Kentucky House Bill 1 Impact Evaluation

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AN ACT relating to controlled substances and making an appropriation therefor.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 218A IS CREATED TO READ AS FOLLOWS:

(1) (a) As used in this section, "pain management facility" means a facility where the majority of patients of the practitioners at the facility are provided treatment for pain that includes the use of controlled substances and:

1. The facility's primary practice component is the treatment of pain; or

2. The facility advertises in any medium for any type of pain management services.

(b) "Pain management facility" does not include the following:

1. A hospital, including a critical access hospital, as defined in KRS Chapter 216, a facility owned by the hospital, or the office of a hospital-employed physician;

2. A school, college, university, or other educational institution or program to the extent that it provides instruction to individuals preparing to practice as physicians, podiatrists, dentists, nurses, physician assistants, optometrists, or veterinarians;

3. A hospice program or residential hospice facility licensed under KRS Chapter 216B;

4. An ambulatory surgical center licensed under KRS Chapter 216B; or

5. A long-term-care facility as defined in KRS 216.510.

(2) Only a physician having a full and active license to practice medicine issued under KRS Chapter 311 shall have an ownership or investment interest in a pain management facility. Credit extended by a financial institution as defined in KRS 136.500 to the facility shall not be deemed an investment interest under this

subsection. This ownership or investment requirement shall not be enforced against any pain management facility existing and operating on the date of this Act being approved by the Governor or otherwise becoming a law unless there is an administrative sanction or criminal conviction relating to controlled substances imposed on the facility or any person employed by the facility for an act or omission done within the scope of the facility's licensure or the person's employment.

(3) Regardless of the form of facility ownership, beginning on the effective date of this Act at least one (1) of the owners or an owner's designee who is a physician employed by and under the supervision of the owner shall be physically present practicing medicine in the facility for at least fifty percent (50%) of the time that patients are present in the facility, and that physician owner or designee shall:

(a) Hold a current subspecialty certification in pain management by a member board of the American Board of Medical Specialties, or hold a current certificate of added qualification in pain management by the American Osteopathic Association Bureau of Osteopathic Specialists;

(b) Hold a current subspecialty certification in hospice and palliative medicine by a member board of the American Board of Medical Specialties, or hold a current certificate of added qualification in hospice and palliative medicine by the American Osteopathic Association Bureau of Osteopathic Specialists;

(c) Hold a current board certification by the American Board of Pain Medicine;

(d) Hold a current board certification by the American Board of Interventional Pain Physicians; or

(e) Have completed an accredited residency or fellowship in pain management.

(4) A pain management facility shall accept private health insurance as one of the

facility's allowable forms of payment for goods or services provided and shall accept payment for services rendered or goods provided to a patient only from the patient or the patient's insurer, guarantor, spouse, parent, guardian, or legal custodian.

(5) If the pain management facility is operating under a license issued by the cabinet, the cabinet shall include and enforce the provisions of this section as additional conditions of that licensure. If the pain management facility is operating as the private office or clinic of a physician under KRS 216B.020(2), the Kentucky Board of Medical Licensure shall enforce the provisions of this section. The provisions of this subsection shall not apply to the investigation or enforcement of criminal liability.

(6) Any person who violates the provisions of this section shall be guilty of a Class A misdemeanor.

➔SECTION 2. A NEW SECTION OF KRS CHAPTER 218A IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Reporting agency" includes:

1. The Department of Kentucky State Police;

2. The Office of the Attorney General;

3. The Cabinet for Health and Family Services; and

4. The applicable state licensing board; and

(b) "State licensing board" means:

1. The Kentucky Board of Medical Licensure;

2. The Kentucky Board of Nursing;

3. The Kentucky Board of Dentistry;

4. The Kentucky Board of Optometric Examiners;

5. The State Board of Podiatry; and

6. Any other board that licenses or regulates a person who is entitled to prescribe or dispense controlled substances to humans.

(2) (a) When a reporting agency or a law enforcement agency receives a report of improper, inappropriate, or illegal prescribing or dispensing of a controlled substance it may, to the extent otherwise allowed by law, send a copy of the report within three (3) business days to every other reporting agency.

(b) A county attorney or Commonwealth's attorney shall notify the Office of the Attorney General and the appropriate state licensing board within three (3) business days of an indictment or a waiver of indictment becoming public in his or her jurisdiction charging a licensed person with a felony offense relating to the manufacture of, trafficking in, prescribing, dispensing, or possession of a controlled substance.

(3) Each state licensing board shall by September 1, 2012, establish the following by administrative regulation for those licensees authorized to prescribe or dispense controlled substances:

(a) Mandatory prescribing and dispensing standards related to controlled substances;

(b) A prohibition on a practitioner dispensing greater than a forty-eight (48) hour supply of any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone unless the dispensing is done as part of a narcotic treatment program licensed by the Cabinet for Health and Family Services;

(c) A procedure for temporarily suspending, limiting, or restricting a license held by a named licensee where a substantial likelihood exists to believe that the continued unrestricted practice by the named licensee would constitute a danger to the health, welfare, or safety of the licensee's patients or of the general public;

(d) A procedure for the expedited review of complaints filed against their licensees pertaining to the improper, inappropriate, or illegal prescribing or dispensing of controlled substances that is designed to commence an investigation within seven (7) days of a complaint being filed and produce a charging decision by the board on the complaint within one hundred twenty (120) days of the receipt of the complaint, unless an extension for a definite period of time is requested by a law enforcement agency due to an ongoing criminal investigation;

(e) The establishment and enforcement of licensure standards that conform to the following:

1. A permanent ban on licensees and applicants convicted after the effective date of this Act in this state or any other state of any felony offense relating to controlled substances from prescribing or dispensing a controlled substance;

2. Restrictions short of a permanent ban on licensees and applicants convicted in this state or any other state of any misdemeanor offense relating to prescribing or dispensing a controlled substance;

3. Restrictions mirroring in time and scope any disciplinary limitation placed on a licensee or applicant by a licensing board of another state if the disciplinary action results from improper, inappropriate, or illegal prescribing or dispensing of controlled substances; and

4. A requirement that licensees and applicants report to the board any conviction or disciplinary action covered by this subsection with appropriate sanctions for any failure to make this required report;

(f) A procedure for the continuous submission of all disciplinary and other reportable information to the National Practitioner Data Bank of the United States Department of Health and Human Services;

(g) If not otherwise required by other law:

1. A process for obtaining a national and state fingerprint-supported criminal record check conducted by the Federal Bureau of Investigation or by the Department of Kentucky State Police on an applicant for initial licensing; and

2. Submitting a query on each applicant for licensure to the National Practitioner Data Bank of the United States Department of Health and Human Services to retrieve any relevant data on the applicant; and

(h) Continuing education requirements beginning with the first full educational year occurring after July 1, 2012, that specify that at least seven and one-half percent (7.5%) of the continuing education required of the licensed practitioner relate to the use of the electronic monitoring system established in Section 4 of this Act, pain management, or addiction disorders.

(4) A state licensing board shall employ or obtain the services of a specialist in the treatment of pain and a specialist in drug addiction to evaluate information received regarding a licensee's prescribing or dispensing practices related to controlled substances if the board or its staff does not possess such expertise, to ascertain if the licensee under investigation is engaging in improper, inappropriate, or illegal practices.

(5) Any statute to the contrary notwithstanding, no state licensing board shall require that a grievance or complaint against a licensee relating to controlled substances be sworn to or notarized, but the grievance or complaint shall identify the name and address of the grievant or complainant, unless the board by administrative regulation authorizes the filing of anonymous complaints. Any such authorizing administrative regulation shall require that an anonymous complaint or grievance be accompanied by sufficient corroborating evidence as

would allow the board to believe, based upon a totality of the circumstances, that a reasonable probability exists that the complaint or grievance is meritorious.

(6) Every state licensing board shall cooperate to the maximum extent permitted by law with all state, local, and federal law enforcement agencies, and all professional licensing boards and agencies, state and federal, in the United States or its territories in the coordination of actions to deter the improper, inappropriate, or illegal prescribing or dispensing of a controlled substance.

➔SECTION 3. A NEW SECTION OF KRS CHAPTER 218A IS CREATED TO READ AS FOLLOWS:

(1) Prior to the initial prescribing or dispensing of any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone to a human patient, a practitioner shall:

(a) Obtain a complete medical history and conduct a physical examination of the patient and document the information in the patient's medical record;

(b) Query the electronic monitoring system established in Section 4 of this Act for all available data on the patient;

(c) Make a written treatment plan stating the objectives of the treatment and further diagnostic examinations required;

(d) Discuss the risks and benefits of the use of controlled substances with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate, including the risk of tolerance and drug dependence; and

(e) Obtain written consent for the treatment.

(2) The practitioner shall conduct, at reasonable intervals based on the patient's individual circumstances, the course of treatment and provide to the patient any new information about the treatment. The course of treatment shall include the practitioner querying the electronic monitoring system established in Section 4 of

this Act no less than once every three (3) months for all available data on the patient and reviewing that data before issuing any new prescription or refills for the patient for any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

(3) For each patient for whom a practitioner prescribes any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone, the practitioner shall keep accurate, readily accessible, and complete medical records which include:

(a) Medical history and physical examination;

(b) Diagnostic, therapeutic, and laboratory results;

(c) Evaluations and consultations;

(d) Treatment objectives;

(e) Discussion of risk, benefits, and limitations of treatments;

(f) Treatments;

(g) Medications, including date, type, dosage, and quantity prescribed or dispensed;

(h) Instructions and agreements; and

(i) Periodic reviews of the patient's file.

(4) This section shall not apply to:

(a) A licensee administering a controlled substance or anesthesia immediately prior to or during surgery;

(b) A licensee administering a controlled substance necessary to treat a patient in an emergency situation:

1. At the scene of an emergency;

2. In a licensed ground or air ambulance; or

3. In the emergency department or intensive care unit of a licensed hospital;

(c) A licensed pharmacist or other person licensed by the Kentucky Board of Pharmacy to dispense drugs or to a licensed pharmacy;

(d) A licensee prescribing or dispensing a controlled substance for a hospice patient when functioning within the scope of a hospice program or hospice inpatient unit licensed under KRS Chapter 216B. The hospice program shall maintain a plan of care in accordance with federal regulations;

(e) The prescribing of a Schedule III, IV, or V controlled substance by a licensed optometrist to a patient in accordance with the provisions of KRS 320.240; or

(f) The prescribing of a three (3) day supply of a Schedule III controlled substance following the performance of oral surgery by a dentist licensed pursuant to KRS Chapter 313.

➔Section 4. KRS 218A.202 is amended to read as follows:

(1) The Cabinet for Health and Family Services shall establish an electronic system for monitoring Schedules II, III, IV, and V controlled substances that are dispensed within the Commonwealth by a practitioner or pharmacist or dispensed to an address within the Commonwealth by a pharmacy that has obtained a license, permit, or other authorization to operate from the Kentucky Board of Pharmacy. ***The cabinet may contract for the design, upgrade, or operation of this system if the contract preserves all of the rights, privileges, and protections guaranteed to Kentucky citizens under this chapter and the contract requires that all other aspects of the system be operated in conformity with the requirements of this or any other applicable state or federal law.***

(2) A practitioner or a pharmacist ***authorized to prescribe or dispense controlled substances to humans shall register with the cabinet to use the system provided for in this section and shall maintain such registration continuously during the practitioner's or pharmacist's term of licensure and*** shall not have to pay a fee or

tax specifically dedicated to the operation of the system.

(3) Every dispenser within the Commonwealth ***who is licensed to prescribe or dispense a controlled substance other than by the Board of Pharmacy,*** or any other dispenser who has obtained a license, permit, or other authorization to operate from the Kentucky Board of Pharmacy**,** shall report to the Cabinet for Health and Family Services the data required by this section~~[in a timely manner]~~ as prescribed by the ***cabinet by administrative regulation until July 1, 2013, at which time the report shall be filed with the cabinet within one (1) day of the dispensing,*** ~~[cabinet]~~ except that reporting shall not be required for:

(a) A drug***, other than any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone,*** administered directly to a patient; or

(b) A drug***, other than any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone,*** dispensed by a practitioner at a facility licensed by the cabinet provided that the quantity dispensed is limited to an amount adequate to treat the patient for a maximum of forty-eight (48) hours.

(4) Data for each controlled substance that is dispensed shall include but not be limited to the following:

(a) Patient identifier;

(b) ***National drug code of the*** drug dispensed;

(c) Date of dispensing;

(d) Quantity dispensed;

(e) Prescriber; and

(f) Dispenser.

(5) The data shall be provided in the electronic format specified by the Cabinet for Health and Family Services unless a waiver has been granted by the cabinet to an

individual dispenser. The cabinet shall establish acceptable error tolerance rates for data. Dispensers shall ensure that reports fall within these tolerances. Incomplete or inaccurate data shall be corrected upon notification by the cabinet if the dispenser exceeds these error tolerance rates.

