Alaska Prescription Drug Monitoring Program Report to the 32nd Alaska State Legislature (2022)

Prepared by
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Division of Corporations, Business and Professional Licensing
on behalf of the Alaska Board of Pharmacy
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I. Introduction

The passage of Senate Bill 196 in 2008 established a federally funded electronic controlled substance prescription database[1], with the intent to improve patient care and to reduce misuse and diversion of federally scheduled controlled substances. The database operates as a state-level opioid intervention strategy and clinical decision support tool under the name of the Prescription Drug Monitoring Program (PDMP).[2] It gives access to prescribing practitioners with a U.S. Drug Enforcement Administration (DEA) registration, pharmacists, authorized delegates, and out-of-state providers opting to obtain access (Table 1).

Required Users (actively licensed under AS 08)	**Criteria**
Dentist, Optometrist, Physician, Veterinarian	Holds DEA registration
Nurse Practitioner	Holds DEA registration and state-level controlled substance prescriptive authority issued by the Alaska Board of Nursing
Pharmacist	Living and dispensing controlled substances in Alaska
Physician Assistant	Holds DEA registration and an active collaborative practice agreement with prescribing physician
Pharmacies	Dispensing controlled substances in Alaska*
Optional Users	**Authorized Access if**
Prescriber or pharmacist delegate	Holds license under AS 08
Indian Health Service (IHS) provider	Employed by the IHS and holds a valid license in another jurisdiction
Military provider	Employed by the military and holds a valid license in another jurisdiction
Veterans Administration (VA) provider	Employed by the VA and holds a valid license in another jurisdiction
Veterans Administration provider delegate	Employed by the VA per the Veterans Health Administration's Mission Act effective November 2020

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. *Pharmacies are required to report dispensations daily if they are dispensing, including those shipping controlled substances to Alaska.*

At present, 49 states, the District of Columbia, Guam, and the Northern Mariana Islands have operational PDMPs. In Alaska, the PDMP is administered by the Board of Pharmacy (the board) under the Department of Commerce, Community, and Economic Development (the department or DCCED), Division of Corporations, Business and Professional Licensing (the division or CBPL).[2] Bamboo Health is the database vendor, which provides the prescription drug monitoring interface, AWARxE. The term PDMP may be used interchangeably with AWARxE as these terms both refer to the database.

> ***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.[2]

> ***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 (t) of this section.[2]

In addition to serving as a tool when assessing medically necessary and clinically appropriate patient care, and in considering treatment with a controlled substance,[1, 9, 10] the database is used as a resource for the board to carry out and report on required grant activities and statutory obligations. These activities (Table 2) relate to the overarching goals of: monitoring and promoting judicious prescribing and dispensing practices; reducing inappropriate prescribing; identifying, and preventing instances of misuse, abuse, and drug diversion; and increasing provider communication across provider settings.

Grant Summary	
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.
Must support interstate datasharing of PDMP information through RxCheck[3]	*(intentionally left blank)*
Provide options for interstate and intrastate data integration with electronic health records (EHRs) and health information exchanges (HIEs).[5, 13,14,15]	*(intentionally left blank)*
Implement automation database features including license integration.[4]	*(intentionally left blank)*

Table 2. *Grant requirements as a condition of receiving federal funding and activities driven by statute. *Indicates an overlap between federal and state requirements.* A license integration project began in 2018 but was unsuccessfully launched in August 2020 and deactivated in September 2020. The project was successfully launched in January 2022.

II. Database Funding and Evolution of the PDMP

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 per AS 08.01.065.[6] As the opioid crisis escalated throughout the nation and in the state, so did the costs to operate and administer the database. To date, the database has received the funding needed to administer and make enhancements; although future funding remains uncertain.

PDMP Grant Funding		
Grant	Funding	Expiration Date
DHSS – Bureau of Justice Assistance	$337,000 annually	September 2023
DHSS – Division Behavior Health	$260,000 annually	September 2023
DHSS – CDC Overdose to Action	TBD	September 2023

Table 3. *Grant source summary.*

These funding sources impact the priorities and trajectory of the PDMP. If the only funding offered is based around increasing law enforcement access or education and outreach efforts, then these deliverables are added to the required workload. The nature of the data within the PDMP and its use in civil and criminal investigations have led to the expectation that the database is to now be used as an integral tool to solve the complex opioid epidemic, which ultimately results in demands beyond the Legislature's original intent as an educational tool for providers. As the capabilities and expectations of the PDMP continue to grow, future funding remains uncertain; the last major federal grants covering base PDMP activities are set to expire in September 2023.

In 2018, uncertainty about federal grant funding led the division to institute a $25 per biennium user fee. Although revenue generated from this fee was minimal and not intended to cover the full cost of the PDMP, it was used to offset some costs not covered by grants. Due to the inefficiency of collecting the $25 fee, and an unexpected increase in grant funding, the division proposed changes to 12 AAC 02.107 to reduce the PDMP fee to $0. After public comment, the fee was reduced as proposed effective December 23, 2021. Should future funding not be awarded, the division will be required to adjust this regulation.

