established a federally-funded electronic controlled substance prescription database[1], with the intent to improve patient care and to reduce misuse, and drug diversion of controlled substances. The database, which operates as a state-level opioid intervention strategy under the name of the "Prescription Drug Monitoring Program" (PDMP) has been operational since 2012, giving access to prescribing practitioners and pharmacists licensed in Alaska (Table 1). At present, 49 states, the District of Columbia, and Guam have an operational PDMP[2]. In Alaska, the PDMP is administered by the Board of Pharmacy (the board) under the Department of Commerce, Community, and Economic Development (DCCED), Division of Corporations, Business and Professional Licensing (CBPL)[3].

> ***Alaska Statute. 08.80.030. Powers and Duties of the Alaska Board of Pharmacy.*** (a) The board is responsible for the control and regulation of the practice of pharmacy. (b) In order to fulfill its responsibilities, the board has the powers necessary for implementation and enforcement of this chapter, including the power to (11) establish and maintain a controlled substance prescription database as provided in AS 17.30.200.[3]
>
> ***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.[3]

In addition to the PDMP providing a tool for providers to use when assessing medically necessary and clinically appropriate patient care and in considering treatment with a controlled substance[1, 10, 11], the database is to be used as a system reference for the board to carry out required grant activities and statutory abilities and obligations. These activities (Table 2) relate to the overarching goals of monitoring and promoting judicious prescribing and dispensing practices, reduce inappropriate prescribing, identifying and preventing instances of misuse, abuse, and drug diversion, and increasing provider communication across the provider settings.

Required Users (actively licensed under AS 08)	**Authorized Users**
Dentist with DEA registration	Delegate with active license under AS 08
Nurse Practitioner with DEA registrations & state-level controlled substance prescriptive authority issued by the Board of Nursing	Indian Health Service prescriber or pharmacist with active license in another jurisdiction
Optometrist with DEA registration	Military prescriber or pharmacist with active license in another jurisdiction
Pharmacist who dispense controlled substances in Alaska	Veterans Administration prescriber or pharmacies with active license in another jurisdiction
Physician with DEA registration	*(intentionally left blank)*

Physician assistant with DEA registration	*(intentionally left blank)*
Veterinarian with DEA registration	*(intentionally left blank)*

Table 1. *Users authorized to access the PDMP. Delegates may access the database only if licensed, registered, certified, or otherwise regulated by DCCED - CBPL under AS 08. Federal providers may access the database only upon submitting documentation to the board indicating an active professional license in another jurisdiction*

Grant Requirements	Statutory Abilities and Obligations
*Must generate and send unsolicited reports to practitioners to compare their prescribing trends to other practitioners in the same health care specialty[4]	Must contain data regarding every prescription for a Schedule II, III, and IV controlled substance under federal law dispensed in the state, updated daily
Must increase usage of the PDMP by providing outreach and training[4]	Must notify the State Medical Board, the Board of Nursing, the Board of Dental Examiners, the Board of Examiners in Optometry, and the Board of Veterinary Examiners when a practitioner registers with the database
Improve data collection and analysis around opioid misuse, abuse, and overdose[5]	May generate and send unsolicited reports to practitioners to compare their prescribing trends to other practitioners in the same health care specialty
Develop strategies that impact behaviors driving prescription opioid dependence and abuse[5]	May generate and send unsolicited notifications to a provider and/or provider's licensing board when a patient has received one or more prescriptions for controlled substances in quantities or with a frequency inconsistent with generally recognized standards of safe practice
[5]Provide options for interstate and intrastate data integration with electronic health records (EHRs) and health information exchanges (HIEs)	*(intentionally left blank)*

Table 2. *Grant requirements as a condition of receiving grant funding and activities driven by statute. *Indicates an overlap between federal and state requirements.*

II. Appriss Health and AWARxE

Appriss Health is the State's current vendor providing prescription drug monitoring database services. Appriss Health uses the prescription drug monitoring interface, AWARxE. The term "PDMP" may be used interchangeably with "AWARxE" as these terms both refer to the controlled substance prescription drug monitoring database. AWARxE provides the PDMP administrator with the following capabilities:

- Approve practitioners, pharmacists and delegates registering for PDMP access
- Manage PDMP account details, including appropriate user role categories
- Approve data submissions from in-state and out-of-state pharmacies or licensed practitioners who dispense Schedule II, III, or IV controlled substances under federal law
- Maintain a list of data submitters from pharmacies or licensed practitioners who dispense and distribute schedule II, III or IV control substances to patients in Alaska
- 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 prescriber and dispensary activity reports

III. Database Funding and Increased Reliance on PDMP

In 2008, the original intent of the legislature was for the PDMP to be funded with federal grants and state appropriations rather than having the licensees absorb the costs [7]. As the opioid crisis escalated throughout the nation and in the state, so did the costs to operate and administer the database. While DCCED, not supported by discretionary funding authority through Unrestricted General Funds (UGF), continued to receive federal grant funding indirectly through reimbursable services agreements from the Alaska Department of Health and Social Services (DHSS), the uncertainty of future funding sources persisted. Under AS 17.30.200(g) the board is required to notify the legislature if the federal government fails to pay for all or part of the costs of the database. Accordingly, DCCED issued letters in January 2009 and in February 2013[8] which resulted in additional grant funding dedicated to the PDMP, however, it also included more grant deliverables without appropriating more dedicated staffing to accomplish the added requirements. In 2018, CBPL anticipated an operating deficit of $239,880 by FY20219 if a licensee user fee was not instituted. Without UGF to support the costs to administer, staff, and carry out required activities of the PDMP, DCCED implemented a $25.00 user fee to be paid on a biannual basis following SB 74[10].

The PDMP was intended to be a tool to assist practitioners and pharmacists in evaluating judicial controlled substance prescribing and dispensing practices. Today, the PDMP is increasingly being used to support law enforcement investigations and initiate punitive action against licensees. Therefore, this transformation has led to the perception that the database is now being used as an integral solution to solve the complex opioid epidemic. As the capabilities and expectations of the PDMP continue to grow, funding remains uncertain; the last major federal grants covering base PDMP activities are set to expire on June 30, 2020.

IV. Mandatory Interactions and Expanded Use

When the controlled substance prescription database went live in 2012, only pharmacists were required to report prescription data, remaining an optional database for prescribing practitioners to use as provided in SB 196[1]. As the opioid epidemic worsened, legislation in 2017 introduced mandatory interactions with the PDMP in House Bill 159, requiring active Alaska-licensed prescribers with DEA registrations, and pharmacists who dispense in the state, to register with the database by July 17, 2017[11, 12]. The requirement to use the database by reviewing a patient's prescription history prior to prescribing, administering, or dispensing a federally schedule II or III controlled substance also went into effect[11, 12]. Additionally, mandatory weekly reporting for practitioners and pharmacists directly dispensing federally scheduled II – IV controlled substances went into effect on July 17, 2017, which changed to daily reporting effective July 1, 2018[11, 12] (Tables 1, 3). Exemptions to use are listed in Table 4.

Mandatory Use: Registration

Mandatory registration for licensees with Drug Enforcement Administration (DEA) registrations regulated by the Board of Dental Examiners, State Medical Board, Board of Nursing, Board of Examiners in Optometry, Board of Pharmacy, and Board of Veterinary Examiners[3] went into effect on July 17, 2017, resulting in an influx of registration from previous years (Figure 1). The Board of Nursing has set the mandatory registration criteria to apply only to licensees who also have a state-issued controlled substance prescriptive authority, and the Board of Pharmacy has set the mandatory registration criteria to apply only to pharmacists who dispense controlled substances in Alaska (Table 1). Figures 2 - 8 indicates registration compliance for each board from January 1, 2016 through December 31, 2019.

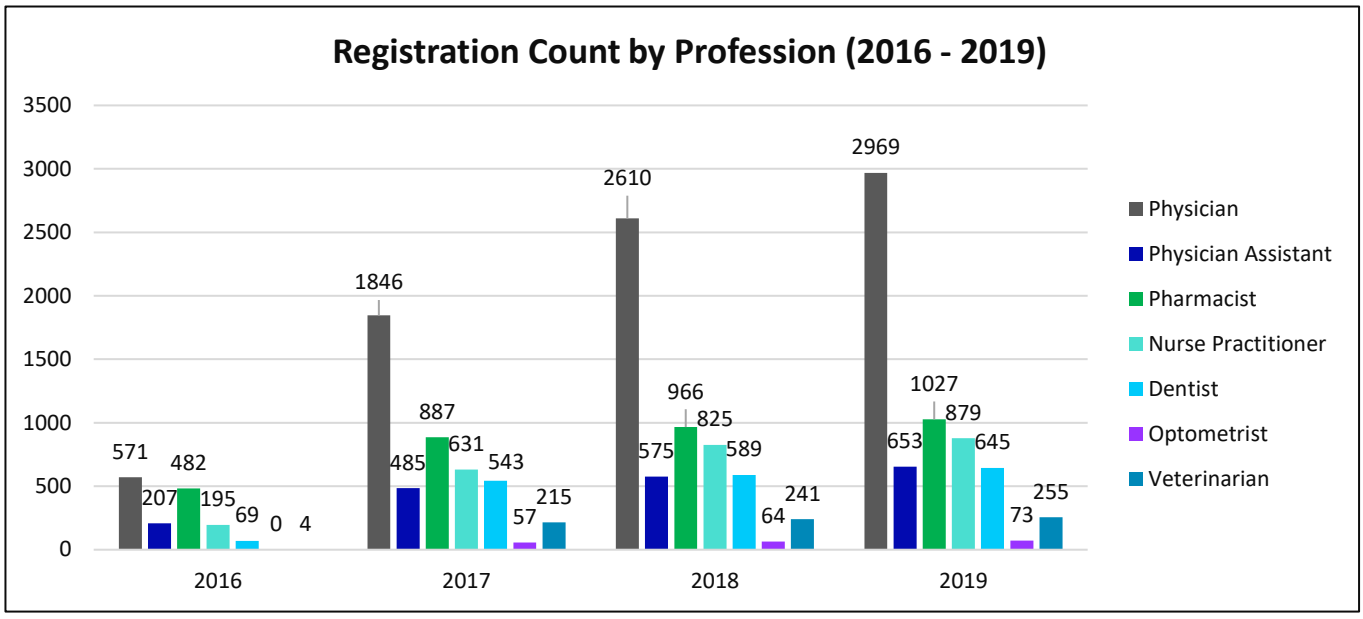

Figure 1. *Cumulative registration count by profession from 2016-2019. Total registration count from 2016 through 12/31/2019 is 6,501.*