(6) The Cabinet for Health and Family Services shall only disclose data to persons and entities authorized to receive that data under this section. Disclosure to any other person or entity, including disclosure in the context of a civil action where the disclosure is sought either for the purpose of discovery or for evidence, is prohibited unless specifically authorized by this section. The Cabinet for Health and Family Services shall be authorized to provide data to:

(a) A designated representative of a board responsible for the licensure, regulation, or discipline of practitioners, pharmacists, or other person who is authorized to prescribe, administer, or dispense controlled substances and who is involved in a bona fide specific investigation involving a designated person;

(b) ***Employees of the Office of the Inspector General of the Cabinet for Health and Family Services who have successfully completed training for the electronic system and who have been approved to use the system,*** ~~[a]~~ Kentucky ***Commonwealth's attorneys and assistant Commonwealth's attorneys, county attorneys and assistant county attorneys, a*** peace officer certified pursuant to KRS 15.380 to 15.404, a certified or full-time peace officer of another state, or a federal peace officer whose duty is to enforce the laws of this Commonwealth, of another state, or of the United States relating to drugs and who is engaged in a bona fide specific investigation involving a designated person;

(c) A state-operated Medicaid program ***in conformity with subsection (7) of this section***;

(d) A properly convened grand jury pursuant to a subpoena properly issued for the

records;

(e) A practitioner or pharmacist***, or employee of the practitioner's or pharmacist's practice acting under the specific direction of the practitioner or pharmacist,*** who requests information and certifies that the requested information is for the purpose of***:***

1. Providing medical or pharmaceutical treatment to a bona fide current ***or prospective*** patient***; or***

2. Reviewing and assessing the individual prescribing or dispensing patterns of the practitioner or pharmacist or to determine the accuracy and completeness of information contained in the monitoring system;

(f) In addition to the purposes authorized under paragraph (a) of this subsection, the Kentucky Board of Medical Licensure, for any physician who is:

1. Associated in a partnership or other business entity with a physician who is already under investigation by the Board of Medical Licensure for improper prescribing ***or dispensing*** practices;
2. In a designated geographic area for which a trend report indicates a substantial likelihood that inappropriate prescribing ***or dispensing*** may be occurring; or
3. In a designated geographic area for which a report on another physician in that area indicates a substantial likelihood that inappropriate prescribing ***or dispensing*** may be occurring in that area;

(g) In addition to the purposes authorized under paragraph (a) of this subsection, the Kentucky Board of Nursing, for any advanced practice registered nurse who is:

1. Associated in a partnership or other business entity with a physician who is already under investigation by the Kentucky Board of Medical Licensure for improper prescribing ***or dispensing*** practices;

2. Associated in a partnership or other business entity with an advanced practice registered nurse who is already under investigation by the Board of Nursing for improper prescribing practices;
3. In a designated geographic area for which a trend report indicates a substantial likelihood that inappropriate prescribing ***or dispensing*** may be occurring; or
4. In a designated geographic area for which a report on a physician or another advanced practice registered nurse in that area indicates a substantial likelihood that inappropriate prescribing ***or dispensing*** may be occurring in that area; or

(h) A judge or a probation or parole officer administering a diversion or probation program of a criminal defendant arising out of a violation of this chapter or of a criminal defendant who is documented by the court as a substance abuser who is eligible to participate in a court-ordered drug diversion or probation program.

(7) The Department for Medicaid Services ***shall*** ~~[may]~~ use any data or reports from the system for the purpose of identifying Medicaid ***providers or*** recipients whose ***prescribing, dispensing, or*** usage of controlled substances may be***:***

(a) Appropriately managed by a single outpatient pharmacy or primary care physician***;***

(b) Indicative of improper, inappropriate, or illegal prescribing or dispensing practices by a practitioner or drug seeking by a Medicaid recipient.

(8) A person who receives data or any report of the system from the cabinet shall not provide it to any other person or entity except ***as provided in this section, in another statute, or*** by order of a court of competent jurisdiction and only to a person or entity authorized to receive the data or the report under this section, except that:

(a) A ***person***~~[peace officer]~~ specified in subsection (6)(b) of this section who is authorized to receive data or a report may share that information with ***any*** other ***persons***~~[peace officers]~~ specified in subsection (6)(b) of this section authorized to receive data or a report if the ***persons***~~[peace officers]~~ specified in subsection (6)(b) of this section are working on a bona fide specific investigation involving a designated person. Both the person providing and the person receiving the data or report under this paragraph shall document in writing each person to whom the data or report has been given or received and the day, month, and year that the data or report has been given or received. This document shall be maintained in a file by each~~[law enforcement]~~ agency engaged in the investigation;~~[and]~~

(b) A representative of the Department for Medicaid Services may share data or reports regarding overutilization by Medicaid recipients with a board designated in subsection (6)(a) of this section, or with a law enforcement officer designated in subsection (6)(b) of this section;~~[and]~~

(c) The Department for Medicaid Services may submit the data as evidence in an administrative hearing held in accordance with KRS Chapter 13B***; and***

(d) A practitioner, pharmacist, or employee who obtains data under subsection (6)(e) of this section may share the report with the patient or person authorized to act on the patient's behalf and place the report in the patient's medical record, with that individual report then being deemed a medical record subject to disclosure on the same terms and conditions as an ordinary medical record in lieu of the disclosure restrictions otherwise imposed by this section.

(9) The Cabinet for Health and Family Services, all peace officers specified in subsection (6)(b) of this section, all officers of the court, and all regulatory agencies and officers, in using the data for investigative or prosecution purposes, shall

consider the nature of the prescriber's and dispenser's practice and the condition for which the patient is being treated.

(10) The data and any report obtained therefrom shall not be a public record, except that the Department for Medicaid Services may submit the data as evidence in an administrative hearing held in accordance with KRS Chapter 13B.

(11) Intentional failure by a dispenser to transmit data to the cabinet as required by subsection (3), (4), or (5) of this section shall be a Class ***B***~~[A]~~ misdemeanor for the first offense and a Class ***A misdemeanor***~~[D felony]~~ for each subsequent offense.

(12) Intentional disclosure of transmitted data to a person not authorized by subsection (6) to subsection (8) of this section or authorized by KRS 315.121, or obtaining information under this section not relating to a bona fide specific investigation, shall be a Class ***B misdemeanor***~~[D felony]~~ for the first offense and a Class ***A misdemeanor***~~[C felony]~~ for each subsequent offense.

(13) ***(a)*** The Commonwealth Office of Technology, in consultation with the Cabinet for Health and Family Services, ***may***~~[shall]~~ submit an application to the United States Department of Justice for a drug diversion grant to fund a pilot ***or continuing*** project to study***, create, or maintain*** a real-time electronic monitoring system for Schedules II, III, IV, and V controlled substances.

(b) The pilot project shall:

1.~~[(a)]~~ Be conducted in two (2) rural counties that have an interactive real-time electronic information system in place for monitoring patient utilization of health and social services through a federally funded community access program; and

2.~~[(b)]~~ Study the use of an interactive system that includes a relational data base with query capability.

(c) Funding to create or maintain a real-time electronic monitoring system for Schedules II, III, IV, and V controlled substances may be sought for a

statewide system or for a system covering any geographic portion or portions of the state.

(14) Provisions in this section that relate to data collection, disclosure, access, and penalties shall apply to the pilot project authorized under subsection (13) of this section.

(15) The Cabinet for Health and Family Services may***, by promulgating an administrative regulation,*** limit the length of time that data remain in the electronic system. Any data removed from the system shall be archived and subject to retrieval within a reasonable time after a request from a person authorized to review data under this section.

(16) (a) The Cabinet for Health and Family Services shall work with each board responsible for the licensure, regulation, or discipline of practitioners, pharmacists, or other persons who are authorized to prescribe, administer, or dispense controlled substances for the development of a continuing education program about the purposes and uses of the electronic system for monitoring established in this section.

(b) The cabinet shall work with the Kentucky Bar Association for the development of a continuing education program for attorneys about the purposes and uses of the electronic system for monitoring established in this section.

(c) The cabinet shall work with the Justice and Public Safety Cabinet for the development of a continuing education program for law enforcement officers about the purposes and ***uses***~~[users]~~ of the electronic system for monitoring established in this section.

(17) If the cabinet becomes aware of a prescriber's or dispenser's failure to comply with this section, the cabinet shall notify the licensing board or agency responsible for licensing the prescriber or dispenser. The licensing board shall

treat the notification as a complaint against the licensee.

(18) The cabinet shall promulgate administrative regulations to implement the provisions of this section. Included in these administrative regulations shall be an error resolution process allowing a patient to whom a report had been disclosed under subsection (8) of this section to request the correction of inaccurate information contained in the system relating to that patient.

➔Section 5. KRS 218A.240 is amended to read as follows:

(1) All police officers and deputy sheriffs directly employed full-time by state, county, city, urban-county, or consolidated local governments, the Department of Kentucky State Police, the Cabinet for Health and Family Services, their officers and agents, and of all city, county, and Commonwealth's attorneys, and the Attorney General, within their respective jurisdictions, shall enforce all provisions of this chapter and cooperate with all agencies charged with the enforcement of the laws of the United States, of this state, and of all other states relating to controlled substances.

(2) For the purpose of enforcing the provisions of this chapter, the designated agents of the Cabinet for Health and Family Services shall have the full power and authority of peace officers in this state, including the power of arrest and the authority to bear arms, and shall have the power and authority to administer oaths; to enter upon premises at all times for the purpose of making inspections; to seize evidence; to interrogate all persons; to require the production of prescriptions, of books, papers, documents, or other evidence; to employ special investigators; and to expend funds for the purpose of obtaining evidence and to use data obtained under KRS 218A.202(7) in any administrative proceeding before the cabinet.

(3) The Kentucky Board of Pharmacy, its agents and inspectors, shall have the same powers of inspection and enforcement as the Cabinet for Health and Family Services.

(4) Designated agents of the Cabinet for Health and Family Services and the Kentucky

Board of Pharmacy are empowered to remove from the files of a pharmacy or the custodian of records for that pharmacy any controlled substance prescription or other controlled substance record upon tendering a receipt. The receipt shall be sufficiently detailed to accurately identify the record. A receipt for the record shall be a defense to a charge of failure to maintain the record.

(5) Notwithstanding the existence or pursuit of any other remedy, civil or criminal, any law enforcement authority may maintain, in its own name, an action to restrain or enjoin any violation of this chapter or to forfeit any property subject to forfeiture under KRS 218A.410, irrespective of whether the owner of the property has been charged with or convicted of any offense under this chapter.

(a) Any civil action against any person brought pursuant to this section may be instituted in the Circuit Court in any county in which the person resides, in which any property owned by the person and subject to forfeiture is found, or in which the person has violated any provision of this chapter.

(b) A final judgment rendered in favor of the Commonwealth in any criminal proceeding brought under this chapter shall estop the defendant from denying the essential allegations of the criminal offense in any subsequent civil proceeding brought pursuant to this section.

(c) The prevailing party in any civil proceeding brought pursuant to this section shall recover his or her costs, including a reasonable attorney's fee.

(d) Distribution of funds under this section shall be made in the same manner as in KRS 218A.420, except that if the Commonwealth's attorney has not initiated the forfeiture action under this section, his or her percentage of the funds shall go to the agency initiating the forfeiture action.

(6) The Cabinet for Health and Family Services shall make or cause to be made examinations of samples secured under the provisions of this chapter to determine whether any provision has been violated.

(7) (a) The Cabinet for Health and Family Services shall ***proactively*** use the data compiled in the electronic system created in KRS 218A.202 for investigations, research, statistical analysis, and educational purposes and shall proactively identify trends in controlled substance usage and other potential problem areas. Only cabinet personnel who have undergone training for the electronic system and who have been approved to use the system shall be authorized access to the data and reports under this subsection. The cabinet shall notify a ***state licensing*** board ***listed in Section 2 of this Act***~~[responsible for the licensure, regulation, or discipline of each practitioner, pharmacist, or other person who is authorized to prescribe, administer, or dispense controlled substances,]~~ if a report or analysis conducted under this subsection indicates that further investigation about ***improper,*** inappropriate or ***illegal***~~[unlawful]~~ prescribing or dispensing may be necessary by the board. ***The board shall consider each report and may, after giving due consideration to areas of practice, specialties, board certifications, and appropriate standards of care, request and receive a follow-up report or analysis containing relevant information as to the prescriber or dispenser and his or her patients.***

(b) The cabinet shall develop criteria, in collaboration with the Board of Medical Licensure***, the Board of Nursing, the Office of Drug Control Policy,*** and the Board of Pharmacy, to be used to generate ***public*** trend reports from the data obtained by the system. Meetings at which the criteria are developed shall be meetings, as defined in KRS 61.805, that comply with the open meetings laws, KRS 61.805 to 61.850.~~[~~

~~(c)]~~The cabinet shall, on a quarterly basis, publish trend reports from the data obtained by the system. ***Except as provided in subsection (8) of this section, these trend reports shall not identify an individual prescriber, dispenser, or patient.***~~[~~

~~(d) ~~]Peace officers authorized to receive data under KRS 218A.202 may request trend reports not specifically published pursuant to ***this*** paragraph~~[(c) of this subsection. A report under this paragraph may be based upon the criteria developed under paragraph (b) of this subsection or upon any of the data collected pursuant to KRS 218A.202(4),]~~ except that the report shall not identify an individual prescriber, dispenser, or patient.

~~[(e) No trend report generated under this subsection shall identify an individual prescriber, dispenser, or patient.]~~

(8) If the cabinet deems it to be necessary and appropriate, upon the request of a state licensing board listed in Section 2 of this Act, the cabinet shall provide the requesting board with the identity of prescribers, dispensers, and patients used to compile a specific trend report.

(9) Any hospital or other health care facility may petition the cabinet to review data from the electronic system specified in Section 4 of this Act as it relates to employees of that facility to determine if inappropriate prescribing or dispensing practices are occurring. The cabinet may initiate any investigation in such cases as he or she determines is appropriate, and may request the assistance from the hospitals or health care facilities in the investigation.

➔Section 6. KRS 218A.245 is amended to read as follows:

(1) The secretary of the Cabinet for Health and Family Services may enter into reciprocal agreements ***or a contract, either directly*** with any other state or states of the United States ***or with an organization administering the exchange of interstate data on behalf of the prescription monitoring program of one (1) or more states,*** to share prescription drug monitoring information if the other state's prescription drug monitoring program ***or the organization's data exchange program*** is compatible with the program in Kentucky. If the secretary elects to evaluate the prescription drug monitoring program of another state ***or organization*** as

authorized by this section, priority shall be given to a state that is contiguous with the borders of the Commonwealth ***or an organization that offers connectivity with a contiguous state***.

(2) In determining compatibility, the secretary shall consider:

(a) The essential purposes of the program and the success of the program in fulfilling those purposes;

(b) The safeguards for privacy of patient records and its success in protecting patient privacy;

(c) The persons authorized to view the data collected by the program;

(d) The schedules of controlled substances monitored;

(e) The data required to be submitted on each prescription ***or dispensing***;

(f) Any implementation criteria deemed essential for a thorough comparison; and

(g) The costs and benefits to the Commonwealth in mutually sharing particular information available in the Commonwealth's database with the program under consideration.

(3) The secretary shall review any agreement on an annual basis to determine its continued compatibility with the Kentucky prescription drug monitoring program.