III. Mandatory Interactions and Expanded Use

When the PDMP went live in 2012, pharmacists were the only user group required to register and report prescription data remaining optional for practitioners as provided in Senate Bill 196.[1] In response to the growing misuse of opioids, Senate Bill 74 in 2016 required active Alaska-licensed prescribers with DEA registrations from any state or practice location, and pharmacists who dispense controlled substances in the state to register with the database by July 17, 2017.[8] The bill also included the requirement to use the database to review a patient's prescription history prior to prescribing, administering, or dispensing a federally schedule II or III controlled

substance.[8, 9, 10] Mandatory weekly reporting for practitioners and pharmacists directly dispensing federally scheduled II – IV controlled substances also went into effect at that time, but the reporting frequency changed to daily on July 1, 2018.[9, 10] A summary of the mandatory interactions is listed in Table 4. Exemptions from use are listed in Table 10.

Requirement	Interaction	Applicable to
Mandatory Registration	Create a PDMP account by completing an online registration through AWARxE	▪ Practitioners who hold an active Alaska professional license under AS 08 and have a valid DEA registration: o 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: 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 daily.	▪ Practitioners who 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. *Advanced practice registered nurses who have controlled substance prescriptive authority in Alaska and a DEA registration number.*

Mandatory Use: Registration

Mandatory registration for licensees with 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 went into effect on July 17, 2017. [8, 9, 10] Although the PDMP is housed in the Board of Pharmacy, each licensing board is responsible for adopting

regulations, communicating with their licensees, and enforcing mandatory registration requirements within each of their respective chapters of AS 08. Registration trends are depicted in Table 5 for all affected boards.

	2018	2019	2020	2021	Change since 2018
Total Registered Users in the PDMP	5,610	6,438	8,031	9,527	3,917 (+41%)

Table 5. *Total number of registered users 2018 – 2021.*

Limitations: Registration data is based off the count of registered users in the PDMP database, AWARxE, for all professions and includes delegate and out of state users. If an account is deactivated or expires, it is reflected in the year the registration was completed, so the number per year can vary depending on when the registration reports are run.

Mandatory Use: Reviewing

Providers are required to review patient prescription information in the PDMP prior to prescribing, administering, or directly dispensing a federally scheduled II – III controlled substance. Prescribing practitioners are not required to review patient prescription information in situations described in AS 17.30.200(k)(4) and listed in Table 10.[2] Pharmacists are not required to review a patient's prescription history information prior to dispensing a federally scheduled II – III controlled substance but may choose to do so.

Mandatory use data started being reported to prescribing boards in the second quarter of CY2020 through courtesy updates provided by the PDMP manager. Table 6 demonstrates the trends in percentage of licensees who had searched patients prior to prescribing a federally scheduled II – III controlled substance for greater than a three-day supply between 2018 and 2021. Surgical, oncology, and emergency specialties have been excluded from this calculation because they are excluded from use per AS 17.30.200.[2]

	2018	2019	2020	2021
Percent of Prescribers Reviewing	35.63%	34.85%	43.88%	45.06%

Table 6*. Reviewing rates 2018 – 2021. This data is not adjusted by the number of registered providers, number patients treated, and number of controlled substances prescribed, administered, or dispensed.*

Limitations: Data on reviewing compliance is based on a provider's user role and healthcare specialty. Due to some prescribers working in more than one capacity, data pulled from the healthcare specialty may result in exclusion of certain patient population data from these review numbers. For example, a prescriber with a healthcare specialty for emergency medicine who also works in family practice is excluded from the reviewing requirement only while practicing in the emergency setting. Consequently, all reviewing data for family practice patients are not accounted for due to the prescriber's emergency user role. The system can only capture this data if the provider updates their healthcare specialty each time before reviewing. The review compliance is not able to exclude those prescriptions that were not reviewed due to exceptions noted in in AS 17.30.200(k)(4). For example, providers are not required to review a prescription

if issued within 48 hours of surgery or a medical procedure; however, since the database does not contain treatment codes, this information is only obtainable through an investigation.

Another limitation to fully understanding the review compliance is the effect of 12 AAC 52.855(f) which allows users to log in under the medical director's access. This creates a void where audit trail data must be provided to verify who was logged in as the medical director, and what patient was viewed by what provider. Facilities accessing the PDMP using this type of login have not provided a statutory compliant audit trail. While the division is hesitant to complicate provider access to the PDMP, as it could possibly reduce use or delay treatment, it is crucial that facilities comply with state law. The division is working with current and potential vendors to roll out an interface that can accomplish these goals.

Mandatory Use: Reporting

Pharmacists and dispensing practitioners are required to report to the PDMP on daily basis all prescription data on federally scheduled II – IV controlled substances dispensed in the state.[2] ClearingHouse, AWARxE's compliance feature and data repository, provides a means to track all pharmacies and prescribers dispensing or distributing federally scheduled II – IV controlled substances in Alaska. The number of providers entered in the database as reporters increased slightly from 2018 to 2020 with a significant jump in 2021 (Table 7).

