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Luckhaupt
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CS FOR HOUSE BILL NO. 316( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES RAMRAS, Chenault

A BILL

FOR AN ACT ENTITLED

"An Act relating to establishing a controlled substance prescription database."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 08.80.030(b) is amended to read:

(b) In order to fulfill its responsibilities, the board has the powers necessary for implementation and enforcement of this chapter, including the power to

(1) elect a president and secretary from its membership and adopt rules for the conduct of its business;

(2) license by examination or by license transfer the applicants who are qualified to engage in the practice of pharmacy;

(3) assist the department in inspections and investigations for violations of this chapter, or of any other state or federal statute relating to the practice of pharmacy;

(4) adopt regulations to carry out the purposes of this chapter;

(5) establish and enforce compliance with professional standards and rules of conduct for pharmacists engaged in the practice of pharmacy;

(6) determine standards for recognition and approval of degree programs of schools and colleges of pharmacy whose graduates shall be eligible for licensure in this state, including the specification and enforcement of requirements for practical training, including internships;

(7) establish for pharmacists and pharmacies minimum specifications for the physical facilities, technical equipment, personnel, and procedures for the storage, compounding, and dispensing of drugs or related devices, and for the monitoring of drug therapy;

(8) enforce the provisions of this chapter relating to the conduct or competence of pharmacists practicing in the state, and the suspension, revocation, or restriction of licenses to engage in the practice of pharmacy;

(9) license and regulate the training, qualifications, and employment of pharmacy interns and pharmacy technicians;

(10) issue licenses to persons engaged in the manufacture and distribution of drugs and related devices;

(11) establish and maintain a controlled substance prescription database as provided in AS 17.30.200.

* **Sec. 2.** AS 17.30 is amended by adding a new section to read:

Article 4A. Controlled Substance Prescription Database.

Sec. 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 IA, IIA, IIIA, IVA, or VA controlled substance under state law or a schedule I, II, III, IV, or V controlled substance under federal law dispensed in the state to a person other than an inpatient in a licensed health care facility. The Department of Commerce, Community, and Economic Development shall assist the board and provide necessary staff and equipment to implement this section.

(b) The pharmacist-in-charge of each licensed or registered pharmacy, regarding each schedule IA, IIA, IIIA, IVA, or VA controlled substance under state law or a schedule I, II, III, IV, or V controlled substance under federal law dispensed

by a pharmacist under the supervision of the pharmacist-in-charge, and each practitioner who directly dispenses a schedule IA, IIA, IIIA, IVA, or VA controlled substance under state law or a schedule I, II, III, IV, or V controlled substance under federal law other than those dispensed for an inpatient at a health care facility, shall submit to the board, by a procedure and in a format established by the board, the following information for inclusion in the database:

(1) the name of the prescribing practitioner and the practitioner's federal Drug Enforcement Administration registration number or other appropriate identifier;

(2) the date of the prescription;

(3) the date the prescription was filled and the method of payment;

(4) the name and address of the person for whom the prescription was written;

(5) the name and national drug code of the controlled substance;

(6) the quantity and strength of the controlled substance prescribed or dispensed;

(7) the name of the drug outlet dispensing the controlled substance;

(8) the name of the pharmacist or practitioner dispensing the controlled substance and other appropriate identifying information; and

(9) other relevant information as required by the board.

(c) The board shall maintain the database in an electronic file or by other means established by the board to facilitate use of the database for identification of

(1) prescribing practices and patterns of prescribing and dispensing controlled substances;

(2) practitioners who prescribe controlled substances in an unprofessional or unlawful manner;

(3) individuals who receive prescriptions for controlled substances from licensed practitioners and who subsequently obtain dispensed controlled substances from a drug outlet in quantities or with a frequency inconsistent with generally recognized standards of dosage for that controlled substance; and

(4) individuals who present forged or otherwise false or altered

prescriptions for controlled substances to a pharmacy.

(d) The database and the information contained within the database are confidential, are not public records, and are not subject to public disclosure. The board shall undertake to ensure the security and confidentiality of the database and the information contained within the database. The board may allow access to the database only to the following persons, and in accordance with the limitations provided and regulations of the board:

(1) personnel of the board regarding inquiries concerning licensees or registrants of the board or personnel of another board or agency regarding license inquiries concerning a practitioner;

(2) authorized board personnel or contractors as required for operational and review purposes;

(3) a licensed practitioner having authority to prescribe controlled substances, to the extent the information relates specifically to a current patient of the practitioner to whom the practitioner is prescribing or considering prescribing a controlled substance;

(4) a licensed or registered pharmacist having authority to dispense controlled substances, to the extent the information relates specifically to a current patient to whom the pharmacist is dispensing or considering dispensing a controlled substance;

(5) federal, state, and local law enforcement authorities may receive printouts of information contained in the database pursuant to a search warrant, subpoena, or order issued by a court establishing probable cause for the access and use of the information; and

(6) an individual who is the recipient of a controlled substance prescription entered into the database may receive information contained in the database concerning the individual on providing evidence satisfactory to the board that the individual requesting the information is in fact the person about whom the data entry was made and on payment of a fee set by the board under AS 37.10.050 that does not exceed $10.

(e) The failure of a pharmacist-in-charge, pharmacist, or practitioner to submit

information to the database as required under this section is grounds for the board to take disciplinary action against the license or registration of the pharmacy or pharmacist or for another licensing board to take disciplinary action against a practitioner.

(f) The board may enter into agreements with tribal and military dispensers and practitioners in this state to submit information to and access information in the database subject to this section and the regulations of the board.

(g) The board shall notify the president of the senate and the speaker of the house of representatives if, at any time after the effective date of this Act, the federal government fails to pay the costs of the controlled substance prescription database.

(h) An individual who has submitted information to the database in accordance with this section may not be held civilly liable for having submitted the information. Nothing in this section requires or obligates a dispenser or practitioner to access or check the database before dispensing, prescribing, or administering a medication, or providing medical care to a person. Dispensers or practitioners may not be held civilly liable for damages for accessing or failing to access the information in the database.

(i) A person who intentionally discloses information in the database without authority or allows an unauthorized person access to the database commits a class A misdemeanor. A person who intentionally obtains unauthorized access to the database or alters or destroys information in the database without authority commits a class C felony.

(j) In this section,

(1) "board" means the Board of Pharmacy;

(2) "database" means the controlled substance prescription database established in this section;

(3) "pharmacist-in-charge" has the meaning given in AS 08.80.480.

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 316
() Publish Date:

Identifier (file name): HB316-CED-OL-02-05-08
Title: Prescription Database
Dept. Affected: DCCED
RDU: Corp, Bus & Prof Licensing (117)
Component: Corp, Bus & Prof Licensing
Sponsor: Ramras, Chenault
Requester: House Labor & Commerce
Component Number: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**	**	**
CAPITAL EXPENDITURES	**400.0**						
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
1156 Receipt Supported Services					**	**	**
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**	**	**

Estimate of any current year (FY2008) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation authorizes the establishment of a controlled substance prescription database under authority of the Alaska Board of Pharmacy with assistance of the Division of Corporations, Business, and Professional Licensing within the Department of Commerce, Community, and Economic Development.

The Federal Government is providing planning and implementation grants to states to implement a prescription drug monitoring program. In FY 08, Alaska received a Federal grant in the amount of $49.4 to begin plans to implement such a program in Alaska. The department is seeking authorization in the supplemental budget for this grant.

Prepared by: Jennifer Strickler, Chief — Phone (907) 465-2144
Division: Corporations, Business, and Professional Licensing — Date/Time 2/5/08 6:36 PM
Approved by: Emil R. Notti, Commissioner — Date 1/25/2008
Commerce, Community, and Economic Development

(Revised 10/05/2006 OMB)

ANALYSIS CONTINUATION

In FY 09, the department anticipates applying for a federal grant of $400.0 to implement Alaska's Prescription Drug Monitoring Program. Because implementation of this program would cover multiple years, the division is requesting a capital expenditure.

Implementation grant funds may be used to enhance a data collection and analysis system; develop infrastructure to support programmatic activities; support collaborations with law enforcement and prosecutors; support collaborations with treatment providers and drug courts; facilitate information sharing among states; expand monitoring to Schedules III, IV, and V; and assess the efficiency and effectiveness of the program.

A preliminary estimate of use of federal funds follows:

125,000	Staff, Range 18 to administer the program
10,000	Travel to National Meetings
250,000	Contractual (primarily for database design/software)
5,000	Supplies
10,000	Lease, Capital Outlay
$ 400,000	*These figures may change as a result of planning efforts.*

Many questions and decisions need to be made regarding implementation of this program, including ongoing costs after Federal grant funds are depleted. Upon implementation of this system, the division anticipates enforcement officials and those writing prescriptions would be required to pay a reasonable fee (receipt supported services) to enable the division to maintain and support this program in future years. An estimated amount of maintenance costs and fees needed cannot be estimated at this time.

NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

February 6, 2008

The Honorable Kurt Olsen
Chair, House Labor and Commerce
State Capitol, Room 408
Juneau, AK 99801

RE: Revised suggested amendments to House Bill 316 Version M – Controlled Substance Prescription Database

Dear Representative Olson and Honorable Members of the House Labor and Commerce Committee,

On behalf of the members of the National Association of Chain Drug Stores (NACDS) operating in Alaska, I would like to thank Representative Ramras and Representative Chenault for sponsoring this legislation. NACDS members in Alaska include Costco, Fred Meyer (Kroger) and Wal-Mart. Community pharmacies (including independent pharmacies) employ 9,933 full and part-time employees and pay over $40 million annually in state and local taxes.

413 North Lee Street
P.O. Box 1417-D49
Alexandria, Virginia
22313-1480

Our members support House Bill 316 with some changes and would like to see this bill become law. We have worked on similar legislation in the lower 48 and have supported the concept of establishing similar databases.

Below are our comments/concerns which we offer in the form of amendments to the existing bill, version C. As you will see, the majority of our requested changes would make the Alaska law similar to those in other states, which is of particular importance to our companies that operate in multiple states. NACDS additions and eliminations are indicated in bold, italics and double strike-through.

We understand the House Labor and Commerce Committee is interested in writing a letter of intent similar to that written by the Senate Committee, making it clear that funding for this program is not to come from increased fees on pharmacists or taxes on citizens. We strongly support this letter and it's intent.

Page 2, beginning on line 29 (b) ***No earlier than ninety days after regulations adopted to implement the requirements of this act are effective,*** ~~t~~The pharmacist-in-charge of each licensed or registered pharmacy, ***or the pharmacy company headquarters,*** regarding each schedule IA, IIA, IIIA, IVA, or VA controlled substance under state law or a schedule I, II, III, IV, or V controlled substance under federal law dispensed by a pharmacist under the supervision of the pharmacist-in-charge, and each practitioner who directly dispenses a schedule IA, IIA, IIIA, IVA, or VA controlled substance under state law or a schedule I, II, III, IV, or V controlled substance under federal law other than those dispensed for an inpatient at a health care facility, shall submit to the board, by a

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Fax (703) 836-4869
www.nacds.org

~~*procedure*~~ *electronic means, on a bi-monthly basis, and in* ~~*a format established by the board*~~ *the ASAP Telecommunication Format for Controlled Substances, published by the American Society for Automation in Pharmacy that is in use in the majority of states operating a controlled substances reporting system*, the following information for inclusion in the database:

Rationale: Pharmacies must be given sufficient time prior to the compliance date to update their pharmacy computer systems to meet the prescription monitoring program's requirements.
Many chain pharmacies handle controlled substance prescription data submission at a central location, which we would request to be clarified in statute.
Typically, states require electronic reporting of controlled substance prescription data on a monthly or bi-monthly basis.
The American Society for Automation in Pharmacy (ASAP) standard is the industry standard for prescription monitoring programs, and as such, we would respectfully request that statute explicitly refers to those standards. The 95 standard is the one used in the majority of states making compliance easier and less costly for all pharmacies. In addition, this will allow pharmacies to comply much more quickly than if we have to undertake costly and time-consuming software and hardware changes.

Note: The American Society for Automation in Pharmacy (ASAP) standard is the industry standard for prescription monitoring programs.

Page 3, beginning on line 7 (1) the name of the prescribing practitioner and the practitioner's federal Drug Enforcement Administration registration number or other *unique prescriber* ~~*appropriate*~~ identifier;

Rationale: Delete "appropriate" and insert "unique prescriber" to reflect the possibility of a future unique prescriber identifier that could be used in lieu of the DEA number.

Page 3, line 11. (3) the date the prescription was filled ~~*and the method of payment*~~;

Rationale: Reporting of the method of payment is not supported by the ASAP 95 standard. For this reason, we respectfully ask that it be stricken.

Page 3, line 15. (6) the quantity and strength of the controlled substance ~~*prescribed or*~~ dispensed;

Rationale: This amendment is for clarification purposes only.

Page 3, line 18. (8) ~~*the name of the pharmacist or practitioner dispensing the controlled substance and other appropriate identifying information*~~ *the dispensing drug outlet's federal Drug Enforcement Administration registration number or other unique*

outlet identifier; and

Rationale: The ASAP standards that our members use do not include this data element, so modifying pharmacy systems to report this for every prescription would be an expensive endeavor and not result in additional patient safety. However, requiring the pharmacy's DEA number or other unique outlet identifier, will allow the Board to determine the pharmacy from which the drug was dispensed, and if there was a problem with a particular pharmacy, contact that entity to determine the identity of the dispensing pharmacist.

Page 3, line 20. ~~***(9) other relevant information as required by the board***~~.

Rationale: Subsection (10) is too broad. It could be misinterpreted to require the reporting of data that's not relevant, and does not further patient care or safety.

Page 4, beginning on line 8. (1) personnel of the board ***for an active investigation*** regarding ~~**inquiries concerning**~~ licensees or registrants of the board or personnel of another board or agency regarding license inquiries concerning a practitioner;

(2) authorized board personnel or contractors as required for ~~***operational and review purposes***~~ ***operation of the database;***

Rationale: Because of the sensitive and highly private nature of the information being collected, we feel it is important to build protections around the release of this information.

On behalf of the members of the National Association of Chain Drug Stores, I thank you for this opportunity to comment on this very important legislation. If I can be of further assistance or provide clarification, please do not hesitate to contact me.

Sincerely,

Lis Houchen
NW Regional Director
State Government Affairs
130-18th Avenue SE
Olympia, WA 98501
(360) 236-1246
lhouchen@nacds.org

cc: Representative Mike Chenault

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

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() Publish Date:

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Prepared by: Jennifer Strickler, Chief — Phone (907) 465-2144
Division: Corporations, Business, and Professional Licensing — Date/Time 2/5/08 6:36 PM
Approved by: Emil R. Notti, Commissioner — Date 1/25/2008
Commerce, Community, and Economic Development

(Revised 10/05/2008 OMB)

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Wed

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Labor & Commerce
Oil & Gas
Military & Veteran Affairs
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Alaska State Legislature
House of Representatives

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Juneau, Alaska 99801-1182
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Representative Jay Ramras
District 10

MEMO

To: Representative Kurt Olson

Fm: Representative Jay Ramras

Date: January 29, 2008

Re: HB 316 – 25-LS1283\C

Please accept this memo as a hearing request for HB 316 (25-LS1283\C) in the House Labor and Commerce Committee. Attached is a copy of the bill packet for your review.

Thank you for your time and consideration to this matter.

Attachments to this memo:

- HB 316
- Sponsor Statement
- Sectional Analysis
- Applicable Statutes
- U.S. Dept. of Justice – Office of Diversion Control PMP Q&A's
- Alliance of States with Prescription Monitoring Program Report
- Optimum Technology PMP Software Report
- DEA Drug Abuse Factsheet
- Applicable Articles
- Letters of Support

Please contact Emily Stancliff at extension 3004 with any questions.

Representative_Jay_Ramras@legis.state.ak.us

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Representative Jay Ramras
District 10

House Bill 316 Sponsor Statement

"An Act relating to establishing a controlled substance prescription database."

Prescription drug diversion is generally recognized as a significant problem throughout the United State Alaska is no exception. The DEA lists Alaska as having one of the highest per capita uses of controlled substances. Prescription drug abuse contributes to this statistic. Illegal prescribing and dispensing, doctor shopping, prescription forgery, and drug thefts from pharmacies, residences, nursing homes, and hospitals are primary methods of prescription drug diversion. One helpful tool in combating methods of drug diversion is prescription databases.

Prescription databases, also known as prescription monitoring programs, or PMPs, have been shown as effective tools to prevent drug diversion at the prescriber, pharmacy, and patient levels. By compiling data from prescribers and dispensers, PMPs provide valuable data for use in prescribing practices. Law enforcement authorities also benefit from databases by having access to data during criminal investigations.