(4) The secretary shall prepare an annual report to the Governor and the Legislative Research Commission that summarizes any agreement under this section and that analyzes the effectiveness of that agreement in monitoring the ***prescribing and*** dispensing of controlled substances in the Commonwealth.

(5) Any agreement between the cabinet and another state ***or organization*** shall prohibit the sharing of information about a Kentucky resident, practitioner, pharmacist, or other prescriber ***or dispenser*** for any purpose not otherwise authorized by this section or KRS 218A.202.

➔SECTION 7. A NEW SECTION OF KRS CHAPTER 72 IS CREATED TO READ AS FOLLOWS:

(1) Unless another cause of death is clearly established, in cases requiring a post-mortem examination under KRS 72.025 the coroner or medical examiner shall take a blood sample and have it tested for the presence of any controlled substances which were in the body at the time of death.

(2) If a coroner or medical examiner determines that a drug overdose is the cause of death of a person, he or she shall provide notice of the death to:

(a) The state registrar of vital statistics and the Department of Kentucky State Police. The notice shall include any information relating to the drug that resulted in the overdose. The state registrar of vital statistics shall not enter the information on the deceased person's death certificate unless the information is already on the death certificate; and

(b) The licensing board for the individual who prescribed or dispensed the medication, if known. The notice shall include any information relating to the drug that resulted in the overdose, including the individual authorized by law to prescribe or dispense drugs who dispensed or prescribed the drug to the decedent.

This subsection shall not apply to reporting the name of a pharmacist who dispensed a drug based on a prescription.

(3) The state registrar of vital statistics shall report, within five (5) business days of the receipt of a certified death certificate or amended death certificate, to the Division of Kentucky State Medical Examiners Office, any death which has resulted from the use of drugs or a drug overdose.

(4) The Justice and Public Safety Cabinet in consultation with the Kentucky State Medical Examiners Office shall promulgate administrative regulations necessary to administer this section.

➔Section 8. KRS 72.280 is amended to read as follows:

The Office of Drug Control Policy, in cooperation with the Division of Kentucky State

Medical Examiners Office and its laboratory services**,** shall prepare ***and publish on its Web site*** an annual ***public*** report to the secretary of the Justice Cabinet which includes***:***

(1) The number of drug-related deaths***;*** ~~[,]~~

(2) The decedent's age, race, and gender but not his or her name or address;

(3) The counties in which those deaths occurred***;*** ~~[, and]~~

(4) The ***scientific, trade,*** ~~[major categories]~~ or generic names of the drugs involved***; and***

(5) The method by which the drugs were obtained, when available.

➔Section 9. KRS 311.530 is amended to read as follows:

(1) There is hereby created in state government an independent board to be known as the State Board of Medical Licensure which shall exercise all medical and osteopathic licensure functions heretofore exercised by the State Board of Health. The offices of the board shall be maintained at such place as is designated by the board.

(2) The board shall consist of fifteen (15) members, including the commissioner of public health, the dean of the University of Kentucky College of Medicine, the vice dean for clinical affairs of the University of Louisville School of Medicine, the dean of the ***University of*** Pikeville~~[College]~~ School of Osteopathic Medicine, and eleven (11) members appointed by the Governor.

(3) Of the Governor's appointees:

(a) One (1) member shall be a licensed osteopathic physician and shall be appointed from a list of three (3) names submitted by the Kentucky Osteopathic Association.

(b) Seven (7) members shall be licensed medical physicians and ***may*** ~~[shall]~~ be appointed from a list of three (3) names submitted for each position by the Kentucky Medical Association. ***In making appointments under this paragraph, the Governor shall ensure that the physician members represent different specialties from a broad cross section of the medical profession.***

(c) Three (3) members shall be citizens at large who are representatives of any recognized consumer advocacy groups with an interest in the delivery of health care and are not associated with or financially interested in the practice or business regulated.

➔Section 10. KRS 314.121 is amended to read as follows:

(1) The Governor shall appoint a Board of Nursing consisting of sixteen (16) members***:*** ~~[,]~~

(a) Nine (9) members shall be registered nurses licensed to practice in the Commonwealth***, with the Governor ensuring that the appointees represent different specialties from a broad cross-section of the nursing profession after soliciting and receiving nominations from recognized specialty state component societies***;

(b) Three (3) members shall be practical nurses licensed to practice in the Commonwealth;

(c) One (1) member shall be a nurse service administrator who is a registered nurse licensed to practice in the Commonwealth;

(d) One (1) member shall be engaged in practical nurse education who is a registered nurse licensed to practice in the Commonwealth; and

(e) Two (2) members shall be citizens at large, who are not associated with or financially interested in the practice or business regulated.

(2) Each appointment shall be for a term of four (4) years expiring on June 30 of the fourth year. The cycle for appointments and expiration of terms shall be as follows:

(a) The first year of the four (4) year cycle, the terms for three (3) registered nurses and one (1) licensed practical nurse shall expire;

(b) The second year of the four (4) year cycle, the terms for three (3) registered nurses and one (1) citizen at large shall expire;

(c) The third year of the four (4) year cycle, the terms for two (2) registered

nurses, one (1) licensed practical nurse, and the one (1) member engaged in practical nurse education who is a registered nurse shall expire; and

(d) The fourth year of the four (4) year cycle, the terms for two (2) registered nurses, one (1) licensed practical nurse, and one (1) citizen at large shall expire.

(3) (a) By March 1, the Kentucky Nurses Association shall submit to the Governor a list of members qualified for appointment as R.N. members, in number not less than twice the number of appointments to be made, from which list the Governor shall make each appointment or appointments necessary by July 1.

(b) By March 1, Kentucky Licensed Practical Nurses Organization Incorporated shall submit to the Governor a list of names qualified for appointment as L.P.N. members, in number not less than twice the number of appointments to be made, from which list the Governor shall make each appointment or appointments as necessary by July 1.

(c) By March 1 of the year in which the nurse service administrator's term shall expire, the Kentucky Organization of Nurse Executives, an affiliate of the Kentucky Hospital Association, shall submit to the Governor two (2) names of qualified individuals for appointment as the nurse service administrator from which list the Governor shall make an appointment as necessary by July 1.

(d) By March 1, the Kentucky Association of Nonprofit Homes and Services for the Aging, Inc., shall submit to the Governor two (2) names of qualified individuals for appointments as its R.N. representative to the board, from which the Governor shall make an appointment by July 1.

(e) By March 1 of the year in which the Kentucky Association of Health Care Facilities representative's term shall expire, the Kentucky Association of Health Care Facilities shall submit to the Governor two (2) names of qualified individuals for appointment as its R.N. representative to the board, from

which list the Governor shall make an appointment as necessary by July 1.

(f) Initially, the Governor shall appoint one (1) member to serve as the registered nurse who is engaged in practical nurse education to serve the term remaining according to the cycle specified in subsection (2) of this section. By August 1, 1996, Kentucky Licensed Practical Nurses Organization Incorporated shall submit to the Governor two (2) names of qualified individuals for the appointment, from which list the Governor shall make the appointment by September 1, 1996. Thereafter, by March 1 of the year in which the practical nurse educator's term expires, Kentucky Licensed Practical Nurses Organization Incorporated shall submit to the Governor two (2) names of qualified individuals for the appointment, from which list the Governor shall make the appointment by July 1.

(g) The Governor shall appoint two (2) members who shall be citizens at large, who are not associated with or financially interested in the practice or business regulated. The Governor shall make the appointments by July 1 of the year in which the citizen members' terms expire.

(4) A vacancy on the board shall be filled by the Governor as provided for under subsection (1) of this section.

(5) The Governor may remove any member from the board for neglect of duty, incompetence, or unprofessional or dishonorable conduct.

(6) Each R.N. member of the board shall be a citizen of the United States, a resident of Kentucky, a graduate of an approved school of nursing, and a registered nurse in this state. All shall have had at least five (5) years of experience in nursing, three (3) of which shall immediately precede such appointment. Five (5) members shall be engaged in nursing practice; three (3) shall be engaged in nursing education; one (1) shall be engaged in advanced practice registered nursing; and one (1) shall be in nursing administration.

(7) Each L.P.N. member of the board shall be a citizen of the United States, a resident of Kentucky, a graduate of an approved school of practical nursing or its equivalent, licensed as a licensed practical nurse in this state, have at least five (5) years of experience in nursing, three (3) of which shall immediately precede this appointment, and be currently engaged in nursing practice.

➔SECTION 11. A NEW SECTION OF KRS CHAPTER 315 IS CREATED TO READ AS FOLLOWS:

(1) A pharmacy located in Kentucky which has a robbery or theft of a controlled substance shall:

(a) Immediately following the robbery or discovery of the theft report the incident to a law enforcement agency serving the geographic area in which the pharmacy is located; and

(b) Within three (3) business days report that robbery or theft to the Department of Kentucky State Police.

(2) A pharmacy which has mailed or shipped a controlled substance to a location in Kentucky and learns that the mailing or shipment did not arrive shall within three (3) business days report that nonreceipt to:

(a) The Department of Kentucky State Police; and

(b) If applicable, the United States Postal Inspection Service.

(3) The reports required pursuant to subsections (1) and (2) of this section shall contain at a minimum, if known and applicable:

(a) The name, National Drug Code, and quantity of each controlled substance involved;

(b) A description of the circumstances of the loss;

(c) The names and contact information of any witnesses; and

(d) The name and description of any person suspected of committing the offense or causing the loss.

➔SECTION 12. A NEW SECTION OF KRS CHAPTER 218A IS CREATED TO READ AS FOLLOWS:

The Prescription Monitoring Program compact is hereby enacted into law and entered into with all other jurisdictions legally joining therein in the form substantially as follows:

ARTICLE I

PURPOSE

The purpose of this interstate compact is to provide a mechanism for state prescription monitoring programs to securely share prescription data to improve public health and safety. This interstate compact is intended to:

A. Enhance the ability of state prescription monitoring programs, in accordance with state laws, to provide an efficient and comprehensive tool for:

1. Practitioners to monitor patients and support treatment decisions;

2. Law enforcement to conduct diversion investigations where authorized by state law;

3. Regulatory agencies to conduct investigations or other appropriate reviews where authorized by state law; and

4. Other uses of prescription drug data authorized by state law for purposes of curtailing drug abuse and diversion; and

B. Provide a technology infrastructure to facilitate secure data transmission.

ARTICLE II

DEFINITIONS

As used in this compact, unless the context clearly requires a different construction:

A. "Authentication" means the process of verifying the identity and credentials of a person before authorizing access to prescription data;

B. "Authorize" means the process by which a person is granted access privileges to prescription data;

C. "Bylaws" means those bylaws established by the interstate commission pursuant to Article VIII for its governance, or for directing or controlling its actions and conduct;

D. "Commissioner" means the voting representative appointed by each member state pursuant to Article VI of this compact;

E. "Interstate commission" or "commission" means the interstate commission created pursuant to Article VI of this compact;

F. "Member state" means any state that has adopted a prescription monitoring program and has enacted the enabling compact legislation;

G. "Practitioner" means a person licensed, registered or otherwise permitted to prescribe or dispense a prescription drug;

H. "Prescription data" means data transmitted by a prescription monitoring program that contains patient, prescriber, dispenser, and prescription drug information;

I. "Prescription drug" means any drug required to be reported to a state prescription monitoring program and which includes but is not limited to substances listed in the federal Controlled Substances Act;

J. "Prescription Monitoring Program" means a program that collects, manages, analyzes, and provides prescription data under the auspices of a state;

K. "Requestor" means a person authorized by a member state who has initiated a request for prescription data;

L. "Rule" means a written statement by the interstate commission promulgated pursuant to Article VII of this compact that is of general applicability, implements, interprets or prescribes a policy or provision of the compact, or an organizational, procedural, or practice requirement of the commission, and has the force and effect of statutory law in a member state, and includes the amendment, repeal, or suspension of an existing rule;

M. "State" means any state, commonwealth, district, or territory of the United States;

N. "Technology infrastructure" means the design, deployment, and use of both individual technology based components and the systems of such components to facilitate the transmission of information and prescription data among member states; and

O. "Transmission" means the release, transfer, provision, or disclosure of information or prescription data among member states.

ARTICLE III

AUTHORIZED USES AND RESTRICTIONS ON THE PRESCRIPTION DATA

A. Under the Prescription Monitoring Program compact a member state:

1. Retains its authority and autonomy over its prescription monitoring program and prescription data in accordance with its laws, regulations and policies;

2. May provide, restrict or deny prescription data to a requestor of another state in accordance with its laws, regulations and policies;

3. May provide, restrict or deny prescription data received from another state to a requestor within that state; and

4. Has the authority to determine which requestors shall be authorized.

B. Prescription data obtained by a member state pursuant to this compact shall have the following restrictions:

1. Be used solely for purposes of providing the prescription data to a requestor; and

2. Not be stored in the state's prescription monitoring program database, except for stored images, nor in any other database.

C. A state may limit the categories of requestors of another member state that will receive prescription data.

D. The commission shall promulgate rules establishing standards for requestor authentication.

1. Every member state shall authenticate requestors according to the rules established by the commission.

2. A member state may authorize its requestors to request prescription data from another member state only after such requestor has been authenticated.

3. A member state that becomes aware of a requestor who violated the laws or regulations governing the appropriate use of prescription data shall notify the state that transmitted the prescription data.

ARTICLE IV

TECHNOLOGY AND SECURITY

A. The commission shall establish security requirements through rules for the transmission of prescription data.

B. The commission shall foster the adoption of open (vendor- and technology-neutral) standards for the technology infrastructure.

C. The commission shall be responsible for acquisition and operation of the technology infrastructure.

ARTICLE V

FUNDING

A. The commission, through its member states, shall be responsible to provide for the payment of the reasonable expenses for establishing, organizing and administering the operations and activities of the interstate compact.

B. The interstate commission may levy on and collect annual dues from each member state to cover the cost of operations and activities of the interstate commission and its staff which must be in a total amount sufficient to cover the interstate commission's annual budget as approved each year. The aggregate

annual dues amount shall be allocated in an equitable manner and may consist of a fixed fee component as well as a variable fee component based upon a formula to be determined by the interstate commission, which shall promulgate a rule binding upon all member states. Such a formula shall take into account factors including, but not limited to the total number of practitioners or licensees within a member state. Fees established by the commission may be recalculated and assessed on an annual basis.