Dentists:

88% Registered

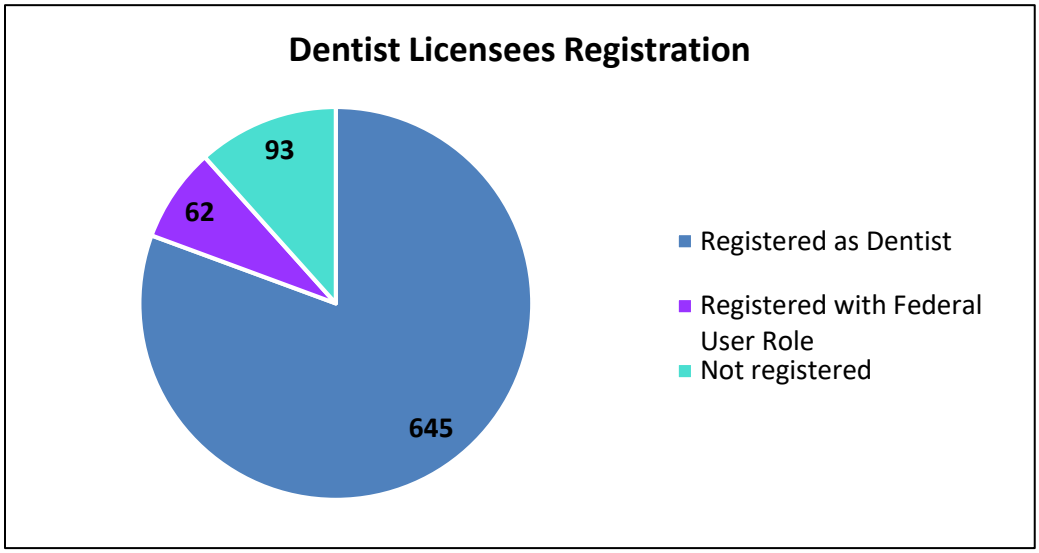

***Figure 2**. The proportion of dentist licensees registered with the PDMP through 12/31/2019. Of total licensees (n = 800), 645 (81%) are registered with a dentist user role; however, this compliance rate increases to 707 (88%) when accounting for dentist licensees registered with a federal user role, e.g.: IHS Prescriber. The number of licensees not registered, 93 (12%), may not be registered due to non-compliance, may have an account pending, or may not have a Drug Enforcement Administration (DEA) registration. Status of DEA registrations is managed by each professional licensing board.*

APRNS:

75% Registered

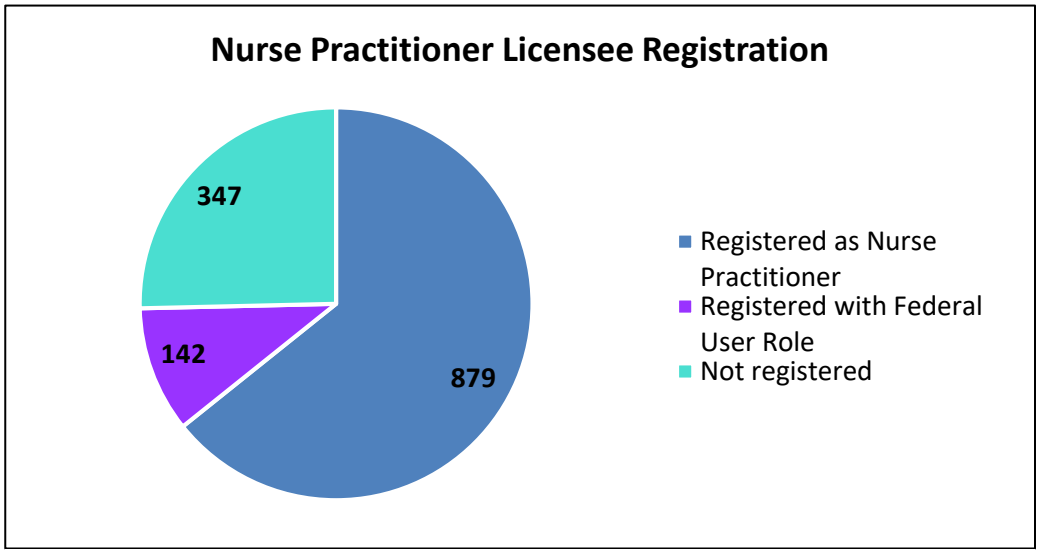

***Figure 3**. The proportion of nurse practitioner licensees registered with the PDMP through 12/31/2019. Of total licensees (n = 1,368), 879 (64%) are registered with a nurse practitioner/clinical nurse specialist user role; however, this compliance rate increases to 1,201 (75%) when accounting for nurse practitioner licensees registered with a federal user role, e.g.: IHS Prescriber. The number of licensees not registered, 347 (25%), may not be registered due to non-compliance, may have an account pending, or may not have a Drug Enforcement Administration (DEA) registration and board-issued controlled substance prescriptive authority designation. Status of DEA registrations and controlled substance prescriptive authority is managed by the Board of Nursing.*

Optometrists:

49% Registered

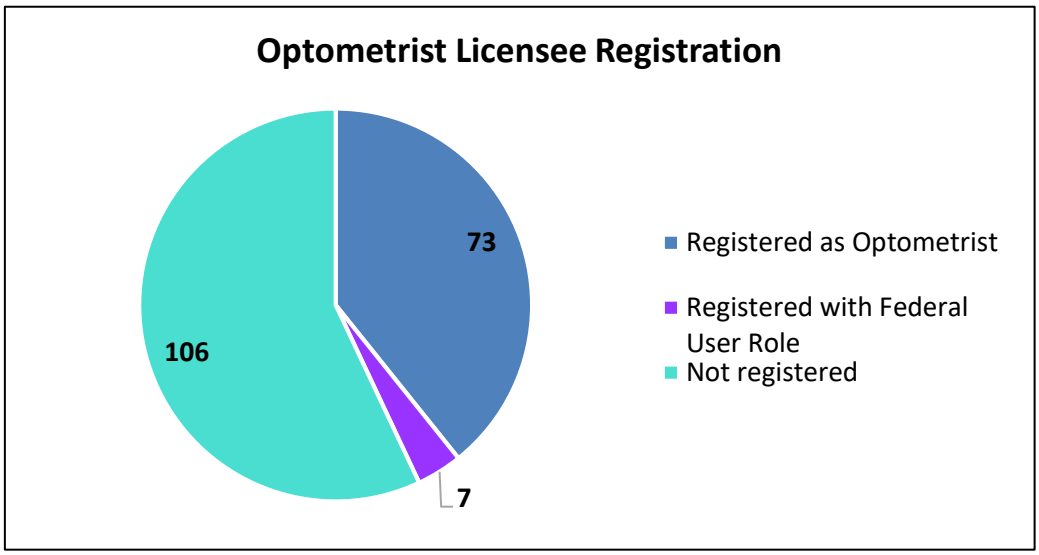

***Figure 4**. The proportion of optometrist licensees registered with the PDMP through 12/31/2019. Of total licensees (n = 206), 73 (35%) are registered with an optometrist user role; however, this compliance rate increases to 100 (49%) when accounting for optometrist licensees registered with a federal user role, e.g.: IHS Prescriber. The number of licensees not registered, 106 (51%), may not be registered due to non-compliance, may have an account pending, or may not have a Drug Enforcement Administration (DEA) registration. Status of DEA registrations is managed by each professional licensing board.*

Pharmacists:

98% Registered

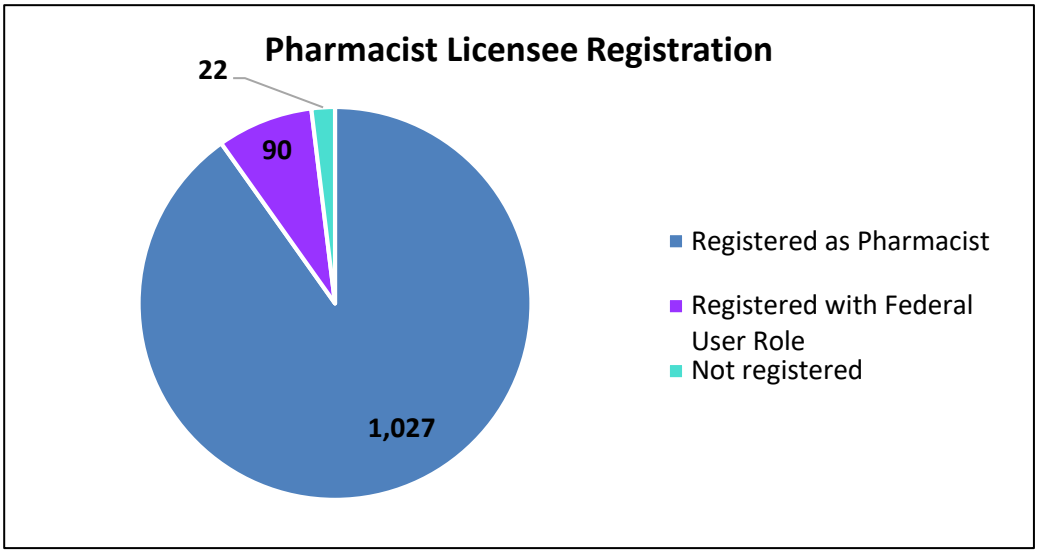

***Figure 5**. The proportion of pharmacist licensees registered with the PDMP through 12/31/2019. Of total licensees (n = 1,139), 1,027 (90%) are registered with an optometrist user role; however, this compliance rate increases to 1,117 (98%) when accounting for pharmacist licensees registered with a federal user role, e.g.: IHS Dispenser. The number of licensees not registered, 22 (2%), may not be registered due to non-compliance, may have an account pending, or may not be dispensing in Alaska. Dispensing status is managed by the Board of Pharmacy.*