House Bill 316 aims to establish a controlled substance prescription database in Alaska. The database would be housed within, and maintained by, the Board of Pharmacy. The Department of Commerce, Community and Economic Development would assist the board with implementation of the database. DCCED has received the first level of federal funding and, upon passage of HB 316, would be eligible for a second level of federal funding for implementation of a database.

The battle against prescription drug abuse in Alaska is ongoing. I ask for your support for House Bill 316 to provide prescribers, dispensers, law enforcement authorities, and the Board of Pharmacy with another tool to prevent drug diversion from becoming an increasing problem in our state.

Representative_Jay_Ramras@legis.state.ak.us

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Representative Jay Ramras
District 10

Sectional Summary

Section 1. Amends AS 08.80.030(b) (11) which provides the Board of Pharmacy the power to establish and maintain a controlled substance prescription database

Section 2. Amends AS 17.30 by creating a new section 17.30.200 Article 4a. Controlled Substance Prescription Database

Subsections:

(a) Describes the purpose of the database and charges the Department of Commerce, Community, and Economic Development with assisting the board with implementation of the program.
(b) Determines who is responsible for reporting information to the board and what information should be included.
(c) Describes specific uses of the database
(d) Establishes who can access the database with permission by the board
(e) Provides the board with the authority to take disciplinary action against those who fail to submit information
(f) Prevents a person who submits required information to the database from being held civilly liable for doing so
(g) Establishes penalties for crimes against the database
(h) Definitions

Sec. 08.80.003. Practice of pharmacy as a profession.

The practice of pharmacy is declared to be a professional practice affecting the public health, safety, and welfare and is subject to regulation and control in the public interest. It is further declared to be a matter of public interest that only qualified persons be permitted to engage in the practice of pharmacy, and to ensure the quality of drugs and related devices distributed in the state.

Sec. 08.80.005. Statement of purpose.

It is the purpose of this chapter to promote, preserve, and protect the public health, safety, and welfare by and through the effective control and regulation of the practice of pharmacy.

Sec. 08.80.010. Creation and membership of board; officers.

(a) There is created the Board of Pharmacy, composed of seven members, five of whom shall be pharmacists licensed in the state who have been actively engaged in the practice of pharmacy in the state for a period of three years immediately preceding their appointment. Two shall be persons with no direct financial interest in the health care industry. Whenever possible, the board shall include at least one member from each judicial district.

(b) An officer elected by the board serves a term of one year and may not serve more than four consecutive full terms in a specific office.

Sec. 08.80.030. Powers and duties of the board.

(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

(1) elect a president and secretary from its membership and adopt rules for the conduct of its business;

(2) license by examination or by license transfer the applicants who are qualified to engage in the practice of pharmacy;

(3) assist the department in inspections and investigations for violations of this chapter, or of any other state or federal statute relating to the practice of pharmacy;

(4) adopt regulations to carry out the purposes of this chapter;

(5) establish and enforce compliance with professional standards and rules of conduct for pharmacists engaged in the practice of pharmacy;

(6) determine standards for recognition and approval of degree programs of schools and colleges of pharmacy whose graduates shall be eligible for licensure in this state, including the specification and enforcement of requirements for practical training, including internships;

(7) establish for pharmacists and pharmacies minimum specifications for the physical facilities, technical equipment, personnel, and procedures for the storage, compounding, and dispensing of drugs or related devices, and for the monitoring of drug therapy;

(8) enforce the provisions of this chapter relating to the conduct or competence of pharmacists practicing in the state, and the suspension, revocation, or restriction of licenses to engage in the practice of pharmacy;

(9) license and regulate the training, qualifications, and employment of pharmacy interns and pharmacy technicians;

(10) issue licenses to persons engaged in the manufacture and distribution of drugs and related devices.

DIVERSION PROGRAMS
APPLICATIONS & ON-LINE FORMS
ARCOS
CHEMICALS
CONTROLLED SUBSTANCE SCHEDULES
CSOS
IMPORT AND EXPORT
NFLIS
QUOTAS
REGISTRATION SUPPORT
REPORTS REQUIRED BY 21 CFR

RESOURCES
CAREER OPPORTUNITIES
DRUGS/CHEMICALS OF CONCERN
e-COMMERCE INITIATIVES
FEDERAL REGISTER NOTICES
MEETINGS & EVENTS
OFFICES & DIRECTORIES
PROGRAM DESCRIPTION
PUBLICATIONS
QUESTIONS & ANSWERS
REGULATIONS & CODIFIED CSA
SIGNIFICANT GUIDANCE DOCUMENTS

LINKS
FEDERAL AGENCIES & RELATED
INDUSTRY RELATED
PUBLIC INTEREST

REGISTRATION VALIDATION

CASES AGAINST DOCTORS

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Questions & Answers

STATE PRESCRIPTION MONITORING PROGRAMS

1. What states have prescription monitoring programs?

As of December 2007, 35 states had enacted legislation which required prescription monitoring programs. 26 of those programs are currently operating and 9 are in the start-up phase.

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The 35 states with prescription monitoring programs and/or enacted legislation are: Alabama, Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nevada, New Mexico, New York, North Dakota, North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Vermont, Washington, West Virginia, and Wyoming. Currently, the state of Washington uses their program only for disciplinary purposes, however legislation has been introduced to expand the program statewide.

2. Are other states planning to implement prescription monitoring programs?

Fourteen additional states are in the process of proposing, preparing, or considering legislation. These states include, Alaska, Arkansas, Delaware, Florida, Georgia, Kansas, Maryland, Missouri, Montana, Nebraska, New Jersey, New Hampshire, Oregon, and South Dakota.

3. Has monitoring program data been used to target potential subjects of investigations?

Program officials state that their systems are not used to target possible subjects of an investigation. Investigations using prescription monitoring data regarding health care professionals are usually conducted after an official complaint is received. Information from the PMP system is, however, gleaned and examined more closely when blatant abuses are revealed in the data. In addition, states use the data to verify that a problem exists and to determine the extent of the diversion or abuse. The systems are also queried regarding patients that are found to be operating as "doctor shoppers"--one individual visiting numerous doctors and pharmacies to obtain pharmaceutical controlled substances.

4. Is the accessibility to controlled substance prescription data a violation of patient confidentiality?

Every prescription monitoring program provides safeguards to protect patient confidentiality and access to controlled substance prescription information through statutes or regulations. After decades of operation, no program has reported a breach of confidentiality. In addition, those state authorities/officials with access to monitoring program data already have the authority to access the controlled substance information. The data doesn't generate a case, it simply makes collection of the information easier and less intrusive.

5. Who is authorized to review the data and once the data is collected, what is done with it?

State statute or regulation limits accessibility to the PMP data. It is important to note that PMP program officials are not privy to any additional information than they are already able to receive by virtue of their existing positions and job functions. The only difference is that the monitoring programs provide ready accessibility to prescription information in a more user friendly format. Historically, when investigators needed to review prescription information for both routine pharmacy inspections and case investigations they would have to manually sort through paper copies of prescriptions. The PMP database eliminates this tedious process by requiring the prescription information to be maintained electronically. This allows investigators to obtain pharmacy data from multiple locations without having to visit each and every pharmacy.

6. What are the annual costs to operate a prescription monitoring program?

The cost of implementing and operating a prescription monitoring program differs from state to state because of the many variables that exist. The average cost to start a prescription monitoring program is approximately $350,000. State annual operating costs for prescription monitoring programs range from $100,000 to nearly $1 million. Cost variations occur due to the frequency of data collection (bi-weekly vs. monthly), the use of a third party vendor, the number of prescriptions written/filled in a state, the number of schedules (II-V) collected, and the use of official forms when required.

7. What are some of the beneficial uses of prescription monitoring programs?

Prescription monitoring programs are being used to deter and identify many types of illegal activity including prescription forgery, indiscriminate prescribing and "doctor shopping" - which is a felony in some states. Most programs provide patient specific drug information upon request of the patient's physician or pharmacist. Some state programs proactively notify physicians when their patients are seeing multiple prescribers for the same class of drugs. This assists health care professionals in enhancing patient care by allowing them to intervene on the patient's behalf and assist them in obtaining appropriate treatment. It has been an extremely successful program to thwart diversion in a number of states.

8. What impact do monitoring programs have on bordering states that do not operate a monitoring program?

States report that after a prescription monitoring program goes into effect, patients that are "doctor shopping" often move their criminal activities to bordering states. Information can be shared with other states if state statutes and regulations authorize them to do so. The National Alliance for Model State Drug Laws has drafted a Model Interstate Compact to assist states in their efforts to share prescription information across state borders. More information on the National Alliance for Model State Drug Laws can be found at www.natlalliance.org

Additionally, the Integrated Justice Information Systems (IJIS) Institute is leading a project funded by the Bureau of Justice Assistance (BJA) to develop a system for the interstate exchange of prescription monitoring data. To accomplish this initiative IJIS is engaging in a pilot project between the states of California and Nevada to share state PMP program information. IJIS is addressing the information technology issues among states for implementing an interstate sharing agreement. For this project, IJIS is working closely with the practitioners from the Alliance of States with Prescription Monitoring programs, the Bureau of Justice Assistance and the Drug Enforcement Administration. IJIS's goal in the project is to provide recommendations to states wishing to exchange PMP data on how to implement the data exchanges based on the new open standards emerging from the Global Justice XML Data Model that has been developed under the leadership of the BJA. More information on the IJIS Interstate PMP exchange project can be found at www.IJIS.org

9. What additional time, if any, is required to submit prescription data to state authorities?

The majority of pharmacies submit prescription information electronically. States have generally expressed satisfaction with the electronic system since it markedly reduced the paper work burden that existed when pharmacies manually submitted prescription data.

10. How can a State start a prescription monitoring program?

The Harold Rogers Prescription Monitoring grant program provides financial assistance to states that want to create, enhance or plan a Prescription Monitoring Program. Additional information can be found at www.ojp.usdoj.gov/bja

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11. What states have received a Harold Rogers Prescription Monitoring grant?

In FY2002, Congress allocated $2 million for the Harold Rogers grant program. Sixteen states applied to receive grants and 9 grants were awarded. Ohio, Pennsylvania, Virginia and West Virginia received grants to start a new state monitoring program. California, Kentucky, Massachusetts, Nevada, and Utah received grants to enhance their existing state monitoring programs.

In FY2003, Congress allocated $7 million for the Harold Rogers grant program. Nine states applied to receive new or enhancement grants and a technical assistance grant was awarded to the National Alliance for Model State Drug Laws. Florida, Maine, Alabama, New Mexico and Wyoming received grants to start new programs in their states. California, Idaho, New York and Nevada received enhancement grants. Additional funding was set aside in FY2003 for

an evaluation of the effectiveness of the existing programs.

In FY2004, Congress appropriated another $7 million for the Harold Rogers grant program. Twenty-seven states applied to receive new, enhancement or planning grants and a total of 23 grants were awarded. Iowa, Mississippi, New Jersey, Oregon, and South Carolina received grants to start new programs. Alabama, Hawaii, Indiana, Kentucky, Massachusetts, Maine, New York, Nevada, Oklahoma, Pennsylvania, Virginia, and West Virginia received enhancement grants. Kansas, Colorado, Connecticut, North Carolina, Tennessee, and Washington received planning grants.

In FY2005, the Harold Rogers Prescription Monitoring Program received $10 million in funding. Twenty-two states were awarded grants. Alabama, California, Hawaii, Illinois, Indiana, Iowa, Kentucky, Maine, Massachusetts, Michigan, Mississippi, New York, Nevada, Oklahoma, and Virginia received enhancement grants; Missouri, Ohio, Tennessee, and Vermont received implementation grants; and Arizona, Louisiana, and New Hampshire received planning grants.

In FY2006, the Harold Rogers Prescription Monitoring Program received $7.5 million in funding. Eighteen states were awarded grant funds: Alabama, California, Colorado, Connecticut, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Mississippi, New York, North Carolina, North Dakota, Ohio, Oklahoma, Texas, and Virginia.

In FY2007, the Harold Rogers Prescription Monitoring Program received $7.5 million in funding. Eighteen states were awarded grant funds: Alabama, Alaska, Arizona, California, Connecticut, Hawaii, Illinois, Indiana, Kentucky, Massachusetts, Montana, Nevada, New York, Ohio, Oklahoma, Texas, Vermont and Virginia.

Since the creation of the Harold Rogers grant program in FY2002, the number of states with PMPs or legislation to initiate PMPs (35) has increased by 150% since 2001. Prior to Harold Rogers funding in 2001, only 14 states, accounting for 40 percent of DEA-registered pharmacies and 44 percent of DEA registered-practitioners, had operational PDMPs.

The FY2008 grant solicitation was posted on BJA's website at www.ojp.usdoj.gov/bja on October 29, 2007 and will close on February 14, 2008. On June 11, 2007 the House Commerce-Justice-Science Appropriations Subcommittee passed the FY08 spending bill. Included in the bill is $7.5 million for the Harold Rogers Prescription Monitoring Program. The timing for full committee consideration is unclear due to an agreement to add earmarks into the legislation before it reaches the House floor. The Senate Appropriations committee considered the companion Senate bill on June 28. Included in the bill is $5 million for the Harold Rogers Prescription Monitoring Program. As of December 1, 2007 final funding for FY2008 has not yet been determined.

12. Should there be a federal mandate for states to establish prescription monitoring programs or should states be encouraged to establish individual programs?

In recognition of the proven effectiveness in curtailing the diversion and abuse of pharmaceutical controlled substances, the DEA has been a long time proponent of prescription monitoring programs (PMP). Further, it is DEA's intent to identify the best available means to facilitate the establishment and/or enhancement of PMPs to ensure prescription data is collected from the largest possible proportion of controlled substance dispensers in the most efficient, cost-effective manner.

Advantages of a national program may include an enhanced ability to identify and track prescription transactions across state lines. This is particularly important given the growing trend of filling prescriptions through mail order and Internet pharmacies. While several states report that their programs have the capability of generating reports regarding out-of-state prescribers or patients, they do not at this time routinely disseminate this information to other states. However, the size and cost of a national database may be prohibitive. The system would be required to collect data from in excess of 673 million prescriptions annually from the nation's 61,000 DEA-registered pharmacies and respond to requests for information from more than 900,000 DEA-registered practitioners. Additionally, the system would duplicate the efforts of state programs currently in operation. While only 35 states are currently operating

prescriptions monitoring programs or have enacted legislation, these states, including those considering or in the process of proposing legislation, cumulatively account for 98 percent of the nation's DEA-registered pharmacies and 98 percent of all practitioners.

Conversely, because state databases are much smaller than that of a national program, state programs can more readily identify specific trends, either those of abuse or outmoded prescribing practices. In addition, state programs can identify patients that may be in need of drug treatment due to abuse or addiction. State programs also have the ability to assist physicians whose patients may be receiving inadequate pain treatment causing the patient to see multiple physicians in an attempt to obtain additional medication. Attempts at implementing prescription monitoring programs tend to meet with opposition from a variety of groups including medical associations, pharmacy groups, pharmaceutical companies, patient advocacy groups, and civil liberty groups. In addition to these interested parties, a federal program would meet with additional opposition from states' rights groups as well as from officials in states currently operating programs. The question arises of whether a national program would be compatible with existing state programs. States currently operating programs may have to revise existing programs to accommodate a national program.

13. What is NASPER?

On August 11, 2005, President Bush signed into law the *National All Schedules Prescription Electronic Reporting Act of 2005* (NASPER). The act creates a grant program for states to create prescription drug monitoring databases and enhance existing ones, similar to the Harold Rogers Prescription Monitoring grant program. NASPER authorizes $60 million for the program through fiscal 2010. While the Harold Rogers grant program is placed within the Department of Justice, the NASPER program is placed within the Department of Health and Human Services (HHS).

The NASPER grant program is authorized for $60 million over five years, with $15 million allocated for 2006 and 2007, and $10 million for 2008, 2009, and 2010. However, HHS did not receive an appropriation in its FY2006 or FY2007 budget for this program. Funding for NASPER in FY2008 has not yet been determined.

14. What are the differences between the Harold Rogers Prescription Drug Monitoring grant program and NASPER?

The Harold Rogers grant program, housed in the Department of Justice, allows states to establish their own requirements with regard to Schedules monitored, information sharing, and accessibility/availability to the program data. Harold Rogers *encourages* the sharing of information and prescription data among states. Harold Rogers *encourages* the submission of data for prescriptions in Schedules II, III, IV & V. Eligibility for Harold Rogers grant funds has a very simple requirement. States applying for grants must have in place an enabling statute or regulation *"that requires submission of controlled substance prescription data to a centralized database administered by an authorized state agency."*

The National All Schedules Prescription Electronic Reporting Act of 2005 (NASPER), housed within the Department of Health and Human Services (HHS), requires states to meet requirements in order to receive grant funding. NASPER *requires states to collect data for prescriptions in* Schedules II, III, and IV. Additionally, NASPER *requires* states to be capable of sharing information and prescription data among states.

