Alaska Prescription Drug Monitoring Program Report to the 31st Alaska State Legislature (2019)

Prepared for the 31st Alaska Legislature on March 8, 2019

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-Sixth Alaska State Legislature in 2008 established a controlled substance prescription database, which operates as a state-level opioid intervention strategy under the name of the" Prescription Drug Monitoring Program" (PDMP). At present, 49 states, the District of Columbia, and Guam have a fully operational PDMP. In Alaska, the PDMP is administered by the Alaska Board of Pharmacy (the board) under the Department of Commerce, Community, and Economic Development (DCCED), Division of Corporations, Business and Professional Licensing (CBPL).

> ***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.

Since the inception of the database, multiple statutory changes have taken place impacting the board and mandating that PDMP-related activities be carried through strategic multi-agency efforts to address the opioid crisis. Among these efforts are those aimed at reducing drug misuse and abuse, improving provider communication, and increasing database interaction requirements through awareness and educational outreach activities.

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

- contain data regarding every prescription for a Schedule II, III, and 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
- assist with investigative efforts to identify potential misuse and abuse

- assist with investigative efforts to identify and reduce drug diversion
- reduce the prescribing of inappropriate controlled substance medications
- generate and send unsolicited reports to practitioners to compare their prescribing trends to other practitioners in the same health care specialty
- provide access to practitioners and dispensers required by law to register and use the database:
    - dentists, physicians, nurse practitioners, optometrists, pharmacists, and veterinarians
- provide delegate access to individuals licensed, certified, or otherwise regulated by DCCED to access the database on behalf of the provider
    - registered nurses, pharmacy interns, pharmacy technicians, veterinary technicians, and other regulated healthcare individuals

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. 30th Legislative Report and Previous Legislative Reports

In 2017, mandatory registering, reviewing, and reporting with the PDMP database (Table 1) were enacted under AS 17.30.200 for practitioners and pharmacists. In July 2018, mandatory data submissions changed from a reporting frequency of weekly to daily, which improved the program's data accuracy and completeness of patient history records. Collectively, these changes have resulted in the state's ability to more thoroughly 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** – The mandatory interactions chart is updated to clarify when pharmacists are required to register
- **Reporting Frequency** – Prescribers directly dispensing federally scheduled II – IV controlled substance prescriptions are required to submit dispensations to the PDMP on a daily basis. Pharmacists dispensing in or distributing to Alaska are also required to report daily, including zero reports
- **Unsolicited Reports** – This report expounds on information previously discussed in the 30th 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 expansion to comparison of tertiary specialty levels.
- **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, 29th, and 30th legislative report.
- **Unsolicited Notifications** – This report adds 2018 information on notifications to prescribing boards when a patient has met or exceeded the threshold level of seeing five prescribers and five pharmacies over a three-month period "5-5-3 threshold."
- **PDMP Fees** – Fees for initial registration and renewal went into effect on April 22, 2018 and are set out in 12 AAC 02.107.
- **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. New information added to the section on security measures include access to medical examiners and death investigator staff.
- **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, mandatory use, 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 with updated data. For top drugs dispensed, previous legislative reports included prescriptions by generic name; however, due to the unavailability of prescription information by generic name for 2018, prescriptions by brand name is reported. Information on federal providers and the new military PDMP is also provided. Login and patient prescription history queries by profession and data on the number of pharmacies reporting are added for the first time in this legislative report.
- **Board Reports** – In 2018, the PDMP manager began producing board-specific reports, which can be found here: pdmp.alaska.gov.
- **Intrastate Data Sharing** – Beginning in 2018, the Alaska PDMP engages in information exchanges with emergency departments and other entities through data integration.

IV. Mandatory Interactions

In 2017, mandatory interactions with the PDMP went into effect following House Bill 159, requiring active Alaska-licensed prescribers with DEA registrations valid to use in any state or practice location to register with the database. Prescribers required to register also became mandated to query the PDMP each time before prescribing, administering, or directly dispensing a federally schedule II or III controlled substance. Pharmacists dispensing these prescriptions were mandated to register if actively practicing in Alaska. The mandatory reporting mandate changed the frequency of reporting controlled substance prescription data from a weekly basis to a daily basis beginning in July 2018, including reporting when no controlled substances are dispensed "zero reporting". The review mandate effectively terminated the need for registered out-of-state pharmacies to submit the Certification of No Controlled Substances Dispensed form; however, a new data reporting survey was issued to collect information on pharmacies to which the mandatory reporting requirement does not apply. AWARxE houses only those accounts that actively dispenses in or distributes controlled substances to end users in Alaska.

Beginning in June 2018, the PDMP began distinguishing mandatorily registered provider accounts from providers not required to register by AS 08, but able to register with the database at the direction of the provider's federal employer. Indian Health Service (IHS), Veterans Administration (VA), Military, and other federal prescribers and dispensers were given the ability to register using the appropriate user role category only 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.

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: ○ advanced practice registered nurses, 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: ○ advanced practice registered nurses, dentists, optometrists, physicians, physician assistants, and veterinarians.
Mandatory Reporting	Submit data electronically to the PDMP via PMP Clearinghouse or manual through AWARxE on a daily basis	• Practitioners who prescribe, administer, or directly dispense federally scheduled II – IV controlled substances: ○ 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 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).

In addition to mandatory interactions, Senate Bill 74 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. At present, certified medical assistants are not regulated by DCCED and are therefore unable to register as delegates.

V. Interaction Exemptions

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

Practitioners:	**Prescriptions:**
• 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 (3) days.	• 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 an emergency procedure, immediate inpatient care, or a supply-limit duration. AS 17.30.200(u).

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.

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 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. 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, however, only 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.

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 the provider's email address.

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. 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 merely sufficient enough 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. PDMP Fees and the New Registration Process

The PDMP is a grant-funded program that needs financial stability to support augmented operational functions. SB74 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. Effective April 22nd, 2018 and under 12 AAC 52.107, the division began requiring a $25.00 fee before granting initial access to the database. Due to the absence of database integration between AWARxE and the division's internal licensing and receipting system "Portal", the registration process is decentralized and requires a two-step process (Table 3).

Providers requesting access to the database for the first time are now required to first create credentials online through AWARxE, then submit an initial paper payment form to the division. While active PDMP accounts are primarily housed in AWARxE, manual validation of professional licenses are confirmed through Portal. Effective June 2018, the PDMP began issuing registration numbers to those submitting initial and renewal applications. The anticipated time for all active registered users to have a unique PDMP registration number is June 2019. Once all registrations are captured in Portal, a streamlined renewal process will be available to its registered users through MyLicense.

Online through AWARxE	Manual Form Submission
1.) Licensee creates login credentials through alaska.pmpaware.net	4.) Submits initial form and payment, if payment is required
2.) Licensee checks email to verify it is a valid email through which to access the PDMP – clicks on verification link	5.) PDMP administrator compares paper submission against online AWARxE submission
3.) Uploads validation documents to AWARxE if a military or VA provider	6.) PDMP administrator approves access and issues a registration number

Table 3.) The two-part registration process for initial access to the PDMP requires that a provider create an access request online before submitting the paper form and payment.