Physicians:

72% Registered

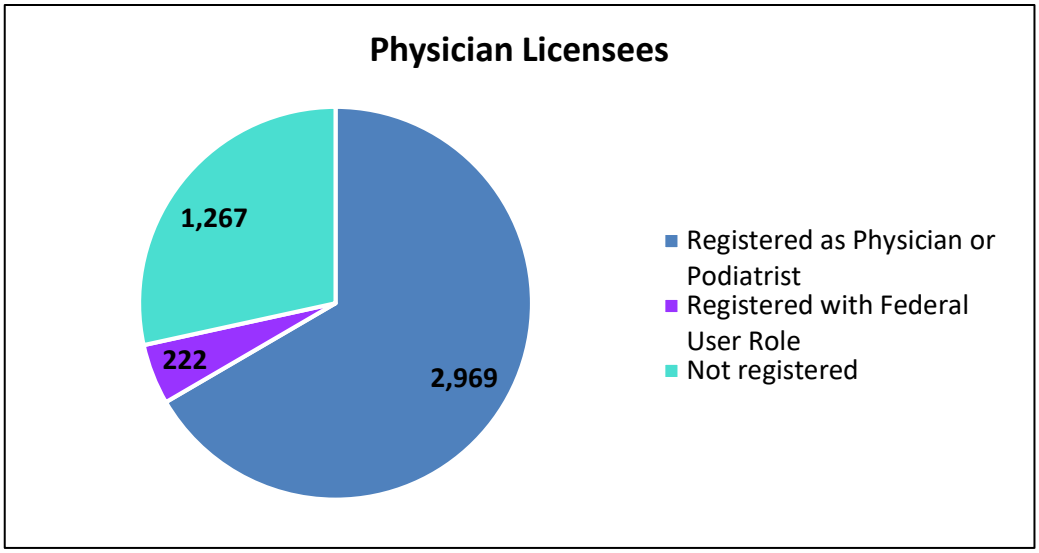

***Figure 6**. The proportion of physician licensees registered with the PDMP through 12/31/2019. Of total licensees (n = 4,458), 2,696 (60%) are registered with a physician user role; however, this compliance rate increases to 3,191 (72%) when accounting for physician licensees registered with a federal user role, e.g.: IHS Prescriber. The number of licensees not registered, 1,267 (28%), may not be registered due to non-compliance, may have an account pending, or may not have a Drug Enforcement Administration (DEA) registration. Status of DEA registrations is managed by each professional licensing board.*

Physician Assistants:

98% Registered

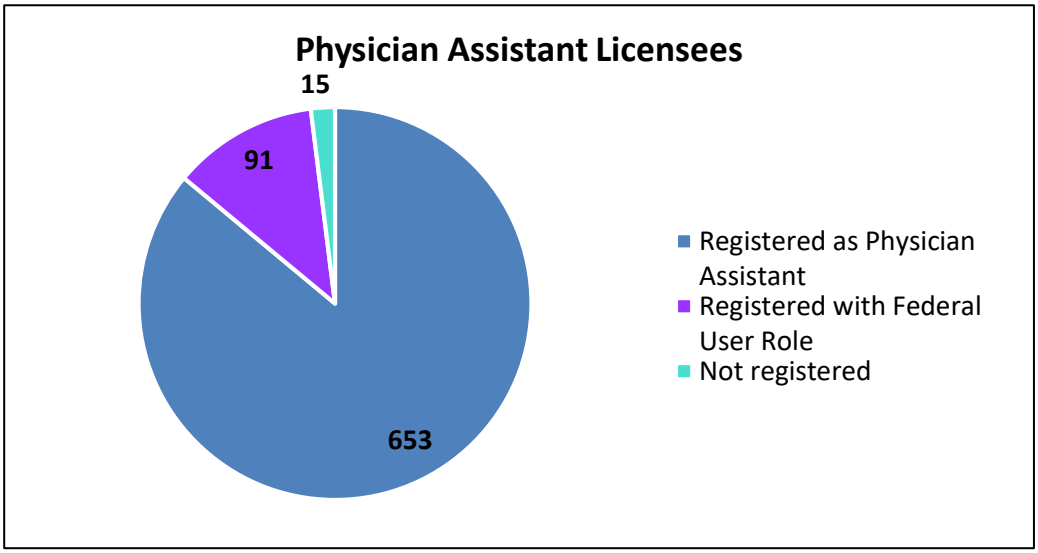

***Figure 7**. The proportion of physician assistant licensees registered with the PDMP through 12/31/2019. Of total licensees (n = 759), 653 (86%) are registered with a physician assistant user role; however, this compliance rate increases to 744 (98%) when accounting for physician assistant licensees registered with a federal user role, e.g.: IHS Prescriber. The number of licensees not registered, 15 (2%), may not be registered due to non-compliance, may have an account pending, may not have a Drug Enforcement Administration (DEA) registration, or may not be authorized to practice due to absence of a collaborative plan. Status of DEA registrations and collaborative plans are managed by the State Medical Board.*

Veterinarians:

64% Registered

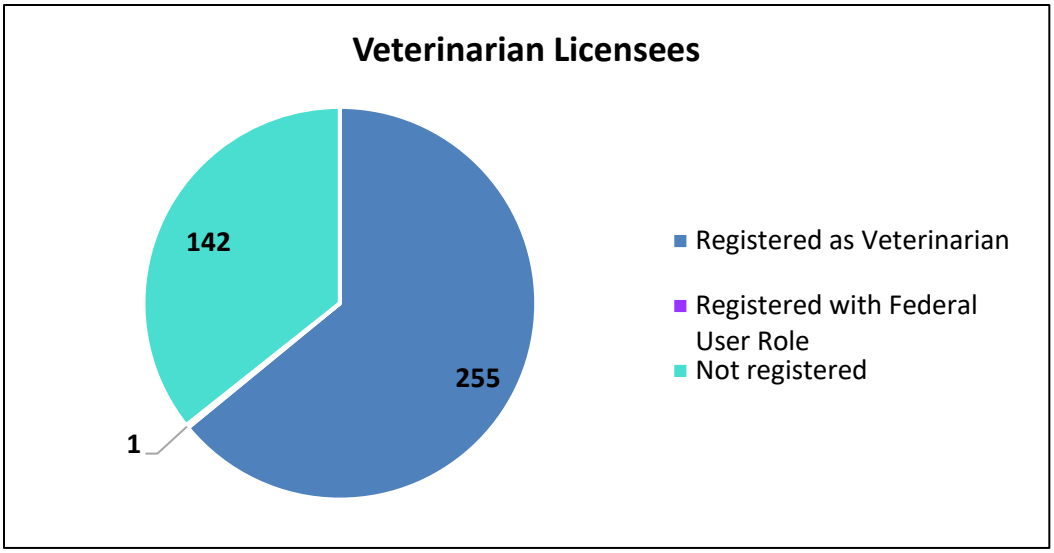

Figure 8*. The proportion of veterinarian licensees registered with the PDMP through 12/31/2019. Of total licensees (n = 398), 255 (64%) are registered with a veterinarian user role. This compliance rate increases only by 1 (n = 256, 64%) when accounting for veterinarian licensees registered with a federal user role, e.g.: Military Prescriber. The number of licensees not registered, 142 (36%), may not be registered due to non-compliance, may have an account pending, or may not have a Drug Enforcement Administration (DEA) registration. Status of DEA registrations is managed by each professional licensing board.*

Mandatory Use: Reviewing

Providers required to register, except pharmacists, are required to review patient prescription information in the PDMP prior to prescribing, administering, or directly dispensing a federally-scheduled II or III controlled substance. Prescribing practitioners are not required to review patient prescription information in situations described in AS 17.30.200(k)(4)[3] and listed in Table 5. Figure 9, below, shows reviewing trends over time. Figures 10 – 16 show total reviews by profession, excluding licensed providers under a federal user role. These numbers may be influenced by the number of registered providers, number patients treated, and number of controlled substances prescribed, administered, or dispensed, but are not adjusted accordingly.