	2018	2019	2020	2021	Change since 2018
Number of Providers Directly Dispensing	359	353	361	690	+92%

Table 7. *Number of dispensing pharmacies and providers reporting dispensations of federally scheduled II – IV controlled substances 2018 – 2021.*

Limitations: Prior to 2020, prescriber license boards had not previously tracked which of their providers were directly dispensing. This information was attempted to be collected on the license applications, however the question was not worded properly and led to some confusion. Attempts have been made to clarify, including sending letters to providers who indicated they directly dispense, however the work on this is ongoing to date.

Expanded Use: Delegate Access

Following the passage of House Bill 159 (HB 159) in 2017,[9] 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 (Figure 1) for both reviewing patient prescription history information and for reporting prescription information daily. They 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[2] and must do so under their own account. Office managers and general support staff are not authorized to access the database. Certified Medical Assistants (CMAs) are also not authorized to register as delegates as they are not regulated under AS 08.

In a 2021 questionnaire required as part of a Centers for Disease Control and Prevention (CDC) grant,[4] 17%of responding providers indicated use of delegates to review and submit prescription

data. Delegates reported their most useful role was reviewing patient prescription history (88%). Half of the delegates reported their role reduced time constraints on the provider, and 42% reported their role allowed for distributing the workload and was helpful in submitting prescription data.

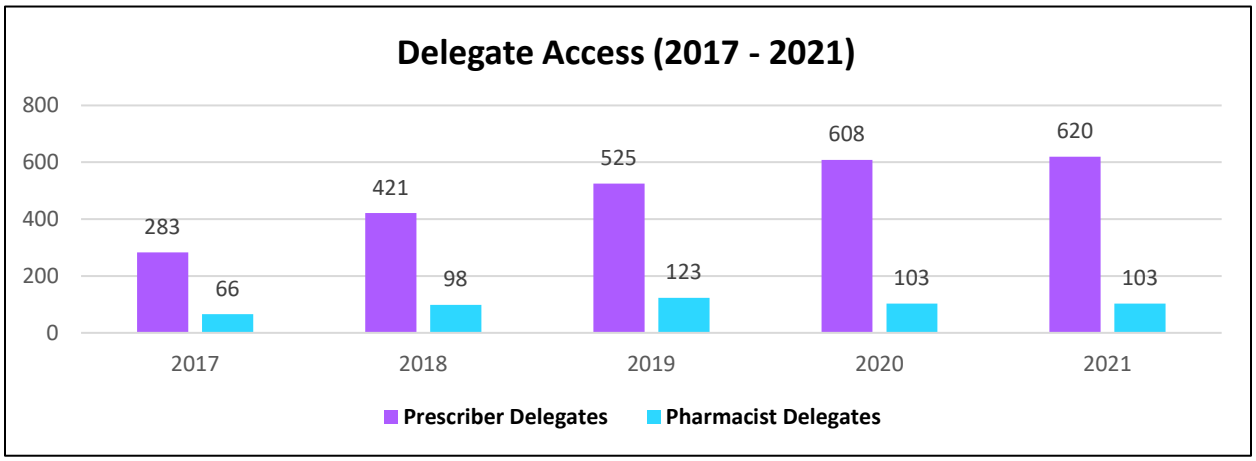

Figure 1. *Delegate access over time.*

Expanded Use: Federal Provider Access

Indian Health Service (IHS), Veterans Administration (VA), military, and other federal prescribers and dispensers can register using an appropriate federal user role category if registering with an email domain indicating affiliation with the federal employer. Alaska law does not require federal providers to register, although internal federal directives have been issued to providers requiring registration with state PDMPs.[11, 12, 16] The total number of federal providers are reflected in Figure 2.