C. Notwithstanding the above or any other provision of law, the interstate commission may accept non-state funding, including grants, awards and contributions to offset, in whole or in part, the costs of the annual dues required under Article V, Section B.

D. The interstate commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same; nor shall the interstate commission pledge the credit of any of the member states, except by and with the authority of the member states.

E. The interstate commission shall keep accurate accounts of all receipts and disbursements subject to the audit and accounting procedures established under its bylaws. All receipts and disbursements of funds handled by the interstate commission shall be audited annually by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the interstate commission.

ARTICLE VI

INTERSTATE COMMISSION

The member states hereby create the Interstate Prescription Monitoring Program Commission. The Prescription Monitoring Program compact shall be governed by an interstate commission comprised of the member states and not by a third-party group or federal agency. The activities of the commission are the formation of public policy

and are a discretionary state function.

A. The commission shall be a body corporate and joint agency of the member states and shall have all the responsibilities, powers and duties set forth herein, and such additional powers as may be conferred upon it by a subsequent concurrent action of the respective legislatures of the member states in accordance with the terms of this compact.

B. The commission shall consist of one (1) voting representative from each member state who shall be that state's appointed compact commissioner and who is empowered to determine statewide policy related to matters governed by this compact. The compact commissioner shall be a policymaker within the agency that houses the state's Prescription Monitoring Program.

C. In addition to the state commissioner, the state shall appoint a non-voting advisor who shall be a representative of the state Prescription Monitoring Program.

D. In addition to the voting representatives and non-voting advisor of each member state, the commission may include persons who are not voting representatives, but who are members of interested organizations as determined by the commission.

E. Each member state represented at a meeting of the commission is entitled to one vote. A majority of the member states shall constitute a quorum for the transaction of business, unless a larger quorum is required by the bylaws of the commission. A representative shall not delegate a vote to another member state. In the event the compact commissioner is unable to attend a meeting of the commission, the appropriate appointing authority may delegate voting authority to another person from their state for a specified meeting. The bylaws may provide for meetings of the commission to be conducted by electronic communication.

F. The commission shall meet at least once each calendar year. The chairperson

may call additional meetings and, upon the request of a simple majority of the compacting states, shall call additional meetings.

G. The commission shall establish an executive committee, which shall include officers, members, and others as determined by the bylaws. The executive committee shall have the power to act on behalf of the commission, with the exception of rulemaking. During periods when the commission is not in session the executive committee shall oversee the administration of the compact, including enforcement and compliance with the provisions of the compact, its bylaws and rules, and other such duties as deemed necessary.

H. The commission shall maintain a robust committee structure for governance (i.e., policy, compliance, education, technology, etc.) and shall include specific opportunities for stakeholder input.

I. The commission's bylaws and rules shall establish conditions and procedures under which the commission shall make its information and official records available to the public for inspection or copying. The commission may exempt from disclosure information or official records that would adversely affect personal privacy rights or proprietary interests.

J. The commission shall provide public notice of all meetings and all meetings shall be open to the public, except as set forth in the rules or as otherwise provided in the compact. The commission may close a meeting, or portion thereof, where it determines by a two-thirds (2/3) vote of the members present that an open meeting would be likely to:

1. Relate solely to the commission's internal personnel practices and procedures;

2. Discuss matters specifically exempted from disclosure by federal and state statute;

3. Discuss trade secrets or commercial or financial information which is

privileged or confidential;

4. Involve accusing a person of a crime, or formally censuring a person;

5. Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

6. Discuss investigative records compiled for law enforcement purposes; or

7. Specifically relate to the commission's participation in a civil action or other legal proceeding.

K. For a meeting, or portion of a meeting, closed pursuant to this provision, the commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exemptive provision. The commission shall keep minutes which shall fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefore, including a description of the views expressed and the record of a roll call vote. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the commission.

ARTICLE VII

POWERS AND DUTIES OF THE INTERSTATE COMMISSION

The commission shall have the following powers and duties:

A. To oversee and maintain the administration of the technology infrastructure;

B. To promulgate rules and take all necessary actions to effect the goals, purposes and obligations as enumerated in this compact, provided that no member state shall be required to create an advisory committee. The rules shall have the force and effect of statutory law and shall be binding in the member states to the extent and in the manner provided in this compact;

C. To establish a process for member states to notify the commission of changes to a

state's prescription monitoring program statutes, regulations, or policies. This applies only to changes that would affect the administration of the compact;

D. To issue, upon request of a member state, advisory opinions concerning the meaning or interpretation of the interstate compact, its bylaws, rules and actions;

E. To enforce compliance with the compact provisions, the rules promulgated by the interstate commission, and the bylaws, using all necessary and proper means, including but not limited to the use of judicial process;

F. To establish and maintain one (1) or more offices;

G. To purchase and maintain insurance and bonds;

H. To borrow, accept, hire or contract for personnel or services;

I. To establish and appoint committees including, but not limited to, an executive committee as required by Article VI, Section G, which shall have the power to act on behalf of the interstate commission in carrying out its powers and duties hereunder;

J. To elect or appoint such officers, attorneys, employees, agents, or consultants, and to fix their compensation, define their duties and determine their qualifications; and to establish the interstate commission's personnel policies and programs relating to conflicts of interest, rates of compensation, and qualifications of personnel;

K. To seek and accept donations and grants of money, equipment, supplies, materials, and services, and to utilize or dispose of them;

L. To lease, purchase, accept contributions or donations of, or otherwise to own, hold, improve or use any property, real, personal, or mixed;

M. To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal or mixed;

N. To establish a budget and make expenditures;

O. To adopt a seal and bylaws governing the management and operation of the

interstate commission;

P. To report annually to the legislatures, Governors and Attorneys General of the member states concerning the activities of the interstate commission during the preceding year. Such reports shall also include any recommendations that may have been adopted by the interstate commission and shall be made publically available;

Q. To coordinate education, training and public awareness regarding the compact, its implementation and operation;

R. To maintain books and records in accordance with the bylaws;

S. To perform such functions as may be necessary or appropriate to achieve the purposes of this compact; and

T. To provide for dispute resolution among member states.

ARTICLE VIII

ORGANIZATION AND OPERATION OF THE INTERSTATE COMMISSION

A. The interstate commission shall, by a majority of the members present and voting, within twelve (12) months after the first interstate commission meeting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes of the compact, including but not limited to:

1. Establishing the fiscal year of the interstate commission;

2. Establishing an executive committee, and such other committees as may be necessary for governing any general or specific delegation of authority or function of the interstate commission;

3. Providing procedures for calling and conducting meetings of the interstate commission, and ensuring reasonable notice of each such meeting;

4. Establishing the titles and responsibilities of the officers and staff of the interstate commission; and

5. Providing a mechanism for concluding the operations of the interstate

commission and the return of surplus funds that may exist upon the termination of the compact after the payment and reserving of all of its debts and obligations.

B. The interstate commission shall, by a majority of the members present, elect annually from among its members a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson or, in the chairperson's absence or disability, the vice-chairperson, shall preside at all meetings of the interstate commission. The officers so elected shall serve without compensation or remuneration from the interstate commission; provided that, subject to the availability of budgeted funds, the officers shall be reimbursed for ordinary and necessary costs and expenses incurred by them in the performance of their responsibilities as officers of the interstate commission.

C. Executive Committee, Officers and Staff

1. The executive committee shall have such authority and duties as may be set forth in the bylaws, including but not limited to:

a. Managing the affairs of the interstate commission in a manner consistent with the bylaws and purposes of the interstate commission;

b. Overseeing an organizational structure within, and appropriate procedures for the interstate commission to provide for the administration of the compact; and

c. Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the purpose of the interstate commission.

2. The executive committee may, subject to the approval of the interstate commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation, as the interstate

commission may deem appropriate. The executive director shall serve as secretary to the interstate commission, but shall not be a member of the interstate commission. The executive director shall hire and supervise such other persons as may be authorized by the interstate commission.

D. The interstate commission's executive director and its employees shall be immune from suit and liability, either personally or in their official capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of or relating to an actual or alleged act, error, or omission that occurred, or that such person had a reasonable basis for believing occurred, within the scope of interstate commission employment, duties, or responsibilities; provided, that such person shall not be protected from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

1. The liability of the interstate commission's executive director and employees or interstate commission representatives, acting within the scope of such person's employment or duties for acts, errors, or omissions occurring within such person's state may not exceed the limits of liability set forth under the constitution and laws of that state for state officials, employees, and agents. The interstate commission is considered to be an instrumentality of the states for the purposes of any such action. Nothing in this subsection shall be construed to protect such person from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

2. The interstate commission shall defend the executive director, its employees, and subject to the approval of the Attorney General or other appropriate legal counsel of the member state represented by an interstate commission representative, shall defend such interstate commission representative in

any civil action seeking to impose liability arising out of an actual or alleged act, error or omission that occurred within the scope of interstate commission employment, duties or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of interstate commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

3. To the extent not covered by the state involved, member state, or the interstate commission, the representatives or employees of the interstate commission shall be held harmless in the amount of a settlement or judgment, including attorney's fees and costs, obtained against such persons arising out of an actual or alleged act, error, or omission that occurred within the scope of interstate commission employment, duties, or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of interstate commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such persons.

ARTICLE IX

RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION

A. Rulemaking Authority - The interstate commission shall promulgate reasonable rules in order to effectively and efficiently achieve the purposes of this compact. Notwithstanding the foregoing, in the event the interstate commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this compact, or the powers granted hereunder, then such an action by the interstate commission shall be invalid and have no force or effect. Any rules promulgated by the commission shall not override the state's authority to govern

prescription drugs or each state's Prescription Monitoring Program.

B. Rulemaking Procedure - Rules shall be made pursuant to a rulemaking process that substantially conforms to the "Model State Administrative Procedure Act," of 1981 Act, Uniform Laws Annotated, Vol. 15, p.1 (2000) as amended, as may be appropriate to the operations of the interstate commission.

C. Not later than thirty (30) days after a rule is promulgated, any person may file a petition for judicial review of the rule; provided, that the filing of such a petition shall not stay or otherwise prevent the rule from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the interstate commission consistent with applicable law and shall not find the rule to be unlawful if the rule represents a reasonable exercise of the interstate commission's authority.

ARTICLE X

OVERSIGHT, ENFORCEMENT, AND DISPUTE RESOLUTION

A. Oversight

1. The executive, legislative and judicial branches of state government in each member state shall enforce this compact and shall take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of this compact and the rules promulgated hereunder shall have standing as statutory law but, shall not override the state's authority to govern prescription drugs or the state's Prescription Monitoring Program.

2. All courts shall take judicial notice of the compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of this compact which may affect the powers, responsibilities or actions of the interstate commission.

3. The interstate commission shall be entitled to receive all service of process in any such proceeding, and shall have standing to intervene in the

proceeding for all purposes. Failure to provide service of process to the interstate commission shall render a judgment or order void as to the interstate commission, this compact or promulgated rules.

B. Default, Technical Assistance, Suspension and Termination - If the interstate commission determines that a member state has defaulted in the performance of its obligations or responsibilities under this compact, or the bylaws or promulgated rules, the interstate commission shall:

1. Provide written notice to the defaulting state and other member states, of the nature of the default, the means of curing the default and any action taken by the interstate commission. The interstate commission shall specify the conditions by which the defaulting state must cure its default.

2. Provide remedial training and specific technical assistance regarding the default.

3. If the defaulting state fails to cure the default, the defaulting state shall be terminated from the compact upon an affirmative vote of a majority of the member states and all rights, privileges and benefits conferred by this compact shall be terminated from the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of the default.

4. Suspension or termination of membership in the compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the interstate commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

5. The state which has been suspended or terminated is responsible for all dues, obligations and liabilities incurred through the effective date of suspension or termination including obligations, the performance of which

extends beyond the effective date of suspension or termination.

6. The interstate commission shall not bear any costs relating to any state that has been found to be in default or which has been suspended or terminated from the compact, unless otherwise mutually agreed upon in writing between the interstate commission and the defaulting state.

7. The defaulting state may appeal the action of the interstate commission by petitioning the United States District Court for the District of Columbia or the federal district where the interstate commission has its principal offices. The prevailing party shall be awarded all costs of such litigation including reasonable attorney's fees.

C. Dispute Resolution

1. The interstate commission shall attempt, upon the request of a member state, to resolve disputes which are subject to the compact and which may arise among member states.

2. The interstate commission shall promulgate a rule providing for both mediation and binding dispute resolution as appropriate.

D. Enforcement

1. The interstate commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this compact.

2. The interstate commission, may by majority vote of the members, initiate legal action in the United States District Court for the District of Columbia or, at the discretion of the interstate commission, in the federal district where the interstate commission has its principal offices, to enforce compliance with the provisions of the compact, its promulgated rules and bylaws, against a member state in default. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary the prevailing party shall be awarded all costs of such litigation

including reasonable attorney's fees.

3. The remedies herein shall not be the exclusive remedies of the interstate commission. The interstate commission may avail itself of any other remedies available under state law or the regulation of a profession.

ARTICLE XI

MEMBER STATES, EFFECTIVE DATE AND AMENDMENT

A. Any state that has enacted Prescription Monitoring Program legislation through statute or regulation is eligible to become a member state of this compact.

B. The compact shall become effective and binding upon legislative enactment of the compact into law by no less than six (6) of the states. Thereafter it shall become effective and binding on a state upon enactment of the compact into law by that state. The Governors of non-member states or their designees shall be invited to participate in the activities of the interstate commission on a non-voting basis prior to adoption of the compact by all states.

C. The interstate commission may propose amendments to the compact for enactment by the member states. No amendment shall become effective and binding upon the interstate commission and the member states unless and until it is enacted into law by unanimous consent of the member states.

ARTICLE XII

WITHDRAWAL AND DISSOLUTION

A. Withdrawal

1. Once effective, the compact shall continue in force and remain binding upon each and every member state; provided that a member state may withdraw from the compact by specifically repealing the statute which enacted the compact into law.

2. Withdrawal from this compact shall be by the enactment of a statute repealing the same, but shall not take effect until one (1) year after the

effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the Governor of each other member state.