The following chart provides information on the 35 states with legislation enabling a prescription monitoring program including the type of program currently being operated, the schedules covered and the year the current version of the program was enacted.

	STATE	PROGRAM TYPE	SCHEDULES COVERED	YEAR ENACTED	DATA COLLECTION Started
1	AL	Electronic	C II-V	2004	April 2006

2.	AZ*	Electronic	C II-IV	2007	
3.	CA	Single copy serialized, Electronic	C II-IV	2005	January 2007 (1939)
4.	CO*	Electronic	C II-V	2005	N/A
5	CT*	Electronic -2008	C II-V	2007	N/A
6.	HI	Electronic	C II-V	2002	July 1999 (1992 –II)
7.	ID	Electronic	C II-V	2001	Oct 1997
8.	IL	Electronic	C II	1999	April 2000
9.	IN	Electronic	C II-V	2004	January 2005
10.	IA*	Electronic - 2007	C II-IV	2006	N/A
11.	KY	Electronic	C II-V	1998	January 1999
12.	LA*	Electronic - 2007	C II-V	2006	N/A
13.	ME	Electronic	C II-V	2003	July 2004
14.	MA	Electronic	C II	1992	April 2002
15.	MI	Electronic	C II-V	2002	January 2003
16.	MS	Electronic	C II-V	2005	May 2006
17.	MN*	Electronic	C II	2007	
18.	NV	Electronic	C II-V	1995	January 1997
19.	NM	Electronic	C II-IV	2004	July 2005
20.	NY	Single copy, serialized/ Electronic (state issued)	C II, Benzos	1998	July 1982
21.	NC	Electronic	C II-V	2005	July 1, 2007
22.	ND*	Electronic		2005	N/A
23.	OH	Electronic	C II-V	2005	May 2006
24.	OK	Electronic	C II-V	1990	July 2006
25.	PA	Electronic	C II	1972	Late 2002
26.	RI	Electronic	C II-III	1997	July 1997
27.	SC*	Electronic – Jan 08	C II-IV	2006	N/A
28.	TN	Electronic	C II-IV	2002	December 2006
29.	TX	Single copy, serialized/ Electronic (state issued)	CII	1997	July 1982
30.	UT	Electronic	C II-V	1995	January 1997
31.	VT*	Electronic	C II-IV	2006	N/A
32.	VA	Electronic	C II-IV	2002	June 2006
33.	WA	Electronic	Limited Trip	1984	Limited program
34.	WV	Electronic	C II-IV	1995	December 2002
35.	WY	Electronic	C II-IV	2004	July 2004

* Program is not currently operational – anticipated start date is listed.

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Alliance of States with Prescription Monitoring Programs

The Goals of Prescription Monitoring

Introduction

All states have laws and regulations that govern the distribution and handling of controlled substances and other pharmaceuticals as well as the provision of medical and pharmaceutical care. States' laws generally must balance the promotion of the safe use of controlled substances for the provision of medical care and services with the need to impede illegal and harmful activities involving these pharmaceuticals. Prescription monitoring programs are tools used by states to assist in the achievement of these goals.

Diversion[1] of controlled substances and other pharmaceuticals is generally recognized as a serious problem throughout the United States. While only a small percentage of patients and health care providers have been involved in pharmaceutical diversion, the number of cases and their consequences are significant. Drug diversion by patients, or individuals posing as patients, may result in harm, including serious injury or death, to themselves and their associates. Diversion by health care providers may, particularly when professionals are themselves impaired, result in the provision of substandard care to patients and thereby compromise their health and safety.

States have found that prescription monitoring programs are among the most effective tools available to identify and prevent drug diversion at the prescriber, pharmacy and patient levels. Prescription monitoring programs collect prescription data from pharmacies either in paper or electronic format. Data is reviewed and analyzed for educational, public health and investigative purposes. States with prescription monitoring programs recognize the legitimate need for pharmaceuticals in medical care; therefore, programs are not intended to interfere, nor have they been shown to have interfered, with the legitimate prescribing, dispensing or procuring of pharmaceuticals.

The goals of prescription monitoring programs managed by the states are manifold and depend upon the missions of the state agencies that operate the programs and use the program data. Such agencies may include regulatory boards, health departments or law enforcement agencies. While each state has a different set of goals for its prescription monitoring program, those goals are generally based on a number of possible major objectives of prescription monitoring, namely:

- Education and information
- Public health initiatives
- Early intervention and prevention
- Investigations and enforcement
- Protection of confidentiality

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[1] Pharmaceutical (or drug) diversion is the channeling of licit controlled substances or other pharmaceuticals for illegal purposes or abuse. Diversion may include, but is not limited to, theft burglary and robbery; tampering; stealing, forging and counterfeiting prescriptions; doctor shopping; indiscriminate prescribing; and illegal sales of prescriptions and pharmaceuticals.

Education and Information

A major goal of many prescription monitoring programs is the provision of information and feedback to prescribers, pharmacists and the public. Programs can provide prescribers with information on their own prescribing records and have assisted prescribers in some states in identifying individuals who forge or illicitly obtain prescriptions. Information on and analysis of prescribing trends in the states can also be generated and disseminated. Such analysis may, for example, provide comparative information between geographic regions, medical specialties or drug classes.

Prescription monitoring programs have also raised the general awareness of the problem of diversion and the illicit use of pharmaceuticals. Increased awareness of health care providers and the public can lead to reductions in drug diversion and abuse.

Public Health Initiatives

States use the information obtained from the review and analysis of prescription monitoring data in the development of public health initiatives. Information on trends in prescribing and dispensing can be used to assist in addressing problems such as under- and over-utilization and inappropriate prescribing. Monitoring information has been used by states in the initiation of education and prevention programs, formulation of laws and regulations, development of controlled substances policies and establishment of practice and treatment guidelines.

One advantage of prescription monitoring is that initiatives can be targeted to selected subsets of prescribers or pharmacists. For example, one state health department was able to use their prescription records database to notify prescribers of glutethimide of the adverse effects of long-term use of the drug and the importance of seeking alternatives.

Early Intervention and Prevention

Another goal of some prescription monitoring programs is early intervention in and prevention of drug diversion. Prescription monitoring programs may provide law enforcement and regulatory agencies with the ability to detect diversion earlier than would be possible with other forms of information gathering. For example, they may be particularly useful in providing early detection of sophisticated scams, doctor shopping and forgeries.

One objective of many of the states that have implemented prescription monitoring programs is the deterrence of drug diversion. An expectation is that knowledge of the existence of a more efficient mechanism for tracking illicit activities will deter individuals from conducting such activities. For example, in some of the states that have implemented serialized or tamper-evident prescription forms as part of their programs, cases of forged and counterfeit prescriptions for monitored drugs have been significantly reduced or eliminated altogether.

Investigations and Enforcement

Most prescription monitoring programs have, as a primary part of their mission, the enforcement of laws and regulations governing licit controlled substances. These programs aid law enforcement and regulatory agencies in responding to illegal prescribing, dispensing and procuring of controlled substances by providing a tool to assist in identifying and investigating potentially illegal activities.

Prescription monitoring is an enhancement to existing methods of information gathering and not a new source of investigative information. Prior to monitoring, and in states without such programs, law enforcement and regulatory agencies have had access to medical records maintained by licensees as well as prescription records in pharmacies. With prescription monitoring, prescription dispensing records are accessible at a single site, often in a computerized database, thus reducing the need to travel to collect information from multiple practice sites. Prescription monitoring programs serve as tools that facilitate the locating of evidence with minimal or no intrusion on prescribers and pharmacies. Therefore, the main impact of programs on law enforcement is to provide a mechanism for increased efficiency in conducting investigations.

Many investigations of alleged diversion are initiated in response to complaints registered with law enforcement and regulatory agencies. Such agencies generally have mandates to respond to complaints, yet they often do not have the resources to thoroughly investigate all complaints. Prescription monitoring programs can assist agencies in meeting their mandates by increasing the efficiency with which information is gathered and analyzed in complaint investigations.

Investigations of alleged drug diversion, including those initiated in response to registered complaints, necessarily involve scrutiny of prescriber and pharmacy records. Since investigative scrutiny can be disruptive to individuals who are subsequently found to have no illegal involvement, it is desirable to have mechanisms to reduce such intrusions. Insofar as prescription monitoring may contribute information that affords cause to suspend or terminate an investigation, the programs provide an avenue to reduce the intrusion for individuals under investigation. Prescription monitoring may be particularly helpful in assisting in the identification of complaints that may be inaccurate or unfounded and thereby enable resources to be focused on investigations that are more likely to result in the uncovering and constraint of illegal activities.

Protection of Confidentiality

Of paramount importance to all prescription monitoring programs is the strict protection of confidentiality of data. All states have mechanisms in place, usually required by statute, to restrict access to prescription monitoring data and to protect the privacy of prescribers, pharmacies and patients. Over the decades during which prescription monitoring programs have been operating, there have been no documented or anecdotal cases of breach of confidentiality of data.

Conclusion

The goals of prescription monitoring programs are manifold, spanning education, prevention and law enforcement. An overriding common goal of such programs is to uphold the laws of the states which encompass both the promotion of access to appropriate pharmaceutical care by the states' citizens and the deterrence of pharmaceutical diversion. Therefore, the objectives of prescription monitoring do not include any restrictions on the legitimate prescribing or dispensing of pharmaceuticals. Rather, these programs are aimed at upholding statutory mandates in a manner that is most supportive of and least disruptive to medical and pharmacy practice.

Prescription Monitoring
for the
State of Alaska

October 8, 2007

Submitted by:

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Statement of Confidentiality

This document is for informational purposes only and is only intended for the State of Alaska. No binding contract or third-party beneficiary rights arise from delivery of this document.

Background

Until recently, the emphasis in drug enforcement and abuse prevention has been on illicit street drugs. Only a small fraction of the federal, state and local funding available has been set-aside for the prevention and investigation of prescription drug diversion – the channeling of legitimate, controlled-substance pharmaceuticals for illegal purposes or abuse. Yet the U.S. Drug Enforcement Administration (DEA) has stated that the diversion and abuse of legitimately produced controlled pharmaceuticals constitute a multibillion-dollar illicit market nationwide.[1]

As they have become more prevalent, prescription drugs have become increasingly easy to obtain illegally through theft, forged prescriptions, "doctor shopping", and other health care fraud. In 2002, about 6.2 million Americans aged 12 and older reported using prescription drugs, including pain relievers, tranquilizers, stimulants, or sedatives, for non-medical purposes in the previous 30 days. [2]

According to the 2004 National Drug Control Strategy, the illegal diversion, theft, and medical mismanagement of prescription drugs present a larger public health and law enforcement challenge than cocaine or heroin.[3] The most recent National Survey of Drug Use and Health informs us that the misuse of pain relievers and other psycho-therapeutic drugs was the second leading category of illicit drug use in 2002, following only marijuana.[4]

Investigating a single incident of suspected illegal activity requires the collection of hundreds, if not thousands, of prescription records. In the absence of an automated system, collecting these records requires the manual review of paper-based pharmacy files, a very time-consuming and invasive process.
A number of states have implemented automated prescription monitoring programs as a means to control the illegal diversion of prescription drugs. Such programs primarily have the following goals[5]:

- Education and information
- Public health initiatives

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[1] Drug Enforcement Association and the National Alliance for Model State Drug Laws, *A Closer Look at State Prescription Monitoring Programs* (http://www.deadiversion.usdoj.gov/pubs/program/rx_monitor_summary.htm accessed July 18, 2003)
[2] 2001-2002 National Household Survey on drug Abuse, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services.
[3] Office of National Drug Control Policy, *National Drug Control Strategy 2004*, p.23 (Washington, D.C.: March, 2004).
[4] Ibid.
[5] Alliance of States with Prescription Monitoring Programs, *The Goals of Prescription Monitoring*, (http://www.nascsa.org/alliance/Goals.PDF accessed March 1, 2004)

- Early intervention and prevention
- Investigations and enforcement
- Protection of confidentiality

Major benefits of these programs include diversion, prevention and deterrence, increasing the likelihood of catching culpable practitioners of diversion, reducing the consequences of abuse, and reducing unnecessary health care expenditures. **The ultimate objective of prescription monitoring programs is to reduce the diversion of legal pharmaceutical controlled substances while promoting their appropriate use for patient care.**

The key to a successful prescription-monitoring program is balance. The most successful prescription monitoring programs attempt to strike a balance between making drugs available for patients and limiting drug diversion.

In addition, prescription-monitoring programs have led to improvements in the timeliness of law enforcement and regulatory investigation. States with such programs have reported a reduction in investigation times by at least 80%.[6]

An emerging need in the fight against prescription drug diversion is sharing information across state lines. Diversion investigators recognize that while patients and providers alike frequently cross state lines for a multitude of reasons, most legitimate, prescription drug abuse has no boundaries. One of the reasons for inability to share information across states lines is the lack of statutory authority permitting such activity. Many states are seeking to amend their laws to include this capability. However, due to the lack of standards for data accumulation among the states currently operating prescription monitoring programs it is often extremely difficult if not impossible to share that information.

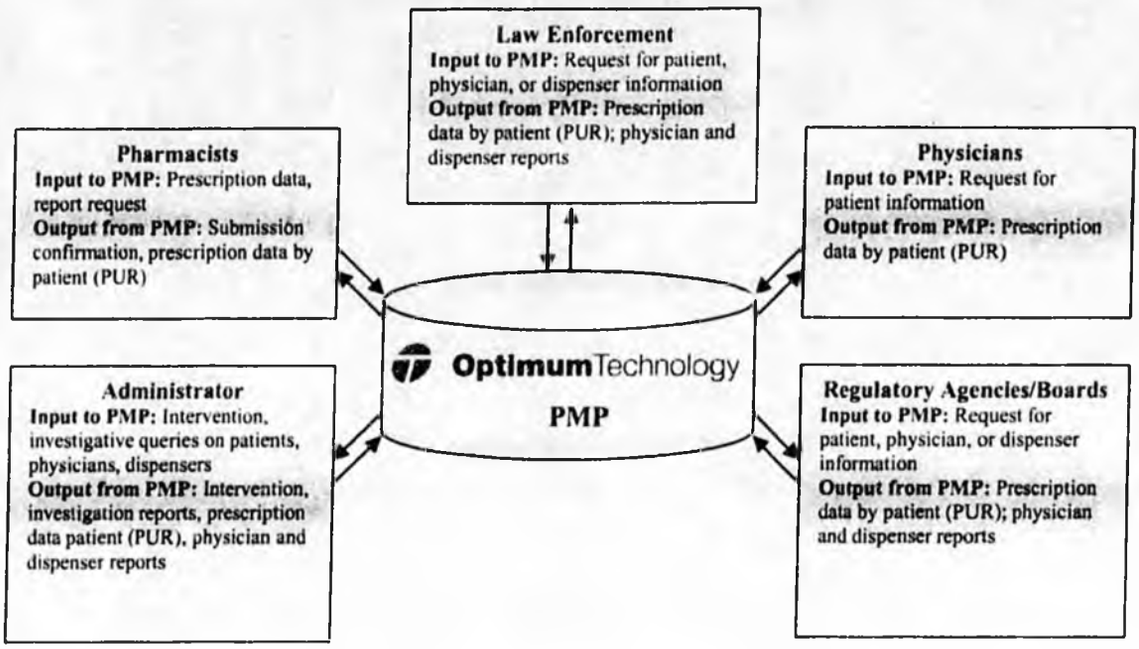
Optimum Technology, Inc. has implemented the first and only multi-state Prescription Monitoring Information Sharing program know as PMIX. It is established between the states of California and Nevada and was sponsored by IJIS.

This was but only the first step. Optimum is now working with IJIS to further establish data sharing standards as well as another PMIX program in the Midwest using Hub and Spoke architecture.

[6] U.S. General Accounting Office, *Prescription Drugs: State Monitoring Programs May Help to Reduce Illegal Diversion*, GAO-04-524T, pp. 9-10 (Washington, D.C.: March 4, 2004).

