Controlled Substance Advisory Committee

Date:	Wednesday, June 17, 2015, 1:00-4:00 PM
Location:	Attorney General's Office, 1031 W 4th Ave, Room 501, Anchorage, AK 99501
Chairperson:	Robert Henderson (LAW)
Member in Attendance:	Leonard (Skip) Coile (public member) Dennis Casanovas (DPS) Eric Jewkes (FPD) Dr. Lawrence Stinson (public member) Jay Butler (DHSS) C.J. Kim (Board of Pharmacy) Dr. Alexander Von Hafften (public member)
Public in Attendance:	Angela Birt Mary Geddes Stacy Kraly
Presenters:	Brian Howes (CED) Bryon Maczynski
Secretary:	Shiloh Werner

Handouts

- Alaska Prescription Drug Monitoring Program

Agenda

- Approval of Minutes from May 18, 2015
- Brian Howes – Alaska's Prescription Drug Monitoring Program
- Byron Maczynski – Bethel City Council Member – Heroin use in rural Alaska
- Controlled Substance Schedules
  - Mary Geddes update – National resources for controlled substance schedules
  - Dr. Stinson – Update from the University of Washington
  - DHSS updated regarding regulatory agency for controlled substances
- Next Steps/Next Meeting

APPROVAL OF MINUTES

Minutes from the previous meeting held on May, 18, 2015 are approved unanimously by the members of the committee.

ALASKA PRESCRIPTION DRUG MONITORING PROGRAM

Presentation – Brian Howes

Mr. Howes gave a PowerPoint presentation on the basic facts and purpose of Alaska's Prescription Drug Monitoring Program. The program is mandatory when dispensing controlled substances such as pharmacies or physician dispensing. The program is a voluntary resource that allows prescribers to view a patient's prescription history and make decisions based on that knowledge.

Discussion Re: Prescription Drug Monitoring Program

When asked who uses the system, Mr. Howes reports that it is used both within the state and out of state by those with licenses to prescribe or dispense. Currently, Alaska Prescription Drug Monitoring Program (PDMP) does not communicate with out of state PDMP programs. However, it is allowed by law. Doing so would be an added cost and there has never been a noticeable need for it. There is, however, a possible grant for exploring such communication with Washington and Oregon reports Ms. Birt. Mr. Coile asks who is responsible for vetting these providers before they are allowed access to the PDMP. Mr. Howes responds that they are done primarily by him personally. His method is to look at whether or not the licenses are active and acceptable.

Turning the conversation to a law enforcement perspective, Mr. Henderson inquires as to the amount of monthly law enforcement inquiries as a result of this program's use. The answer is unknown. Mr. Howes explains the system does not have the capability at this point to send out unsolicited reports which alert providers about someone who may be excessively being prescribed controlled substances. By law, the PDMP is not able to do so at this point. They are allowed to look for anomalies; however there is no system in place for alerting people when an anomaly is found. It is a shortcoming of the current law. Mr. Henderson notes that this is something the committee could consider and work on changing. Ms. Birt reminds the committee that it is important to consider the original intent of the PDMP and whether or not that intent includes using the PDMP as a law enforcement tool.

The committee discusses the mandatory versus voluntary use of the PDMP. Some states are actually requiring providers to use the PDMP; in Alaska, is use is only voluntary. When asked how many providers have registered for use of the system, Howes reports about 20%, and of that 20% they are very active. Howes reports that there are successes that have been recorded from the program use. Providers were able to identify a problem patient and perform an intervention. That patient is now a model patient. Mr. Henderson asks if we see the same trend in Alaska as we see nationwide for deaths related to controlled substances. Mr. Butler responds yes, and reports that the deaths exceed motor vehicle accidents. He thinks there is a role for regulation in order to help people. Ms. Birt reports that loosening the restrictions on sharing information with law enforcement would be a big help. Howes reports that people are somewhat concerned that law enforcement may go on fishing expeditions and it is possible providers may not want to prescribe anymore if they feel people are checking up on them. Mr. Butler reports that the program could be made more user friendly, and Ms. Birt states that with additional funding they would certainly want to provide a professional education component to get people using the system. Mr. Butler adds that it is a difficult challenge to manage pain and determine those who need it and those who are possibly abusing. There is room for more education certainly.