IX. 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). 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 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 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 the purpose of 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.

2.) 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 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 provides feedback that allows 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 2). Detailed information on mandatory utilization is further described in this report in figures 4 – 9 and tables 4 – 5.

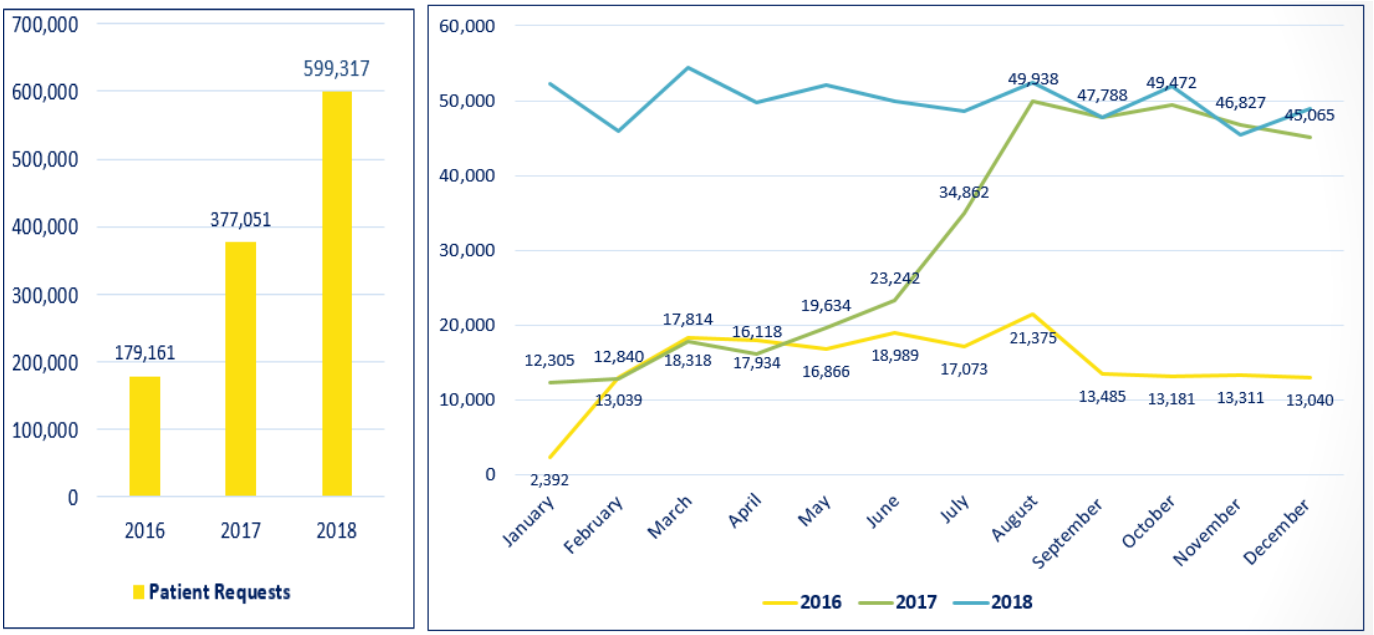

Figure 2. The bar graph on the left shows the number of patient prescription history requests conducted by practitioners from 2016 to 2018. The line graph indicates patient prescription history request trends over a three-year period.

The above graph shows an increase of 234.5% in practitioners conducting one or more patient prescription history requests from 2016 to 2018, a relative increase of 89% since last year. This indicates recognition by providers 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))

A PDMP administrator forum, Basecamp, was launched to bring together PDMP administrators from 49 states, D.C. and Guam to discuss a range of topics including: mandatory use; data integration with federal

entities; audit trail requests; dispensation errors; and access to medical directors for quality improvement purposes.

In 2018, the Alaska PDMP manager continued as 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 met periodically in 2018 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. This multi-agency team was 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 in 2018, the team met to discuss various updates with the ultimate goal of improving health outcomes in our state.

Alaska Opioid Action Plan Summit – The Office of Substance Misuse and Addiction Prevention (OSMAP) partnered with the Advisory Board on Alcoholism and Drug Abuse (ABADA), as well as the Alaska Mental Health Trust to develop a statewide opioid action plan. As part of the Prescribing Practices Advisory Committee, the PDMP manager participated in the development of objectives and strategies centered around a prescribing practice and provider education vision. Vision: Alaskans have access to and are engaged by medical professionals who are supported in their decision-making through efficient access to critical information and data, availability of treatment options that are most appropriate and evidence-based for the individual's health status; easy access to quality training, education and resources, and a collaborative professional environment. Strategies were developed for the objectives of facilitating real-time integration of opioid data, increase provider's knowledge and incorporation of evidence-based medicine guidelines for prescribing for various conditions and circumstances, and to expand utilization of integrated care team models throughout the state.

X. PDMP Data

The following data is provided from information contained in the PDMP.

Number of Registered Users

The graph below (Figure 4) shows the number of total registered users since 2013. Figure 5 and Table 4 illustrate the number of registered users by profession and the compliance rate for each, respectively. Detailed information and mandatory use is illustrated in Figures 6 – 9. Federal

providers are recorded separately and presented in Figure 10. The number of pharmacies reporting prescriptions to the PDMP are provided in Table 7.

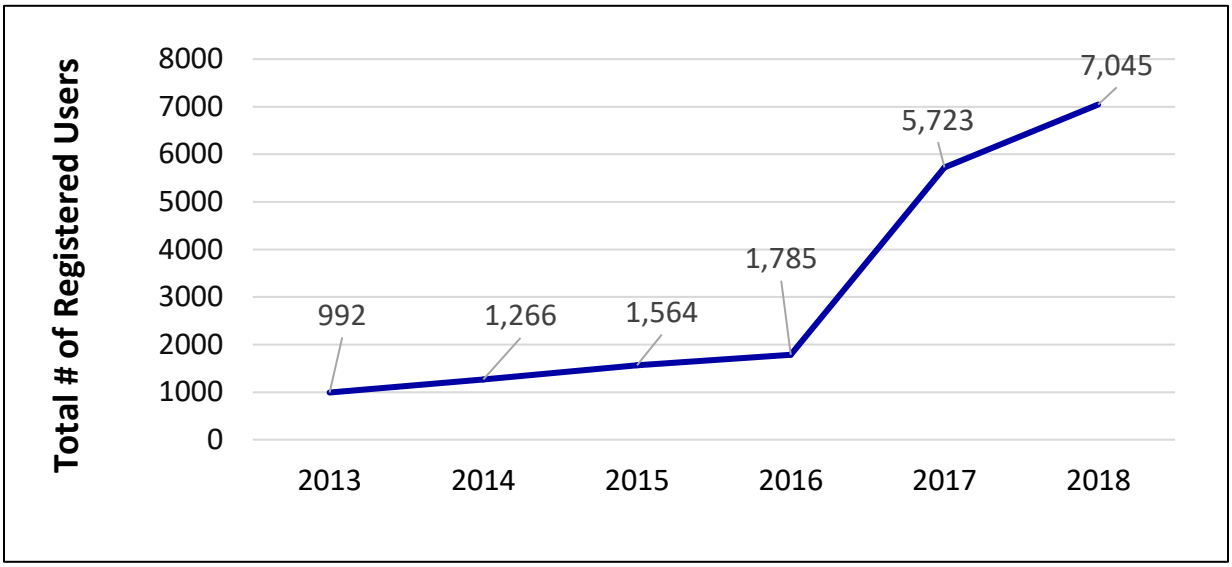

Figure 4. The cumulative number of registered users has increased exponentially since 2013; the growth rate of registered users from 2013 to 2018 is 610%.