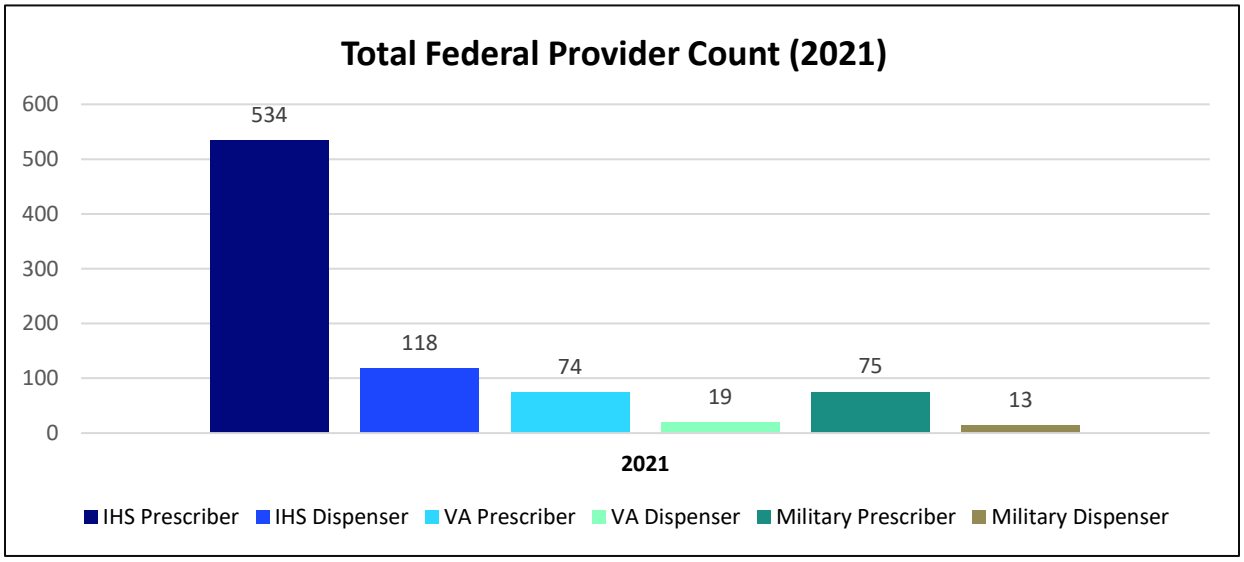

Figure 2. *Federal provider counts as of Dec. 31, 2021 (n = 833). Some of these registered users include licensees regulated under AS 08.*

Expanded Use: Emergency Department and Hospital Integration

Although providers working in emergency settings are exempt from reviewing and reporting to the database, hospital providers in emergency departments review data contained within the PDMP as a result of collaboration among DCCED, the Alaska State Hospital and Nursing Home Association (ASHNHA), the Alaska Chapter of the American College of Emergency Physicians (AK-ACEP), Collective Medical Technologies, and the State of Alaska's health information exchange established in AS 18.23.300.[16] In 2021, there were 10 new PDMP integrations with health information systems across the state.

The division is actively pursuing a statewide integration enhancement in Alaska since 2019, which will help improve mandatory reviewing by integrating the PDMP with clinical workflows. Grant funds have not been able to cover the additional cost of this enhancement in the past, and the State has continued to explore options through partnerships and other funding options. The division is confident enough in the importance of statewide integration to run this course and believe it will be successful in implementing a program that will allow for easier access to all providers in the state through their existing clinical workflows.

IV. Interaction Exemptions

There are situational and supply-day exemptions to reviewing and reporting listed in AS 17.30.200(k) and (t), respectively.[2] 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 8).[2]

Practitioners exempt from <u>reviewing</u> when (AS 17.30.200(k)	**Prescriptions exempt from being <u>reported</u> when (AS 17.30.200(t)**

▪ Issued to a person who is receiving treatment:
  o At an inpatient setting; or
  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 a patient at 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; or
	  o Emergency department.

Table 8. *Exemptions to mandatory use, including reviewing and reporting.*

Challenges: Exemptions to use make it impossible to know if a provider has complied with the mandatory review. For example, the PDMP does not contain treatment or diagnosis codes, so if a provider is not required to review as exempted under (k)(4)(A)(iv) "immediately before, during, or within the first 48 hours after surgery or a medical procedure," it is impossible for the

database to know if the review was missed because it was not reviewed or if it fell within this exemption.

V. Unsolicited Reports - "Prescriber Report Cards"

Changes to AS 17.30.200 in House Bill 159 (HB 159), effective July 17, 2017, authorized the board to issue unsolicited prescriber reports, also known as "report cards", to licensed practitioners holding an active registration with the PDMP.[10] Prescriber Report Cards became interactive in Quarter 3 of calendar year 2021, which allows providers to see the metrics that make up each section of the report card including the patients and prescriptions issued. The interactive report cards are available within the PDMP and copies are no longer emailed to each provider.

Report Card

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(s) 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. The report cards were previously sent confidentially, on behalf of the PDMP, from Bamboo Health to the email address associated with the practitioner's account. Starting in Quarter 3 of calendar year 2021, the report cards are available within the PDMP and allow the user to interact with the metrics of each section of their report. Only practitioners who hold a current DEA registration number, have registered with the PDMP, and have prescribed during the quarter will receive a prescriber report card. Pharmacists and delegate users do not receive report cards.

VI. Performance Measures

On an annual basis, the Board of Pharmacy is required to report performance measures to the Legislature via this annual report. 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)). While framed as optional to report to the legislature activities addressing AS 17.30.200(m)(1), this report explains why the board cannot comply with or measure the progress of these activities.

Performance Measure: Federally required grant deliverables (AS 17.30.200(m)(1))

This report cannot address many of the performance measures outlined in (m)(1) because DCCED is not the primary source holder for this information. While the board may be compelled to report reductions, improvements, changes in trends, etc. on these issues, neither HB 159 nor SB 74 provided the board the authority to connect PDMP data with relevant data from outside parties—or to provide PDMP data to relevant DHSS analysts[8,9].