3. The withdrawing state shall immediately notify the chairperson of the interstate commission in writing upon the introduction of legislation repealing this compact in the withdrawing state. The interstate commission shall notify the other member states of the withdrawing state's intent to withdraw within sixty (60) days of its receipt thereof.

4. The withdrawing state is responsible for all dues, obligations and liabilities incurred through the effective date of withdrawal, including obligations, the performance of which extend beyond the effective date of withdrawal.

5. Reinstatement following withdrawal of a member state shall occur upon the withdrawing state reenacting the compact or upon such later date as determined by the interstate commission.

B. Dissolution of the Compact

1. This compact shall dissolve effective upon the date of the withdrawal or default of the member state which reduces the membership in the compact to one (1) member state.

2. Upon the dissolution of this compact, the compact becomes null and void and shall be of no further force or effect, and the business and affairs of the interstate commission shall be concluded and surplus funds shall be distributed in accordance with the bylaws.

ARTICLE XIII

SEVERABILITY AND CONSTRUCTION

A. The provisions of this compact shall be severable, and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the compact shall be enforceable.

B. The provisions of this compact shall be liberally construed to effectuate its purposes.

C. Nothing in this compact shall be construed to prohibit the applicability of other interstate compacts to which the states are members.

ARTICLE XIV

BINDING EFFECT OF COMPACT AND OTHER LAWS

A. Other Laws

1. Nothing herein prevents the enforcement of any other law of a member state that is not inconsistent with this compact.

B. Binding Effect of the Compact

1. All lawful actions of the interstate commission, including all rules and bylaws promulgated by the interstate commission, are binding upon the member states.

2. All agreements between the interstate commission and the member states are binding in accordance with their terms.

3. In the event any provision of this compact exceeds the constitutional limits imposed on the legislature of any member state, such provision shall be ineffective to the extent of the conflict with the constitutional provision in question in that member state.

➔SECTION 13. A NEW SECTION OF KRS CHAPTER 218A IS CREATED TO READ AS FOLLOWS:

The Governor shall be the appointing authority for those appointments Kentucky is entitled to make under Section 12 of this Act, provided that all such appointments shall be subject to confirmation by the Senate.

➔Section 14. The Legislative Research Commission is requested to appoint a House Bill 1 Implementation Oversight Committee consisting of three senators and three representatives to monitor the implementation of this Act during the 2012 legislative

interim.

➔Section 15. National Mortgage Settlement proceeds received by the Office of the Attorney General not to exceed $4,000,000 over the 2012-2014 fiscal biennium shall be transferred to the Cabinet for Health and Family Services, General Administration and Support budget unit, to be expended only for upgrades to and operation of the KASPER system in accordance with this Act. If sufficient funds from the National Mortgage Settlement proceeds are less than $4,000,000, then the balance necessary shall be deemed a necessary government expense and shall be paid from the General Fund Surplus Account (KRS 48.700) or the Budget Reserve Trust Fund Account (KRS 48.705).

APPENDIX II: Full Text of HB 217 and Summary of Regulations

AN ACT relating to controlled substances and declaring an emergency.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔Section 1. KRS 218A.172 is amended to read as follows:

(1) ***Administrative regulations promulgated under subsection (3) of Section 4 of this Act shall require that,*** prior to the initial prescribing or dispensing of any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone to a human patient, a practitioner shall:

(a) Obtain a~~[complete]~~ medical history and conduct a physical ***or mental health*** examination of the patient***, as appropriate to the patient's medical complaint,*** and document the information in the patient's medical record;

(b) Query the electronic monitoring system established in KRS 218A.202 for all available data on the patient ***for the twelve (12) month period immediately preceding the patient encounter and appropriately utilize that data in the evaluation and treatment of the patient***;

(c) Make a written~~[treatment]~~ plan stating the objectives of the treatment and further diagnostic examinations required;

(d) Discuss the risks and benefits of the use of controlled substances with the patient, the patient's parent if the patient is an unemancipated minor child, or the patient's legal guardian or health care surrogate, including the risk of tolerance and drug dependence; and

(e) Obtain written consent for the treatment.

(2) ***(a) Administrative regulations promulgated under subsection (3) of Section 4 of this Act shall require that a***~~[the]~~ practitioner ***prescribing or dispensing additional amounts of Schedule II controlled substances or Schedule III controlled substances containing hydrocodone for the same medical complaint and related symptoms*** shall***:***

1. Review~~[conduct]~~, at reasonable intervals based on the patient's

individual circumstances ***and***~~[, the]~~ course of treatment***, the plan of care;***~~[and]~~

2. Provide to the patient any new information about the treatment***; and***

3. Modify or terminate the treatment as appropriate.

(b) If the course of treatment ***extends beyond three (3) months, the administrative regulations shall also require that the practitioner:***~~[shall include the practitioner querying]~~

1. Query the electronic monitoring system established in KRS 218A.202 no less than once every three (3) months for all available data on the patient ***for the twelve (12) month period immediately preceding the query;*** and

2. Review~~[reviewing]~~ that data before issuing any new prescription or refills for the patient for any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

(3) ***Administrative regulations promulgated under subsection (3) of Section 4 of this Act shall require that,*** for each patient for whom a practitioner prescribes any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone, the practitioner shall keep accurate, readily accessible, and complete medical records which include***, as appropriate***:

(a) Medical history and physical ***or mental health*** examination;

(b) Diagnostic, therapeutic, and laboratory results;

(c) Evaluations and consultations;

(d) Treatment objectives;

(e) Discussion of risk, benefits, and limitations of treatments;

(f) Treatments;

(g) Medications, including date, type, dosage, and quantity prescribed or dispensed;

(h) Instructions and agreements; and

(i) Periodic reviews of the patient's file.

(4) ***Administrative regulations promulgated under subsection (3) of Section 4 of this Act may exempt, in whole or in part, compliance with the mandatory diagnostic, treatment, review, and other protocols and standards established in this section for***~~[This section shall not apply to]~~:

(a) A licensee ***prescribing or*** administering a controlled substance~~[or anesthesia]~~ immediately prior to**,**~~[or]~~ during***, or within the fourteen (14) days following an operative or invasive procedure or a delivery if the prescribing or administering is medically related to the operative or invasive procedure or the delivery and the medication usage does not extend beyond the fourteen (14) days***~~[surgery]~~;

(b) A licensee ***prescribing or*** administering a controlled substance necessary to treat a patient in an emergency situation~~[:~~

~~1. At the scene of an emergency;~~

~~2. In a licensed ground or air ambulance; or~~

~~3. In the emergency department or intensive care unit of a licensed hospital]~~;

(c) A licensed pharmacist or other person licensed by the Kentucky Board of Pharmacy to dispense drugs or~~[to]~~ a licensed pharmacy;

(d) A licensee prescribing or dispensing a controlled substance***:***

1. For administration in a hospital or long-term-care facility if the hospital or long-term-care facility with an institutional account, or a practitioner in those hospitals or facilities where no institutional account exists, queries the electronic monitoring system established in Section 3 of this Act for all available data on the patient or resident for the twelve (12) month period immediately preceding the query within

twelve (12) hours of the patient's or resident's admission and places a copy of the query in the patient's or resident's medical records during the duration of the patient's stay at the facility;

2. As part of the patient's hospice or end-of-life treatment;

3. For the treatment of pain associated with cancer or with the treatment of cancer;

4. In a single dose to relieve the anxiety, pain, or discomfort experienced by a patient submitting to a diagnostic test or procedure;

5. Within seven (7) days of an initial prescribing or dispensing under subsection (1) of this section if the prescribing or dispensing;

a. Is done as a substitute for the initial prescribing or dispensing;

b. Cancels any refills for the initial prescription; and

c. Requires the patient to dispose of any remaining unconsumed medication;

6. Within ninety (90) days of an initial prescribing or dispensing under subsection (1) of this section if the prescribing or dispensing is done by another practitioner in the same practice or in an existing coverage arrangement, if done for the same patient for the same medical condition; or

7. To a research subject enrolled in a research protocol approved by an institutional review board that has an active federalwide assurance number from the United States Department of Health and Human Services, Office for Human Research Protections where the research involves single, double, or triple blind drug administration or is additionally covered by a certificate of confidentiality from the National Institutes of Health~~[for a hospice patient when functioning within the scope of a hospice program or hospice inpatient unit licensed~~

~~under KRS Chapter 216B. The hospice program shall maintain a plan of care in accordance with federal regulations~~];

(e) The prescribing of a Schedule III, IV, or V controlled substance by a licensed optometrist to a patient in accordance with the provisions of KRS 320.240; or

(f) The prescribing of a three (3) day supply of a Schedule III controlled substance following the performance of oral surgery by a dentist licensed pursuant to KRS Chapter 313.

(5) (a) A state licensing board promulgating administrative regulations under subsection (3) of Section 4 of this Act may promulgate an administrative regulation authorizing exemptions supplemental or in addition to those specified in subsection (4) of this section. Prior to exercising this authority, the board shall:

1. Notify the Kentucky Office of Drug Control Policy that it is considering a proposal to promulgate an administrative regulation authorizing exemptions supplemental or in addition to those specified in subsection (4) of this section and invite the office to participate in the board meeting at which the proposal will be considered;

2. Make a factual finding based on expert testimony as well as evidence or research submitted to the board that the exemption demonstrates a low risk of diversion or abuse and is supported by the dictates of good medical practice; and

3. Submit a report to the Governor and the Legislative Research Commission of its actions, including a detailed explanation of the factual and policy basis underlying the board's action. A copy of this report shall be provided to the regulations compiler.

(b) Within one (1) working day of promulgating an administrative regulation authorizing an exemption under this section, the promulgating board shall

e-mail to the Kentucky Office of Drug Control Policy:

1. A copy of the administrative regulation as filed, and all attachments required by KRS 13A.230(1); and

2. A request from the board that the office review the administrative regulation in the same manner as would the Commission on Small Business Advocacy under KRS 11.202(1)(e), and submit its report or comments in accordance with the deadline established in KRS 13A.270(1)(c). A copy of the report or comments shall be filed with the regulations compiler.

➔Section 2. KRS 218A.175 is amended to read as follows:

(1) (a) As used in this section, "pain management facility" means a facility where the majority of patients of the practitioners at the facility are provided treatment for pain that includes the use of controlled substances and:

1. The facility's primary practice component is the treatment of pain; or
2. The facility advertises in any medium for any type of pain management services.

(b) "Pain management facility" does not include the following:

1. A hospital, including a critical access hospital, as defined in KRS Chapter 216, a facility owned by the hospital, or the office of a hospital-employed physician;
2. A school, college, university, or other educational institution or program to the extent that it provides instruction to individuals preparing to practice as physicians, podiatrists, dentists, nurses, physician assistants, optometrists, or veterinarians;
3. A hospice program or residential hospice facility licensed under KRS Chapter 216B;
4. An ambulatory surgical center licensed under KRS Chapter 216B; or

5. A long-term-care facility as defined in KRS 216.510.

(2) Only a physician having a full and active license to practice medicine issued under KRS Chapter 311 shall have an ownership or investment interest in a pain management facility. Credit extended by a financial institution as defined in KRS 136.500 to the facility shall not be deemed an investment interest under this subsection. This ownership or investment requirement shall not be enforced against any pain management facility existing and operating on April 24, 2012, unless there is an administrative sanction or criminal conviction relating to controlled substances imposed on the facility**,**~~[or]~~ any person employed by the facility***, or any person working at the facility as an independent contractor*** for an act or omission done within the scope of the facility's licensure or the person's employment.

(3) Regardless of the form of facility ownership, beginning on July 20, 2012, at least one (1) of the owners or an owner's designee who is a physician employed by and under the supervision of the owner shall be physically present practicing medicine in the facility for at least fifty percent (50%) of the time that patients are present in the facility, and that physician owner or designee shall:

(a) Hold a current subspecialty certification in pain management by a member board of the American Board of Medical Specialties, or hold a current certificate of added qualification in pain management by the American Osteopathic Association Bureau of Osteopathic Specialists;

(b) Hold a current subspecialty certification in hospice and palliative medicine by a member board of the American Board of Medical Specialties, or hold a current certificate of added qualification in hospice and palliative medicine by the American Osteopathic Association Bureau of Osteopathic Specialists;

(c) Hold a current board certification by the American Board of Pain Medicine;

(d) Hold a current board certification by the American Board of Interventional Pain Physicians;~~[or]~~

(e) Have completed ***a***~~[an accredited residency or]~~ fellowship in pain management ***or an accredited residency program that included a rotation of at least five (5) months in pain management; or***

(f) If the facility is operating under a registration filed with the Kentucky Board of Medical Licensure, have completed or hold, or be making reasonable progress toward completing or holding, a certification or training substantially equivalent to the certifications or training specified in this subsection, as authorized by the Kentucky Board of Medical Licensure by administrative regulation.

(4) A pain management facility shall accept private health insurance as one (1) of the facility's allowable forms of payment for goods or services provided and shall accept payment for services rendered or goods provided to a patient only from the patient or the patient's insurer, guarantor, spouse, parent, guardian, or legal custodian.

(5) If the pain management facility is operating under a license issued by the cabinet, the cabinet shall include and enforce the provisions of this section as additional conditions of that licensure. If the pain management facility is operating as the private office or clinic of a physician under KRS 216B.020(2), the Kentucky Board of Medical Licensure shall enforce the provisions of this section. The provisions of this subsection shall not apply to the investigation or enforcement of criminal liability.

(6) Any person who violates the provisions of this section shall be guilty of a Class A misdemeanor.

➔Section 3. KRS 218A.202 is amended to read as follows:

(1) The Cabinet for Health and Family Services shall establish an electronic system for monitoring Schedules II, III, IV, and V controlled substances that are dispensed within the Commonwealth by a practitioner or pharmacist or dispensed to an

address within the Commonwealth by a pharmacy that has obtained a license, permit, or other authorization to operate from the Kentucky Board of Pharmacy. The cabinet may contract for the design, upgrade, or operation of this system if the contract preserves all of the rights, privileges, and protections guaranteed to Kentucky citizens under this chapter and the contract requires that all other aspects of the system be operated in conformity with the requirements of this or any other applicable state or federal law.