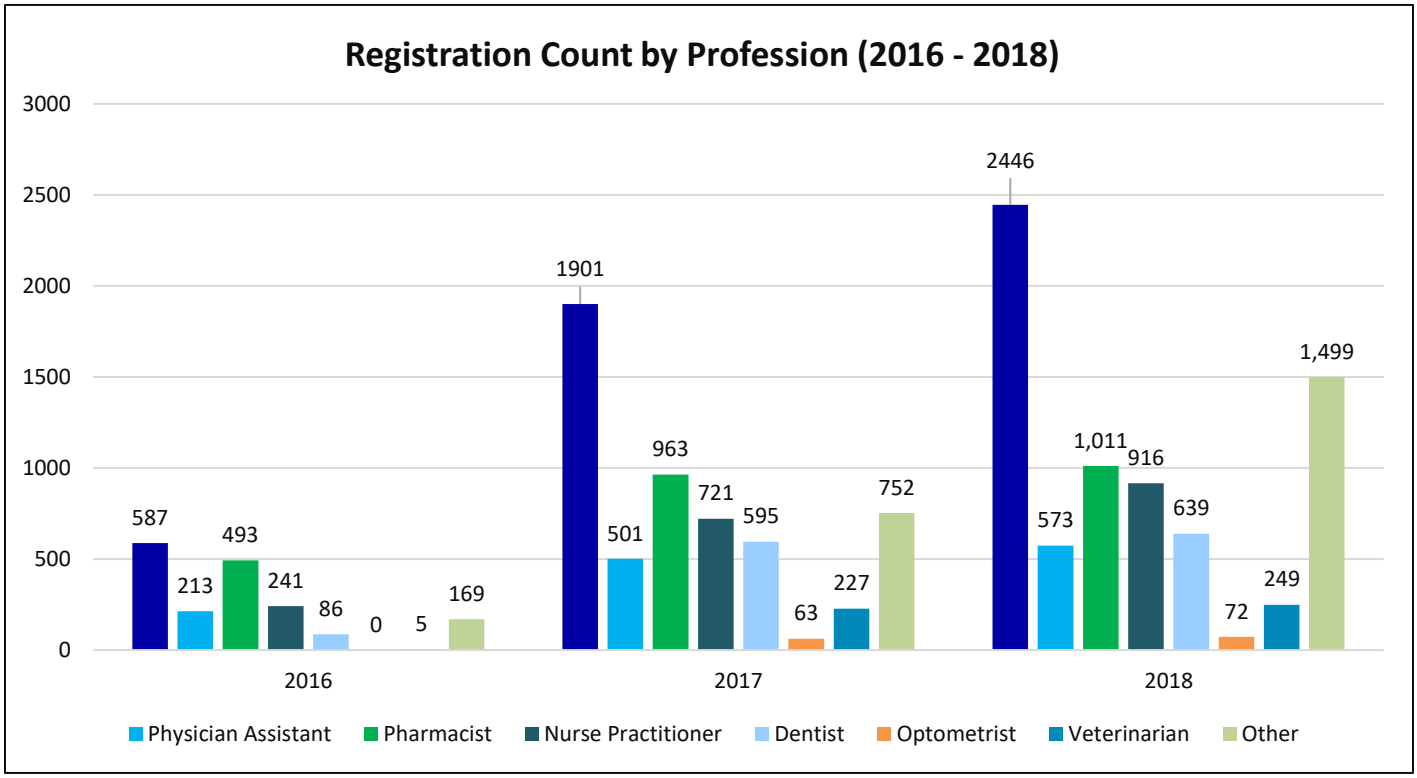

Figure 5. Registration details prior to 2015 are incomplete due to changing PDMP vendors. The 'Other' category includes admin, medical examiner/coroner, medical interns with prescriptive authority, out-of-state prescribers and dispensers, delegates, IHS, VA, and military user roles.

Profession	# of active licensees	# of registered users	Compliance Rate	# not registered**
Physician	4,643	2,446	53%	2,197
Physician Assistant	631	573	90%	58
Pharmacist*	1,054	1,011	96%	43
Nurse Practitioner	1,185	916	77%	269
Dentist	865	639	74%	226
Optometrist	187	72	39%	115
Veterinarian	346	248	72%	98

Table 4. The registration compliance rate for mandatory professions ranges from 39% to 96%.

*The pharmacist category includes both in-state pharmacists but exclude out-of-state pharmacists (n=47; access authorized by AS 17.30.200(d)(4)); however, the current number of pharmacists with Alaska addresses is 607 and the current number of registered users with in-state PDMP accounts is 1,011. The number of registered users with in-state accounts may be exceeding the in-state license base due to incorrect user role selections, e.g.: "pharmacist" rather than "out-of-state pharmacist" or address update delays.

**This is only an approximation of the number not registered; properly licensed individuals may be registered under a federal user role category, e.g.: "IHS dispenser" rather than under the role of their practicing profession.

More detailed reports on registration and use by professions can be found in the respective board reports at pdmp.alaska.gov.

Number of Pharmacies Reporting

AWARxE's compliance feature provides a repository to track all pharmacies and prescribers dispensing or distributing federally scheduled II – IV controlled substances in Alaska. Through the pharmacy management compliance feature, the PDMP Manager can add pharmacies and prescribers with DEA registrations, which provides the ability to perform pharmacy analyses on a quarterly basis. These analyses assist in identifying pharmacies and prescribers who are non-compliant with the daily reporting requirement under AS 17.30.200(r).

	2015	2016	2017	2018	% change
# of Pharmacies Reporting	178	208	268	289	62% (increase)

Table 5. The cumulative increase of pharmacies reporting from 2015 to 2018 is 62%.