Dentists:

9.9% decrease in reviews since 2018

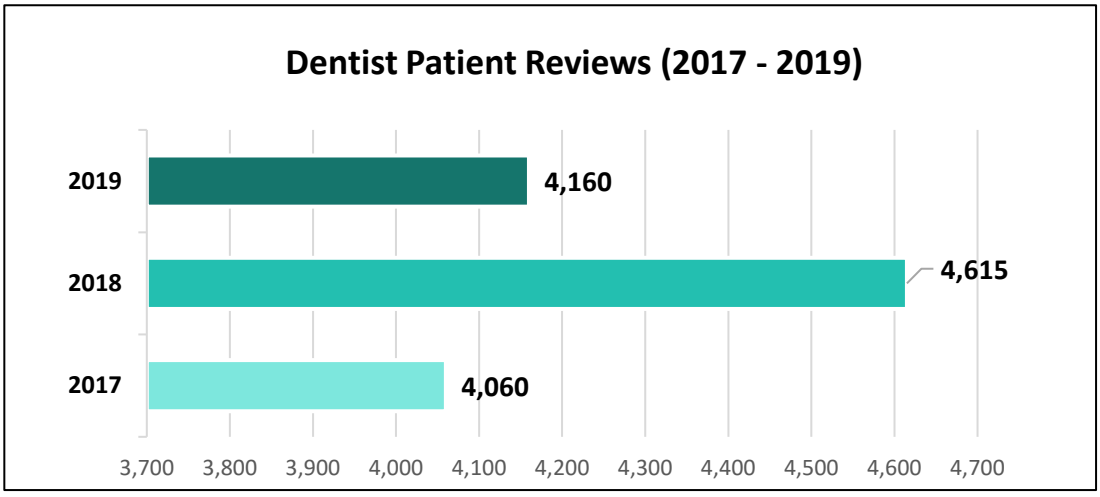

Figure 10. *Non-cumulative patient reviews per year for dentists.*

APRN:

7.7% increase in reviews since 2018

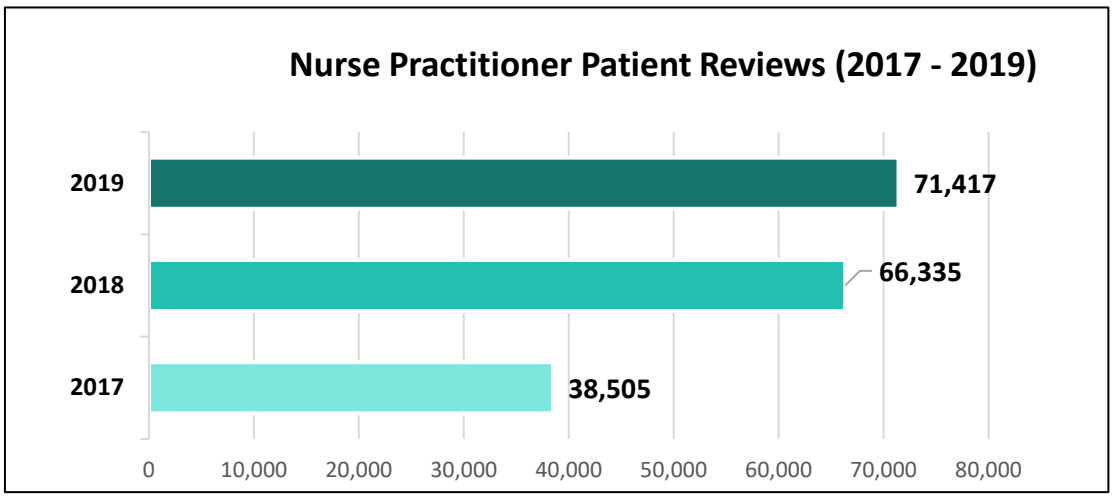

Figure 11. *Non-cumulative patient reviews per year for nurse practitioners.*

Optometrist:

233% increase in reviews since 2018

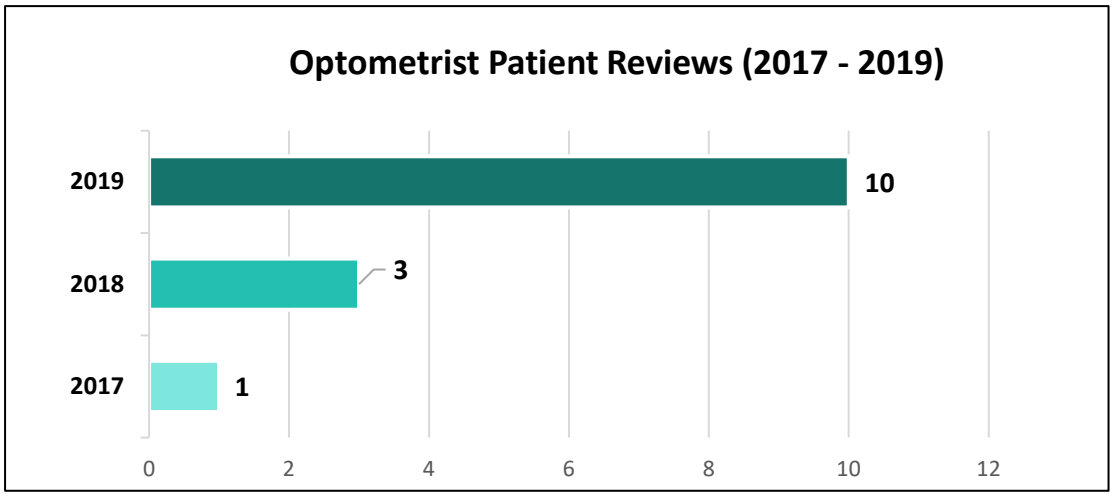

Figure 12. *Non-cumulative patient reviews per year for optometrists.*

Pharmacist:

2.73% decrease in reviews since 2018

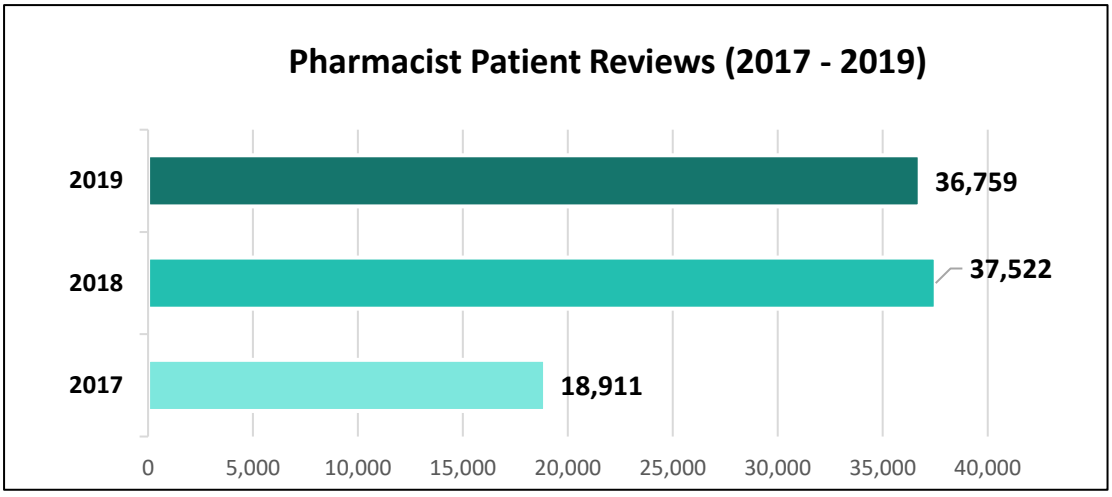

Figure 13. *Non-cumulative patient reviews per year for pharmacists. Pharmacists are exempt from reviewing.*

Physician:

20.5% decrease in reviews since 2018

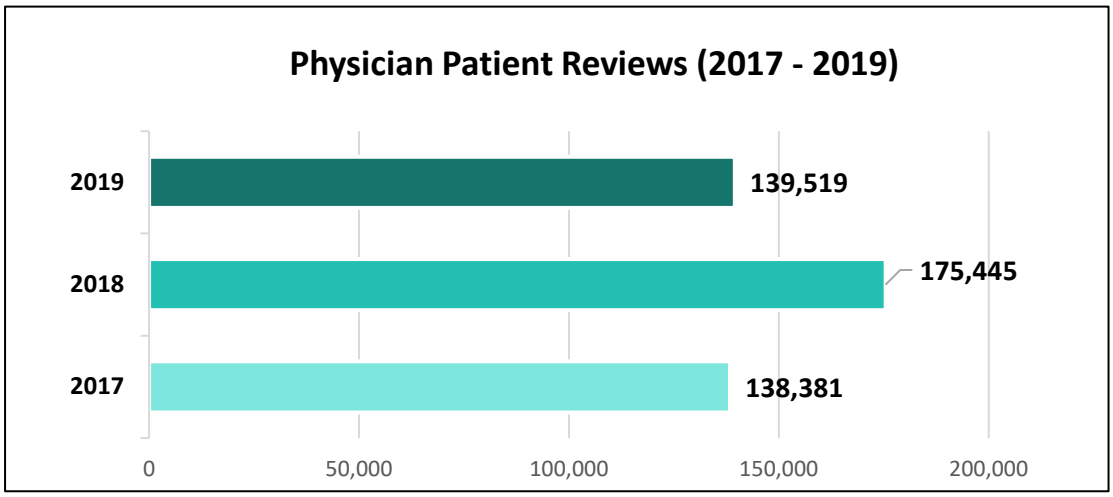

Figure 14. *Non-cumulative patient reviews per year for physicians.*

Physician Assistant:

17.8% decrease in reviews since 2018

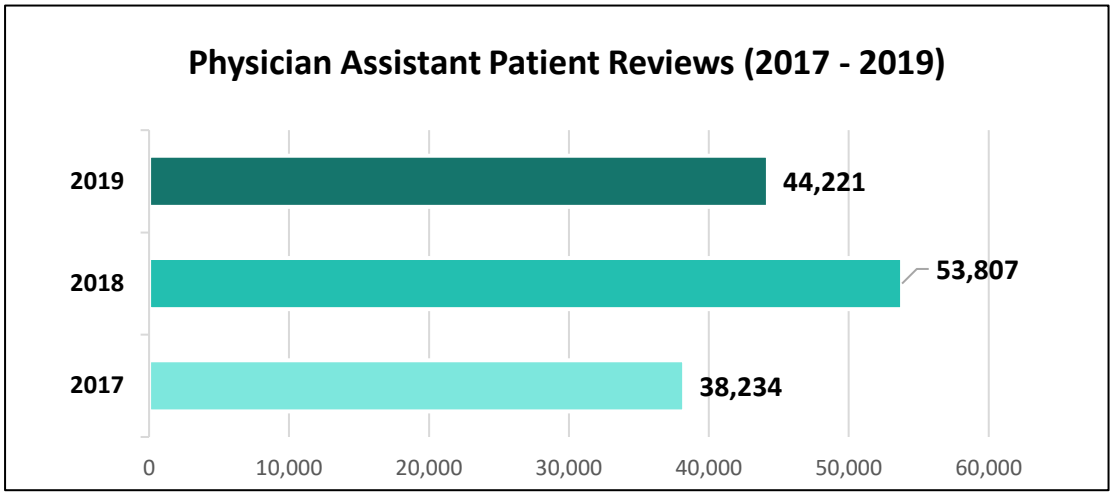

Figure 15. *Non-cumulative patient reviews per year for physician assistants.*

Veterinarian:

24.4% decrease in reviews since 2018

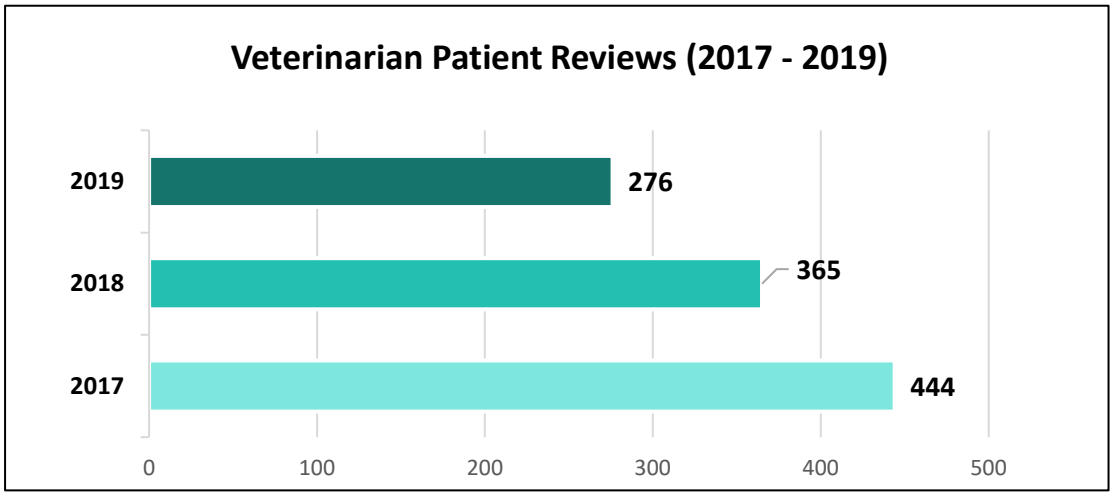

Figure 16. *Non-cumulative patient reviews per year for physician assistants.*

Mandatory Use: Reporting

Pharmacists and dispensing practitioners are required to report prescription data on federally scheduled II – IV controlled substances dispensed in the state to the PDMP on daily basis[3]. AWARxE's compliance feature provides a repository to track all pharmacies and prescribers dispensing or distributing federally scheduled II – IV controlled substances in Alaska (Table 3).

	2015	2016	2017	2018	2019	Change
# of Providers Reporting	408	562	375	359	349	-2.8%

Table 3. *The number of providers reporting decreased by almost 3% since the previous year.*

Expanded Use: Delegate Access

Following HB 159[11], required users of the database were authorized to delegate access to other individuals regulated by CBPL under AS 08. Delegate use is authorized for prescribing practitioners and pharmacists (Table 17) for both reviewing patient prescription history information and for reporting prescription information daily, but are limited to access the database only to the extent the delegate is directly involved in a supportive capacity with treating a current patient of the provider[3]. Office managers and general support staff are not authorized to access the database. Certified Medical Assistants are not authorized to register as delegates as they are not currently regulated under AS 08. In a 2018 questionnaire required as part of a CDC grant[5], 64 and 33 providers indicated use of delegates to review and submit prescription data, respectively, on their behalf. Providers also identified three primary benefits of delegate use, including: assisting with improving office work flow; distributing work load; and reducing time constraints[14].

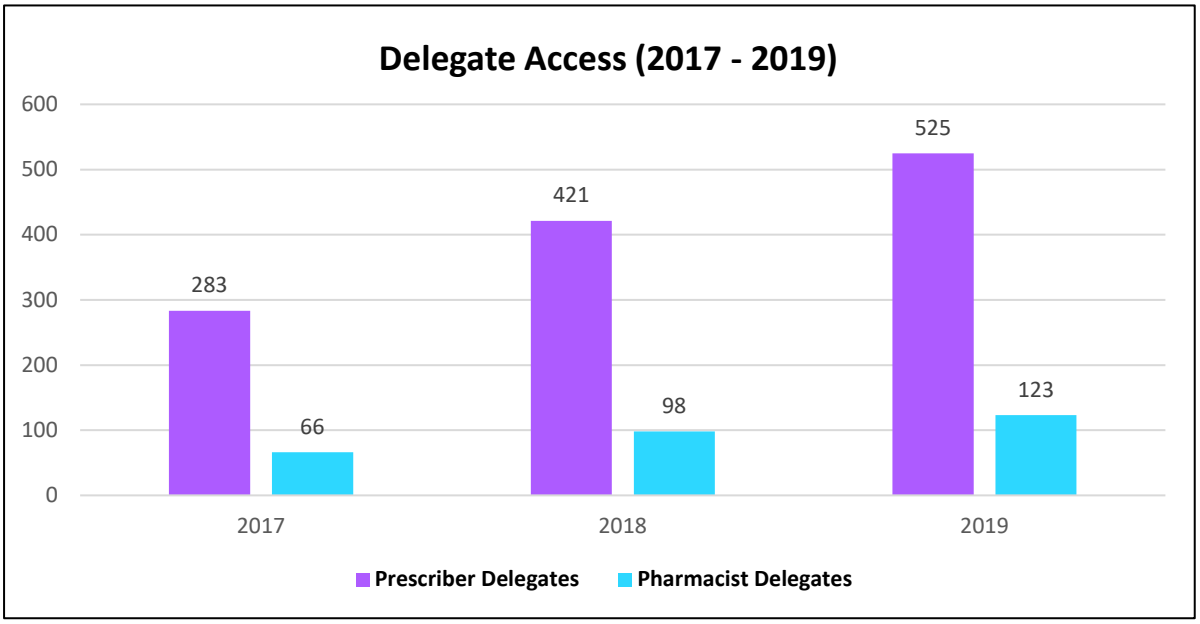

Figure 17. *Delegate access over time.*

Expanded Use: Federal Provider Access

Indian Health Service (IHS), Veterans Administration (VA), military, and other federal prescribers and dispensers have the ability to register using an appropriate federal user role category if registering with an email domain indicating affiliation with a federal employer. Federal providers are exempt from paying the fee set out in 12 AAC 02.107, but are not exempt if licensed by the CBPL under AS 08. DCCED does not require federal providers to register, although internal directives have been issued to providers requiring registration with state PDMPs[13]. The total number of federal providers are reflected in Figure 18.

In December 2018, the Defense Health Agency (DHA) launched its own controlled substance prescription database, the Military Health System Prescription Drug Monitoring Program (MHS PDMP). The MHS PDMP is administered by TRICARE Pharmacy's contractor, Express Scripts Inc., using Appriss Health's AWARxE platform, and with interstate sharing facilitated by the National Association of Boards of Pharmacy (NABP)[18]. The MHS PDMP will contain global PDMP data issued by military prescribers and aims to eventually connect with all state PDMPs. Alaska is in the process of exploring this bi-directional data, which will allow military providers access to view controlled substance prescriptions filled at military treatment facilities not previously available. Users will be able to obtain dual enrollment with the state and MHS PDMPs.

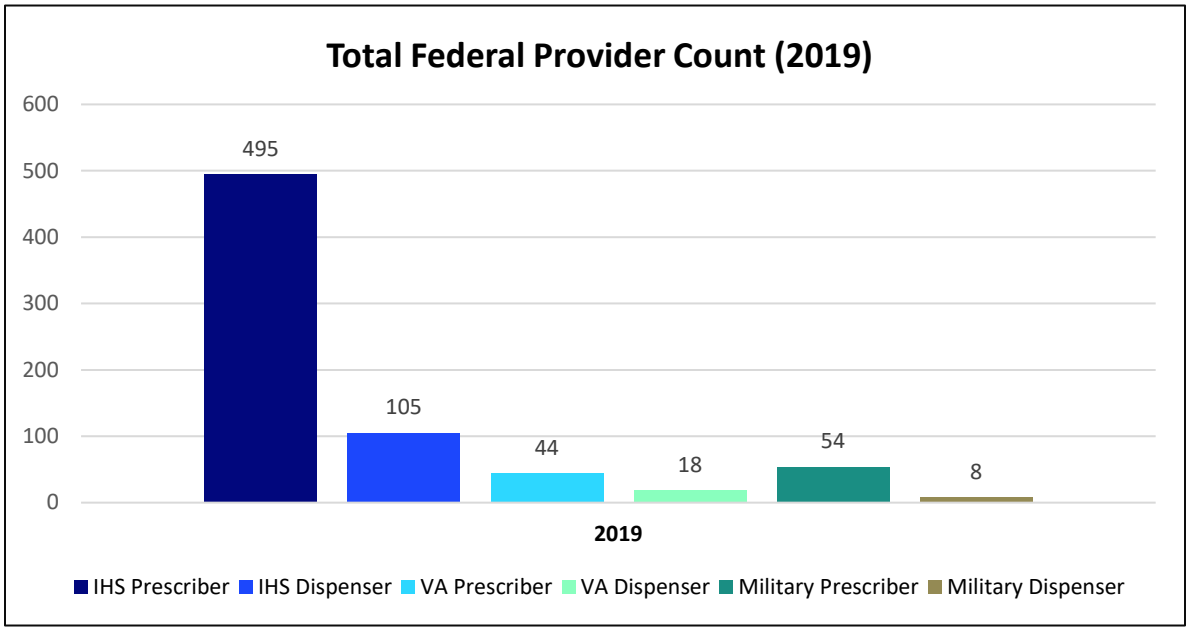

Figure 18. *Federal provider count as of 12/31/2019 (n = 689). Some of these registered users include licensees regulated under AS 08 (Figures 2 – 8.)*

Expanded Use: Emergency Department and Hospital Integration

Although providers working at emergency settings are exempt from reviewing and reporting to the database, hospital providers in emergency departments review data contained with the PDMP as a result of an agreement with CBPL, efforts made possible by the Alaska State Hospital and Nursing Home Association (ASHNHA), the Alaska Chapter of the American College of

Emergency Physicians (AK-ACEP), Collective Medical, and supported by the state's health information exchange established in AS 18.23.300[17].