Dr. Stinson reads a quote to the committee from a colleague with the University of Washington Medical Center:

"Most providers are pleased that they have a boundary below which they are free to prescribe, but above which their patients face significant risk and rarely (if ever) derive further benefit. Primary care prescribers comfort zone includes parameters/scope of practice that are enabled by the law. There have been no disciplinary actions reported to my knowledge due to the law itself, though some few providers who did prescribe extremely high doses in the face of extremely high risk and no clinical improvement have lost their licenses; they would have been disciplined even without this law. Doses overall have declined in this state, and OD deaths from prescribed drugs have dropped 30%. PCPs are still taking care of pain, prescribing opioids when they are called for, and are no longer struggling with patients pressuring them for perpetually escalating doses in the absence of benefits."

– Dr. Tauben, Chairman of the Department of Pain Management

Mandatory versus Voluntary

Mr. Jewkes poses the question - what is the fear or apprehension associated with pressuring providers to use the system to check their patients? Mr. Howes responds that it is mostly a 'change' from the past requirements. Mr. Henderson asks if medical professionals can face sanctions – non-criminal – for over prescribing, and could that be a fear? Ms. Birt says yes that could be where some of the apprehension is coming from. The Board of Pharmacy would have to decide whether or not something is over prescribed. Such a decision is subjective. Dr. Stinson further notes that among prescribers, there are very different ideas of what and how much should be prescribed. Also, by prescribing more pain management drugs you can essentially 'lock-in' a patient and have a patient for life, which has the potential of being very lucrative. Doctors may have an incentive of not checking PDMP, with the idea that if they don't check they won't know the extent of the problem.

Mr. Coile points out that the State of Alaska does not have DEA diversion investigators and that is something that we could pressure for. It is essentially undercover officers that go to doctors and complain of injuries to see if they can access pain medications and report back to the DEA. This is a federal program, but perhaps we could lobby for one here. Mr. Henderson wonders if adding diversion investigators would be an important prong of improving the system's use. Dr. Von Hafften reminds the committee of the importance of identifying those patients that may need treatment for drug use as opposed to those who are acquiring the drugs to sell, etc.

Mr. Jeweks asks is there a 'high user' warning that may alert people regardless if someone is checking up on the PDMP? Is it possible to set up a proactive warning system? Mr. Howe responds that that is essentially what the unsolicited reports would do. It would require statutory change in order to send out those reports to law enforcement because the current law does not allow such reporting. The primary concern when drafting the PDMP was privacy of patients. Dr. Von Hafften asks if we were able to send such reports now, how many would be sent? Mr. Howe responds that he can think of approximately 100 letters that could be sent right now of people who have an access of 15 providers. Dr. Von Hafften recommends that working on getting those unsolicited letters sent out is a good first step to take *before* pressuring the providers to mandatorily use the system. There are several improvements that can also be made on the system side such as the following: make it more user friendly, automatic reports, education, etc.

Mandatory enrollment, as opposed to mandatory review, could be a good step or answer suggests Mr. Howes. Requiring mandatory use could cause some hesitation among providers, but

mandatory enrollment could be a good baby step for getting users on the system. Funding is a big issue. Dr. Von Hafften wonders if license renewals could be linked somehow to registration in the PDMP system. Mr. Howe and Dr. Stinson suggest it be a simple and easy process such as sending in the registration as part of your licensing renewal. Ms. Birt reminds the committee that it would have to be a law change in order to require providers to enroll in PDMP.