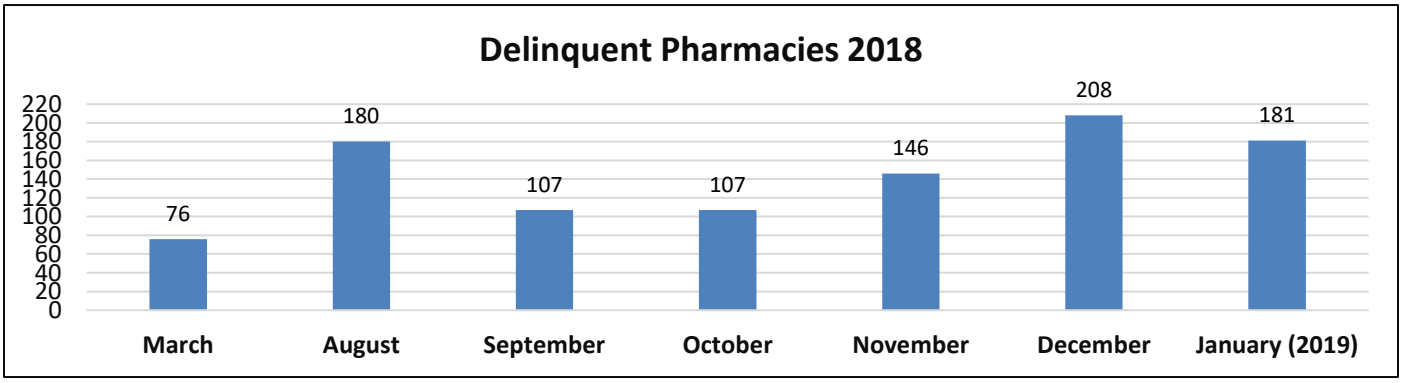

Figure 6. The number of delinquent pharmacies has more than doubled since the last compliance report. Pharmacies will be contacted via mail to correct reporting gaps. This also includes delinquent prescribers required to be reporting daily.

Login and Review Activity

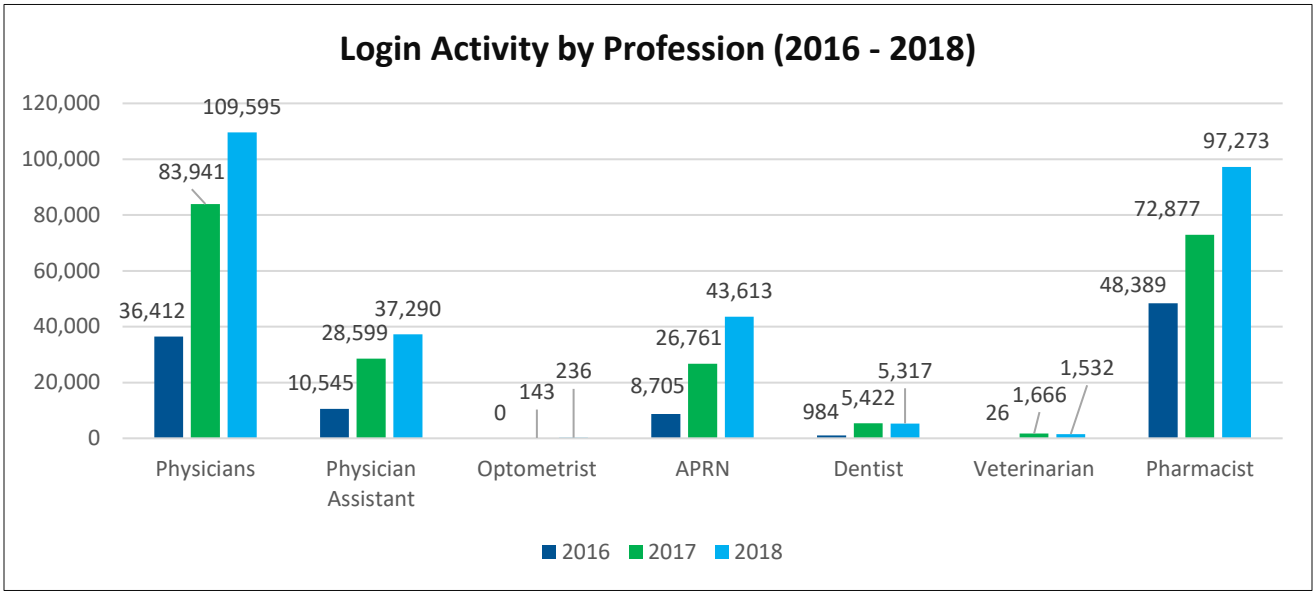

Figure 7. Login activity has increased since 2016 for every profession. Pharmacists are not mandatorily required to login to review patient prescription history; however, login rates for this profession continue to increase each year.

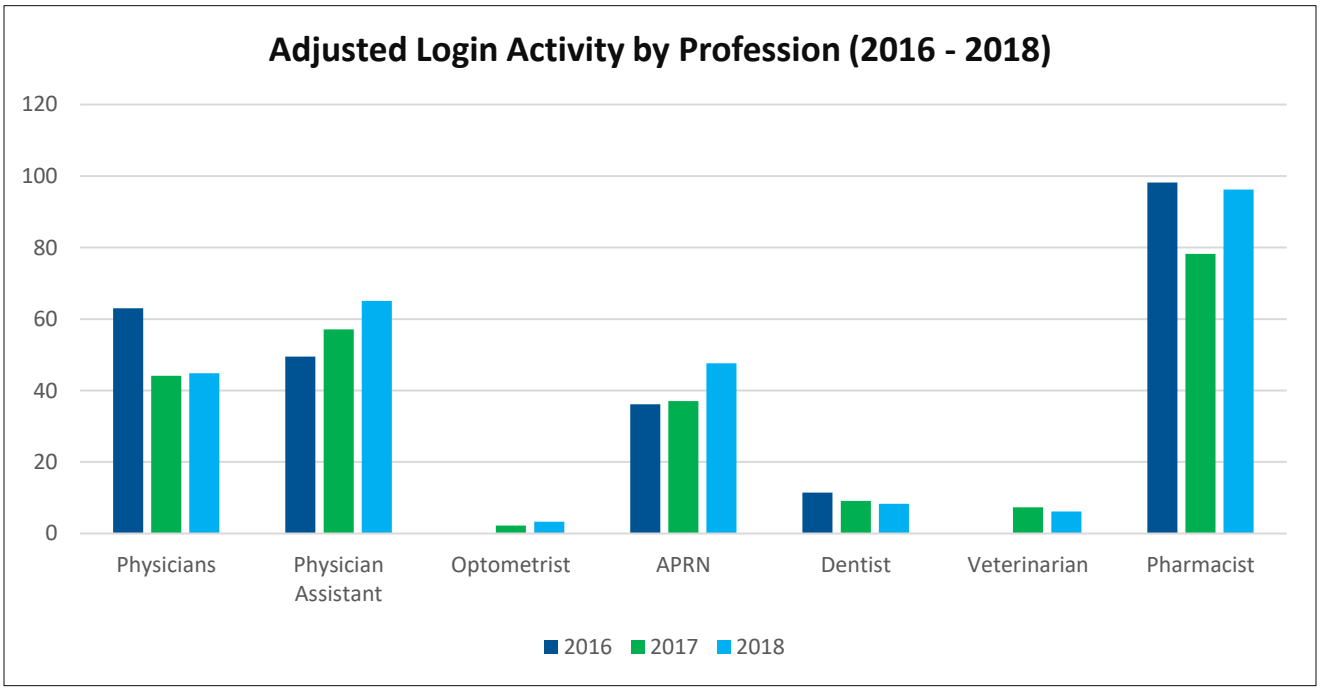

Figure 8. Login activity adjusted by the number of users in each profession. Note: these numbers are based on the absolute number of registered users and not on the number of practitioners with active DEA registrations.