Requirement	Interaction	Applicable to
Mandatory Registration	Create a PDMP account by completing an online registration through AWARxE and submitting the requisite form and payment	▪ Practitioners who hold an active Alaska professional license under AS 08 AND have a valid DEA registration: o advanced practice registered nurses (with state-level controlled substance prescriptive authority), dentists, optometrists, physicians, physician assistants, and veterinarians ▪ Pharmacists who dispense federally scheduled II - IV controlled substances in Alaska
Mandatory Review	Conduct a patient prescription history query before prescribing, administering, or dispensing federally scheduled II – IV controlled substances	▪ Practitioners who prescribe, administer, or directly dispense federally scheduled II or III controlled substances: o advanced practice registered nurses, dentists, optometrists, physicians, physician assistants, and veterinarians
Mandatory Reporting	Submit data electronically to the PDMP via PMP Clearinghouse or manually through AWARxE on a daily basis	▪ Practitioners who prescribe, administer, or directly dispense federally scheduled II – IV controlled substances: o advanced practice registered nurses, dentists, optometrists, physicians, physician assistants, and veterinarians ▪ Pharmacists-in-charge (PIC) of a licensed (in-state) or registered (out-of-state) pharmacy, or pharmacist if the PIC is not present, if dispensing or distributing federally scheduled II – IV controlled substances in/to Alaska

Table 4. *Mandatory registration, reviewing, and reporting.*

V. Interaction Exemptions

There are situational and supply-day exemptions to reviewing and reporting listed in AS 17.30.200(k) and (u), respectively[3]. Generally, exemptions to utilization apply when prescriptions are issued in inpatient, long-term care, or emergency and medical procedure-related settings, as well as when prescriptions are issued in a short supply (Table 5)[3].

Practitioners and pharmacists exempt from reviewing when:	**Prescriptions exempt from being reported when:**

▪ Issued to a person who is receiving treatment
  o At in inpatient setting
  o At the scene of an emergency or in an ambulance
▪ Given in an emergency room
▪ Given immediately before, during, or within the first 48 hours after surgery or a medical procedure
▪ Given in a hospice or nursing home that has an in-house pharmacy
▪ It is intended to last for three (3) days or less
	▪ Administered to an inpatient admitted to a health care facility or correctional facility.
	▪ Dispensed to a patient for an outpatient supply of 24 hours or less at
	  o A hospital
	  o Inpatient pharmacy
	  o Emergency department

Table 5. *Exemptions to mandatory use, including reviewing and reporting.*

VI. Unsolicited Reports - "Prescriber Report Cards"

Changes to AS 17.30.200 in HB159, 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[3].

Report Card Background

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. Report cards were first issued 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 health care specialty. For example, a practitioner whose specialty is family medicine will see how their prescribing practices compared to other physicians who specialize in family medicine. Beginning in 2018, Appriss Health enabled tertiary specialty comparison measures. Guidelines on how to interpret prescription metrics are sent to providers along with their report card.

Graphic 1. *A practitioner must indicate a specialty to be associated with their PDMP registration. The secondary and tertiary specialties are used as a comparison measure on a prescriber report card.*

Additional Metrics

- Top three medications prescribed
- Number of patients receiving a dangerous combination therapy
- Number of patient prescription history queries
- Morphine milligram equivalent (MME) range

Converting an opioid prescription to an MME value based on its quantity and dosage provides a standardized measurement of the amount of morphine within that prescription. MMEs calculated per day allows providers to assess whether prescribing a certain prescription may contribute to a patient exceeding MME threshold levels, which may increase a patient's risk of addiction, overdose, or death. The higher the MME, the higher risk the patient is for an adverse outcome. Quantifying prescriptions in this way also allows providers to prescribe within acceptable standards of practice adopted or recommended by federal and state regulatory agencies. For example, the CDC, recommends prescribing within 0 – 50 MME/day, and advises exercising caution when prescribing beyond this amount[20].

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. Pharmacists and delegate users do not receive report cards. The report cards are sent confidentially, on behalf of the PDMP, from Appriss Health to the email address associated with the practitioner's account. This ensures the report cards will only be accessed by the registered practitioner.

VII. Unsolicited Notifications - "Threshold Reports"

Effective July 17, 2017, changes to AS 17.30.200(q) authorized the issuance of unsolicited notifications to licensees and prescribing boards when a patient meets or exceeds the threshold of receiving prescriptions from five prescribers and five pharmacies over a three-month period "5-5-3 threshold". This threshold was established by the Alaska Board of Pharmacy in 2014 but is not codified in regulation, and prescribing guidelines are not established in regulation for all prescribing professions.

When prescribing boards are notified that a licensee has contributed, typically in combination with treatment given by another prescriber, to a patient meeting or exceeding the threshold, boards are only given notice of the incident but are not given the name of the practitioner or patient. As indicated in the authorizing statute, the notice to the board can be given in a summary format sufficient to provide the notification. Threshold notifications assist in informing prescribing boards of the need for additional guidance and education on opioid pain management and the requirement to review patient prescription history prior to prescribing, administering, or directly dispensing.

VIII. NarxCare

On September 9, 2019, a visual enhancement feature called NarxCare was implemented into the existing database as a visual representation of patient prescription data. NarxCare provides prescribing practitioners and pharmacists with a graphical snapshot of a patient's controlled substance usage and behaviors, based on an algorithm using the number of prescribers and pharmacists a patient has seen, total quantity of MMEs, and overlapping prescriptions. Within this visual snapshot, a separate numerical value "NarxScore" ranging from 000 - 999 for narcotics, stimulants, and sedatives are provided, which represent the patient's use of prescriptions for these drug classes. Higher NarxScores correspond to more prescriptions, more providers, more MMEs, and/or more overlapping prescriptions[21].

NarxCare also provides an overdose risk score (ORS) ranging from 000 – 990. A score between 0 – 200 indicates low to no risk of an overdose, and as scores increase incrementally by 100, the odds ratio doubles. For example, an ORS of 300 indicates a patient is two times more likely to experience an overdose event than a patient who has an ORS of 200[21].

NarxScores and ORS are not to be used solely when making a clinical determination. NarxCare is available as an additional tool to assess potential patient doctor shopping and to support providers as they assess for adverse health outcomes. NarxCare reports do not replace the standard prescription history data display available to providers within a patient query.

IX. Compliance Module

On November 13, 2019, a compliance module feature became available within the PDMP to allow providers to perform a self-audit of their reviewing compliance. This function allows prescribers to review patients for whom they did not query in the PDMP prior to prescribing a controlled substance; however, there situations in which providers are exempt from reviewing as described in Table 5.

X. Performance Measures

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)).

Performance Measure: 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 AWARxE 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 AWARxE 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. Passwords expire every three months.

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 PDMP shares information with emergency departments and Alaska hospitals through secure information exchange networks. Providers are able to query the PDMP to review patient prescription history information using a single sign-on mechanism; however, data is not stored for reuse or redistribution. The division executed a memorandum of understanding indemnifying

data contained in the database and limiting access to authorized users under AS 17.30.200. PDMP information is also shared with the Department of Health and Social Services (DHSS) through the Commissioner or Commissioner's delegate; however, data transmitted to DHSS is de-identified and contains regional information only.

Security for medical examiners and medicolegal death investigators:

Medical examiners employed by the State of Alaska are authorized to have direct access to the PDMP under AS 17.30.200(d)(9) for investigating the cause and manner of death. The PDMP administrator manually reviews a medical examiner's account details prior to approval. Once a medical examiner is approved and a death investigator has submitted an access request to serve as a medical examiner delegate, both the medical examiner and PDMP administrator must approve the delegate before access is granted. Passwords expire every three months.

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

The PDMP serves as a tool to assist authorized law enforcement in detecting drug diversion, misuse, and abuse. Patient prescription histories detailing prescription information 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 (Figure 19).