Reduce the rate of inappropriate use of prescription drugs by reporting education efforts conducted by the Board of Pharmacy (m)(1)(A):

It is not possible to determine whether education efforts alone have a correlating relationship with changes in the inappropriate use of prescriptions. The board, its staff, and the PDMP

manager have provided ongoing training on how to utilize the PDMP and navigate database analytics features. Each affected prescribing board, except for the Board of Veterinary Examiners, has their own statutory requirement for licensees to complete at least two (2) hours of opioid education.[17, 18, 19, 20] The intent of the requirement is to support appropriate opioid prescribing but is independent of PDMP education efforts.[9]

Reduce the quantity of pharmaceutical controlled substances obtained by individuals attempting to engage in fraud and deceit (m)(1)(B):

Criminal law enforcement agencies subpoena PDMP information to create an investigative nexus between prescribing and criminal intent. The board is not equipped to synthesize or report on these trends, nor is it appropriate for the board to do so. Without inter-agency data sharing, it is impossible to know whether trends in controlled substance prescribing have had a direct effect on criminal outcomes.

Increase coordination among prescription drug monitoring program partners (m)(1)(C):

The board, its staff, the PDMP manager, and division have established ongoing relationships with key stakeholders, including other State of Alaska departments and divisions, other state PDMPs, and federal agencies. The chairs of the PDMP provider licensing boards meet biweekly. These relationships are crucial to identifying challenges, opportunities, and solutions for the effective use of the PDMP. To continue advancing program outcomes, statutory authorization of inter-agency data sharing agreements is an ideal next step to program improvement for all users.

Involve stakeholders in the planning process (m)(1)(D):

As mentioned above, efforts to involve stakeholders in the planning process has been ongoing and involves as needs arise. The division is currently engaging in collaboration with stakeholders as it pursues a review and assessment of the PDMP. Previous efforts to involve stakeholders in the planning process culminated in HB 242, which ultimately did not pass[22], but includes some components the PDMP chairs group is interested in pursuing, particularly around sharing of data between departments.

Performance Measure: Maintain security of the database (AS 17.30.200(m)(2)(A))

The PDMP 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, the Board of Pharmacy's Executive Administrator, and the board's investigator are the only personnel authorized to access the database for operational and review purposes in accordance with AS 17.30.200(d)(1). The PDMP vendor, Bamboo 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), respective board staff review credentials and approve or deny registration requests. Credentials include an active professional license in Alaska and a valid DEA registration. Professional licenses are reviewed using a primary verification source,

which is the professional licensing database, CBP Portal. CBP Portal serves as a primary source verification because it is the system used to review application packets and issue licenses. Upon initial registration, the provider must agree to an End User Licensing Agreement statement related to the intended use of the PDMP and its confidentiality.

Once approved, providers 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 requestor posting announcements on the dashboard. DEA registration numbers are not shared, and all but the last four digits are redacted when issuing prescriber report cards. Passwords expire every 180 days to support continued confidentiality for each user authorized to access the database.

Concerns persist about the lack of audit trail of users accessing PDMP data under the login of the facility medical director. As mentioned earlier in the report, potential updates in technology provided to all user health care facilities may resolve this problem.

Security for delegates:

In accordance with AS 17.30.200(d)(3)(4) and 12 AAC 52.860, PDMP staff ensures that individuals submitting registration requests as delegates to AWARxE for PDMP credentials are screened for requisite information, which includes holding an active professional license in Alaska. Delegate registrations are not approved by the PDMP staff 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 be approved after one practitioner has approved the individual. The individual will only be able to query or report on behalf of the approved supervisor.

Security for law enforcement:

In accordance with AS 17.30.200(d)(5), the PDMP manager screens requests for patient, prescriber, and dispenser search and dispensation history for documentation that demonstrates probable cause for investigative access to the confidential information. Per statute, information contained within the database is not released to federal, state, or local law enforcement unless a court-ordered subpoena or search warrant is presented with the request. 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 can query the PDMP to review patient prescription history information using a single sign-on mechanism if their clinic or institution's electronic health record (EHR) system has integrated with the PDMP through the intrastate data sharing hub, Gateway. Data is not stored for reuse or redistribution. In 2020, the division began executing memorandums of understanding (MOU) with emergency departments to improve access to patient prescription information within the patient's medical record; and created a

standard template MOU for integrations. 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 manager 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 manager must approve the delegate before access is granted.

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

Although the PDMP serves as a tool to assist authorized law enforcement in detecting drug diversion, misuse, and abuse, its contribution to reduce the inappropriate use or prescription of controlled substances is indirect. Additionally, it is not possible to quantify the reduction of inappropriate use of, or prescription of these medications as the PDMP does not contain or receive prosecutorial data from law enforcement agencies, e.g.: the DEA, local police departments, or state and federal courts, regarding diversion cases when an individual, whether a patient or provider, has avoided inappropriate use or prescribing. Because of these limitations, the PDMP is not able to report on the inappropriate use or prescriptions of controlled substances as a direct result of the database. There also may be other factors that can be attributed to reductions of inappropriate controlled substance use or prescribing, if any, including provider education, which is independent of the database. Further, the system does not log when a practitioner or pharmacist has considered but ultimately declined to prescribe, administer, or dispense a controlled substance.