Pharmacists have the highest login activity rate, but are not required by law login for the purpose of reviewing patient prescription history information. This indicates the pharmacy profession is maximizing PDMP use and engaging in active surveillance efforts to identify potential doctor shopping of controlled substance prescriptions.

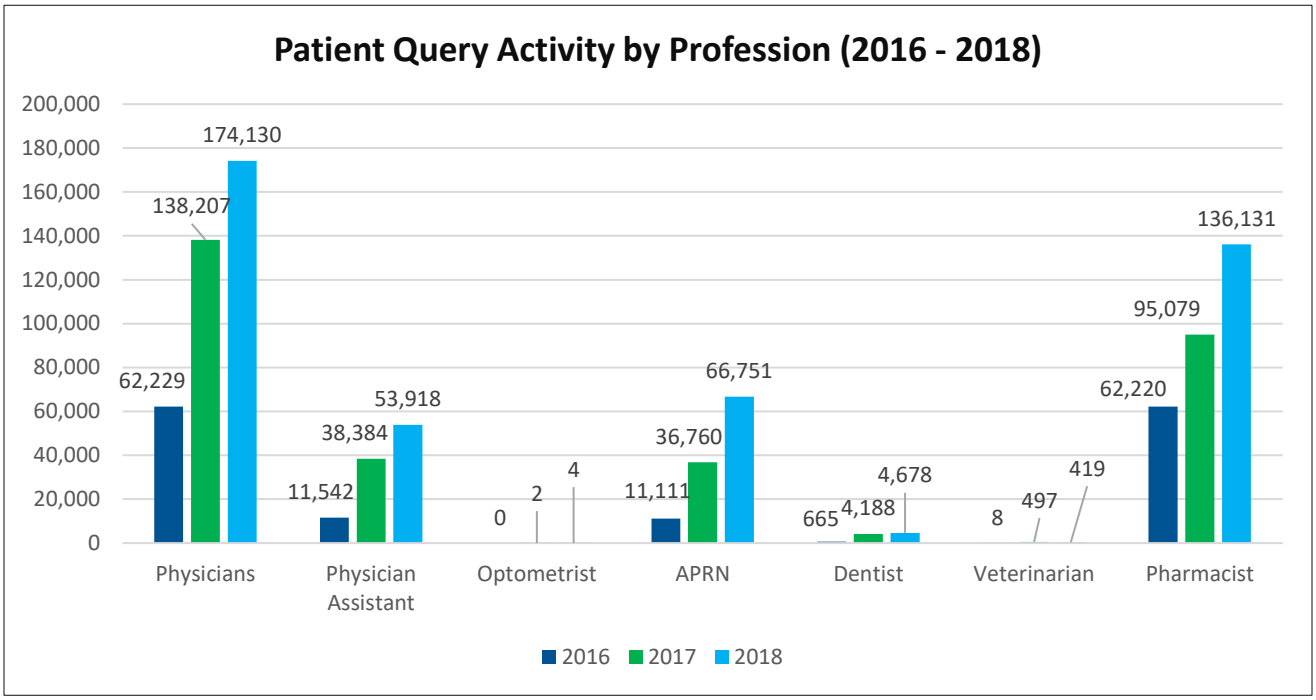

Figure 9. Patient query activity has increased since 2016 for every profession. Pharmacists are not mandatorily required to login to review patient prescription history; however, reviewing rates also continue to increase.

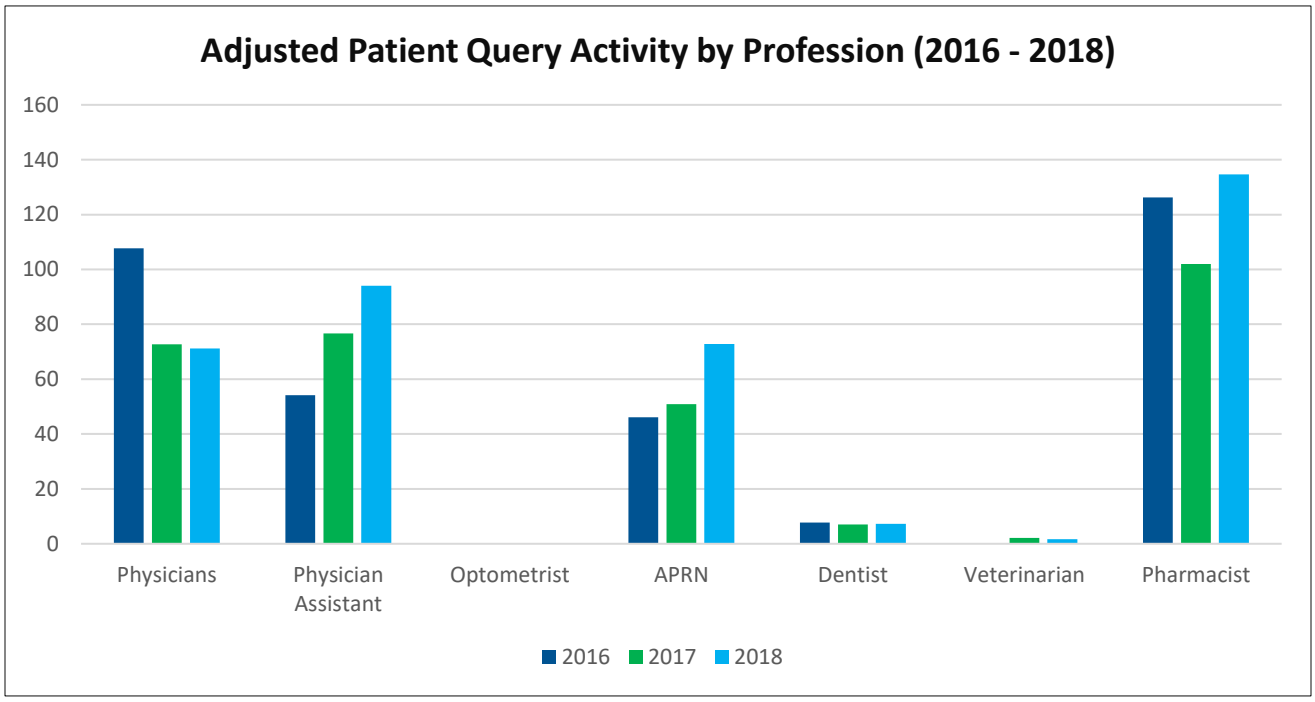

Figure 10. Patient prescription history queries adjusted by the number of users in each profession. Note: these values are based on the absolute number of registered users and not on the number of practitioners actively prescribing under a valid DEA registration.