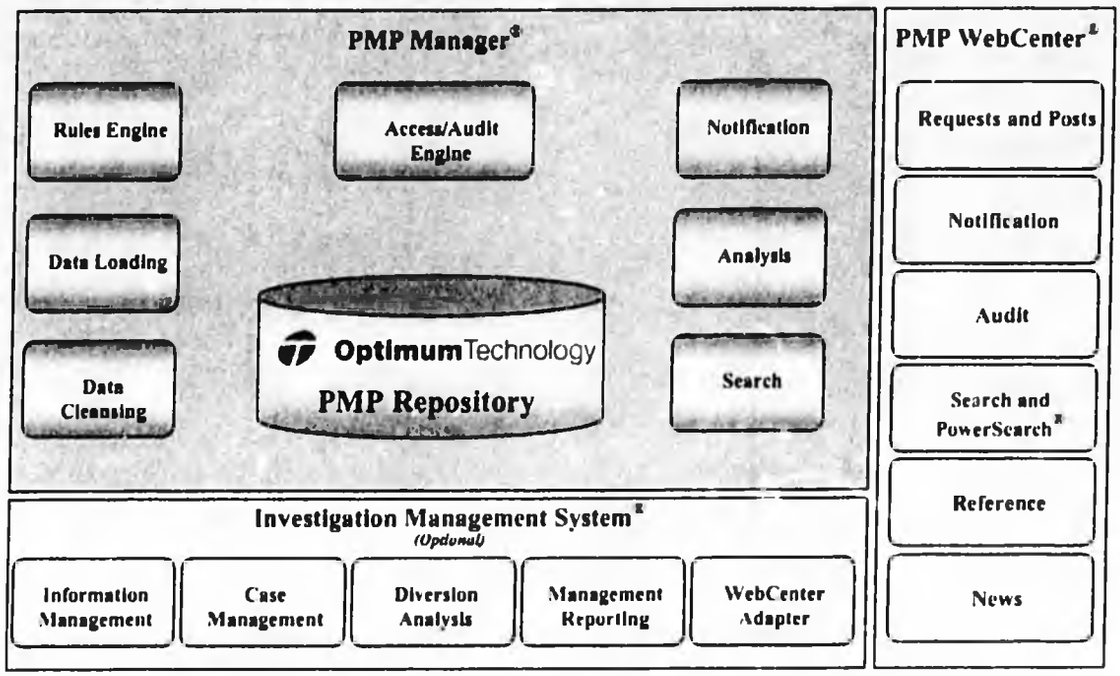
Proposed Solution

FIGURE 1: PRESCRIPTION MONITORING PROGRAM INTERACTIONS



Solution Overview

Optimum Technology's Prescription Monitoring and Investigation System framework is comprised of three primary sets of software components. Each set of components is designed to work alone or in combination with either or both of the other two, depending on the needs of the agency.



Prescription Monitoring & Investigation System Framework

Prescription Monitoring Program (PMP) Manager

PMP Manager® is designed to be used by a state board of pharmacy to facilitate the collection, analysis and reporting of information on the prescribing, dispensing and use of prescription drugs. It allows the PMP administrator to:

- Automate the process of loading pharmacy, drug and physician data into the repository
- Improve searching and reporting accuracy by standardizing names, addresses and drug names
- Define the rules that govern data loading, exception reporting, automatic notification and system access
- Track the "who, what, when and why" of all search requests and report deliveries
- Proactively notify select users of potential diversion activity

- Find information quickly and easily using any combination of names, numbers, words, phrases, "sounds like" functions, or a thesaurus

PMP WebCenter®

PMP WebCenter® is a secure web site that facilitates automated communication with law enforcement agencies, pharmacies, prescribers, and the general public. It is designed to be implemented by a state pharmacy board, a regional drug task force or the drug enforcement unit of a local law enforcement agency. WebCenter® provides secure, automated facilities to:

- Respond more quickly to requests for pharmacy dispensing records searches by allowing authorized users to fill out online web forms
- Save time and money by delivering the results of a pharmacy records request electronically
- Broadcast alerts of potential diversion activity and request information and tips
- Generate reports and statistics for use by policymakers, researchers and the public
- Improve public awareness by providing "one-stop" access to news, announcements and specialized reference and other educational material

PMP PowerSearch®

PowerSearch® is a module of the PMP Framework® which provides advanced searching, linking and automatic request fulfillment of patient information requests. It provides the PMP administrator the ability to:

- Match records using identifying information using such identifiers as first and last name, gender, address information, numerical identifiers, date of birth, etc.
- Use configurable settings to assure appropriate matching and linking automatically
- Link multiple patient records which are similar using sophisticated match processes while allowing the PMP Administrator to define the elements to use for a match from combinations of the collected data, and to use phrases, soundex, wildcards, and name thesaurus in such definitions
- Automatically generate and respond to queries from practitioners and others

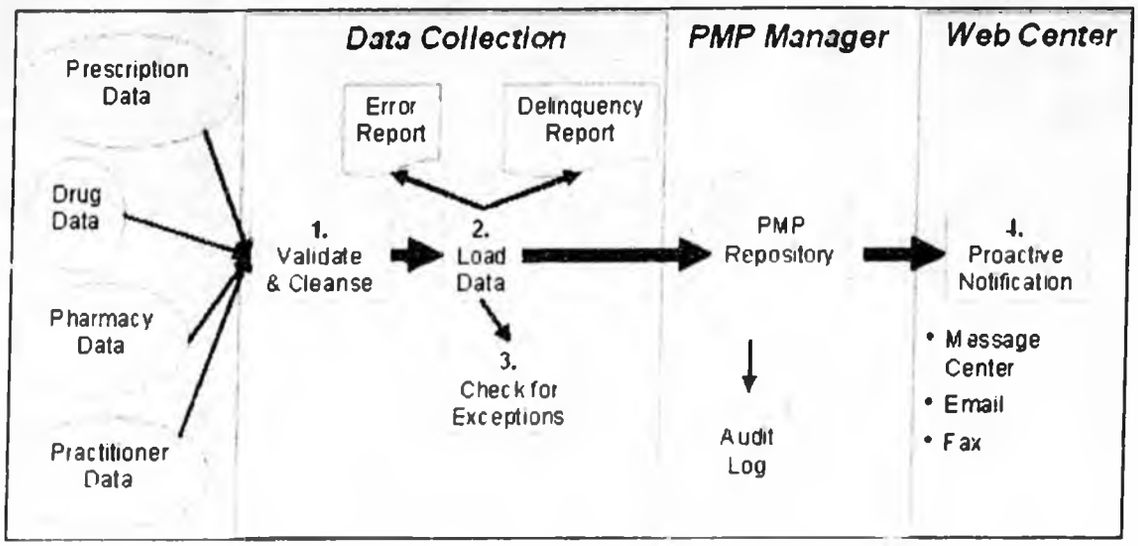
Investigation Management System (IMS)®

IMS® serves as a centralized information database and case management system for collecting, managing and analyzing detailed information about patients, prescribers, pharmacists, and prescriptions – and the links between them. IMS is designed for prescription drug diversion intervention specialists and their supervisors. IMS not only assists in the successful intervention with prescription drug abusers, but, more importantly, helps to realize the goal of preventing prescription drug abuse. With IMS a regulatory or law enforcement investigator can:

- Record, track and search any information related to people, organizations, places, property, vehicles and prescriptions.
- Open, assign, close cases, file supplemental reports, record time and expenses.
- Select data to analyze by patient, physician, pharmacy and/or date range; analyze dispensing information to identify potential diversion activity.
- Track cases by assignment and disposition; report case volume, time, expense, seizure and forfeiture statistics.
- Properly monitor cases which have been necessarily referred for prosecution.
- Engage in valuable collaborative opportunities among health professionals, state licensing and regulatory agencies and law enforcement to proactively address prescription drug abuse.

Solution Features

FIGURE 2: PRESCRIPTION MONITORING SYSTEM INTERACTION



The following is a description of the functionality for each module:

PMP Manager®

Data Loading

- Provide facilities to map pharmacy records from compliant reporting sources (such as recommendations of the American Society for Automation in Pharmacy [ASAP], the National Association of State Controlled Substance Authority [NASCSA] Prescription Monitoring Program Model Act, or the Model Prescription Monitoring Act propounded by the National Alliance for Model State Drug Laws), NDC drug data and existing law or regulatory enforcement agency database fields to PMP Repository fields
- Allow the administrator to load pharmacy dispensing record data received from the pharmacy records and reporting systems, NDC and existing law or regulatory enforcement agency databases in a pre-defined format into the PMP repository
- Generate a report of loading errors and data inconsistencies
- Allow the administrator to test run the load process and generate a report of errors encountered

PMP Direct Prescription Data Upload®

- Facilitate the collection of prescription data from multiple sources (pharmacies and others) and provides the PMP administrator with monitoring and reporting facilities to ensure conformance with the State's prescription data submission standards
- Extend PMP Manager® data upload facilities by enabling mechanisms for collecting prescription data directly from multiple sources, including upload using PMP WebCenter® or via transferring files to a specific directory
- Provide facilities to process uploaded files, perform validation and other error checking, notification to pharmacies of errors
- Upload tracking and monitoring features, including pharmacies that have and have not submitted required data
- Generate reports on the data uploads for a pharmacy or across pharmacies for a specific period

Data Cleansing

- Allow the administrator to standardize address information using U.S. Postal Service rules on a global basis
- Allow the administrator to standardize drug name information using NDC drug names on a global basis
- Allow the administrator to make "global search & replaces" of information such as patient name and doctor name. This functionality would be similar to Word's "Replace" functionality

Rules Engine

- Allow the administrator to define rules used in validating incoming data from pharmacy records and reporting systems (e.g. flag incoming data when pharmacist's name is not found in the law or regulatory enforcement agency's database)
- Allow the administrator to define exception reporting rules based on certain thresholds (e.g. single patient with pharmacies per month greater than n)
- Allow the administrator to add, edit and delete rules for automatic notification based on the presence of new data in the repository (e.g. notify an authorized individual or agency of the presence of new data related to a particular person or entity in an open regulatory or enforcement matter)
- Allow the administrator to define threshold criteria for standard Diversion Analysis
- Allow the administrator to specify the data range and subject (patient, doctor, pharmacist or pharmacy) of a Diversion Analysis

Access/Audit Engine

- Allow the administrator to track all access to data in the PMP repository
- Allow the administrator to add, edit and delete system usage profiles
- Allow the administrator to add, edit and delete user accounts and profile assignments
- Automatically warn users of privacy restrictions and require them to indicate the purpose for their requested data access
- Automatically record to the audit log the data related to who accessed (add, edit, delete, query, report) what information when and for what purpose
- Allow the administrator to query, view, report and archive audit log information

Notification Engine

- Automatically notify named users (by rule) of each exception occurrence via e-mail or a PMP WebCenter® message. Exception messages will state the patient name or doctor name, timeframe and exception condition.
- Allow a notified user to easily query the database and create a result set using the exception rule
- Provide ability for the notified user to easily create an Excel file of the result set

Search Engine

- Provide a facility to search for names in the repository using: any word or phrase, wildcards, soundex and a name thesaurus
- Provide a facility to search for addresses in the repository using: any word or phrase, wildcards, soundex and a name thesaurus
- Provide a facility to search for data in the repository using a form displaying all searchable fields for a particular type of data: patients, doctors, pharmacists, addresses or pharmacies
- Provide a facility to search for data in the repository by "building" a query using any combination of fields (from multiple data types) and operators

PMP WebCenter®

Search Requests

- Allow the administrator to set up and maintain user profiles and system access profiles for secure areas of the site; providing both group-level and individual access and privilege levels
- Provide a web form for authorized users to request a repository search
- Allow the administrator to automatically confirm receipt of a search request

- Allow the administrator to send the results of a search to request to an authorized user electronically

Alerts

- Automatically alert area doctors, pharmacists and law enforcement personnel of suspected criminal activity via automated web postings and/or e-mails driven by the rules defined by the administrator
- Alerts can include attached images, photos and other documents
- Provide a web form for users to enter tips and other information in response to an alert or activity. The system will perform validation checking on completed forms and route them to the appropriate personnel.
- Allow authorized users to search the alerts database using any combination of name, date, address, physical characteristics, or text string
- Automate the process of surveying area pharmacies to request patient profile information for a specific case (not necessary in PMP states)

Reports Center

- Allow the administrator to generate standard statistical reports
- Allow the administrator to generate ad hoc reports, charts and maps
- Allow the administrator to make selected reports, statistics, related links and other content available to PMP WebCenter® users to support awareness and education

News Center

- Allow the administrator to publish information of interest to users such as announcements, memos and news articles via a simple news posting facility
- Provide a means for authorized users of the site to access the news items from the home page

Reference Center

- Provide a facility for authorized users to update their own contact information
- Provide all members with easy access to a directory of member contact information to facilitate communication
- Allow the administrator to post and maintain a set of answers for frequently asked questions. Authorized users will be able to access the FAQs without having to rely on phone calls or e-mails to staff.
- Provide links to online reference material published by the law or regulatory enforcement agency (e.g. white papers, PowerPoint presentations)

- Provide links to related sites and online reference material published by other government agencies

PMP Data Collection Portal®

Data Upload/Data Management

- Accept standard electronic files of prescription data from pharmacies/dispensers over a secure Internet connection
- Perform automated cleansing of the data for person names, addresses and drug names
- Load the prescription data into the PMP system and detects any errors in prescription records

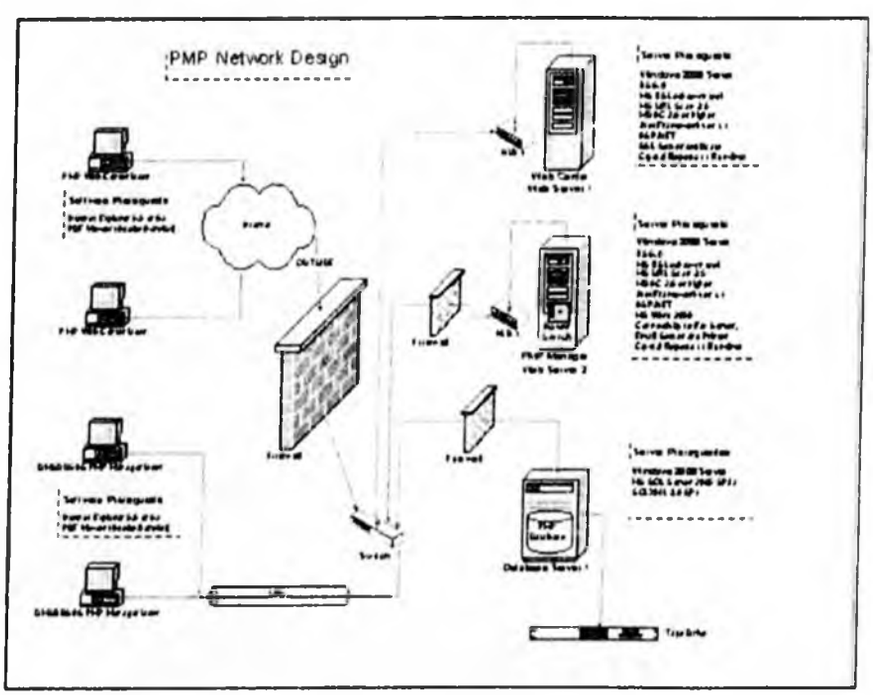
Reporting

- Generate reports for the end-user and PMP administrator of the results of the prescription data upload

PMP Framework® Network Hardware and Operating Environments

The following is a complete description of the PMP Framework® Network Diagram, with hardware and operating environments.