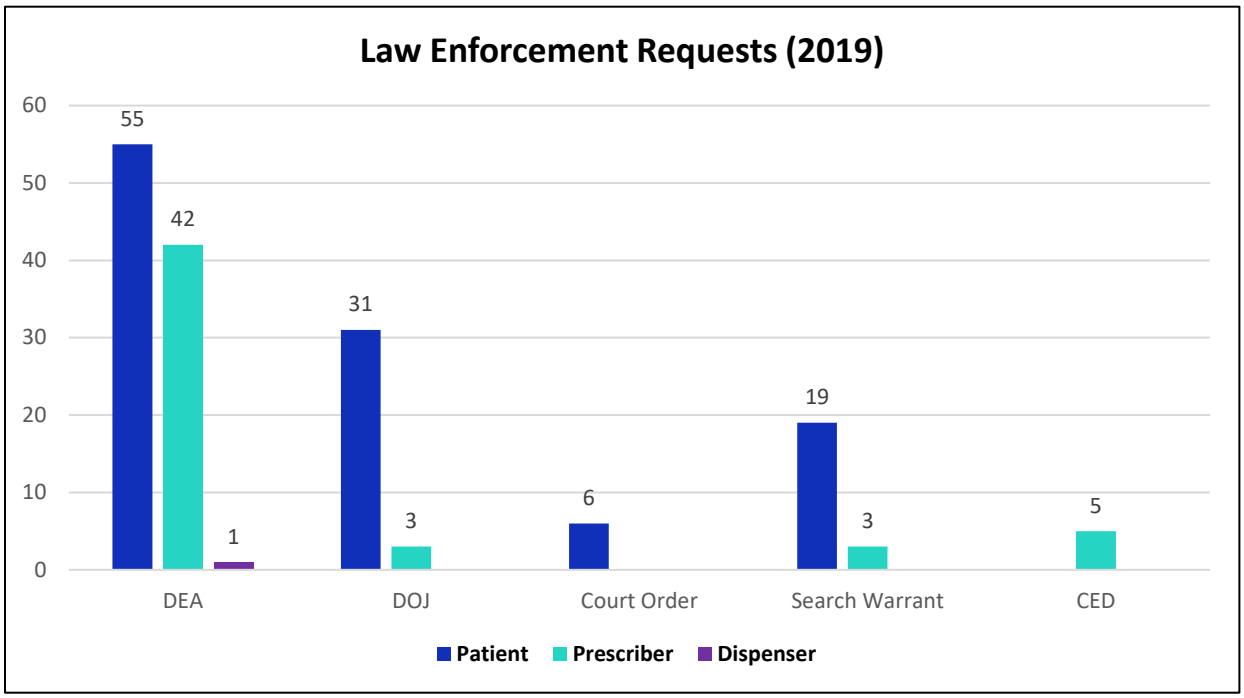

Figure 19. *Law enforcement requests for PDMP data.*

Unsolicited prescriber reports, described in section VI, also provides feedback that aims to reduce inappropriate prescribing practices. On November 13, 2019, the PDMP launched a compliance module feature which allows prescribers to perform self-audits on written prescriptions that were ultimately dispensed, but for which they did not perform a patient prescription review for. This secondarily provides a mechanism for identifying potential non-compliance cases; however, results may also include prescriptions written and dispensed in exempt scenarios described in AS 17.30.200(k)[3] and as summarized in Table 5.

Each prescribing board, and the Board of Pharmacy, make the ultimate determinations following an investigation as to whether a licensee has prescribed or dispensed prescriptions inappropriately or outside the scope of generally safe standards of practice. Data described in Figures 19 – 20 may reflect the benefits to use of the PDMP.

XI. Prescription Data Trends

In 2019, total opioid prescriptions dispensed in Alaska dipped below 1 million. The below data illustrates how the Prescription Drug Monitoring Program has had an impact on prescribing and dispensing practices, however, changes in treatment practices may also be explained by required continuing education relating to opioid abuse, misuse, and diversion; changes in the number of providers maintaining DEA registrations; increased communication between prescribers and dispensers; and internal motivations to reduce controlled substance prescribing, particularly opioids. There may also be a shift from abuse of prescription drugs to illicit drug use; the Alaska Department of Public Safety reported an increase of 19,507 (55.6%) in heroin, cocaine, and methamphetamine drug seizures from 2018 to 2019[19]. See Figures 20 – 23 for PDMP data.

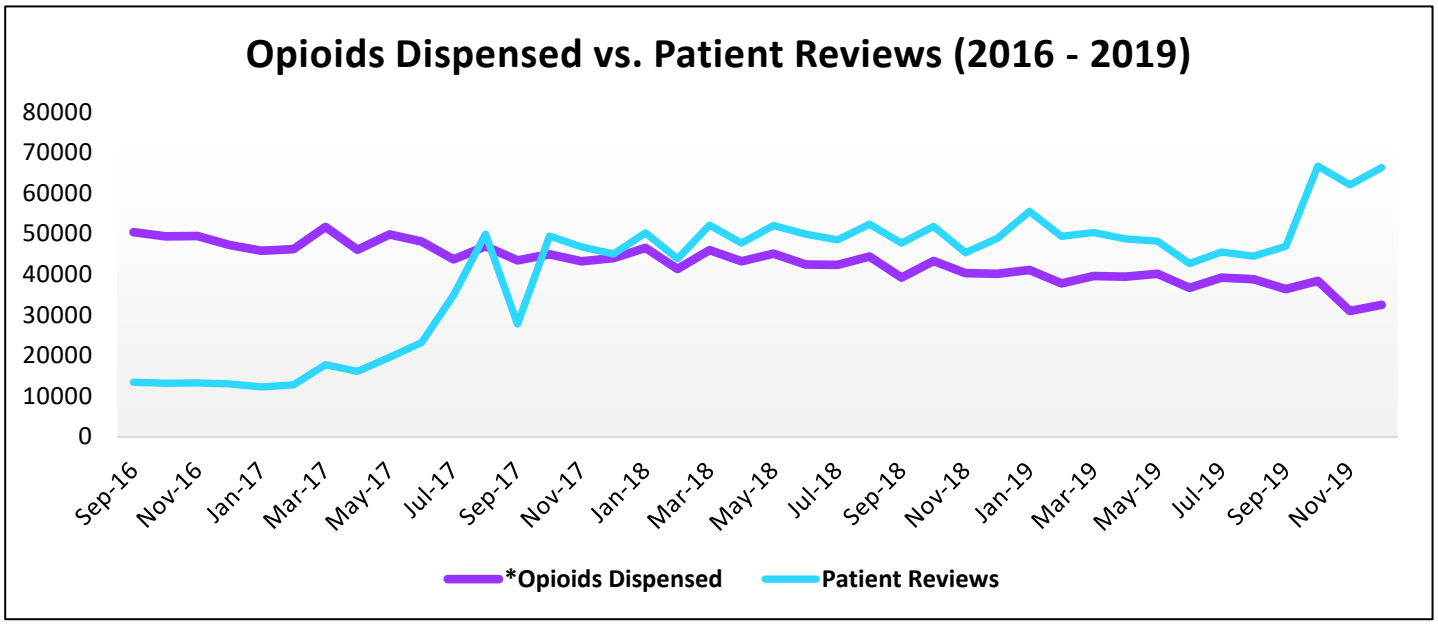

Figure 20. *Reviewing patient prescription history appears to assist with the downward trends in opioid prescriptions being prescribed and subsequently dispensed. *Reduction in opioids dispensed may be attributed to other factors, such as increased awareness of regulatory oversight, increased communication between providers regarding patient care, and required continuing medical education.*

2016		2017		2018		2019		Percent Change
Total = 1,108,771		Total = 1,035,093		Total = 1,002,330		Total = 937,107		• In total prescriptions: 15.48% decrease • In opioids: 25.04% decrease
55.5% opioids	44.5% non-opioids	54 % opioids	46% non-opioids	51% opioids	49% non-opioids	49% opioids	51% non-opioids	

Table 6. *Trends in prescribing from 2016 to 2019. Total opioid prescriptions have decreased by 25%. See Figure 21 for a visual representation.*