The review rate per physician decreased from 2016 to 2018 and has remained steady for dentists and veterinarians during this time. Review rates among physician assistants, nurse practitioners, and pharmacists showed increases over the last two years. Pharmacists have the highest number

Federal Providers

Prescribers and pharmacists working with Tribal Health Organizations or the Indian Health Service (IHS), Veterans Administration (VA), military, or other federal employer may register with the PDMP under the authority of AS 17.30.200(f). Federal providers are not *obligated* to register by AS 08; however, internal directives issued by both the IHS and VA indicate that registration with the State's PDMP is binding upon its employees. The registration and renewal fees do not apply to these federal providers. The division began distinguishing between federal and non-federal user roles in June 2018 (Figure 5).

In December 2018, the military launched its own controlled substance prescription database, the Military Health System Prescription Monitoring Program "MHS PMP" in collaboration with the National Association of Boards of Pharmacy (NABP) and the Defense Health Agency (DHA). The MHS PMP will contain global PDMP data issued by military prescribers and aims to connect with all state PDMPs in 2019. Alaska is in the process of exploring this bi-directional data, which will allow non-military registered users 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.

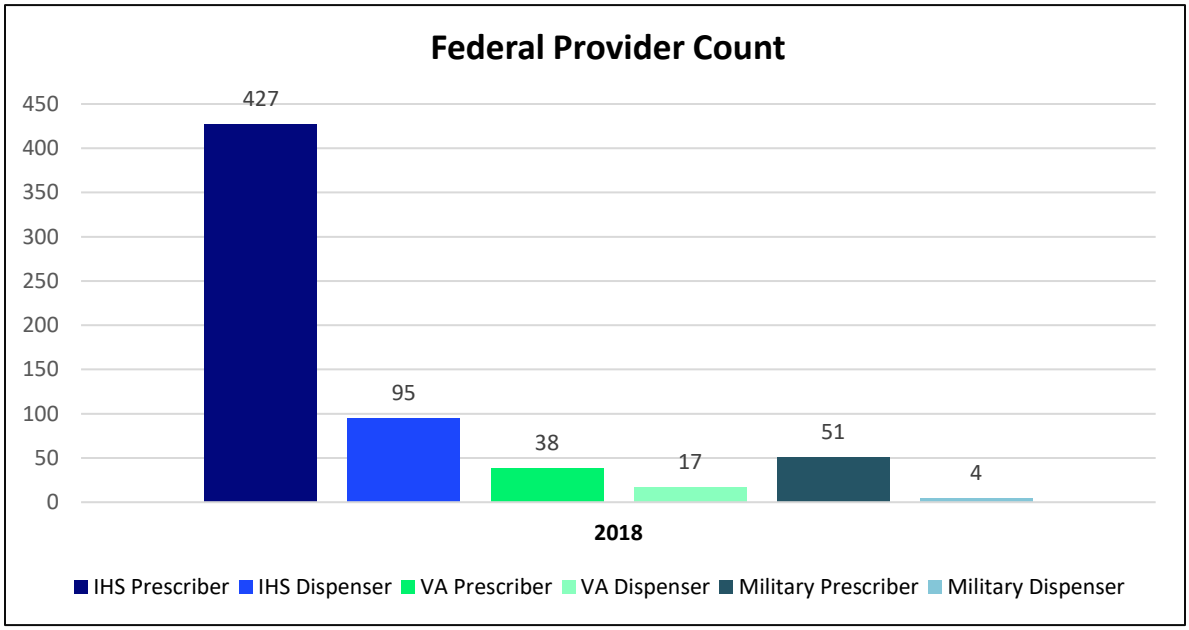

Figure 11. As of December 31, 2018, the total registration count for federally-employed prescribers and dispensers is 632. Providers who work exclusively for a federal employer are not required to pay the PDMP registration fee; however, providers working both with a federal agency and outside of this capacity are permitted to have two user roles, e.g.: "IHS prescriber" and "physician" user roles for a physician who provides relief work at an IHS facility and also in private practice.

Total Prescriptions

Table 6 and Figure 6 shows the number of total prescriptions written from 2016 to 2018. 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		2018		Percent Change
Total = 1,053,999		Total = 965,659		Total = 1,000,957		• In total prescriptions: 5% decrease • In opioids: 15.24% decrease
55.47% opioids	44.53% non-opioids	54.26% opioids	45.74% non-opioids	49.51% opioids	50.49% non-opioids	

Table 6. Controlled substance prescriptions dispensed from 2016 to 2018.