FIGURE 3: OPTIMUM TECHNOLOGY'S NETWORK ENVIRONMENT



Investigation Management

Intelligence Management

- Lead tracking
  - File a new lead form
  - Notify team of new lead information
  - Assign a lead to an investigator
- Recording information not associated with a particular case
  - Events
  - People (suspect, witness, victim, associate, etc.)
  - Locations (street address, geocode, type of structure, etc.)
  - Organizations (business, gang, school, etc.)
  - Vehicles (make, model, color, plates, etc.)
  - Property (weapons, drugs, prescriptions, etc.)
- Flexible search capability
  - Search a shared collection of intelligence information by name (including aliases and nicknames), address, date range, and other characteristics

Case Management

- Opening a case
  - File complaint/incident report
  - Associate intelligence data with a case
  - Assign an investigator
- Supplemental reporting
  - File activity reports (Buy, Search, Seizure, Interrogation, Interview, Arrest, Observation, Surveillance Log, Lab Report)
  - Add documents of any type, including word processing, spreadsheets, images, photographs and sound files to your case folders
  - Automatically submit the case for supervisory review and approval
- Closing a case
  - Record the final case disposition

Diversion Analysis

- Profile data loading
  - Provide screens designed for rapid data entry of profile information received in hard copy format
  - Cleanse profile data to normalize drug names, patient name and addresses

- Pharmacy Profile analysis
  - Choose from a variety of analysis types, including: quantities, scripts, doctors, payment types or pharmacies per patient; scripts or addresses per doctor
  - Specify quantity thresholds for each type of analysis
  - Choose from a variety of selection criteria, including: date range, patient names, doctor names, pharmacies, and pharmacists
  - Save, print or export analysis results

- Other analysis
  - Provide facilities for general investigation analysis, such as:
    - Link Chart, Event Timeline, Pin Map, Known Offender Mapping, and Photo Line Up

Management reporting

- Current case assignments
- Cases by disposition
- Activities
- Statistical reports, including: Pending/New/Closed Cases, Seized and Forfeited Assets, Arrests, Sentences, Drug Removals, and Weapons

Alaska
2007

DEA Offices & Telephone Nos.
Anchorage—907-271-5033
Fairbanks —907-455-1818

State Facts	2006 Federal Drug Seizures
Population: 663,661	**Cocaine:** 13.8 kgs.
State Prison Population: 4,554	**Heroin:** 0 kgs.
Probation Population: 5,547	**Methamphetamine:** 6.9 kgs.
Violent Crime Rate	**Marijuana:** 222.6 kgs.
National Ranking: 7	**Hashish:** 0.0 kgs.
	MDMA: 0.0 kgs./895 DU
	Meth Lab Incidents: 4 (DEA, state, and local)

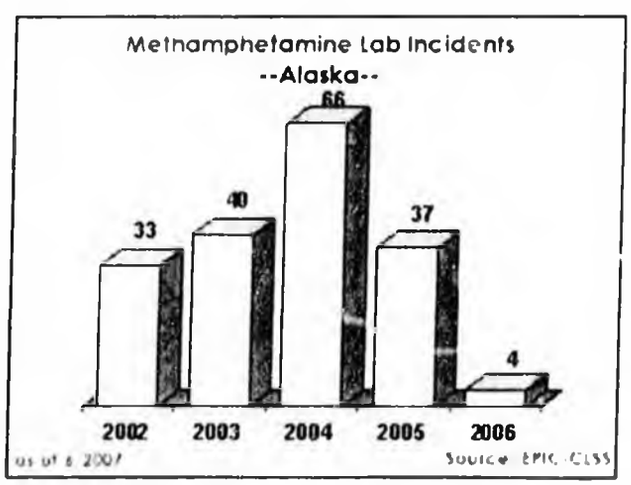
Sources

Drug Situation: Due to its non-contiguous location with the rest of the United States and shared border with Canada, Alaska is both a transshipment state as well as consumer state for controlled substances. Dominican and Mexican organizations are primarily responsible for cocaine distribution in Alaska. Methamphetamine seizures and abuse are on the increase. Alaska has one of the highest per capita uses of controlled substances, partially attributing to the equally high per capita incidence of alcoholism, rape, and suicide compared with the rest of the United States. Drug trafficking organizations in Alaska also engage in money laundering, using a variety of methods to legitimize and reposition illicit proceeds.

Cocaine: Several different organizations are involved in trafficking cocaine to Alaska. Mexican and Dominican drug trafficking organizations dominate cocaine distribution in Alaska. Crack cocaine continues to be a threat in Alaska, with many organizations dealing in both cocaine and crack. These organizations obtain cocaine from the lower 48 states. Due to Alaska's remote location, these organizations are able to resell cocaine in Alaska at grossly inflated rates.

Heroin: Small amounts of black tar heroin are available in Alaska. Mexican organizations control the distribution of black tar heroin. OxyContin, with effects similar to heroin, has become the drug of choice for heroin abusers in the state.

Methamphetamine: Some local law makers, in an attempt to slow the increase of methamphetamine labs, have mandated that cold remedies containing pseudoephedrine be removed from shelves and placed behind the counter or within the pharmacy. Many retailers of such cold remedies have chosen, without being mandated, to remove those products as well. Preliminary results indicate that such steps have actually decreased the number of small user-type labs seized by law enforcement. Methamphetamine continues to be readily available. Drug trafficking organizations obtain the majority of



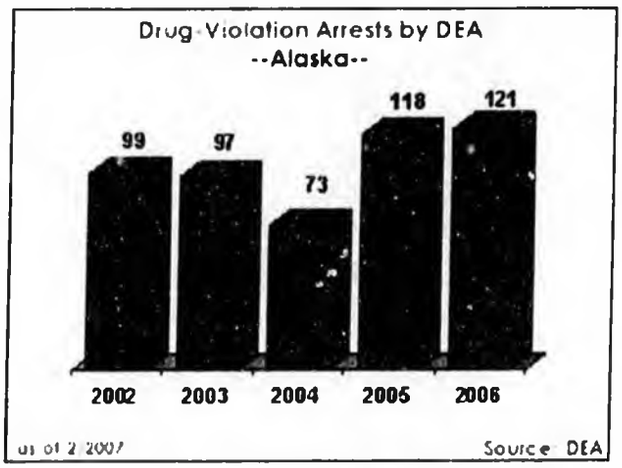
methamphetamine for sale in Alaska from sources in the lower 48 states. Southeast Asian methamphetamine tablets known as "yaba," reportedly manufactured in Burma and Laos, are becoming available in Alaska.

Club Drugs: MDMA (4-methylenedioxymethamphetamine/street name Ecstasy) is available in Alaska. Drug trafficking organizations distributing cocaine, methamphetamine, and marijuana are acquiring small amounts of MDMA for distribution. LSD (lysergic acid diethylamide) and GHB (gamma-hydroxybutyrate) are available in Alaska.

Marijuana: Marijuana is the most abused and widespread drug in Alaska. In June,Alaska Governor Frank Murkowski signed HB49 which re-criminalizes the use and possession of marijuana. Almost all of the marijuana grown in Alaska is harvested in indoor growing operations. The availability of BC Bud smuggled from Canada continues to increase in the Anchorage area.

Pharmaceutical Diversion: In the United States, prescription drugs are the second most abused drug by youth. The primary methods of diversion of legitimate pharmaceuticals continues to be illegal dispensing and prescribing by physicians, illegal distribution by pharmacists, prescription forgery, doctor shopping, and drug thefts from pharmacies, nursing homes, and hospitals. Pharmacy burglaries are prevalent throughout the state and Diversion Investigators are also encountering pharmaceuticals that have been purchased via the Internet without a doctor's prescription. The abuse and trafficking of oxycodone (OxyContin®, Percocet, Percodan), hydrocodone (Vicodin, Lortab), and anabolic steroids continues to be a concern.

DEA Mobile Enforcement Teams: This cooperative program with state and local law enforcement counterparts was conceived in 1995 in response to the overwhelming problem of drug-related violent crime in towns and cities across the nation. Since the inception of the MET Program, 473 deployments have been completed nationwide, resulting in 19,643 arrests. There have been no MET deployments in the State of Alaska.



More information about the Seattle Division Office.

Sources

Factsheet last updated: 6/2007

Click here for last year's 2006 factsheet>>

MSNBC.com

Teen drug use drops, painkiller abuse rises

Study finds abuse of prescription drugs is steadily increasing

The Associated Press
updated 11:13 a.m. HT, Tues., Dec. 11, 2007

WASHINGTON - Illicit drug use by teens continued to gradually decline overall this year, but the use of prescription painkillers remains popular among young people, according to a federally financed study released Tuesday at the White House.

The survey, by the University of Michigan's Institute for Social Research, looked at the behavior of 8th, 10th and 12th graders nationwide. The study, in its 33rd year, found that overall drug use is falling, thanks to a drop in the popularity of marijuana and methamphetamines. But it also found that teen use of other drugs, such as cocaine, is holding steady, and narcotics like OxyContin and Vicodin remain in vogue.

Overall, the proportion of 8th graders reporting use of an illicit drug at least once in the 12 months before the survey was 24 percent in 1996. It now has fallen to 13 percent — a drop of nearly half.

Among 10th graders, the rates dropped from 39 percent to 28 percent between 1997 and 2007. Twelfth graders saw a decline from a peak of 42 percent in 1997 to 36 percent this year.

"The cumulative declines since recent peak levels of drug involvement in the mid-1990s are quite substantial especially among the youngest students," said Lloyd Johnston, the principal investigator for the study, which was financed by the National Institute on Drug Use. It surveyed 50,000 teens.

The drugs most responsible for this year's decline in illicit drug use are marijuana and various stimulants, including amphetamines, methamphetamine and crystal methamphetamine.

"The most encouraging statistic relates to the use of methamphetamine, which has plummeted by an impressive 64 percent since 2001," President Bush said.

Painkiller abuse rising

"One exception to this trend is a rise in the abuse of certain prescription painkillers," Bush said. "This is troubling, and we're going to continue to confront the challenge and the overall direction is hopeful."

At least one in every 20 high school seniors has at least tried OxyContin, a powerful narcotic drug, in the past year, the study said. The popularity of the painkiller Vicodin also remained constant. The percentage of students using Vicodin was 2.7 percent, 7.2 percent and 9.6 percent in 8th, 10th and 12th grades, respectively.

While the use of most illicit drugs has shown declines in the past decade or so, most prescription psychotherapeutic drugs did not. A number of them showed steady increases in use outside of their legitimate medical purpose. These include sedatives, tranquilizers and narcotic drugs other than heroin.

The study also reported an increase in the use of ecstasy. Ecstasy use among teens dropped dramatically in the early 2000s, as concern about the consequences of use grew. However, the proportion of students seeing great risk in using this drug has been in decline for the past two or three years at all three grade levels, and use has begun to increase, at least in the upper grades.

Among 10th graders, annual prevalence with ecstasy has risen from a recent low of 2.4 percent in 2004 to 3.5 percent in 2007, while in 12th grade it has risen from a recent low of 3 percent in 2005 to 4.5 percent in 2007. While none of the one-year increases were statistically significant for 2007, a clear pattern of gradually rising use is discernible in the upper grades; and their cumulative increases over the past couple of years are statistically significant.

Teens less wary of ecstasy

"These prevalence rates are not very high yet, but there is evidence here of this drug beginning to make a comeback," Johnston said. "Young people are coming to see its use as less dangerous than did their predecessors as recently as 2004, and that is a warning signal that the increase in use may continue."

Among the study's other findings:

- Amphetamine use peaked in the mid-1990s among eighth and 10th graders, but since then, use has fallen by more than one-half among 8th graders to 4 percent and by one-third among 10th graders to 8 percent this year. Amphetamine use peaked a little later among 12th graders and has fallen by about one-third to 8 percent this year.
- Use of methamphetamine, called "meth," has been declining since it was first measured in 1999. Annual prevalence is now down by about two-thirds in all three grades from what it was in 1999.
- Marijuana still remains the most widely used of all the illicit drugs. The decline in 2007 in the annual prevalence of marijuana use among 8th graders fell from 11.7 percent in 2006 to 10.3 percent in 2007. Tenth graders showed a modest continuing decline in marijuana use, while 12th graders showed no further change this year after a significant decline in 2006.
- Cocaine was the one stimulant that did not show a decline this year. Between 2 percent and 5 percent of the 8th, 10th and 12th graders surveyed said they had tried it in the 12 months before the survey. Crack use, which previously declined in all three grades, showed no further decline this year.

- The study tracked a fairly sharp increase in the use of anabolic steroids by male teens in the late 1990s, 2000, 2001 and 2002. Since those peak years, the annual prevalence rate has dropped by more than half among the 8th and 10th grade males — to 1.1 percent and 1.7 percent, respectively — and by 40 percent among 12th-grade males to 2.3 percent this year.
- The number of U.S. teens who smoke has shown significant declines in recent years, particularly among those in their early teens. The rate of teens who reported smoking in the 30 days before the survey is now down by two-thirds among 8th graders to 7 percent from the peak level reached in 1996 of 21 percent.

URL: http://www.msnbc.msn.com/id/22202803/

<<Back

Study finds teen drug users trend toward prescription pills

NBC News
Tuesday, Dec. 11, 2007

ANCHORAGE, Alaska -- A new study of teenagers and drugs offers mixed news.

A University of Michigan report finds that while illicit drug use by U.S. teens declined this year, use of prescription painkillers is on the rise.

Still, overall decreases in drug use were seen among 8th, 10th and 12th-graders nationwide.

President Bush celebrated the study's findings at a forum on drug use at the White House Tuesday but also said more work must be done.

"It's really important for professional sports associations to crack down on drug abuse by athletes," he said. "And it's important that more people in Hollywood stand up and send the right message to our children."

In 2002 the president announced a five-year initiative to cut drug use among young people by 25 percent.

The Partnership for a Drug-Free America®

GENERATION RX: NATIONAL STUDY CONFIRMS ABUSE OF PRESCRIPTION AND OVER-THE-COUNTER DRUGS

Print Email

9/21/2006 11:09:22 AM

Today's teens are more likely to abuse Rx and OTC medications than many illegal drugs and think abusing medicines to get high is 'safer' than using illegal drugs.

Washington, D.C., May 16, 2006 – The intentional abuse of prescription (Rx) and over-the-counter (OTC) medications to get high is now an entrenched behavior among today's teen population, according to a national study released by the Partnership for a Drug-Free America®.

The Partnership's 18th annual study of teen drug use and attitudes confirms that Generation Rx has arrived as an alarming number of today's teenagers are more likely to have abused Rx and OTC medications than a variety of illegal drugs like Ecstasy, cocaine, crack and meth. **Nearly one in five teens (19 percent or 4.5 million) report abusing prescription medications to get high; and one in 10 (10 percent or 2.4 million) report abusing cough medicine to get high.**

"This study removes any doubt that intentional abuse of medications among teens is a real issue threatening the health and well-being of American families," said Steve Pasierb, president & CEO of the Partnership. "We have a situation where a widespread and dangerous teen behavior has become normalized and has found its way into our homes. These findings should serve as a wake-up call to parents that their teen is facing a drug landscape that did not exist when they were teens. The abuse of prescription and over-the-counter drugs has taken root among America's teens and the behavior is not registering with parents. Unless we all take action, it is a problem that will only get worse."

Released today in Washington, D.C., the 2005 Partnership Attitude Tracking Study (PATS) surveyed more than 7,300 teenagers in grades 7-12 (margin of error +/-1.5 percent). Top-line findings from this nationally projectable tracking study show the culture of "pharming" – abusing a host of medicines and chemical products intentionally to get high – has established itself among America's teen population:

- **Nearly one in five (19 percent or 4.5 million) teens has tried prescription medication** (pain relievers such as Vicodin and OxyContin; stimulants like Ritalin and Adderall) **to get high**
- **One in 10 (10 percent or 2.4 million) teens report abusing cough medicine to get high**
- Abuse of Rx and OTC medications is on par or higher than the abuse of illegal drugs such as Ecstasy (8 percent), cocaine/crack (10 percent), methamphetamine (8 percent) and heroin (5 percent).

"There is a world of difference between good medicine and bad behavior," said Dr. Michael Maves, executive vice president & CEO of the American Medical Association and a Partnership board member. "When these medicines are abused – when they are used for anything other than their intended and approved purpose – they can be every bit as dangerous as illegal street drugs."

Teens Think Intentionally Abusing Medicines to Get High is 'Safer' Than Using Illegal Drugs

According to the data, an alarming number of teens have a false sense of security about the safety of abusing Rx and OTC medications:

- **Two in five teens** (40 percent or 9.4 million) agree that Rx medicines, even if they are not prescribed by a doctor, are "much safer" to use than illegal drugs;
- **Nearly one-third of teens** (31 percent or 7.3 million) believe there's "nothing wrong" with using Rx medicines without a prescription "once in a while;"
- **Nearly three out of 10 teens** (29 percent or 6.8 million) believe prescription pain relievers – even if not prescribed by a doctor – are not addictive; and
- **More than half of teens** (55 percent or 13 million) don't agree strongly that using cough medicines to get high is risky.

The study also found teens believe a key driver for abusing prescription pain relievers is their

RELATED ARTICLES

What Every Parent Needs to Know About Cough Medicine Abuse

RELATED INFO

Additional Experts/Resources in the Field of Substance Abuse

Campaign to Reduce the New Substance Abuse Trend (What the Partnership is Doing)

List of Credits for TV, Radio and Print Messages

TV Messages About Rx OTC Abuse

Partnership Launches First Education Campaign Targeting Abuse of Prescription and Over-the-Counter Medications

RESEARCH

Key Findings of Hispanic Teen Drug Trends (PATS 2005)

Key Findings on Teen Drug Trends (PATS 2005)

PATS Teens 2005 Full Report

widespread availability and easy access. According to the data, **more than three in five teens say Rx pain relievers are easy to get from parents' medicine cabinets; half of teens say they're easy to get through other people's prescriptions; and more than half of teens say pain relievers are "available everywhere;" 43 percent of teens believe pain relievers are cheap and 35 percent believe they are safer to use than illegal drugs.**

"What we have here is a case of misinformation and poor attitudes – teens seeing few health risks associated with intentional abuse – teamed with easy access at home and via the Internet. Together it's a potentially lethal combination," said Pasierb.