In the 2021 Awareness and Feedback Questionnaire conducted as a grant requirement of the CDC,[4,5] a majority of all advanced practice registered nurses (APRNs), physicians, and physician assistants (PAs) had denied a prescription in the past (63%, 59%, and 79% respectively). A significant number of pharmacists also reported denying a prescription (70%). The top three reasons for providers were: the patient would have overlapping opioid prescriptions (61%), the patient had multiple provider episodes for prescriptions (52%), and a dangerous combination of treatment (46%). Of respondents who provided further information, 81% stated they had a discussion with the patient about their concerns. [12]

While there is no requirement in statute or regulation to report to the PDMP why a prescription is ultimately not dispensed, pharmacists perform drug utilization reviews and exercise discretion within their professional judgment on the appropriateness and safety of dispensing medications. Pharmacists reported they denied a prescription because it was not in the best interest of the patient (80%), not in the usual course of medical treatment (42%), or because they did not agree with the prescriber (40%). Similar to prescribers, 77% of pharmacists reported having a conversation with the patient about their concerns, and about half reported utilizing information in the PDMP to guide conversations with patients. [12]

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 3). Further, the PDMP announcement tool allows the PDMP manager to issue notices to providers regarding fraudulent or stolen prescriptions in their areas. These notices support law enforcement as the messaging includes guidance for practitioners to notify their local police department if encountering suspected diversion.

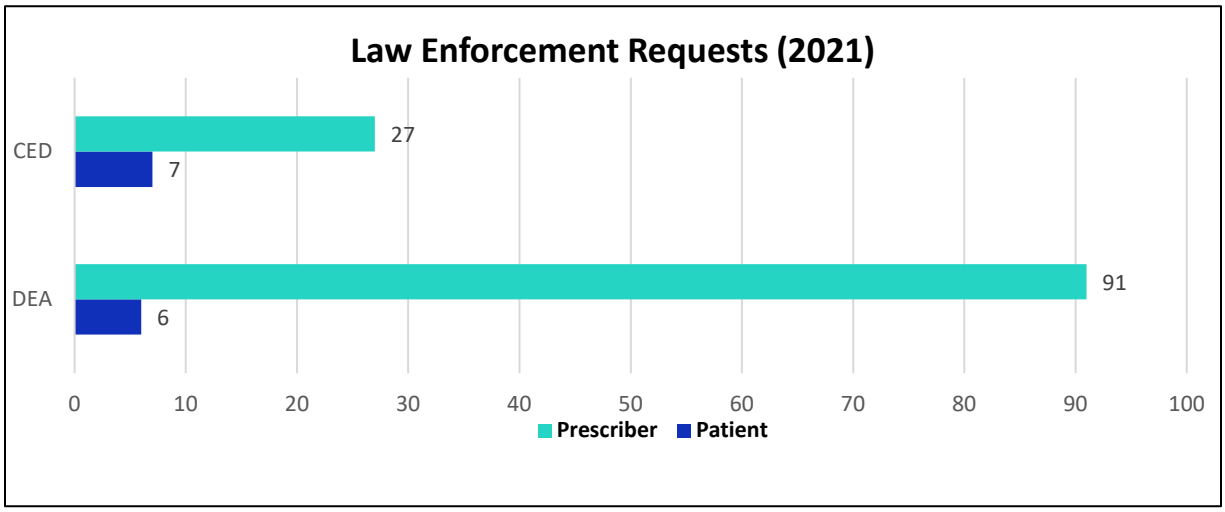

Figure 3. *Law enforcement requests for PDMP data.*

Each licensing board makes the ultimate determination following an investigation and due process 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.

VII. Prescription Data Trends

The CDC maintains a Multiple Cause of Death database for 1999 – 2000 called the Wide-ranging Online Data for Epidemiologic Research (WONDER). This database contains statistics on mortality and population counts for all U.S. counties. According to the CDC WONDER database, the rate of overdose deaths since the state began collecting data in the PDMP in 2008 have been declining[21]. Since mandatory use went into effect in July 2017, the fatal overdose rates from prescription medication in Alaska also declined until the recent uptick in cases in 2020. While there are multiple factors that contribute to the rates of overdose and the reduction in prescribing, the PDMP is a one part of the equation to reduce the abuse, misuse, and diversion of controlled substances. Overall, prescribing of controlled substances rates decreased by 19.7% since 2017 (Table 9) and opioid prescribing decreased by 30% (Figure 6).