Presentation – Heroin Use in Rural Alaska, Byron Maczynski

The primary issue facing rural Alaskans, specifically Bethel, is losing a generation to heroin. It is serious problem in rural Alaska and people seem to be more willing to 'try' heroin and other serious drugs. Heroin became a big thing through prescription pain killers. Reports from those Mr. Maczynski has spoken with on the issue say that they began by abusing pain killers. Tramadol is a big issue at the moment. It is very addictive and the user can become tolerant to it. Mr. Maczynski stresses that he wants leadership from the medical community in stricter oversight. Sudden withdrawal of a drug is not necessarily the answer. The answer is treatment. Mr. Coile asks if the crime rate has risen in tandem with the arrival of these drugs. Mr. Maczynski responds that yes, they have seen a surge in crime that he associates with drugs such as tramadol. Street value is $5 a pill, and somehow thousands of pills are being imported into the villages. The tramadol seems to be coming from China. Currently Tramadol is a federally controlled substance, but is pending scheduling by our State - House Bill 51.

Mr. Henderson points out that this is a great example of the problem our system faces in the scheduling of drugs. If a drug is only federally scheduled, than the feds are the ones who can deal with the drug – not local law enforcement. Ms. Geddes expands on Mr. Maczynski's message about how rural communities deal with drug use. Education and family support are important tools. Mr. Maczynski reports that an awareness of the drugs and treatment has been a big help, but it is expensive and not especially accessible. Putting the abusers in jail is not helpful. Their addictions are not being addressed in jail, and the use continues upon release.

Dr. Butler asks if it is known how the drugs are getting into Bethel. Mr. Maczynski answers that there are approximately 8 known dealers - a couple from Anchorage and the rest local. These dealers are getting out to surrounding villages and are able to double or triple the price of heroin and other drugs.

Ending his presentation, Mr. Maczynski notes that a treatment facility is desperately needed in Bethel, but there are budget concerns. Bethel is a hub for surrounding villages, so it is an ideal location for a treatment facility.

GENERAL DISCUSSION

How do we as a committee tackle the scheduling of controlled substances? Is it a good idea to do so by regulation as opposed to statute. Mr. Henderson brings up that tramadol is a great example of the benefit of using regulation to schedules drugs as opposed to statute.

Ms. Geddes provides the committee an update on what other places around the country are doing to schedules drugs. There are a couple major resources at our disposal. The most helpful appears to be National Alliance for Model State Drug Laws. This group is non-profit, independent, and small. They are able to provide technical assistance to groups such as this one on how to structure laws, etc. www.namsdl.org is their website and provides lots of detailed information regarding treatment, laws,

and 'hot button' topics currently being worked through the legislature. There is no need to reinvent the wheel because a lot of groups have gone before and worked on similar issues. The website contains model laws that pull from what is being done in other states. There is one on a Prescription Drug Monitoring Program that could be very useful for this group. Another organization National Association of State Controlled Substances, NASCSA, can be used for networking and conferencing based education. Another resource is the Council of State Governments. It provides a different sort of help that is primarily in the form of reports that their staff of researchers are able to provide. They are looking at new models for categorizing drugs. There is a challenge for law enforcement to respond to newly created drugs.

Dr. Stinson provides an update to committee about what the University of Washington is doing. They have well documented research and policies. UW will make available to the State of Alaska a meeting in which providers can call in and be involved in discussions regarding pain medication prescriptions, etc. This is a great resource for education and would be cost saving to the State of Alaska because it provides public awareness that they are willing to share with us for free.

Mr. Henderson opens up the general discussion to the two main issues that are being settled on: the PDMP and how to reschedule drugs. Does DHSS have any input on the committee's thoughts? Ms. Kraly provides that our idea would be bold and aggressive and we would really need to think things through but agrees that there needs to be adjustments that are made in order to make scheduling smoother and more efficient, and a way to do emergency scheduling for drugs that keep popping up on the streets. A possibility does exist to remove the scheduling from statutes and put them into a regulatory framework. Who would be the keeper of that framework and adding, removing, and reclassifying drugs? Would this be a broad departure from the norm? How would we handle the logistics? An emergency regulation could allow for scheduling within a week, giving us the ability to do something immediate – or it could be an annual review that allows for public comments, etc. before coming to a final product. Ms. Kraly's initial thinking is that it is not unreasonable, but it is a broad departure from what Alaska has been doing. We need to ensure we are researching and not accidentally creating loopholes via the transfer that people could then exploit.