Parents Completely Unaware of Teens' Intentional Abuse of Medications

Parents are crucial in helping prevent this behavior, but are largely unaware and feel ill-equipped to respond. **Parents must educate themselves and get through to their kids:**

- Kids who learn a lot about the risks of drugs at home are up to **50 percent less likely to use drugs;**
- **Nine out of 10 parents of teens** (92 percent or 22 million) say they have talked to their teen about the dangers of drugs, **yet fewer than one third of teens** (31 percent or 7.4 million) say they "learn a lot about the risks of drugs" from their parents.
- While three out of five parents report discussing drugs like marijuana "a lot" with their children, **only a third of parents report discussing the risks of using prescription medicines or non-prescription cold or cough medicine to get high.**

"Today's cohort of parents is the most drug-experienced in history, but they do not understand this new drug abuse behavior among their teens," said Roy Bostock, chairman of the Partnership. "They are looking for the classic signs of illegal drug abuse and are missing this trend. Parents need to be aware that the drugs their teens abuse today, including medicines, are not the drugs from decades past. Only through education and parental involvement can this trend be reversed."

Partnership Launches First National Rx and OTC Medicine Abuse Education Campaign

The Partnership's annual tracking study – the largest, ongoing analysis of drug-related attitudes in the country – began measuring teen abuse of select medications in 2003. With three years of data in hand and last year's data heralding the emergence of this new category of substance abuse, the Partnership recognized this shift in teen drug abuse behavior as one of the most significant in recent history and immediately began developing a necessary prevention and education campaign directed at parents.

Launching today, the campaign is a comprehensive, multi-year prevention communications effort targeting the abuse of Rx and OTC medications. The Partnership created this effort with support from the Consumer Healthcare Products Association and its member companies. The campaign speaks directly to parents by alerting them that their own homes are easily accessible sources for teens to obtain and abuse these medications. The campaign is comprised of hard-hitting television, newspaper, magazine and radio messages, a multifaceted interactive online component, and is supplemented by informational brochures to help parents get the conversation started with their teen. A multi-faceted public relations effort will provide additional media support for the campaign.

The campaign also features an innovative online component consisting of unique and engaging websites focused on the dangers of abusing cough medicine/dextromethorphan (dextromethorphan, or DXM, is the active ingredient in cough medicine). The Partnership's Web site features comprehensive online content on the abuse of prescription drugs. Original online content created specifically for parents and teens on the abuse of cough medicine can be found at:

- For parents - www.drugfree.org/Parent
- For teens - www.theinstories.com

"The message of this campaign can be summed up in three words," Pasierb said. "Educate, communicate and safeguard. Educate yourself about the medications kids are abusing. Communicate with your kids and dispel the notion – for yourself as well as for your kids – that these medicines can be safely abused. And safeguard your medications by learning which ones can be abused, limit access to them and keep track of the quantities you have in your home. Make sure your friends do the same."

All advertising for the campaign was created pro bono by advertising agencies Grey, DDB Chicago, Lumina Films and Dieste Harmel & Partners (Spanish-language), along with a number of production companies that donated their time and effort. All actors appear in campaign ads pro bono through the generosity of the Screen Actors Guild and the American Federation of Television and Radio Artists. The Rx and OTC education effort will be a priority campaign for the Partnership, which will work directly with national and local media to gain significant media placements for campaign messages.

Steady Decline in Teen Drug Use, With Marked Areas of Concern

The 2005 PATS study confirms that overall substance abuse is steadily declining among teens. The

data show noteworthy decreases in teens' use of tobacco, and steady declines in the number of teens using alcohol. Anti-marijuana attitudes have continued to strengthen since 1998 with 37 percent of teens reporting experimentation with the drug, compared to 42 percent in 1998. Ecstasy use also continues to decline with lifetime trials at 8 percent compared to 12 percent in 2001. Use of cocaine or crack – either lifetime trial, past year and past month – remain stable at 8 percent.

However, the PATS data has identified inhalants and methamphetamine abuse as two areas that are cause for concern and careful monitoring:

- **Inhalants** (inhaled fumes of household products) – Teen trial of inhalants has increased over the past three years to an alarming **20 percent** and inhalants are currently the second most abused substances behind marijuana (37 percent). While all measures of teen inhalant abuse have not reached the record highs of 1998, falling perceptions of risk indicate tha[illegible]itional increases in use are likely to follow.
- **Methamphetamine or meth** (stimulant) – Teen perception of the risks associated with both trying or using meth regularly have steadily increased over the last three years and this year's data show usage stabilized at 8 percent at the national level. While teen use of meth is relatively low, only 54 percent of teens see great risk in trying meth once or twice.
- "Teens' low perception of risk in abusing a drug can lead to abuse," said Pasierb. "History would tell us that we need to stay out in front of meth and inhalants before teen use of these drugs increases."

Abusing Prescription Drugs

Prescription drugs account for almost one-third of all drug abuse in the United States. Treatment admission rates have more than doubled in the past 10 years. State prescription drug monitoring programs, typically created by the legislature, require pharmacies to log each prescription they fill. The reports created by the logs are stored in a state electronic database that includes the patient's name, address, type and amount of drug, prescribing physician's name and other pertinent information.

Information contained in the database can help authorized agencies determine patterns of abuse, identify outmoded prescribing practices and can help states in their efforts to combat abuse and addiction. Medical professionals can use the information to prevent abusers from obtaining multiple prescriptions and to get patients the help they need.

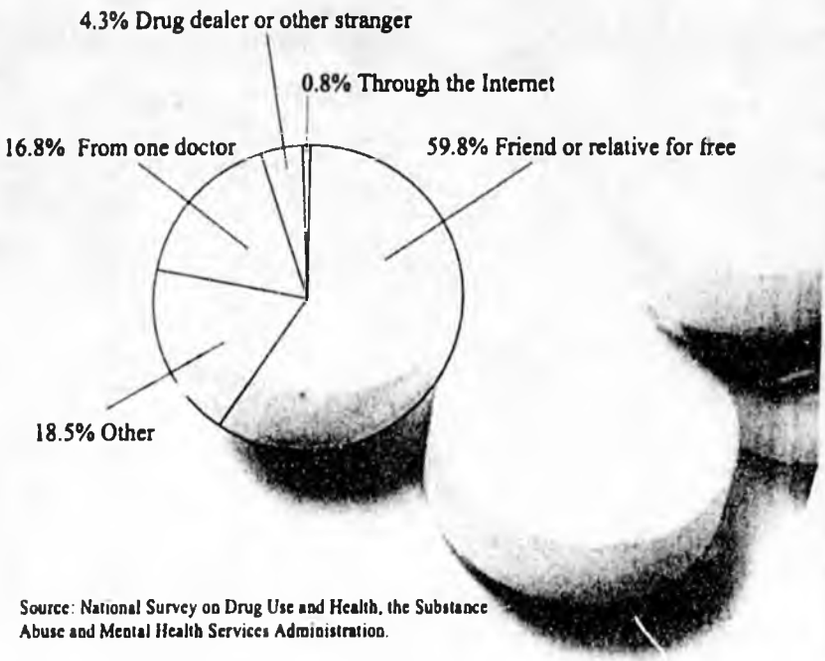
Since 2002, Congress has appropriated funds to the U.S. Department of Justice to support the Harold Rogers Prescription Drug Monitoring Program. State governments are eligible for grant funds if they have in place or have pending an enabling statute or regulation that requires the submission of prescription data to a centralized database administered by an authorized state agency.

HOW WIDESPREAD IS IT?

- One in five teens report having used a prescription painkiller without a doctor's prescription.
- In 2005, 6.4 million Americans, without a medical need, used prescription drugs: 4.7 million used pain relievers, 1.8 million used tranquilizers, 1.1 million used stimulants, 272,000 used sedatives.

SOURCE OF PRESCRIPTION DRUGS

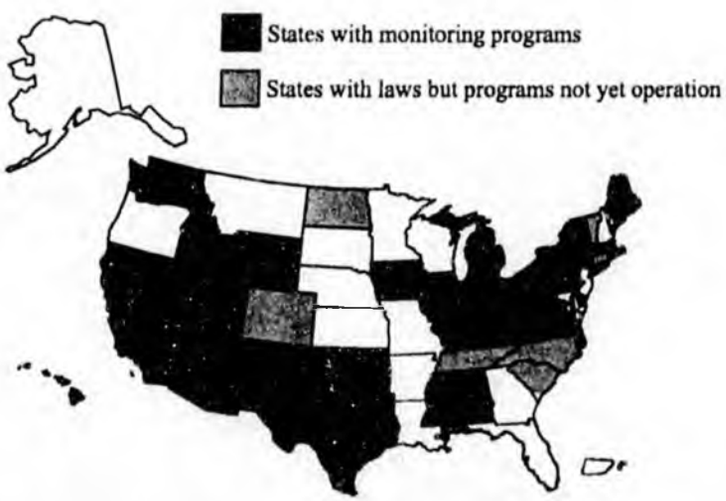
Where people who used pain relievers nonmedically in the past 12 months got the drugs.



Source: National Survey on Drug Use and Health, the Substance Abuse and Mental Health Services Administration.

MONITORING PRESCRIPTION DRUG USE

State programs require pharmacies to log each prescription they fill.



Source: The National Alliance for Model State Drug Laws, Oct. 11, 2006.
Note: Washington's program applies to licensed practitioners and is used for disciplinary purposes.

DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT
Division of Corporations, Business and Professional Licensing

Sarah Palin, Governor
William C. Noll, Commissioner
Rick Urion, Director

January 4, 2007

Re: Proposal for the Prescription Drug Monitoring Program

To: Brian Howes, Investigator III

From: Dorothy Fulton, MA, RN
Nancy Sanders, PhD, RN
Executive Administrators, Board of Nursing

Thank you for your December 7th presentation to the Board of Nursing about a proposed prescription drug monitoring program for the State of Alaska. The Board members were interested in the information and could see how the data base would help ensure the safety of the consumer. We hope that such a data base will shorten the time it takes to investigate complaints against nurses and certified nurse aides. Several questions were raised by Board members. Specifically, what safeguards will be in place to maintain confidentiality of the consumer and the nurse? Will all prescription drugs be monitored or only controlled drugs? Who will have access to the information on the data base?

After discussion, the Board of Nursing asked us to convey the Board's support of the concept of a prescription drug monitoring program. As nurses in Advanced Practice have prescriptive authority for legend and controlled drugs, the Board would like to be kept informed as the program is designed.

Thank you.

550 West 7th Avenue, Suite 1500, Anchorage, AK 99501-3567
Telephone: (907) 269-8160 Fax: (907) 269-8156 Website: www.commerce.state.ak.us/occ

STATE OF ALASKA
DEPARTMENT OF
COMMERCE
COMMUNITY AND
ECONOMIC DEVELOPMENT

Sarah Palin, Governor
Emil Notti, Commissioner
Rick Urion, Director

Division of Corporations, Business and Professional Licensing

ALASKA STATE MEDICAL BOARD

20 December 2007

Jennifer Strickler, Acting Director
Division of Corporations, Business, and Professional Licensing
Department of Commerce, Community, and Economic Development
Post Office Box 110806
Juneau AK 99811-0806

Ms. Strickler, at the July 19-20, 2007 meeting of the Alaska State Medical Board, the board heard a presentation given by Investigator Brian Howes regarding a proposed prescription drug monitoring program for the state of Alaska.

The board members discussed with Mr. Howes the need for such a program and the benefits to health care providers in the state. It was the consensus of the board that this is a worthwhile and important program that will provide significant benefits to both physicians and physician assistants who prescribe medications and to the patients to whom they prescribe those medications.

Once implemented, the program has the potential to: 1) reduce the amount of legal prescription drugs being diverted for illegal purposes taking those drugs off the streets; 2) to prevent drug seeking patients from "doctor shopping" to obtain drugs for illegal use or diversion; and 3) it will provide another safeguard against potentially harmful drug interactions for patients. The program will be another tool in our arsenal to provide quality, safe health care to our patients.

The board voted unanimously to support the creation of this program and we urge you to also lend your endorsement to this valuable endeavor.

David M. Head, MD, Chair
Alaska State Medical Board

H:\Word\Dec-07\pdmp ltr.doc

550 West Seventh Avenue, Suite 1500, Anchorage, AK 99501-3567
Telephone: (907) 269-8163 Fax: (907) 269-8196 Website: www.commerce.state.ak.us/occ/pmed.htm

HB

319

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **HB391**
() Publish Date:

Identifier (file name): **HB391-DOT-CA-02-29-08**
Title: Project Labor Agreements
Sponsor: Representative Kelly
Requester: House Labor and Commerce

Dept. Affected: DOT&PF
RDU: Admin & Support
Component: Contracting & Appeal
Component Number: 2355

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services		0.0	0.0	0.0	0.0	0.0	0.0
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts		0.0					
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

HB 391 allows for project labor agreements that create an alternate method for non union members to pay into a "fringe benefit program".

Prepared by: Mary Siroky — Phone 465-4772
Division: Commissioner's Office, DOT&PF — Date/Time 2/29/08 8:00 AM
Approved by: Nancy Slagle — Date 3/29/2008
Administrative Services Director, DOT&PF

(Revised 10/05/2008 OMB)

Chair, House Judiciary
Labor & Commerce
Oil & Gas
Military & Veteran Affairs

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Alaska State Legislature
House of Representatives

While in Session
State Capitol, Room 118
Juneau, Alaska 99801-1182
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Toll Free: (877) 465-3004

Representative Jay Ramras
District 10

Sponsor Statement for HB 319

"An Act relating to the supervision and duties of dental assistants by dentists, establishing a restorative function certificate and a coronal polishing certificate."

The objective of House Bill 319 is to improve access to dental care and reduce treatment costs, by expanding the functions dental assistants are permitted to perform.

HB 319 does the following:

- Allows a **certified** dental assistant, under a dentist's direct supervision, to place "fillings" into a cavity prepared by a licensed dentist.
- Allows a **certified** dental assistant, under a dentist's direct supervision, to polish teeth that are already clean of tarter.

Oral health plays a key role in overall health. Untreated dental problems can cause pain, effect nutrition, and influence quality of life. Good dental health contributes to a healthy lifestyle and promotes good self esteem. Unfortunately, not all Alaskan's enjoy good dental health due to limitations on dental personnel, geographical barriers, fear of dental treatment, and cost of dental care.

Dental Assistants are not currently regulated by the state. HB319 will require dental assistants who perform the expanded duties of packing cavities or polishing teeth to pass a training program and exam to become certified by the Alaska Dental Board. The supervising dentist must personally authorize the procedure, examine the patient afterwards, and ensure the quality of work performed by the dental assistant.

I believe this bill will increase the efficiency of delivering dental care, while upholding the quality of that care.

Representative_Jay_Ramras@legis.state.ak.us

Alaska State Legislature

Session:
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Representative Jay Ramras
House District 10

Chair, House Judiciary Committee • Member, House Labor & Commerce Committee • Member, House Oil & Gas Committee • Member, House Military & Veteran Affairs Committee

Sectional HB 319- An Act relating to the practice of dentistry and to dental assistants

(Version 25-LS1281\V)

*** Section 1.** Adds a new section to AS 08.36 defining dental assistants.

Sec. 08.36.342 Describes the coronal polishing certificate.
Sec. 08.36.344 Describes the restorative function certificate.
Sec. 08.36.346 Describes delegated duties to a dental assistant.
Sec. 08.36.349 Defines "direct" and "indirect" supervision.

*** Section 2.** AS 08.36.370 Adds the definitions "calculus", "coronal polishing", and "dental assistant".

*** Section 3.** Repeals AS 08.32.110(d).

E-Mail Representative_Jay_Ramras@legis.state.ak.us

Representative Jay Ramras
Chair, House Judiciary
House Labor & Commerce
House Oil & Gas
House Military & Veteran Affairs
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Alaska State Legislature

While in Session
State Capitol, Room 118
Juneau, Alaska 99801-1182
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House District 10

House of Representatives

Memo

To: Representative Kurt Olson and
Members of the House Labor and Commerce Committee

From: Representative Jay Ramras,

Date: February 21, 2008

Subject: Changes to HB 319 25-LS1281\E to CSHB 319( ) 25-LS1281\V

Changes to CSHB 319(HES) 25-1281\L to CSHB 319( ) 25-LS1281\V:

Page 3, Rows 4-6 Contained wording problems per Legal Memorandum dated February 13, 2008. Recommendations made by Legislative Legal were adopted. Restrictions on duties which may be delegated to a dental assistant by a dentist are more clearly defined by this change.