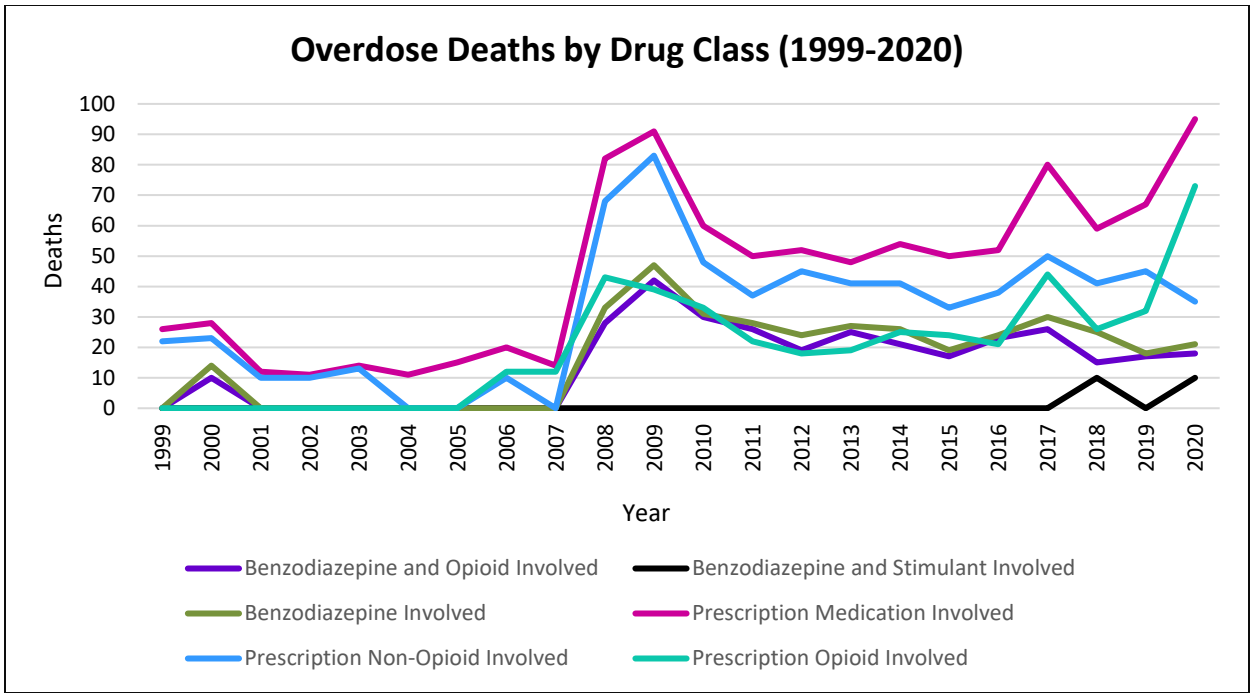

***Figure 4**. Overdose deaths by drug class from CDC Wonder (1999 – 2000).*

Figure 5 illustrates how the PDMP may have 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.

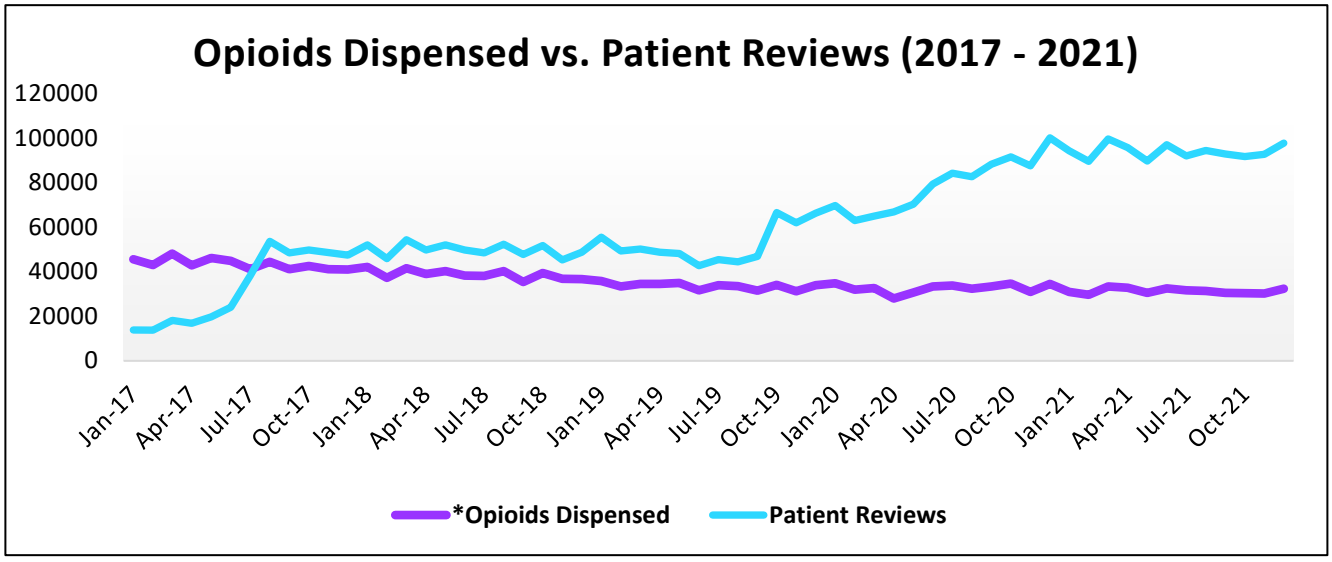

***Figure 5**. Reviewing patient prescription history appears to assist with the downward trends in opioid prescriptions being prescribed and subsequently dispensed. *Reduction in opioids dispensed may be attributed to other factors, such as increased awareness of regulatory oversight, increased communication between providers regarding patient care, and required continuing medical education.*