(2) A practitioner or a pharmacist authorized to prescribe or dispense controlled substances to humans shall register with the cabinet to use the system provided for in this section and shall maintain such registration continuously during the practitioner's or pharmacist's term of licensure and shall not have to pay a fee or tax specifically dedicated to the operation of the system.

(3) Every dispenser within the Commonwealth who is licensed***, permitted, or otherwise authorized*** to prescribe or dispense a controlled substance ***to a person in Kentucky***~~[other than by the Board of Pharmacy, or any other dispenser who has obtained a license, permit, or other authorization to operate from the Kentucky Board of Pharmacy,]~~ shall report to the Cabinet for Health and Family Services the data required by this section~~[as prescribed by the cabinet by administrative regulation until July 1, 2013, at which time the report shall be filed with the cabinet within one (1) day of the dispensing]~~, except that reporting shall not be required for:

(a) A drug~~[, other than any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone,]~~ administered directly to a patient ***in a hospital, a resident of a health care facility licensed under KRS Chapter 216B, a resident of a child-caring facility as defined by KRS 199.011, or an individual in a jail, correctional facility, or juvenile detention facility***;~~[or]~~

(b) A drug, other than any Schedule II controlled substance or a Schedule III

controlled substance containing hydrocodone, dispensed by a practitioner at a facility licensed by the cabinet**,** provided that the quantity dispensed is limited to an amount adequate to treat the patient for a maximum of forty-eight (48) hours***; or***

(c) A drug administered or dispensed to a research subject enrolled in a research protocol approved by an institutional review board that has an active federalwide assurance number from the United States Department of Health and Human Services, Office for Human Research Protections where the research involves single, double, or triple blind drug administration or is additionally covered by a certificate of confidentiality from the National Institutes of Health.

(4) Data for each controlled substance that is dispensed shall include but not be limited to the following:

(a) Patient identifier;

(b) National drug code of the drug dispensed;

(c) Date of dispensing;

(d) Quantity dispensed;

(e) Prescriber; and

(f) Dispenser.

(5) The data shall be provided in the electronic format specified by the Cabinet for Health and Family Services unless a waiver has been granted by the cabinet to an individual dispenser. The cabinet shall establish acceptable error tolerance rates for data. Dispensers shall ensure that reports fall within these tolerances. Incomplete or inaccurate data shall be corrected upon notification by the cabinet if the dispenser exceeds these error tolerance rates.

(6) The Cabinet for Health and Family Services shall only disclose data to persons and entities authorized to receive that data under this section. Disclosure to any other

person or entity, including disclosure in the context of a civil action where the disclosure is sought either for the purpose of discovery or for evidence, is prohibited unless specifically authorized by this section. The Cabinet for Health and Family Services shall be authorized to provide data to:

(a) A designated representative of a board responsible for the licensure, regulation, or discipline of practitioners, pharmacists, or other person who is authorized to prescribe, administer, or dispense controlled substances and who is involved in a bona fide specific investigation involving a designated person;

(b) Employees of the Office of the Inspector General of the Cabinet for Health and Family Services who have successfully completed training for the electronic system and who have been approved to use the system, Kentucky Commonwealth's attorneys and assistant Commonwealth's attorneys, county attorneys and assistant county attorneys, a peace officer certified pursuant to KRS 15.380 to 15.404, a certified or full-time peace officer of another state, or a federal peace officer whose duty is to enforce the laws of this Commonwealth, of another state, or of the United States relating to drugs and who is engaged in a bona fide specific investigation involving a designated person;

(c) A state-operated Medicaid program in conformity with subsection (7) of this section;

(d) A properly convened grand jury pursuant to a subpoena properly issued for the records;

(e) A practitioner or pharmacist, or employee of the practitioner's or pharmacist's practice acting under the specific direction of the practitioner or pharmacist, who requests information and certifies that the requested information is for the purpose of:

1. Providing medical or pharmaceutical treatment to a bona fide current or

prospective patient; or

2. Reviewing and assessing the individual prescribing or dispensing patterns of the practitioner or pharmacist or to determine the accuracy and completeness of information contained in the monitoring system;

(f) ***The chief medical officer of a hospital or long-term-care facility, an employee of the hospital or long-term-care facility as designated by the chief medical officer and who is working under his or her specific direction, or a physician designee if the hospital or facility has no chief medical officer, if the officer, employee, or designee certifies that the requested information is for the purpose of providing medical or pharmaceutical treatment to a bona fide current or prospective patient or resident in the hospital or facility;***

(g) In addition to the purposes authorized under paragraph (a) of this subsection, the Kentucky Board of Medical Licensure, for any physician who is:

1. Associated in a partnership or other business entity with a physician who is already under investigation by the Board of Medical Licensure for improper prescribing or dispensing practices;

2. In a designated geographic area for which a trend report indicates a substantial likelihood that inappropriate prescribing or dispensing may be occurring; or

3. In a designated geographic area for which a report on another physician in that area indicates a substantial likelihood that inappropriate prescribing or dispensing may be occurring in that area;

(h) ~~[(g)]~~ In addition to the purposes authorized under paragraph (a) of this subsection, the Kentucky Board of Nursing, for any advanced practice registered nurse who is:

1. Associated in a partnership or other business entity with a physician who is already under investigation by the Kentucky Board of Medical

Licensure for improper prescribing or dispensing practices;

2. Associated in a partnership or other business entity with an advanced practice registered nurse who is already under investigation by the Board of Nursing for improper prescribing practices;

3. In a designated geographic area for which a trend report indicates a substantial likelihood that inappropriate prescribing or dispensing may be occurring; or

4. In a designated geographic area for which a report on a physician or another advanced practice registered nurse in that area indicates a substantial likelihood that inappropriate prescribing or dispensing may be occurring in that area;~~[or]~~

(i) ~~[(h)]~~ A judge or a probation or parole officer administering a diversion or probation program of a criminal defendant arising out of a violation of this chapter or of a criminal defendant who is documented by the court as a substance abuser who is eligible to participate in a court-ordered drug diversion or probation program***; or***

(j) A medical examiner engaged in a death investigation pursuant to KRS 72.026.

(7) The Department for Medicaid Services shall use any data or reports from the system for the purpose of identifying Medicaid providers or recipients whose prescribing, dispensing, or usage of controlled substances may be:

(a) Appropriately managed by a single outpatient pharmacy or primary care physician; or

(b) Indicative of improper, inappropriate, or illegal prescribing or dispensing practices by a practitioner or drug seeking by a Medicaid recipient.

(8) A person who receives data or any report of the system from the cabinet shall not provide it to any other person or entity except as provided in this section, in another

statute, or by order of a court of competent jurisdiction and only to a person or entity authorized to receive the data or the report under this section, except that:

(a) A person specified in subsection (6)(b) of this section who is authorized to receive data or a report may share that information with any other persons specified in subsection (6)(b) of this section authorized to receive data or a report if the persons specified in subsection (6)(b) of this section are working on a bona fide specific investigation involving a designated person. Both the person providing and the person receiving the data or report under this paragraph shall document in writing each person to whom the data or report has been given or received and the day, month, and year that the data or report has been given or received. This document shall be maintained in a file by each agency engaged in the investigation;

(b) A representative of the Department for Medicaid Services may share data or reports regarding overutilization by Medicaid recipients with a board designated in subsection (6)(a) of this section, or with a law enforcement officer designated in subsection (6)(b) of this section;

(c) The Department for Medicaid Services may submit the data as evidence in an administrative hearing held in accordance with KRS Chapter 13B;~~[and]~~

(d) ***If a state licensing board as defined in Section 4 of this Act initiates formal disciplinary proceedings against a licensee, and data obtained by the board is relevant to the charges, the board may provide the data to the licensee and his or her counsel, as part of the notice process required by KRS 13B.050, and admit the data as evidence in an administrative hearing conducted pursuant to KRS Chapter 13B, with the board and licensee taking all necessary steps to prevent further disclosure of the data; and***

(e) A practitioner, pharmacist, or employee who obtains data under subsection (6)(e) of this section may share the report with the patient or person authorized

to act on the patient's behalf and place the report in the patient's medical record, with that individual report then being deemed a medical record subject to disclosure on the same terms and conditions as an ordinary medical record in lieu of the disclosure restrictions otherwise imposed by this section.

(9) The Cabinet for Health and Family Services, all peace officers specified in subsection (6)(b) of this section, all officers of the court, and all regulatory agencies and officers, in using the data for investigative or prosecution purposes, shall consider the nature of the prescriber's and dispenser's practice and the condition for which the patient is being treated.

(10) The data and any report obtained therefrom shall not be a public record, except that the Department for Medicaid Services may submit the data as evidence in an administrative hearing held in accordance with KRS Chapter 13B.

(11) Intentional failure by a dispenser to transmit data to the cabinet as required by subsection (3), (4), or (5) of this section shall be a Class B misdemeanor for the first offense and a Class A misdemeanor for each subsequent offense.

(12) Intentional disclosure of transmitted data to a person not authorized by subsection (6) to subsection (8) of this section or authorized by KRS 315.121, or obtaining information under this section not relating to a bona fide specific investigation, shall be a Class B misdemeanor for the first offense and a Class A misdemeanor for each subsequent offense.

(13) (a) The Commonwealth Office of Technology, in consultation with the Cabinet for Health and Family Services, may submit an application to the United States Department of Justice for a drug diversion grant to fund a pilot or continuing project to study, create, or maintain a real-time electronic monitoring system for Schedules II, III, IV, and V controlled substances.

(b) The pilot project shall:

1. Be conducted in two (2) rural counties that have an interactive real-time

electronic information system in place for monitoring patient utilization of health and social services through a federally funded community access program; and

2. Study the use of an interactive system that includes a relational data base with query capability.

(c) Funding to create or maintain a real-time electronic monitoring system for Schedules II, III, IV, and V controlled substances may be sought for a statewide system or for a system covering any geographic portion or portions of the state.

(14) Provisions in this section that relate to data collection, disclosure, access, and penalties shall apply to the pilot project authorized under subsection (13) of this section.

(15) The Cabinet for Health and Family Services may, by promulgating an administrative regulation, limit the length of time that data remain in the electronic system. Any data removed from the system shall be archived and subject to retrieval within a reasonable time after a request from a person authorized to review data under this section.

(16) (a) The Cabinet for Health and Family Services shall work with each board responsible for the licensure, regulation, or discipline of practitioners, pharmacists, or other persons who are authorized to prescribe, administer, or dispense controlled substances for the development of a continuing education program about the purposes and uses of the electronic system for monitoring established in this section.

(b) The cabinet shall work with the Kentucky Bar Association for the development of a continuing education program for attorneys about the purposes and uses of the electronic system for monitoring established in this section.

(c) The cabinet shall work with the Justice and Public Safety Cabinet for the development of a continuing education program for law enforcement officers about the purposes and uses of the electronic system for monitoring established in this section.

(17) If the cabinet becomes aware of a prescriber's or dispenser's failure to comply with this section, the cabinet shall notify the licensing board or agency responsible for licensing the prescriber or dispenser. The licensing board shall treat the notification as a complaint against the licensee.

(18) The cabinet shall promulgate administrative regulations to implement the provisions of this section. Included in these administrative regulations shall be***:***

(a) An error resolution process allowing a patient to whom a report had been disclosed under subsection (8) of this section to request the correction of inaccurate information contained in the system relating to that patient***; and***

(b) Beginning July 1, 2013, a requirement that data be reported to the system under subsection (3) of this section within one (1) day of dispensing.

➔Section 4. KRS 218A.205 is amended to read as follows:

(1) As used in this section:

(a) "Reporting agency" includes:

1. The Department of Kentucky State Police;
2. The Office of the Attorney General;
3. The Cabinet for Health and Family Services; and
4. The applicable state licensing board; and

(b) "State licensing board" means:

1. The Kentucky Board of Medical Licensure;
2. The Kentucky Board of Nursing;
3. The Kentucky Board of Dentistry;
4. The Kentucky Board of Optometric Examiners;

5. The State Board of Podiatry; and

6. Any other board that licenses or regulates a person who is entitled to prescribe or dispense controlled substances to humans.

(2) (a) When a reporting agency or a law enforcement agency receives a report of improper, inappropriate, or illegal prescribing or dispensing of a controlled substance it may, to the extent otherwise allowed by law, send a copy of the report within three (3) business days to every other reporting agency.

(b) A county attorney or Commonwealth's attorney shall notify the Office of the Attorney General and the appropriate state licensing board within three (3) business days of an indictment or a waiver of indictment becoming public in his or her jurisdiction charging a licensed person with a felony offense relating to the manufacture of, trafficking in, prescribing, dispensing, or possession of a controlled substance.

(3) Each state licensing board shall~~[by September 1, 2012,]~~ establish the following by administrative regulation for those licensees authorized to prescribe or dispense controlled substances:

(a) Mandatory prescribing and dispensing standards related to controlled substances**, *the requirements of which shall include the diagnostic, treatment, review, and other protocols and standards established for Schedule II controlled substances and Schedule III controlled substances containing hydrocodone under Section 1 of this Act and which may include the exemptions authorized by subsection (4) of Section 1 of this Act***;

(b) A prohibition on a practitioner dispensing greater than a forty-eight (48) hour supply of any Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone unless the dispensing is done as part of a narcotic treatment program licensed by the Cabinet for Health and Family Services;

(c) A procedure for temporarily suspending, limiting, or restricting a license held by a named licensee where a substantial likelihood exists to believe that the continued unrestricted practice by the named licensee would constitute a danger to the health, welfare, or safety of the licensee's patients or of the general public;

(d) A procedure for the expedited review of complaints filed against their licensees pertaining to the improper, inappropriate, or illegal prescribing or dispensing of controlled substances that is designed to commence an investigation within seven (7) days of a complaint being filed and produce a charging decision by the board on the complaint within one hundred twenty (120) days of the receipt of the complaint, unless an extension for a definite period of time is requested by a law enforcement agency due to an ongoing criminal investigation;

(e) The establishment and enforcement of licensure standards that conform to the following:

1. A permanent ban on licensees and applicants convicted after July 20, 2012, in this state or any other state of any felony offense relating to controlled substances from prescribing or dispensing a controlled substance;
2. Restrictions short of a permanent ban on licensees and applicants convicted in this state or any other state of any misdemeanor offense relating to prescribing or dispensing a controlled substance;
3. Restrictions mirroring in time and scope any disciplinary limitation placed on a licensee or applicant by a licensing board of another state if the disciplinary action results from improper, inappropriate, or illegal prescribing or dispensing of controlled substances; and
4. A requirement that licensees and applicants report to the board any

conviction or disciplinary action covered by this subsection with appropriate sanctions for any failure to make this required report;

(f) A procedure for the continuous submission of all disciplinary and other reportable information to the National Practitioner Data Bank of the United States Department of Health and Human Services;

(g) If not otherwise required by other law***, a process for*** ~~[~~:

~~1. A process for obtaining a national and state fingerprint-supported criminal record check conducted by the Federal Bureau of Investigation or by the Department of Kentucky State Police on an applicant for initial licensing; and~~

~~2.]~~submitting a query on each applicant for licensure to the National Practitioner Data Bank of the United States Department of Health and Human Services to retrieve any relevant data on the applicant; and

(h) Continuing education requirements beginning with the first full educational year occurring after July 1, 2012, that specify that at least seven and one-half percent (7.5%) of the continuing education required of the licensed practitioner relate to the use of the electronic monitoring system established in KRS 218A.202, pain management, or addiction disorders.