Page 3, Line 13 Deleted "facility" and inserted "office" for consistency.

Changes to HB 319 25-LS1281\E to CSHB 319(HES) 25-LS1281\L:

Deleted sections 1, 2, and 3. By defining "direct" and "indirect" supervision in this section it excluded general supervision under which dental hygienists work.

Page 3, Line 30 deleted "subgingival". Corrected a drafting error.

The language in Section AS 08.36.346 Delegation to dental assistants. More narrowly defined what duties can be delegated to dental assistants due to concerns brought forth by the Health, Education and Social Services Committee.

Representative_Jay_Ramras@legis.state.ak.us

25-LS1281\V
Bullard
2/19/08

CS FOR HOUSE BILL NO. 319( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES RAMRAS, Thomas, Salmon

A BILL

FOR AN ACT ENTITLED

"An Act relating to the practice of dentistry, to dental assistants, and to dental hygienists."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 08.36 is amended by adding new sections to read:

Article 3A. Dental Assistants.

Sec. 08.36.342. Coronal polishing certificate. (a) The board shall issue a coronal polishing certificate to a dental assistant if the dental assistant furnishes evidence satisfactory to the board that the dental assistant has completed a program of instruction approved by the board.

(b) A certificate issued under (a) of this section authorizes a dental assistant under the direct supervision of a dentist licensed in the state to perform coronal polishing on teeth without calculus.

(c) The board may by regulation establish fees, renewal, and continuing education requirements for a certificate issued under this section.

Sec. 08.36.344. Restorative function certificate. (a) The board shall issue a restorative function certificate to a dental assistant if the dental assistant furnishes evidence satisfactory to the board that the dental assistant has

(1) successfully completed a program accredited by the Commission on Dental Accreditation of the American Dental Association or other course of instruction approved by the board; and

(2) passed the Western Regional Examining Board's restorative examination or other equivalent examination approved by the board within the five years preceding the dental assistant's certificate application, or the dental assistant has legal authorization from another state or jurisdiction to perform restorative functions.

(b) A certificate issued under this section authorizes a dental assistant under the direct supervision of a licensed dentist to place restorations into a cavity prepared by the licensed dentist and thereafter carve, contour, and adjust contacts and occlusion of the restoration.

(c) The board may by regulation establish fees, renewal, and continuing education requirements for a certificate under this section.

Sec. 08.36.346. Delegation to dental assistants. (a) Except as otherwise provided in this chapter, a dentist licensed in this state may delegate to a dental assistant under indirect supervision

(1) the exposure and development of radiographs;

(2) application of topical preventive agents or pit and fissure sealants: and

(3) other dental operations and services except

(A) those that may be performed by a dental hygienist under AS 08.32.110(a); and

(B) those that may not be delegated to a dental hygienist under AS 08.32.110(c).

(b) A dentist licensed in this state may delegate to a dental assistant under direct supervision

(1) coronal polishing on teeth without calculus, if the dental assistant is certified under AS 08.36.342;

(2) the placement of a restoration into a cavity prepared by a dentist licensed under this chapter and the subsequent carving, contouring, and adjustment of the contacts and occlusion of the restoration, if the dental assistant is certified under AS 08.36.344; and

(3) other dental operations and services as defined and regulated by the board; however, a dentist may not delegate to a dental assistant a dental operation or service that requires the professional skill of a licensed dentist or licensed dental hygienist, including those dental operations and services specified in AS 08.32.110(c).

Sec. 08.36.349. Definitions. In AS 08.36.342 - 08.36.349,

(1) "direct supervision" means a dentist licensed in this state is in the dental office, personally diagnoses the condition to be treated, personally authorizes the procedure, and, before dismissal of the patient, evaluates the performance of the dental assistant;

(2) "indirect supervision" means a dentist licensed in this state is in the dental office, authorizes the procedures, and remains in the dental office while the procedures are being performed by the dental assistant.

* **Sec. 2.** AS 08.36.370 is amended by adding new paragraphs to read:

(4) "calculus" means a hardened deposit of mineralized plaque;

(5) "coronal polishing" means the removal of supragingival plaque and stains;

(6) "dental assistant" means a person employed to provide clinical assistance to a dentist licensed in the state.

* **Sec. 3.** AS 08.32.110(d) is repealed.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 13, 2008

SUBJECT: CSHB 319(HES) Wording Problem (Work Order No. 25-LS1281\L)

TO: Representative Peggy Wilson
Chair of House Health, Education, and Social Services Committee
Attn: Becky Rooney

FROM: Kathryn L. Kurtz KK
Assistant Revisor

Enclosed is the committee substitute you requested.

The language the committee inserted at page 3, lines 4 - 6 is internally inconsistent. With the change, the section provides:

> (b) A dentist licensed in this state may delegate to a dental assistant under direct supervision
>
> ...
>
> (3) other dental operations and services as defined and regulated by the board that do not require the professional skill of a licensed dentist or licensed dental hygienist, ***including those dental operations and services provided in AS 08.32.110(c) and this chapter***.

(Emphasis added). AS 08.32.110 addresses the scope of practice of dental hygienists, and subsection (c) limits the tasks which may be delegated by a dentist:

> (c) This section does not authorize delegation of
>
> (1) diagnosing, treatment planning, and writing prescriptions for drugs; writing authorizations for restorative, prosthetic, or orthodontic appliances;
>
> (2) operative or surgical procedures on hard or soft tissues except as allowed in (a)(4) of this section; or
>
> (3) ***other procedures that require the professional competence and skill of a dentist***.

(Emphasis added). Obviously, this is not a list of tasks that do not require the professional skill of a licensed dentist or licensed dental hygienist, as the lead-in language

The simplest solution to this drafting problem would be to remove the phrase "*including those dental operations and services provided in AS 08.32.110(c) and this chapter*" on page 3, l. 5 - 6. Another approach would be to clarify the language to match what the committee presumably intended, perhaps along these lines:

> (b) A dentist licensed in this state may delegate to a dental assistant under direct supervision
>
> ...
>
> (3) other dental operations and services as defined and regulated by the board; however, a dentist may not delegate to a dental assistant a dental operation or service that requires the professional skill of a licensed dentist or licensed dental hygienist, including those dental operations and services specified in AS 08.32.110(c).

Please alert the next committee of referral to this issue, and please call if you have questions or would like us to draft an amendment.

KLK:med
08-096.med

Enclosure

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB 319
() Publish Date:

Identifier (file name): HB319-OL-02-06-07
Title: Dentists & Dental Assistants
Sponsor: Ramras, Thomas, Salmon
Requester: House HES

Dept. Affected: Commerce
RDU: Corp, Bus & Prof Licensing (117)
Component: Corp, Bus & Prof Licensing
Component Number: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2008) cost: _____

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This legislation amends AS 08.36 Dentistry to revise the grounds for discipline, suspension or revocation of licenses; and requires the board to issue certain certificates to dental assistants. This legislation is not expected to increase the board's operating expenses.

Occupational licensing programs are required to cover operating costs with licensing fees under AS 08.01.065; revenue generated by fees covers the full operating costs.

Prepared by: Chris Wyatt, Administrative Officer — Phone: (907) 465-2572
Division: Corporations, Business, and Professional Licensing — Date/Time: 2/6/08 5:46 PM
Approved by: Emil R. Notti, Commissioner — Date: 2/6/2008
Commerce, Community, and Economic Development

EXPANDED FUNCTIONS FOR DENTAL ASSISTANTS

STATE	RESTORATIVE FUNCTION	CORONAL POLISHING
ARIZONA		COURSE AND EXAM
ARKANSAS		COURSE AND EXAM
CALIFORNIA	COURSE AND EXAM	COURSE AND EXAM, OR MAY BE TRAINED BY DENTIST
COLORADO		NO EXAM REQUIRED
FLORIDA		COURSE AND EXAM
GEORGIA		NO EXAM REQUIRED
IDAHO		BOARD CERTIFICATION
ILLINOIS		COURSE AND EXAM
KANSAS		NO EXAM REQUIRED
MAINE	BOARD CERTIFICATION	NO EXAM REQUIRED
MASSACHUSETTS		COURSE AND EXAM
MICHIGAN		COURSE AND EXAM
MINNESOTA		COURSE AND EXAM
MISSOURI	COURSE AND EXAM	COURSE AND EXAM
MONTANA	COURSE AND EXAM	COURSE AND EXAM
NEBRASKA		COURSE AND EXAM
NEVADA		NO EXAM REQUIRED
NEW JERSEY		COURSE AND EXAM
NEW MEXICO		COURSE AND EXAM
NEW YORK	COURSE AND EXAM	COURSE AND EXAM
NORTH CAROLINA		COURSE AND EXAM
NORTH DAKOTA		COURSE AND EXAM
OHIO	BOARD CERTIFICATION	BOARD CERTIFICATION
OKLAHOMA		COURSE AND EXAM
OREGON		COURSE AND EXAM
PENNSYLVANIA	COURSE AND EXAM	COURSE AND EXAM
RHODE ISLAND		COURSE AND EXAM
SOUTH CAROLINA		COURSE AND EXAM
SOUTH DAKOTA		COURSE AND EXAM
TENNESSEE	BOARD CERTIFICATION	COURSE AND EXAM
UTAH		NO EXAM REQUIRED
VERMONT	BOARD CERTIFICATION	BOARD CERTIFICATION
WASHINGTON	BOARD CERTIFICATION (2008)	NO EXAM REQUIRED
WEST VIRGINIA		COURSE AND EXAM
WISCONSIN		NO EXAM REQUIRED
WYOMING		NO EXAM REQUIRED

DAVID L. EICHLER, D.M.D.

3375 Badger Road, Suite 1
North Pole, AK 99705
Telephone: (907) 488-0978

January 16, 2008

To whom it may concern:

At the December 7, 2007 meeting of the Alaska Board of Dental Examiners, we considered the proposed change to the Dental Practice Act enabling a broader scope of practice for dental assistants as presented by the Alaska Dental Society, introduced as HB 319. After discussion by the Board we voted unanimously to support the proposal as beneficial to the citizens of the State by improving access to care while still maintaining the oversight to ensure safety and quality of care. We look forward to providing for these proposed changes and introducing this innovative way to help our profession deliver care to all Alaskans.

Sincerely

David L. Eichler DMD
President, Alaska Board of Dental Examiners

Alaska Native
Tribal Health Consortium

Administration 4000 Ambassador Drive · Anchorage, Alaska 99508 · Phone: (907) 729-1900 · Fax: (907) 729-1901 · www.anthc.org

February 5, 2008

Representative Jay Ramras
Alaska State House
Juneau, AK 99801

Dear Representative Ramrus:

According to the U.S. Surgeon General, periodontal disease in American Indian and Alaska Native adults is 2.5 times greater than in the general U.S. population. Data from Alaska shows that 92 percent of Alaska Native adolescents have signs of early periodontal disease. In the last decade, research has demonstrated the association of periodontal disease in pregnant women with premature birth and studies are underway now to test interventions. Infant mortality is a problem in Alaska and oral health problems can only contribute to this unnecessary loss.

Virtually without exception, the studies of dental therapists in other countries and even expanded duty personnel in the U.S. show that these highly competent technicians perform fillings at the same level as their dentist supervisors. A study in Michigan showed that expanded duty personnel had one-third as many failures of dental sealants over 10 years as dentists with an overall retention rate similar to published studies. A study in Canada showed that 79 percent of pit and fissure sealants applied by dental therapists were retained for at least three years and 46 percent less caries in these teeth. Similarly studies in the U.S. showed good agreement between trained dental extenders and dentists in dental caries screening.

In the United States, dentistry is an aging profession. Of the nation's roughly 162,000 practicing dentists, 22.5 percent were ages 55–64, and 10 percent were age 65 and older in 2005. A large portion of this group is expected to retire over the next five to ten years, leaving an even greater need for other dental disciplines to be fully trained and ready to move into the workforce. The national shortage of dentists means even greater hardships for the Alaska Native people living in rural Alaska.

Given the high number of oral health disparities faced by our people, the Alaska Native Tribal Health Consortium supports the expanded function practices of Dental Hygienists and Dental Health Aide Therapists across Alaska and the United States.

Sincerely,

Paul Sherry
Chief Executive Officer

Alaska Dental Outreach Consortium

Dentists reaching out to those in need

The Honorable Peggy Wilson, Chair; &
Honorable Members
House Committee for Health Education & Social Services
State Capitol Building
Juneau, AK 99901

1 February 2008

Chairman Wilson & Honorable Members:

On behalf of the Board of Directors of the Alaska Dental Outreach Corporation (ADOC), I urge you to support the passage of House Bill 319 & Senate Bill -239 concerning the expansion of duties for certified dental assistants.

These bills would allow greater access to care in rural areas and increase the ability of dentists to deliver care under the Medicaid and Denali Kid Care system.

ADOC is a non-profit organization started by the Alaska Dental Society in 2007. It has requested IRS designation as a tax-exempt entity, and is currently awaiting a ruling prior to commencing operations. ADOC has been established to provide care in underserved rural areas of Alaska using volunteer dentists.

The adoption of HB-319/SB-239 will ensure that ADOC's volunteer dentists are able to use the expanded duty for dental assistants to significantly increase the amount of care they are able to provide compared to than would be possible under the exist statutes. Certified dental assistants placing fillings after the dentists have prepared teeth will allow our dental teams to work efficiently. One dentist working in concert with several assistants will be able to provide care to 50-75% more patients than a dentist who is not allowed to delegate the "restorative services" authorized by these bills.

Allowing certified dental assistants to perform coronal polishing is also crucial to the efficient delivery of care. Unless ADOC is able to recruit hygienists willing to accompany our volunteer dentists and provide their services without compensation or remuneration, it will be cost prohibitive for ADOC to provide basic dental hygiene services. This will severely hinder ADOC's ability to provide this most basic of preventive services. Our dentists, due to the more pressing need to restore decayed teeth, will be unable to provide little more than a minimal number of the cleanings needed in the communities we will serve. However, with the adoption of these bills, dental assistants can provide coronal polishing, under the supervision of a dentist, who after removing any calculus (tarter) and treating any sub-gingival (below the gum line) treatment deemed appropriate, can focus on providing restorative and periodontal (gum) treatment that is needed.

Respectfully yours

James R. Towle
Secretary

9170 Jewel Lake Rd. #203; Anchorage, AK 99502
907-563-3003 (In Alaska 800-478-4675)

Alaska Dental Society, Inc.
9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(907) 563-3003 • FAX: 563-3009
akdental@alaska.net

The Honorable Jay Ramras
Alaska House of Representatives
State Capitol Bldg. Rm 118
Juneau, AK 99801

Dear Representative Ramras,

The Alaska Dental Society welcomes you back, for what we hope will be a productive and rewarding 2008 session of the Alaska Legislature.

This session the Alaska Dental Society (ADS) is backing legislation sponsored by Sen Joe Thomas and Rep. Jay Ramras These bills are one of several steps the is undertaking to increase access to dental care to rural and other Alaskans in need. A packet enclosed provides information on the Expanded Duty for Dental Assistants Bills, HB-319 and SB-239, as well as other components of a strategic plan for dealing with the shortage of dental care in Alaska.

Given the short 90 day session in 2008 we hope you will give HB-319 and SB-239 your support and urge you fellow lawmakers to take prompt attention before preparation of the FY2009 budget takes center stage.

Enclosed are complementary toothbrushes, floss for you and your staff.

Respectfully yours,

David Logan

David Logan, DDS, Chairman
Legislative Committee

Alaska Dental Society, Inc.
9170 Jewel Lake Road, Suite 203
Anchorage, Alaska 99502-5390
(907) 563-3003 • FAX: 533-3009
akdental@alaska.net

Long Term Strategic Plan for Providing Care for the Underserved in Alaska

The majority of Alaskans enjoy access to excellent and affordable dental care – some of the best in the world. A segment of the Alaska's population does not have ready access to basic dental care and struggles to pay for the treatment they need; particularly if they have delayed seeking care and their condition has gotten worse and more difficult and costly to treat.

The Alaska Dental Society has developed a long term strategic plan which will increase access to care for those Alaskans most in need and with the greatest challenges to getting regular care and treatment. It will require cooperation between the Alaska Dental and the Alaska Dental Board, the Legislature, as well as the other state and federal agencies responsible for dental and health care.

The Alaska Dental Society recommends the following steps to increase access to dental care:

1. Legislation to expand the duties that can be assigned to auxiliary dental personnel. Increasing the tasks performed by hygienists and assistants will increase efficiency while lowering costs.
2. Implement a 10% tax at the wholesale level on soda pop, soft drinks that contain significant percentages of sugar and candy products. Proceeds of the tax would be directed to the general fund and used to offset key programs to improve and increase access to dental care.
3. Implementation of a state grant program for delivery of preventive care in underserved areas.
4. Institute a loan program to encourage health care providers to deliver care in underserved areas.
5. Modifications to the Medicaid system by the Department of Health and Social Services that will encourage rather than discourage dentists to participate.
6. Incentives from the state to encourage communities to fluoridate community water systems and development of a state program to provide fluoride supplementation in communities without fluoridated water.