Mr. Henderson notes that some states have already taken on this sort of system of regulation and use boards such as the board of pharmacy to provide the primary management. What are the consequences or concerns? Ms. Kraly responds that we would have to make a comprehensive legislative pitch that could be a hard political sell. It may appear that some of their power or authority in the scheduling of drugs is being taken away. She does not think it could happen in 90 days, it would take lobbying and could take up to the next year and next legislative session to present. It would need to not be subjected to administrative changes.

Ms. Geddes comments that the current scheduling is based on 'dangerousness' and what we may be planning to do will be a major task that is going to take focus on the criteria and any penalties attached to drug schedules. Mr. Henderson points out that what we recommend to the governor, the governor is then obligated to present to the legislature based on the statute establishing the committee. If we suggest that the scheduling of drugs be handled by a regulatory board, would the governor have to present that?

Mr. Casanovas wonders about the timing for this based on what we see the current legislature is doing with a single drug. Would they see a benefit to pushing the regulation of a whole bunch of drugs

off onto a regulatory board so they don't have to take up their valuable time? Ms. Kraly responds that yes, they could respond positively, but there is that concern that they will push back on the idea of giving up some authority to the executive branch.

Dr. Von Hafften brings up the question about the offenses and criminal penalties statutorily slated in reference to misconduct involving controlled substances. Mr. Henderson responds that our committee cannot make suggestions based on the penalties but suggests that the statute instead refers to the regulatory body as opposed to the list of specific drugs. In other words, the statutory authority for prohibited controlled substances would be cross-referenced to regulatory authority.

Mr. Henderson asks the committee, is this a task we want to undertake? Do we want to go through the drugs one by one and reschedule them, or do we want to go for this regulatory change? Ms. Geddes responds that there is a way to structure laws that do not contain these 'lists' of drugs and instead refer to categories. From a prosecutorial standpoint, Mr. Henderson notes that that would mean in court we would have to have lab experts in trials that testify to the drug being part of a certain category such as a stimulant. Mr. Casanovas further notes that many drugs are combos of these sorts of things, and doesn't think our crime lab is prepared to do that sort of analysis and provide that sort of expert testimony.

Next Steps

Dr. Butler says that the idea sounds great, but noting the major changes it will take, suggests the group continues to do research. The committee agrees, lets continue to gather information. Mr. Henderson asks what information. Mr. Casanovas suggests we share amongst ourselves as we discover things searching through these new resources, instead of waiting for the next meeting. Mr. Henderson says yes, but would prefer if these ideas that our shared between meetings are documented in an organized format.

Dr. Van Hafften wonders if we can have the National Alliance conduct some of the research we want done to compare the schedules around the nation to our own. Ms. Geddes responds that we would have to ask them and see. Mr. Coile wonders why we would need to work through classifying drugs differently than the federal level. Dr. Stinson notes that we have to depart from the list format because a long time ago we could itemize the substances, but currently they are many more drugs and they are being created all the time.

Mr. Kim suggests that the board of pharmacists look into the funding that may or not come through in the future for the PDMP. This could determine what would even be possible to enact. Mr. Jewkes suggests we continue looking at things under the assumption it will be funded.

ASSIGNMENTS

- Mr. Henderson, Ms. Geddes and Ms. Kraly will reach out to NAMSDL on the possibility of research being conducted by their organization in regards to the scheduling of drugs using a regulatory format as opposed to a list format.
- Members of the committee will independently work through varying resources and begin sharing ideas on the following:
    - Model schedules

- The process of getting authority for the PDMP to send out unsolicited letters.
- Mandatory versus voluntary participation in the PDMP and education and system side improvements that can be made.

Next Meeting: Tentatively scheduled for August 4, 2015 at 9:00 AM