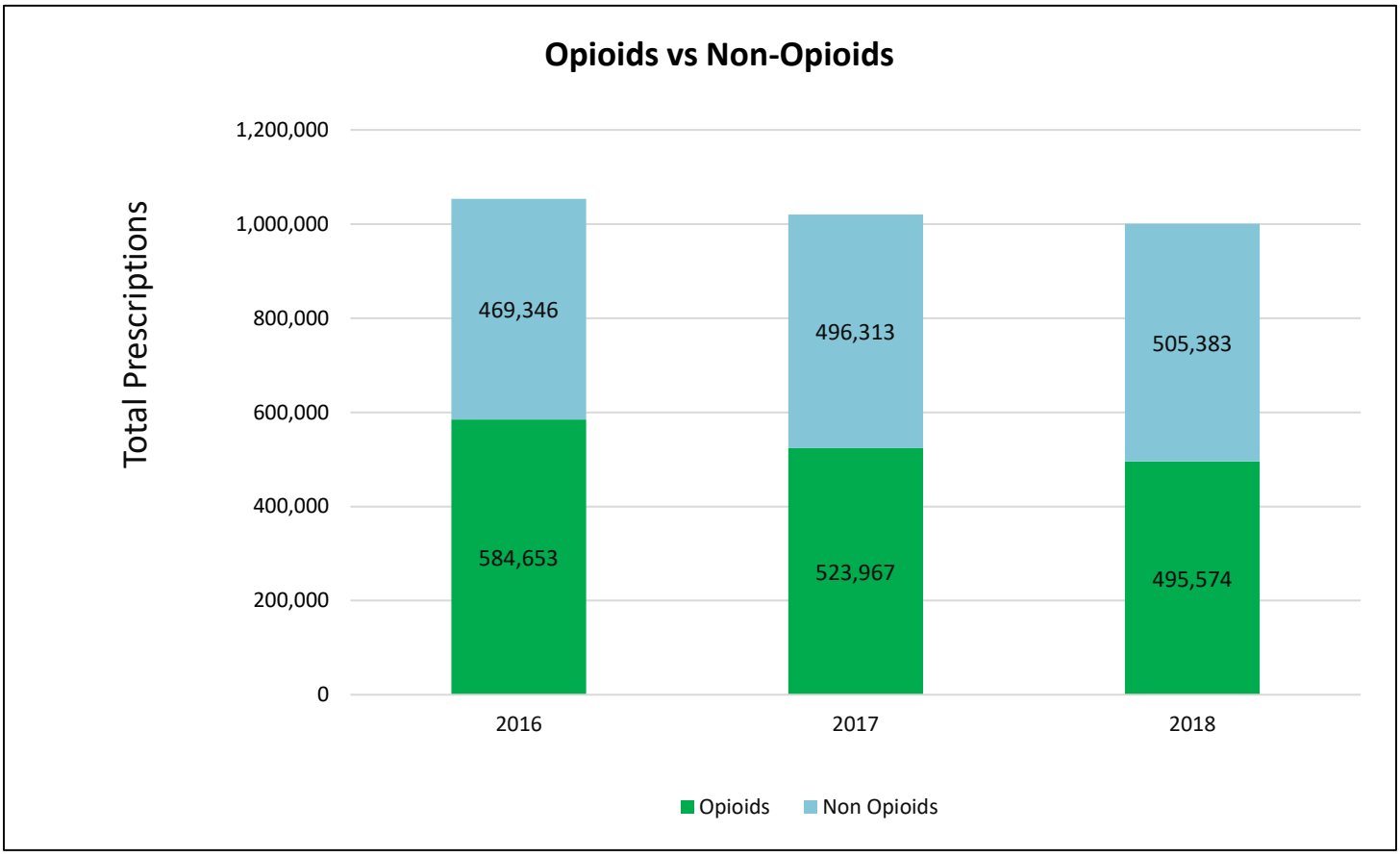

Figure 12. The number of opioid prescriptions has decreased since 2016, with 2018 marking the first year since opioids dispensed comprised less than half of non-opioids.

Morphine Milligram Equivalents (MMEs)

MMEs is a standardized measurement assigned to opioids to indicate its relative potency. Figure 7 illustrates the number of MMEs dispensed from 2016-2018. While opioid prescriptions have decreased, MMEs have increased.

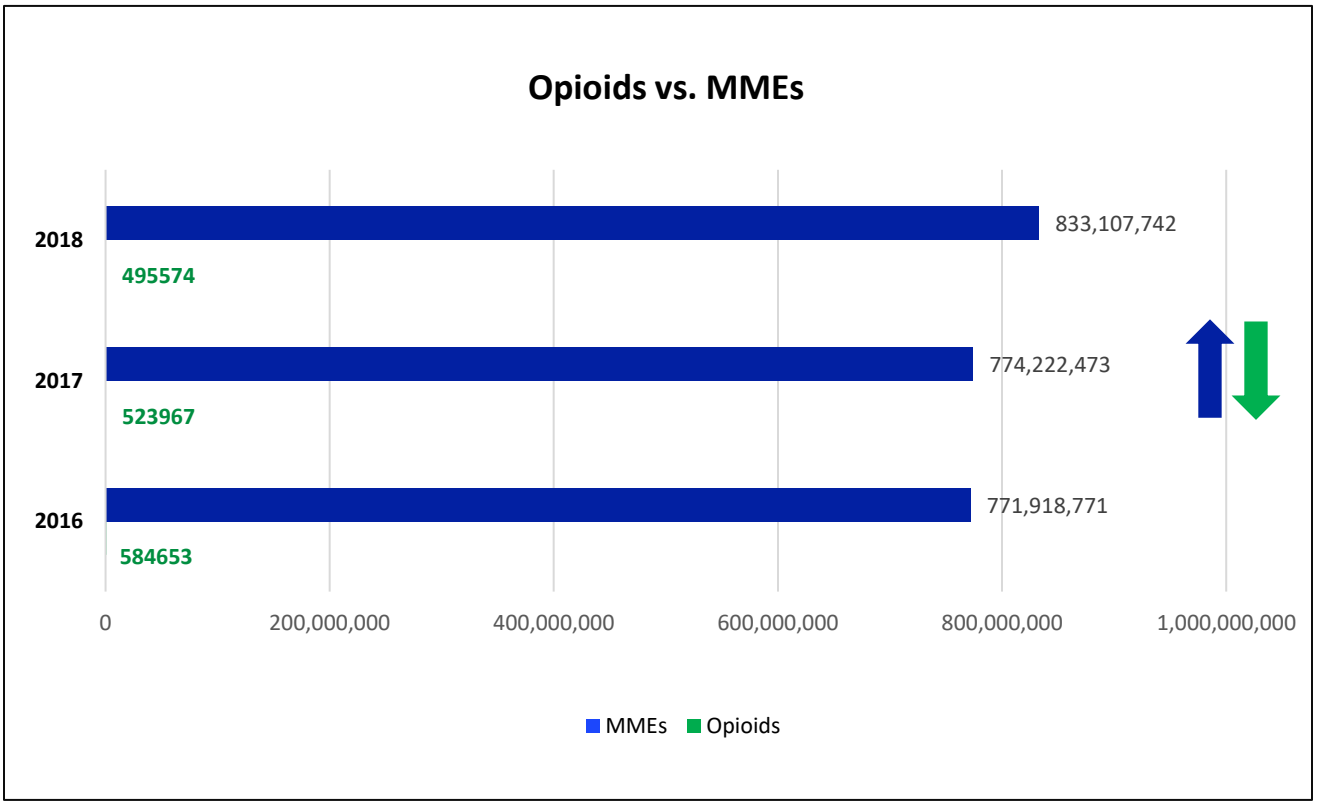

Figure 12. The adverse relationship between opioid prescriptions and MMEs may suggest that while opioid prescriptions are generally decreasing, it is possible that the overall strength of dosages prescribed have increased.

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 MMEs are at significant risk of overdose. The Centers for Disease Control and Prevention (CDC) recommends careful consideration before prescribing up to 50 MME/day and should exercise further caution when increasing dosage to 90 MME/day. In 2016, CBPL's Joint Committee on Prescriptive Guidelines adopted a 90mg/day as a dosing threshold for which to use as a strategy to prevent such adverse outcomes. 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 7 demonstrates this change from 2017 to 2018.

	2017	2018	Percent Change	MME Conversion Factor	90 MME equivalent dose
# of patients receiving an opioid prescription	220,314	201,259	8.65% (decrease)	-	-
# of patients receiving oxycodone-acetaminophen	65,362	55,632	14.88% (decrease)	1.5	60 mg or 2 tablets
# of patients receiving hydrocodone-acetaminophen	33,227	27,281	17.90% (decrease)	1	90 mg or 9 tablets
# of patients receiving tramadol HCL	17,650	17,287	2.05% (decrease)	.1	
# of patients receiving oxycodone HCL	12,688	13,152	3.66% (increase)	1.5	60 mg or 2 tablets
% of patients receiving more than an average daily dose of 90 MMEs	15.89%	10.52%	33.8% (decrease)	-	-

Table 7. Opioid prescriptions and prescriptions exceeding 90mg MME per day. The Joint Committee's guidelines are adopted from the state of Washington, with the exception of the 90 MME threshold: https://www.commerce.alaska.gov/web/Portals/5/pub/PHA_PDMP.Report.2016.pdf

Top 3 Drugs Dispensed by Brand 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.