More detailed information on the above listed programs can be found in the accompanying material.

From: housemajority_email@housemajority.org
Sent: Thursday, February 07, 2008 6:09 PM
To: Rep. Jay Ramras
Subject: HB 319

From: swighs@yahoo.com

Dear Representative Ramras,

I am writing to you as a dental hygienist who loves her job and loves her patients. I worked hard for my degree and am proud of the level of training I received. I am very concerned about HB 319.

Dental Hygienists are highly trained and highly educated professionals. You Bill states that only tarter free children would be polished by assistants, why would you want someone with less hands on training and less education working on our most precious resource? We should expect the same high level care for children that we do for adults and that is with a hygienist.

Recently Dental Health Aides were allowed to practice in our rural areas and a new Dental Hygiene program was opened in Fairbanks. As more students graduate more professionals will be available to treat the needs of Rural Alaska. They will be professionals with at least 2 years of intense clinical training, which is what our states deserves.

Thank you,
Sarah Sullivan

~ Sarah Sullivan
Zip Code: 99709

HB

320

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **HB 320**
() Publish Date:

Identifier (file name): **HB320-DPS SAR-01-25-08**
Dept. Affected: Public Safety
Title "An Act relating to the certification of search and rescue personnel and organizations; . . .".
RDU Alaska State Troopers
Component Search & Rescue
Sponsor Representative Meyer
Requester House Labor and Commerce
Component Number 513

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services	261.1		261.1	261.1	261.1	261.1	261.1
Travel	25.0		25.0	25.0	25.0	25.0	25.0
Contractual	103.9		74.3	74.3	74.3	74.3	74.3
Supplies	9.8		9.8	9.8	9.8	9.8	9.8
Equipment	100.9						
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**500.7**	**0.0**	**370.2**	**370.2**	**370.2**	**370.2**	**370.2**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	500.7		370.2	370.2	370.2	370.2	370.2
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**500.7**	**0.0**	**370.2**	**370.2**	**370.2**	**370.2**	**370.2**

Estimate of any current year (FY2008) cost: 0.0

POSITIONS

Full-time	3	3	3	3	3	3	3
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill requires that the DPS establish qualifications required to certify search and rescue (SAR) personnel and organizations, and provide certification of such. The DPS is also required to maintain a register of the certified SAR personnel and organizations. This bill allows a political subdivision to provide benefits and compensation to volunteer search and rescue personnel. Finally, this bill provides that a SAR person, who is providing a service outside an incorporated city or borough, is an employee of the state and may be eligible for workers compensation coverage.

Prepared by: Lt. Rodney Dial
Phone (907) 247-4480
Division Alaska State Troopers
Date/Time 1/25/08 9:00 AM
Approved by: Walt Monegan, Commissioner
Date 1/25/2008
Department of Public Safety

(Revised 11/19/2007 OMB)

STATE OF ALASKA
2008 LEGISLATIVE SESSION

BILL NO. HB 320

ANALYSIS CONTINUATION

Passage of this legislation will result in a significant allocation of DPS resources to manage and oversee the training and certification of SAR personnel and groups. Currently there are approximately 1000 active SAR volunteers located in numerous communities throughout the state. To fully comply with this legislation it is anticipated that at a minimum, three new employees would need to be added to the DPS. The justification for the additional positions is as follows:

A DPS Lieutenant to lead and supervise the DPS SAR section. This position would establish statewide SAR qualifications and work with the various SAR agencies to conduct certification of the units and personnel.

A DPS Sergeant that would act as a training coordinator. This position would require extensive travel and would be actively involved in conducting and coordinating the training necessary to certify SAR agencies and personnel.

An Administrative Assistant III to support the Lieutenant and Sergeant and maintain the records associated with the certification of SAR agencies and personnel.

Included in this analysis is the funding needed for staff travel, communications, lease space, office supplies, uniforms, ammunition, law enforcement supplies, vehicles for the two police officers, and one-time costs such as academy training, portable radio, computers, firearms, and office furniture.

It is expected that if SAR agencies and personnel are required to certify, the DPS will assume the responsibility of providing the training necessary for them to comply with the requirements. It is also known by the DPS that there is significant and ongoing turnover within in the SAR community which will require the DPS to provide constant oversight, certification and training in perpetuity, if this legislation passes.

Finally, there will be additional and ongoing costs to the DPS to pay the workers compensation coverage premiums for those covered by this legislation. At this time, Risk Management is unable to predict what this premium will be so DPS is unable to provide an estimated annual cost. DPS may need to seek future appropriations to cover this cost.

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **HB320**
() Publish Date:

Identifier (file name): **HB320-DOA-RM-01-25-08**
Dept. Affected: Administration
Title "An Act relating to certain search and rescue volunteers to be considered state employees for purposes of worker's..."
RDU Risk Management
Component Risk Management
Sponsor Representatives Meyer, Buch and Holmes
Requester
Component Number 71

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services	*		*	*	*	*	*
Travel	*		*	*	*	*	*
Contractual	*		*	*	*	*	*
Supplies	*		*	*	*	*	*
Equipment	*		*	*	*	*	*
Land & Structures	*		*	*	*	*	*
Grants & Claims	*		*	*	*	*	*
Miscellaneous	*		*	*	*	*	*
TOTAL OPERATING	*	**0.0**	*	*	*	*	*
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	*		*	*	*	*	*
1003 GF Match	*		*	*	*	*	*
1004 GF	*		*	*	*	*	*
1005 GF/Program Receipts	*		*	*	*	*	*
1037 GF/Mental Health	*		*	*	*	*	*
Other Interagency Receipts	*		*	*	*	*	*
TOTAL	*	**0.0**	*	*	*	*	*

Estimate of any current year (FY2008) cost: 0.0

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

Risk Management (RM) will be financially impacted by the changes in this legislation.
RM administers the self insurance program providing workers' compensation protection for all state employees, which will now include any claims filed by the new stautory employee group created by this legislation.
As the number of searchers covered by this new law is not certain and actual exposure is very intermittent, it is impossible to present loss cost projections.
Future Risk Management's workers' compensation assessments to Public Safety will increase to reflect actual costs incurred as premiums charged each agency are developed from actual claims expenses incurred. RM cannot predict and present those costs at this time.

Prepared by: J. Brad Thompson, Director
Phone 465-5723
Division Risk Management
Date/Time 1/25/08 12:00 AM
Approved by: Kevin Brooks, Deputy Commissioner
Date 1/25/2008
Department of Administration

(Revised 11/19/2007 OMB)

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: **HB 320**
() Publish Date:

Identifier (file name): **HB320-DOLWD-WC-1-25-08**
Title: Search & Rescue: Certification/Work.Comp
Sponsor: Representative Meyer
Requester: House Labor and Commerce

Dept. Affected: Labor and Workforce Development
RDU: Workers' Compensation
Component: Workers' Compensation
Component Number: 344

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
1157 Workers' Safety/Comp Account							
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2008) cost: None

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

There is no anticipated financial impact to the department as a result of this legislation.

Prepared by: Paul F. Lisankie, Director — Phone 465-6059
Division: Workers' Compensation — Date/Time 1/25/08 1:20 PM
Approved by: Click Bishop, Commissioner — Date 1/25/08
Department of Labor and Workforce Development

(Revised 11/19/2007 OMB)

REPRESENTATIVE KEVIN MEYER

HOUSE DISTRICT 30

MEMORANDUM

DATE: **February 5, 2008**

TO: **Representative Kevin Meyer**

FROM: **Mike Pawlowski**

RE: **Sectional Analysis for CSHB 320**
(Version No. 25 – LS1176\E)

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds a new section to AS 18.60 allowing the Commissioner of Public Safety or his designee to organize and conduct a search and rescue training mission.

Section 2. Amends AS 18.60.120 to clarify that only the Commissioner of Public Safety or his designee may authorize a person to participate in the search and rescue party.

Section 3. Makes a conforming amendment to AS 18.60.125 to include a reference to new AS 18.60.115.

Section 4. Makes a conforming amendment to AS 18.60.175 to include a reference to new AS 18.60.115.

Section 5. Amends AS 23.30.092 to allow a political subdivision to elect to provide workers compensation benefits to search and rescue personnel.

Section 6. Adds a new section to AS 23.30 providing workers compensation coverage to search and rescue volunteers participating in a search and rescue mission under AS 18.60.120 or a training exercise under AS 18.60.115.

Email: Representative_Kevin_Meyer@legis.state.ak.us • **Toll Free:** (866) 465-4945
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25-LS1176\E
Bailey
2/5/08

CS FOR HOUSE BILL NO. 320( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVES MEYER, Buch, Holmes

A BILL

FOR AN ACT ENTITLED

"An Act relating to search and rescue training and search and rescue parties; requiring certain search and rescue volunteers to be considered state employees for purposes of workers' compensation coverage; and allowing political subdivisions to elect to provide workers' compensation insurance coverage for search and rescue personnel."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 18.60 is amended by adding a new section to article 2 to read:

Sec. 18.60.115. Search and rescue training. The commissioner of public safety or the commissioner's designee may organize and conduct a search and rescue training exercise to prepare for a response to a search and rescue activity under AS 18.60.120. Only the commissioner or the commissioner's designee may authorize a person to participate in a search and rescue training exercise under this section.

*** Sec. 2.** AS 18.60.120 is amended to read:

Sec. 18.60.120. Search and rescue parties. Upon being notified that a person is lost, injured, killed, or is in need of immediate rescue, the commissioner of public

safety or a designee may appoint a competent person to organize, direct, and guide a search and rescue party for the purpose of rescuing or retrieving the person or the person's remains. **Only the commissioner, the commissioner's designee, or the person appointed to organize, direct, and guide a search and rescue party may authorize a person to participate in the search and rescue party.**

*** Sec. 3.** AS 18.60.125 is amended to read:

Sec. 18.60.125. Civil immunity. A person may not bring a civil action for damages against the state, a political subdivision of the state, or the officers, agents, or employees of the state or a political subdivision of the state for a death, personal injury, or property damage that results from an act or omission in performing or failing to perform activities or duties authorized under **AS 18.60.115 - 18.60.175** [AS 18.60.120 - 18.60.175]. This section does not apply to a civil action for damages as a result of intentional misconduct within the course and scope of employment or agency and with complete disregard for the safety and property of others.

*** Sec. 4.** AS 18.60.175 is amended to read:

Sec. 18.60.175. Regulations. The Department of Public Safety shall adopt regulations necessary to carry out the duties assigned by **AS 18.60.115 - 18.60.170** [AS 18.60.120 - 18.60.170], including regulations dealing with the handling of nonexpendable property purchased during a search or rescue mission and expenditures of money for search and rescue. The regulations shall be adopted in accordance with AS 44.62 (Administrative Procedure Act).

*** Sec. 5.** AS 23.30.092 is amended to read:

Sec. 23.30.092. Volunteer ambulance attendants', police officers', [AND] fire fighters', and search and rescue personnel's insurance. A political subdivision may elect to provide benefits and compensation to its volunteer ambulance attendants, police officers, [OR] fire fighters**, or search and rescue personnel** by obtaining insurance that would provide its volunteer ambulance attendants, police officers, [OR] fire fighters**, or search and rescue personnel** with benefits and compensation at least equivalent to those conferred upon volunteer ambulance attendants, police officers, [OR] fire fighters**, or search and rescue personnel** by this chapter, and the election shall be considered compliance with the coverage and insurance provisions of this

chapter. The election shall be made by filing copies of the insurance policy or policies with the commissioner.

* **Sec. 6.** AS 23.30 is amended by adding a new section to read:

Sec. 23.30.246. Search and rescue personnel as state employees. (a) A resident of the state who temporarily volunteers to participate in a search and rescue training exercise or a search and rescue activity and who suffers injury or death during the course and within the scope of training for or providing search and rescue services is considered an employee of the state for purposes of this chapter if, at the time of the injury or death, the volunteer

(1) is an authorized participant in a search and rescue training exercise under AS 18.60.115 or a search and rescue activity under AS 18.60.120; and

(2) is not otherwise covered for that injury or death by an employer's workers' compensation insurance policy or self-insurance certificate.

(b) Notwithstanding the methods for calculating an employee's gross weekly earnings under AS 23.30.220, the gross weekly earnings for a resident of the state temporarily engaged as a volunteer under (a) of this section are equal to the state average weekly wage, but the gross weekly earnings for calculating compensation may not be less than the minimum wage computed based on 40 hours of work a week.

REPRESENTATIVE KEVIN MEYER

HOUSE DISTRICT 30

MEMORANDUM

DATE: **January 17, 2008**

TO: **Representative Kurt Olson, Chairman**
House State Affairs Committee

FROM: **Representative Kevin Meyer** K. Meyer

RE: **Hearing Request for House Bill 320 *Search & Rescue: Certification/Work.Comp***

Please schedule House Bill 320 *Search & Rescue: Certification/Work.Comp* for a hearing in the House Labor and Commerce Committee at your earliest convenience.

HB 320 requires that the Department of Public Safety certify volunteer search and rescue organizations and that volunteer search and rescue personnel receive workers compensation if injured while providing a search and rescue service. HB 320 also allows a political subdivision of the State to extend workers coverage to volunteer search and rescue personnel within their jurisdiction.

Included in this packet:

- HB 320 25-LS1176\A
- Sponsor Statement
- Sectional Analysis
- Backup Information
    - Alaska Mountain Rescue Group
        - AMRG Handbook

Thank you for your consideration of this request. If you have any questions, please feel free to contact me or my staff, Mike Pawlowski at x4945.

Email: Representative_Kevin_Meyer@legis.state.ak.us • **Toll Free:** (866) 465-4945
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REPRESENTATIVE KEVIN MEYER

HOUSE DISTRICT 30

Sponsor Statement for House Bill

"An Act relating to certification of search and rescue personnel and organizations; requiring certain search and rescue personnel to be considered state employees for purposes of workers' compensation coverage; and allowing municipalities to elect to provide workers' compensation insurance coverage for search and rescue personnel."

The majesty of the last frontier is a primary reason many Alaskans live here and one of the main reasons more than a million tourists visit Alaska annually. Alaskans are raised with an awareness and appreciation for the great outdoors and the dangers that exist in the wilderness. Alaskans are prepared for accidents and are rarely surprised when accidents do occur. When accidents do happen, it is primarily volunteers that perform the search and rescue missions Alaskans and our visitors rely upon.

House Bill 320 extends workers compensation coverage to volunteers during the course of providing a search and rescue service. These volunteers must be certified by the State and registered with the Department of Public Safety. HB 320 also allows municipalities to extend the same coverage they provide to search and rescue volunteers that they extend to volunteer firefighters, police officers and ambulance attendants. HB 320 however does not require a municipality to extend workers compensation coverage.

Currently, the volunteer emergency medical technicians that treat the injured are given workers compensation coverage by the State, but the volunteer search and rescue personnel do not have the same coverage. Municipalities are also allowed to provide coverage to their volunteer fire departments, ambulance attendants and police, but not the volunteers that perform search and rescue operations.

Most Alaskans know someone who has had an accident while enjoying the outdoors, and many have lost loved ones to tragedy. When accidents do happen, the volunteers in Alaska's search and rescue community are ready 24 hours a day, 365 days a year to put them selves at risk saving others in the backcountry. In the past six years, the Department of Public Safety and the volunteers in the search and rescue community have safely returned over 2,350 individuals to their friends and families.

HB 320 recognizes the valuable service these volunteers provide and ensures that if they are injured while providing a search and rescue service, they will receive workers compensation.

1/16/2008

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REPRESENTATIVE KEVIN MEYER

HOUSE DISTRICT 30

MEMORANDUM

DATE: **January 10, 2008**

TO: **Representative Kevin Meyer**

FROM: **Mike Pawlowski**

RE: **Sectional Analysis for HB 320**
(Version No. 25 – LS1176\A)

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds a new section to AS 18.60 requiring the Department of Public Safety to develop qualifications for, certify and maintain a registry of search and rescue organizations and personnel.

Section 2. Amends AS 23.30.092 to allow political subdivisions to extend workers compensation coverage to search and rescue personnel.

Section 3. Amends AS 23.30.238(b) to specify the appropriate level of coverage a search and rescue personnel is entitled to.

Section 4. Adds a new subsection to AS 23.30.238 to provide workers compensation to a person injured during the course of providing a search and rescue service.

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