(4) A state licensing board shall employ or obtain the services of a specialist in the treatment of pain and a specialist in drug addiction to evaluate information received regarding a licensee's prescribing or dispensing practices related to controlled substances if the board or its staff does not possess such expertise, to ascertain if the licensee under investigation is engaging in improper, inappropriate, or illegal practices.

(5) Any statute to the contrary notwithstanding, no state licensing board shall require that a grievance or complaint against a licensee relating to controlled substances be sworn to or notarized, but the grievance or complaint shall identify the name and

address of the grievant or complainant, unless the board by administrative regulation authorizes the filing of anonymous complaints. Any such authorizing administrative regulation shall require that an anonymous complaint or grievance be accompanied by sufficient corroborating evidence as would allow the board to believe, based upon a totality of the circumstances, that a reasonable probability exists that the complaint or grievance is meritorious.

(6) Every state licensing board shall cooperate to the maximum extent permitted by law with all state, local, and federal law enforcement agencies, and all professional licensing boards and agencies, state and federal, in the United States or its territories in the coordination of actions to deter the improper, inappropriate, or illegal prescribing or dispensing of a controlled substance.

(7) Each state licensing board shall require a fingerprint-supported criminal record check by the Department of Kentucky State Police and the Federal Bureau of Investigation of any applicant for initial licensure to practice any profession authorized to prescribe or dispense controlled substances.

➔Section 5. KRS 315.335 is amended to read as follows:

(1) A pharmacy located in Kentucky which has a robbery or theft of a controlled substance shall~~[:~~

~~(a)]~~ immediately following the robbery or discovery of the theft report the incident to a law enforcement agency serving the geographic area in which the pharmacy is located~~[; and~~

~~(b) Within three (3) business days report that robbery or theft to the Department of Kentucky State Police]~~.

(2) A pharmacy which has mailed or shipped a controlled substance to a location in Kentucky and learns that the mailing or shipment did not arrive shall within three (3) business days report that nonreceipt to:

(a) The Department of Kentucky State Police; and

(b) If applicable, the United States Postal Inspection Service.

(3) ***(a)*** The reports required pursuant to subsections (1) and (2) of this section shall contain at a minimum, if known and applicable:

1.~~[(a)]~~ The name, National Drug Code, and quantity of each controlled substance involved;

2.~~[(b)]~~ A description of the circumstances of the loss;

3.~~[(c)]~~ The names and contact information of any witnesses; and

4.~~[(d)]~~ The name and description of any person suspected of committing the offense or causing the loss.

(b) The Board of Pharmacy may by administrative regulation authorize a pharmacy to submit a completed DEA 106 form or a successor form in lieu of the data elements required by this subsection.

➔Section 6. Whereas the epidemic of prescription drug abuse represents a clear and present danger to the lives, safety, and health of all Kentuckians and no just cause exists for delay, an emergency is declared to exist and this Act takes effect upon its passage and approval by the Governor or upon its otherwise becoming a law.

Summary of Regulations

KENTUCKY BOARD OF MEDICAL LICENSURE
201 KAR 9:260 Summary

***Please note this is a summary of 201 KAR 9:260. Physicians should review and refer to the actual regulation, which is available at the Board's website, www.kbml.ky.gov. This summary does not replace 201 KAR 9:260 and should not be considered legal advice or a legal opinion.**

Section 1 – Exceptions to Standards in 201 KAR 9:260 – Prescribing Controlled Substances

- Where part of the patient's hospice or end-of-life treatment;
- If patient admitted to a hospital as an inpatient, outpatient, or observation patient;
- Cancer patients or pain related to cancer treatment;
- Patients in long-term care facilities;
- During any period of disaster or mass casualties;
- In a single dose prescribed/dispensed to relieve anxiety, pain, or discomfort for diagnostic test or procedure; and
- Any Scheduled V Controlled Substance.

Section 2 – Standards for Documentation

- If unable to conform to the standards or if a determination is made that it is not appropriate to comply:
  - Only prescribe/ dispense to patient when the record appropriately justifies the action.

Section 3 – Initial Prescribing to Treat Non-Cancer Pain - Acute

- History & physical appropriate to condition;
- KASPER review;
- Avoid prescribing more than necessary to treat condition;
- Patient education/Counseling on Controlled Substances.

Section 4 – Commencement of Long-term Prescribing (AFTER 90 Days) to Treat Non-Cancer Pain

- Different licensed practitioners working in same practice location may perform tasks to meet the required standards so long as in their scope;
- Comprehensive history to include:
  - History of substance abuse/treatment for patient & history of abuse for first degree relatives;
  - Past family history of relevant illness & Psychosocial history;
  - Appropriate Physical Exam to support long-term use of controlled substances;
  - Baseline Assessments to establish & monitor treatment plan;
  - Obtain Prior Medical Records, if needed to justify continued prescribing;
- Formulate Working Diagnosis;
  - Refer if necessary to formulate a working diagnosis;
  - Only prescribe if medically indicated & appropriate if no working diagnosis can be established despite referral;
- Develop and document treatment plan if improvement is medically expected;
- Baseline drug screen – do not prescribe if medication is determined being used/likely to be used for other than medicinal purpose;
- Screen for other conditions that may impact treatment or necessitate a referral;
- Diversion risk – if patient determined to be high risk – prescribing agreement;
- Written Informed Consent;
- Attempt trial of other modalities and lower doses, or document a previous attempt by another;
- KASPER Review.

Section 5 – Continued Long-Term Prescribing Non-Cancer Pain in Patients

- Ensure patient is seen monthly, until titrated to appropriate level;
- At appropriate intervals:
    - Update H&P as necessary;
    - Perform Measurable Exams; and
    - Evaluate and update working diagnosis and treatment plan;
- Annual Preventive Health Screening - conduct or ensure is done;
- KASPER review every 3 months; More frequent or immediately if indicated;
- Notify other practitioners if you suspect "doctor shopping";
- Random pill counts if appropriate;
- Random Drug Screens appropriate to the drug prescribed and the patient's condition and if the patient is noncompliant, discontinue prescribing, do a controlled taper or make referral;
- Consultative Assistance – as appropriate;
- Significant Risk of Diversion – discontinue prescribing or document /justify use in record;
- No Significant Improvement Where Expected – obtain consultative assistance;
- Mood, Anxiety or Psychotic Disorders – obtain psychiatric consult if appropriate;
- Document Treatment or Refer to Addiction Management – no improvement where medically expected; significant adverse effects; or patient exhibits inappropriate or behavior/ diversion;
- Breakthrough Pain – Identify triggers – attempt non-controlled substances or if adding controlled substances, take steps to minimize likelihood of improper/illegal use;

Section 6 - Prescribing and Dispensing of Controlled Substances in an Emergency Room Department

- Comply with standards for <u>initial prescribing for pain</u> and <u>other conditions</u>;
- Physicians are strongly discouraged and shall not routinely:
    - Administer intravenous controlled substances for relief of acute exacerbations of chronic pain, unless it is the only medically appropriate means of delivery;
    - Provide replacement prescriptions that were lost, destroyed, or stolen;
    - Provide replacement doses of methadone, suboxone, or subutex;
    - Prescribe long-acting, controlled release medication, or replacement doses of such medication;
    - Administer Meperidine to the patient;
    - Prescribe or dispense more than minimum amount necessary to treat condition until patient can be seen by their physician, with no refills. If the prescribing exceeds 7 days, the patient record must justify the amount prescribed.

Section 7 – Treatment of Other Conditions – Not Pain

<u>Initial Prescribing to Treat Other Conditions</u>

- History and Physical;
- KASPER Review ;
- If a request by established patient for a script to deal with non-recurring single episode or event involving anxiety/depression:
    - KASPER review
    - Decide to prescribe with or w/o a personal encounter;
    - Prescribe minimum amount necessary;

<u>Subsequent/Ongoing Prescribing to Treat Other Conditions</u>

- Conform to standards of acceptable & prevailing medical practice for that drug and condition

Section 8 – Responsibility to Educate Patients - See Regulation

Section 9 – Additional Standards for Prescribing or Dispensing Schedule II Controlled Substances or Schedule III Controlled Substances Containing Hydrocodone – AS REQUIRED BY HB 217

- **In addition to the other standards in this regulation**:
  - Query KASPER
  - Make a written plan;
  - Obtain written consent;
- Prescribing/ dispensing additional amounts for same medical complaint/symptoms:
  - Review, at reasonable intervals the plan of care;
  - Provide to patient any new information about the treatment; and
  - Modify or terminate the treatment as appropriate;
- If the course of treatment goes beyond 3 months:
  - Query KASPER once every 3 months;
- Keep accurate, readily accessible and complete medical records;
- **Exemptions from additional standards involving Schedule II & III w/Hydrocodone**:
  - Prescribing/ dispensing for administration to a patient admitted to a hospital/long-term care facility if the facility/ practitioner puts a KASPER in the chart within 12 hours;
  - Prescribing or dispensing:
    - No more than a 14 day supply following an operative or invasive procedure/ delivery – longer supply requires compliance w/additional standards;
    - As part of patient's hospice or end-of –life treatment;
    - For treatment of pain associated w/ cancer or cancer treatment;
    - A substitute prescription within 7 days of the initial prescription so long as any refills to the initial prescription are cancelled and the patient is required to dispose of any unused medication;
    - To the same patient for the same condition by a partner or other cover arrangement within 90 days of the initial prescription; or
    - To an IRB approved research subject enrolled in blind study.

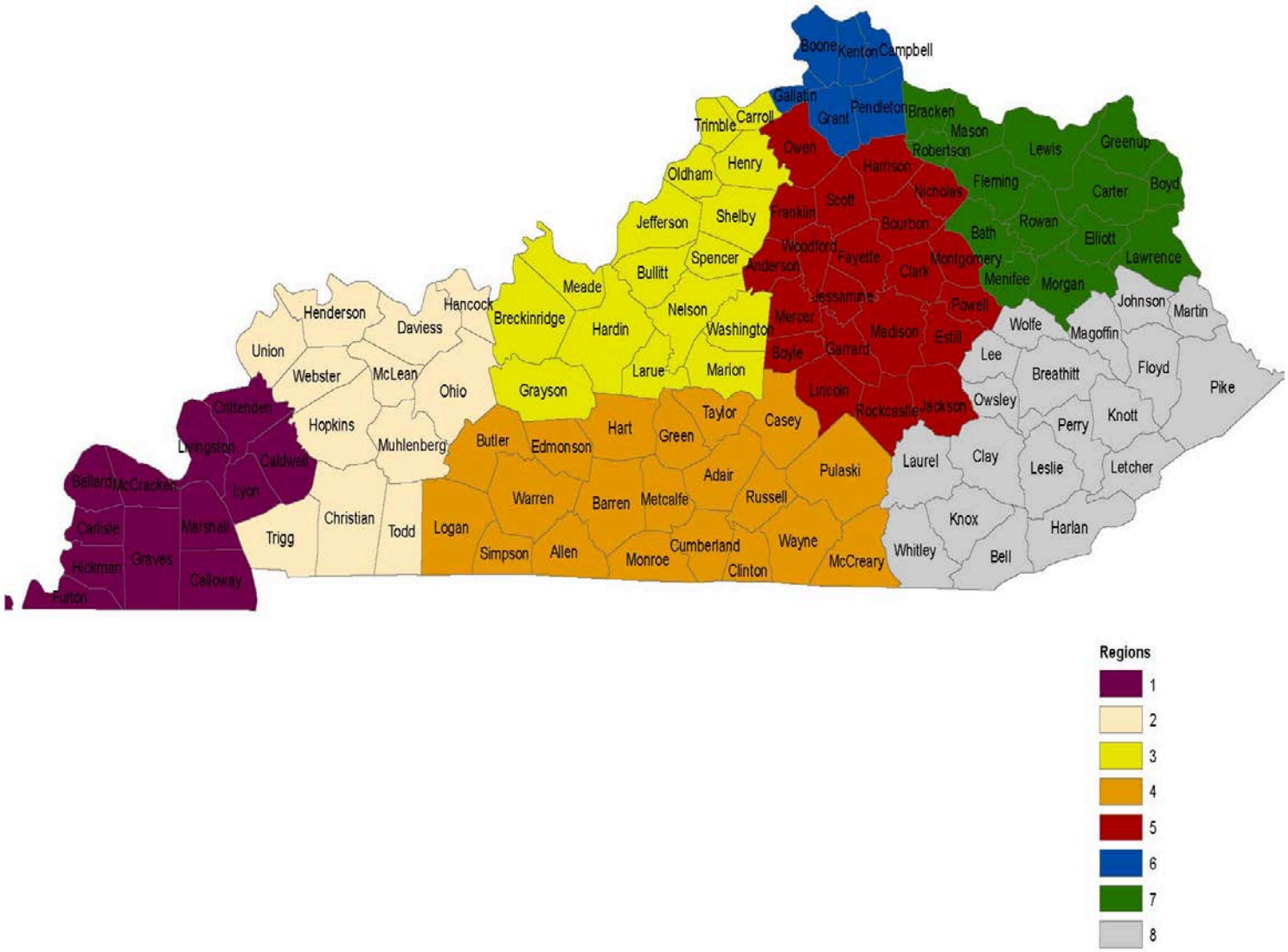
Section 10 – Violations – See Regulation