Generic Drug	Federal Schedule	2016	2017	2018	Percent Change
Hydrocodone Bitartrate/Acetaminophen	II	203,064	171,508	143,767	29.20% (decrease)
Oxycodone HLC/Acetaminophen	II	102,447	90,052	73,815	27.95% (decrease)
Oxycodone HCL	II	61,736	59,082	73,406	18.90% (decrease)

Table 8. The average decrease among top three brand name opiate agonists from 2016 to 2018 is 25.35%. Previous legislative reports reported quantities by generic name; however, data for 2018 was unavailable using that measure.

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 to law enforcement or regulatory agencies only after the requestor has provided adequate information justifying their legal ability

to access the information contained in the database. Figure 8 and Table 9 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.

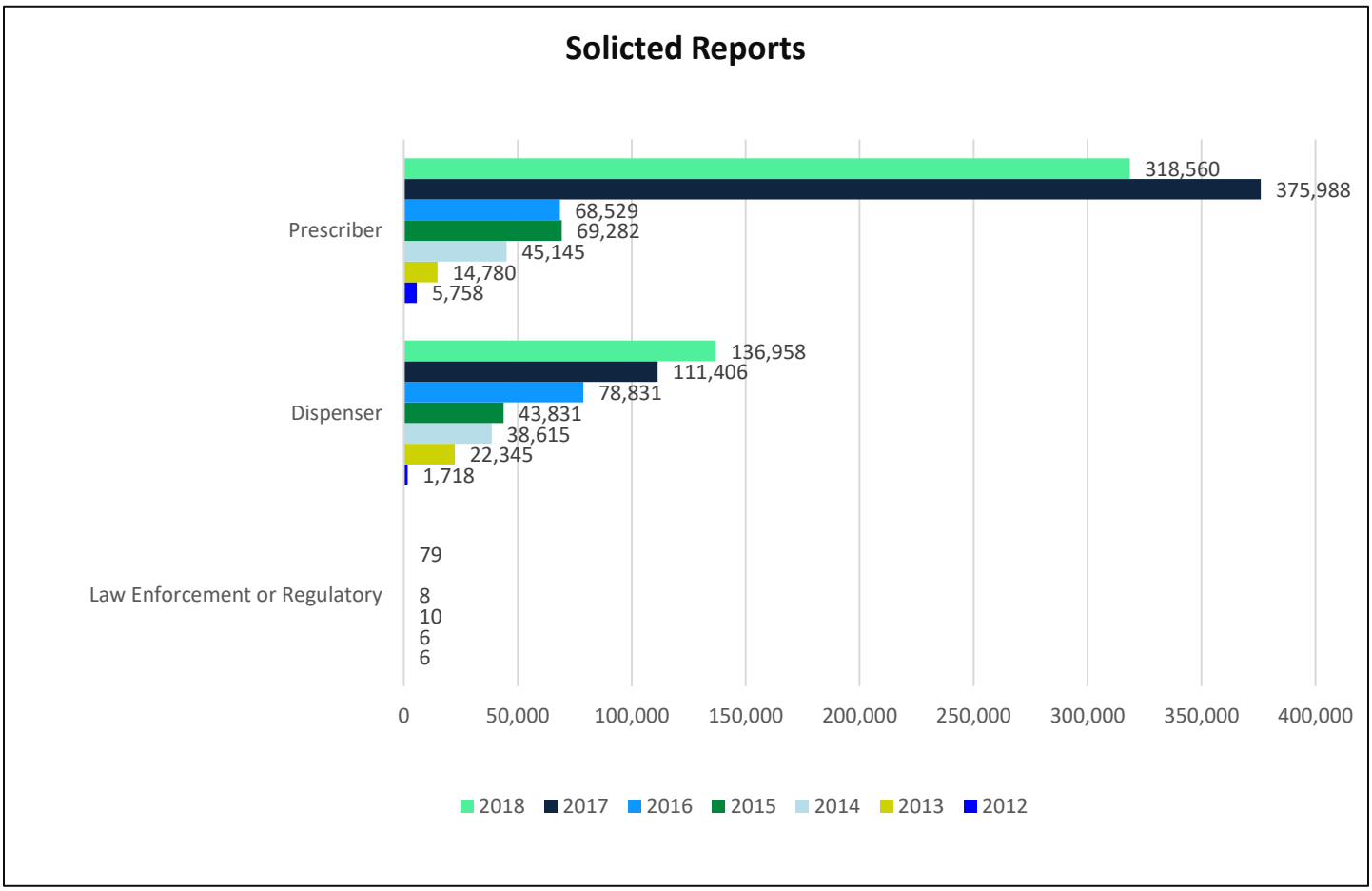

Figure 13. The number of solicited reports increased significantly from 2012 to 2018; however, patient prescription history reviews fell by 15 % by prescribers and increased among pharmacists by 23%.

User Type	2012	2013	2014	2015	2016	2017	2018	% change since previous year
Prescriber	6	6	10	8	18	79	111	40.5% (increase)
Dispenser	1,718	22,345	38,615	43,831	78,831	111,406	136,958	22.9% (increase)
Law enforcement or regulatory agency	5,758	14,780	45,145	69,282	68,529	375,988	318,560	15.3% (decrease)
Total	7,482	37,131	83,770	113,121	147,378	487,473	455,629	6.5% (decrease)

Table 9. The number of patient prescription history requests conducted by prescribers and dispensers, and the number of patient, prescriber, and dispenser requests received from law enforcement or regulatory agencies.

Unsolicited Notifications

The following table indicates the number of patients who received prescriptions from five or more prescribers and five pharmacies over a three-month period.

Threshold Period	Criteria	# of Patients
03-01-2018 to 06-01-2018	5 prescribers + 5 pharmacies over a three-month period	40
06-01-2018 to 09-01-2018	5 prescribers + 5 pharmacies over a three-month period	21
09-01-2018 to 12-01-2018	5 prescribers + 5 pharmacies over a three-month period	21
12-01-2018 to 03-01-2019	5 prescribers + 5 pharmacies over a three-month period	TBD

Table 10. The number of patient prescription history requests conducted by prescribers and dispensers, and the number of patient, prescriber, and dispenser requests received from law enforcement or regulatory agencies.

XI. 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 AS 17.30.200(d)(3)(4) which authorizes practitioners not licensed in Alaska to access patient prescription information from the Alaska PDMP, so long as the practitioner holds a license in another state. 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 AWARxE platform in Alaska, however, they sign-in to the AWARxE 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 1).

Graphic 1. 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.