Total Prescriptions Dispensed									
2017		2018		2019		2020		2021	
1,035,076		1,002,262		937,258		861,523		831,662	
54% opioids	46% non-opioids	51% opioids	49% non-opioids	49% opioids	51% non-opioids	48% opioids	52% non-opioids	47% opioids	53% non-opioids

Table 9. *Trends in prescribing from 2017 to 2021 of all federally-schedule drugs reported to the PDMP.*

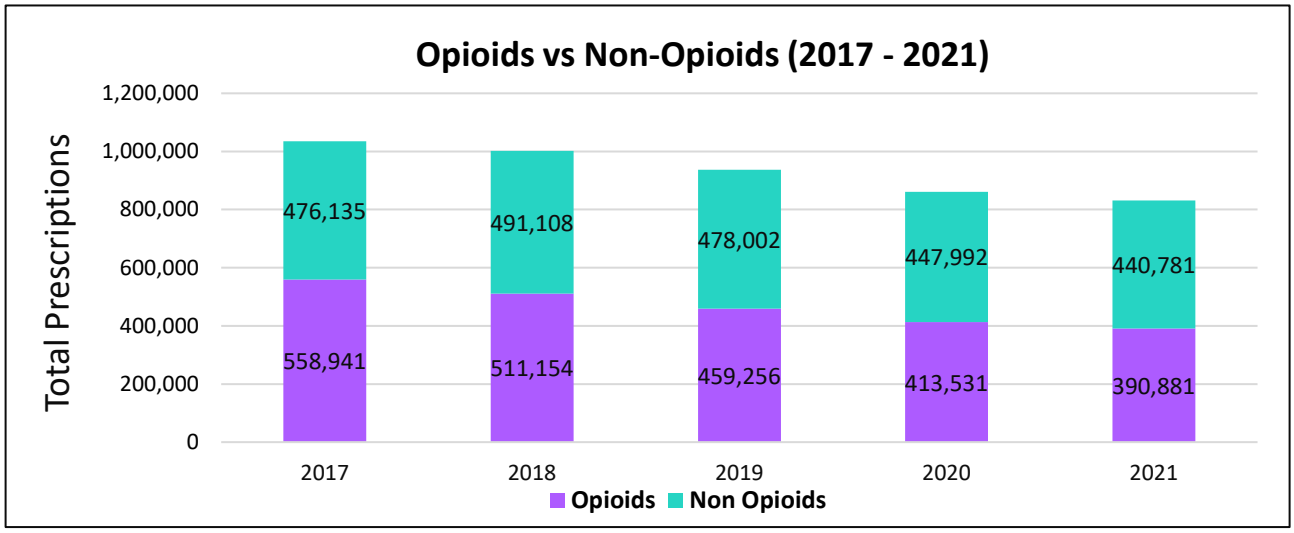

Figure 6. *Opioid versus non-opioid prescriptions dispensed over time. Total opioid prescriptions (n = 558,941 in 2017 vs. 390,881 in 2021) have decreased by 30%.*

VIII. Challenges

The PMDP in Alaska, like other states, is still evolving. Many stakeholders were required to shift focus over the last two years to address the COVID-19 pandemic. As the state moves out of this crisis, time and resources can be realigned with needs associated with opioid misuse. Prescriber boards have continued to address challenges to PDMP use with assistance from the Board of Pharmacy to implement the requirements set out in AS 17.30.200; however, some challenges remain as boards navigate, and attempt to find a balance, between a punitive versus an educational approach to compliance. Despite inherent technological challenges, statutory limitations, and priority shifts during the pandemic, collaborative efforts between affected boards and the division have resulted in efficiencies to the registration process and improvements in availability of resources to help guide proper PDMP use.

An example of this shift is the creation of a biweekly PDMP Board Chairs Group meeting in September 2020. Participants include the chairperson of each board, a staff representative, and the PDMP manager. On occasion, other stakeholders and partners, including division

investigators, the DEA, and staff from DHSS. The intent of the meetings is to foster collaborative relationships, strategize ways to improve compliance amongst licensees, and address challenges and opportunities within the system. Topics discussed include:

- Updating applications and forms to gather dispensing status to facilitate monitoring of reporting compliance.
- Establishing a uniform agreement to provide consistency across all boards in relation to disciplinary matrices and setting safe standards of practice.
- Use of delegates, including potential statutory changes, to expand the types of persons authorized to review patient prescription histories on behalf of the practitioner.

To coordinate the assessments and suggestions of all key stakeholders, the division is hiring a contractor to analyze the current PDMP and recommend changes for further improvement. DHSS has committed to providing the division $75,000 in federal opioid grant funds to fund this project.

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