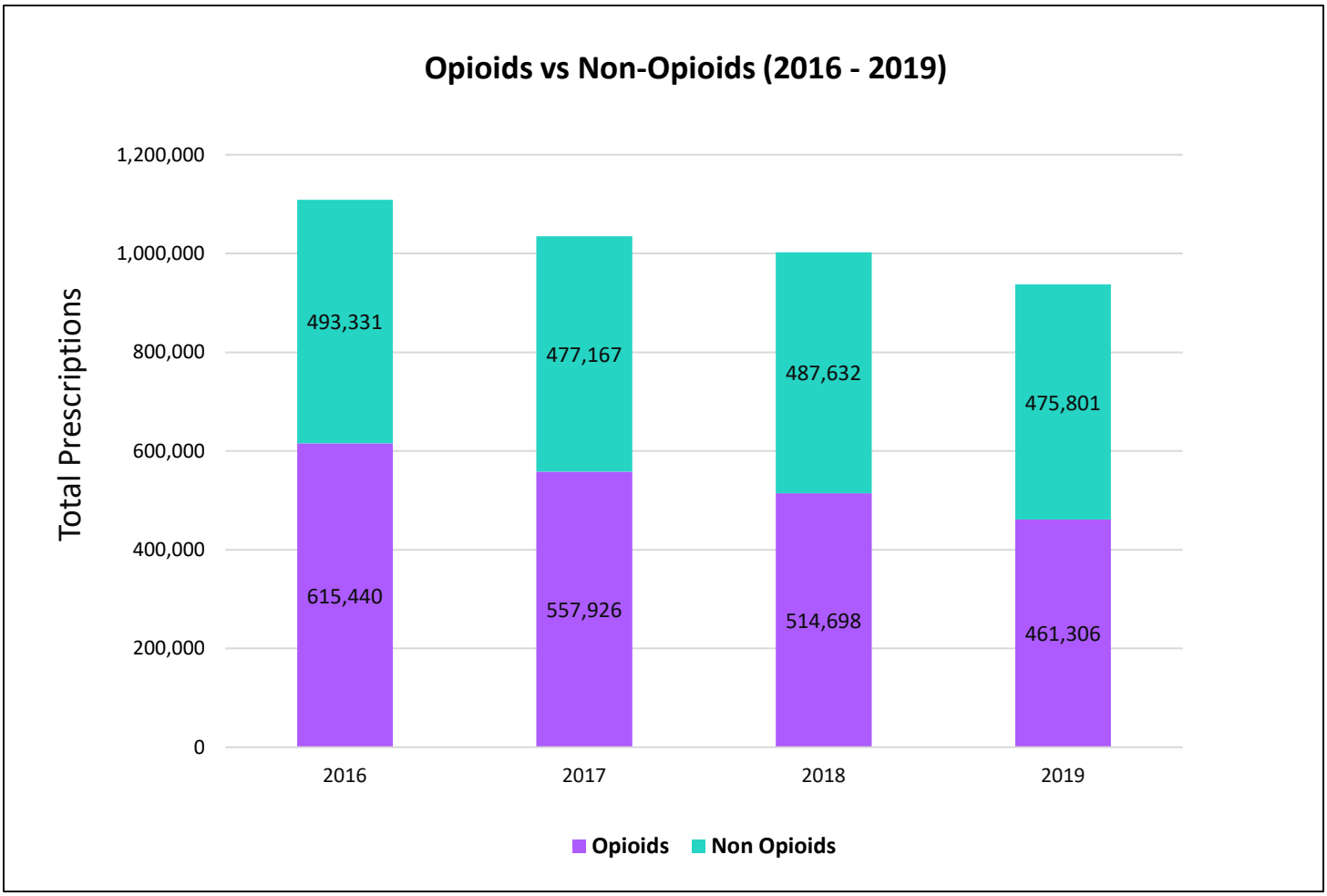

Figure 21. *Opioid prescriptions over time.*

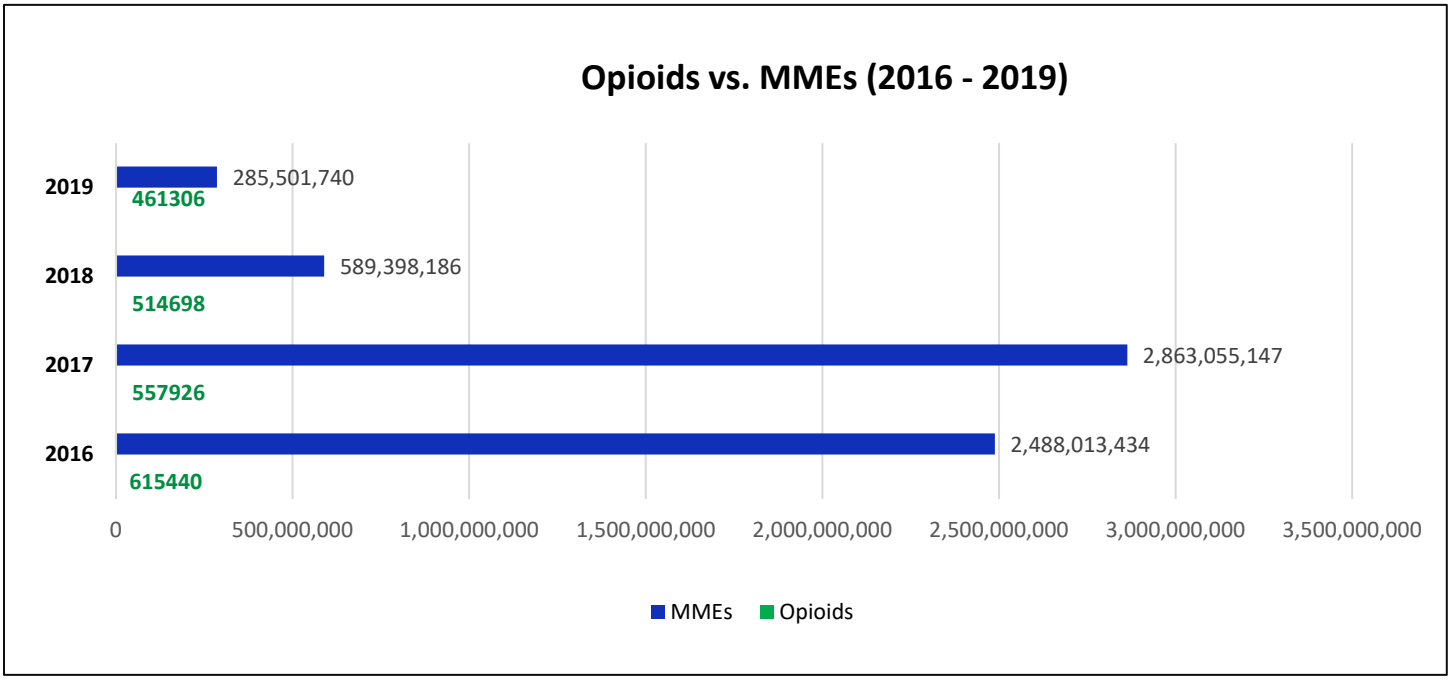

Figure 22. *Morphine Milligram Equivalents (MME) is a standardized measurement assigned to opioids to indicate its relative potency. Figure 7 illustrates the number of MMEs dispensed from 2016-2019.*

[1]Alaska State Legislature. *House Bill 196: An Act relating to establishing a controlled substance prescription database*. April 2008 [Internet]. Juneau, Alaska. Available from: http://www.akleg.gov/PDF/25/Bills/SB0196Z.PDF

[2] Prescription Drug Monitoring Program Training and Technical Assistance Center (PDMP TTAC). Bureau of Justice Assistance Prescription Drug Monitoring Program, Office of Justice Programs, U.S. Department of Justice. *Status of State PMPs.* October 2016 [Internet]. Washington (DC). Available from: http://www.pdmpassist.org/pdf/pdmpstatustable.pdf

[3]Board of Pharmacy Statutes and Regulations: October 2019 [Internet]. Juneau, Alaska. Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing. Available from: https://www.commerce.alaska.gov/web/portals/5/pub/PharmacyStatutes.pdf

[4]Bureau of Justice Assistance, Office of Justice Assistance, U.S. Department of Justice. FY17 Comprehensive Opioid Abuse Site-based Program Awards Category 5: Harold Rogers Prescription Drug Monitoring Program (PDMP). September 2017. [Internet, p. 2]. Washington (DC). Available from: https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/FY-2017-COAP-Category-5-awards.pdf

[5]Centers for Disease Control and Prevention. Data Drive Prevention Initiative (DDPI). October 2017 [Internet]. Available from: https://www.cdc.gov/drugoverdose/foa/ddpi.html

[6]Centers for Disease Control and Prevention. Overdose Data to Action (OD2A). September 2019 [Internet]. Available from: https://www.cdc.gov/drugoverdose/od2a/index.html

[7]Alaska State Legislature. *2008-02-06 Senate Journal. House Bill 196*. February 2008 [Internet]. Juneau, Alaska. Available from: http://www.akleg.gov/basis/Journal/Pages/25?Chamber=S&Bill=SB 196&Page=01785#1785

[8]Alaska State Legislature, Division of Legislative Audit. A Sunset Review of the Department of Commerce, Community and Economic Development, Board of Pharmacy. August 7, 2017 [Internet]. Available from: http://legaudit.akleg.gov/docs/audits/sunset/dcced/Pharmacy-FINAL-Report-WEB.pdf

[9]Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing. *Prescription Drug Monitoring Program (PDMP) Controlled Substance Prescription Database Registration Fees FAQs.* March 2018 [Internet]. Available from: https://www.commerce.alaska.gov/web/portals/5/pub/PHA_PDMP.FeeFAQ_04.2018.pdf

[10]Alaska State Legislature. *Senate Bill 74: Medicaid reform; telemedicine; drug database.* June 2016 [Internet]. Juneau, Alaska. Available from: http://www.akleg.gov/PDF/29/Bills/SB0074Z.PDF

[11]Alaska State Legislature. *House Bill 159: Opioids; prescriptions; database; licenses.* June 2017 [Internet]. Juneau, Alaska. Available from: http://www.akleg.gov/PDF/30/Bills/HB0159Z.PDF

[12]Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing. Controlled Substance Legislative Update. August 2017 [Internet]. https://www.commerce.alaska.gov/web/portals/5/pub/PDMP_EffectiveDates_08.2017.pdf

[13]Suba C, Davis C. Network for Public Health Law (Robert Wood Johnson Foundation). *Indian Health Service and Military Medical Prescription Drug Monitoring Program Requirements.* 2018 [Internet]. https://www.commerce.alaska.gov/web/Portals/5/pub/PHA_IHSdirectives_2018.06.pdf

[14]Alaska Department of Commerce, Community, and Economic Development, Division of Corporations, Business and Professional Licensing, Board of Pharmacy. Awareness and Feedback Questionnaire. May 2018 [Internet; via Survey Monkey]. Available from: https://www.commerce.alaska.gov/web/Portals/5/pub/PDMP_FeedbackQuestionaire_07.2018.pdf

[15]McDavitt K, Collective Medical. Connection Between Alaska State PDMP and Collective Medical Goes Live for Hospitals Across the State. July 10, 2018 [Internet]. Available from: https://www.businesswire.com/news/home/20180710005123/en/Connection-Alaska-State-PDMP-Collective-Medical-Live

[16]Alaska State Hospital and Nursing Home Association (ASHNHA): Behavioral Health Partnerships [Internet]. Available from: https://www.ashnha.com/behavioral-health-partnerships/

[17]Alaska State Legislature. Title 7: Health and Social Services; Chapter 166: Statewide electronic health information exchange system. Creation of health information exchange system. Available from: http://www.akleg.gov/basis/aac.asp#7.166.900

[18]Military Health System, Defense Health Agency. Prescription Drug Monitoring Program Procedures. January 2020 [Internet]. Available from: https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Access-to-Healthcare/Pharmacy-Program/Prescription-Drug-Monitoring-Program-Procedures

[19]Alaska Department of Public Safety. Drug Seizure Dashboard – Archive. YTD 2018 – 2019. Available from: https://dps.alaska.gov/ast/sdeu/drug-stats

[20]Centers for Disease Control and Prevention. Calculating Total Daily Dose of Opioids for Safer Dosage. Internet. Available from: https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

[21]Appriss Health. Requestor User Support Manual, Alaska Prescription Drug Monitoring Program. Version 2.1. December 2019 [Internet]. Available from: https://www.commerce.alaska.gov/web/portals/5/pub/PDMP_UseGuide.pdf