Additional Resources for 201 KAR 9:260

- **To review a copy of the actual regulation, you can visit the Board's website, http://www.kbml.ky.gov/NR/rdonlyres/41B554D0-DB32-4A23-8923-E8ACAB913CF0/0/201_009_260.pdf. Physicians should review the regulations themselves, as the Board's summary is not comprehensive or intended to take the place of reading the regulations.**

- **KMA Summary - for a more detailed summary of the controlled substance regulations, the Board directs your attention to one currently available on the Kentucky Medical Association website. To access the summary, simply visit https://www.kyma.org/content.asp and look for the headline "KMA Publishes Summary of Revised KBML/OIG Controlled Substance Regulations".**

APPENDIX III: Geographic Distribution of Controlled Substance Prescriptions Dispensed in Kentucky by Kentucky Medicaid Managed Care Regions



Number of Prescriptions Dispensed by Schedule and Region of Patient: KASPER, FY 2010 to FY 2013

Region	Fiscal year	Schedule II	Schedule III	Schedule IV	Schedule V	NEC
Region 1 - Largest city: Paducah						
	2010	108,045	213,658	268,516	27,079	6,249
	2011	117,102	232,026	268,487	26,784	5,627
	2012	125,269	241,958	266,732	23,406	4,967
	2013	129,562	232,954	258,342	24,440	7,340
Region 2 - Largest city: Owensboro						
	2010	183,057	326,085	415,843	46,735	7,739
	2011	192,424	347,503	407,092	47,068	7,187
	2012	207,791	382,896	411,507	41,637	7,829
	2013	208,382	350,796	374,962	39,712	4,199
Region 3 - Largest city: Louisville						
	2010	547,756	991,386	1,132,610	107,439	51,821
	2011	584,740	1,050,909	1,093,986	104,364	34,616
	2012	618,237	1,043,998	1,050,858	92,448	16,219
	2013	609,628	933,365	984,565	90,394	6,393
Region 4 - Largest city: Bowling Green						
	2010	170,469	488,912	568,331	55,956	46,005
	2011	180,195	498,568	543,136	54,389	17,107
	2012	199,251	532,346	558,254	49,449	14,757
	2013	201,080	508,545	537,110	49,383	7,130
Region 5 - Largest city: Lexington						
	2010	366,361	593,344	731,839	72,611	22,418
	2011	415,638	619,669	753,320	69,000	22,651
	2012	448,238	648,997	753,157	59,906	21,844
	2013	428,045	646,889	714,295	56,172	9,118
Region 6 - Largest city: Covington						
	2010	272,283	256,810	370,294	36,549	3,460
	2011	297,059	250,749	368,116	32,618	4,342
	2012	303,609	245,944	363,066	28,759	5,454
	2013	295,000	224,582	338,191	25,843	2,398
Region 7 - Largest city: Ashland						
	2010	124,836	171,798	251,689	25,701	5,432
	2011	130,312	185,461	254,968	24,918	5,189
	2012	129,391	200,672	246,674	22,578	11,852
	2013	122,259	199,655	240,131	22,175	2,629
Region 8 - Largest city: Middlesboro						
	2010	210,234	748,552	781,756	75,156	24,617
	2011	237,358	801,863	801,194	74,903	27,732
	2012	276,132	898,235	835,731	70,704	23,744

Region	Fiscal year	Schedule II	Schedule III	Schedule IV	Schedule V	NEC
	2013	247,148	900,063	760,795	63,616	17,757
Out-of-state						
	2010	50,962	107,679	176,512	11,038	21,309
	2011	51,683	110,063	181,134	10,980	24,303
	2012	57,832	120,037	206,491	10,752	23,325
	2013	47,572	109,305	203,112	9,001	5,578
No geography specified						
	2010	41,761	85,565	95,267	9,630	2,041
	2011	41,636	77,270	95,075	8,314	1,380
	2012	31,415	61,846	73,844	6,383	836
	2013	7,106	20,100	18,505	1,522	3,478

Number of Prescriptions Dispensed by Drug Class and Region of Patient: KASPER, FY 2010 to FY 2013

Region	Fiscal year	Opioid	Benzodiazepine	Stimulants	NEC
Region 1 - Largest city: Paducah					
	2010	325,077	146,839	64,749	86,882
	2011	337,481	153,521	69,036	89,988
	2012	341,070	157,092	70,279	93,891
	2013	323,671	154,070	75,429	99,468
Region 2 - Largest city: Owensboro					
	2010	513,182	229,336	122,890	114,051
	2011	521,868	235,696	128,080	115,630
	2012	549,955	244,957	131,577	125,171
	2013	502,368	223,668	130,812	121,203
Region 3 - Largest city: Louisville					
	2010	1,548,214	618,643	287,727	376,428
	2011	1,570,453	617,147	310,649	370,366
	2012	1,531,147	603,241	329,284	358,088
	2013	1,347,021	569,124	352,987	355,213
Region 4 - Largest city: Bowling Green					
	2010	743,572	343,033	76,138	166,930
	2011	730,508	341,144	80,936	140,807
	2012	758,820	359,707	88,417	147,113
	2013	713,875	348,109	100,312	140,952
Region 5 - Largest city: Lexington					
	2010	1,005,473	402,967	155,266	222,867
	2011	1,049,408	426,899	169,768	234,203
	2012	1,071,832	436,185	182,453	241,672
	2013	1,000,048	411,773	202,659	240,039
Region 6 - Largest city: Covington					
	2010	508,133	226,690	108,189	96,384
	2011	507,602	228,531	117,595	99,156
	2012	492,503	225,244	126,134	102,951
	2013	443,976	207,500	135,076	99,462
Region 7 - Largest city: Ashland					
	2010	331,157	146,190	40,350	61,759
	2011	339,553	150,942	46,066	64,287
	2012	343,702	151,288	42,582	73,595
	2013	323,784	143,388	55,486	64,191
Region 8 - Largest city: Middlesboro					
	2010	1,106,879	475,671	70,784	186,981
	2011	1,162,356	501,897	76,951	201,846
	2012	1,275,141	538,004	85,905	205,496

Region	Fiscal year	Opioid	Benzodiazepine	Stimulants	NEC
	2013	1,213,139	495,074	90,430	190,736
Out-of-state					
	2010	171,620	72,917	68,952	54,011
	2011	169,223	71,565	80,328	57,047
	2012	181,564	80,785	95,380	60,708
	2013	154,647	64,141	118,721	37,059
No geography specified					
	2010	135,528	57,651	17,173	23,912
	2011	118,524	60,933	18,572	25,646
	2012	92,407	48,819	13,465	19,633
	2013	27,227	10,753	3,835	8,896

Number of Opioid Prescriptions by Selected Drugs and Region of Patient: Hydrocodone, Oxycodone, Hydromorphone, Oxymorphone: KASPER, FY 2010 to FY 2013

Region	Fiscal year	Hydrocodone	Oxycodone	Hydromorphone	Oxymorphone
Region 1 - Largest city: Paducah					
	2010	197,161	36,696	2,151	786
	2011	212,140	41,364	2,356	868
	2012	217,934	45,168	2,367	1,130
	2013	200,675	45,665	2,204	816
Region 2 - Largest city: Owensboro					
	2010	298,993	48,139	3,950	721
	2011	316,138	55,081	4,090	1,082
	2012	346,345	62,177	4,690	1,435
	2013	305,508	62,201	4,794	1,383
Region 3 - Largest city: Louisville					
	2010	909,185	210,586	8,269	5,739
	2011	954,046	223,851	9,354	7,836
	2012	934,558	236,513	10,540	7,776
	2013	796,597	216,546	10,166	3,475
Region 4 - Largest city: Bowling Green					
	2010	437,810	64,489	1,303	1,024
	2011	442,989	71,904	1,523	1,671
	2012	460,865	82,357	2,029	2,400
	2013	411,109	80,821	2,583	1,854
Region 5 - Largest city: Lexington					
	2010	524,674	162,803	4,302	2,255
	2011	533,391	199,511	4,800	3,125
	2012	533,520	216,146	4,983	4,658
	2013	475,838	183,129	5,054	3,405
Region 6 - Largest city: Covington					
	2010	223,028	147,114	1,918	2,367
	2011	214,522	164,105	2,087	3,378
	2012	201,110	164,533	1,758	4,296
	2013	169,893	149,157	1,804	2,510
Region 7 - Largest city: Ashland					
	2010	144,128	74,521	1,005	531
	2011	151,539	79,292	1,100	882
	2012	158,196	75,475	1,164	1,013
	2013	142,901	64,653	1,121	991
Region 8 - Largest city: Middlesboro					
	2010	652,448	119,436	1,289	1,782
	2011	687,324	143,364	1,485	2,322

Region	Fiscal year	Hydrocodone	Oxycodone	Hydromorphone	Oxymorphone
	2012	734,483	171,378	1,753	3,457
	2013	657,261	139,584	1,717	2,668
Out-of-state					
	2010	92,926	26,261	1,147	406
	2011	93,008	26,633	892	716
	2012	97,992	27,507	963	1,038
	2013	78,640	22,614	898	421
No geography specified					
	2010	78,003	19,277	351	254
	2011	68,320	19,924	385	322
	2012	53,907	15,576	366	385
	2013	14,722	3,523	97	108

Number of Opioid Prescriptions by Selected Drugs and Region of Patient: Fentanyl, Morphine, Buprenorphine-Total, Methadone: KASPER, FY 2010 to FY 2013

Region	Fiscal year	Fentanyl	Morphine	Buprenorphine-Total	Methadone
Region 1 - Largest city: Paducah					
	2010	4,322	6,875	3,955	3,629
	2011	4,261	6,843	4,976	3,518
	2012	4,274	7,245	6,619	3,428
	2013	4,068	7,009	8,848	3,361
Region 2 - Largest city: Owensboro					
	2010	9,075	12,062	5,189	4,146
	2011	8,216	11,670	6,037	3,989
	2012	8,507	13,015	7,869	4,356
	2013	8,508	13,130	12,028	4,400
Region 3 - Largest city: Louisville					
	2010	22,267	31,075	17,467	15,979
	2011	22,543	30,475	23,011	14,925
	2012	23,383	32,997	32,339	15,367
	2013	22,514	31,541	39,890	14,055
Region 4 - Largest city: Bowling Green					
	2010	10,942	13,343	22,011	7,266
	2011	11,382	13,964	25,817	7,695
	2012	12,169	16,022	38,413	8,644
	2013	12,041	17,405	52,689	8,648
Region 5 - Largest city: Lexington					
	2010	16,318	20,532	35,586	20,261
	2011	16,407	22,442	48,179	21,111
	2012	17,310	23,956	69,336	22,718

Region	Fiscal year	Fentanyl	Morphine	Buprenorphine-Total	Methadone
	2013	18,102	26,970	105,937	21,395
Region 6 - Largest city: Covington					
	2010	7,742	11,849	14,482	9,148
	2011	8,155	12,383	14,942	9,065
	2012	8,085	13,085	20,300	9,319
	2013	8,373	14,012	24,978	8,999
Region 7 - Largest city: Ashland					
	2010	4,828	7,176	15,182	3,478
	2011	4,781	7,178	19,169	3,506
	2012	5,007	7,517	26,328	3,253
	2013	4,881	8,072	37,929	3,041
Region 8 - Largest city: Middlesboro					
	2010	11,626	11,699	61,620	12,768
	2011	11,398	13,479	76,972	13,024
	2012	12,519	16,787	122,359	13,108
	2013	11,866	17,755	182,553	12,045
Out-of-state					
	2010	3,162	3,802	5,821	1,500
	2011	2,455	3,258	7,701	1,563
	2012	3,885	3,842	10,683	1,802
	2013	1,628	3,272	17,277	1,163
No geography specified					
	2010	1,837	2,105	2,587	1,844
	2011	1,547	2,069	2,654	1,703
	2012	1,001	1,850	3,099	1,349
	2013	318	435	3,277	334

Number of Opioid Prescriptions by Selected Drugs and Region of Patient: Codeine, Tramadol: KASPER, FY 2010 to FY 2013

Region	Fiscal year	Codeine	Tramadol
Region 1 - Largest city: Paducah			
	2010	16,309	24,676
	2011	17,387	28,282
	2012	14,937	30,413
	2013	16,420	27,842
Region 2 - Largest city: Owensboro			
	2010	36,823	36,508
	2011	40,276	46,443
	2012	35,985	53,540
	2013	32,752	46,410
Region 3 - Largest city: Louisville			

2010	87,212	106,581
2011	85,229	128,880
2012	72,197	135,970
2013	69,106	119,488
Region 4 - Largest city: Bowling Green		
2010	47,150	67,402
2011	45,257	71,046
2012	40,722	76,268
2013	44,215	67,694
Region 5 - Largest city: Lexington		
2010	54,296	103,860
2011	51,612	113,725
2012	43,704	114,595
2013	38,736	104,366
Region 6 - Largest city: Covington		
2010	32,017	31,233
2011	29,255	35,058
2012	25,582	37,353
2013	23,233	35,087
Region 7 - Largest city: Ashland		
2010	16,339	37,576
2011	16,550	42,472
2012	14,935	45,719
2013	14,209	41,539
Region 8 - Largest city: Middlesboro		
2010	47,115	134,471
2011	45,846	139,859
2012	42,738	144,961
2013	51,436	126,034
Out-of-state		
2010	9,044	14,856
2011	9,139	17,354
2012	8,773	22,332
2013	9,441	16,830
No geography specified		
2010	7,006	13,222
2011	5,387	12,841
2012	3,848	10,263
2013	1,294	2,815

Number of Benzodiazepine Prescriptions by Region of Patient by Selected Drugs: Alprazolam, Diazepam, Clonazepam: KASPER, FY 2010 to FY 2013

Region	Fiscal year	Alprazolam	Diazepam	Clonazepam
Region 1 - Largest city: Paducah				
	2010	56,414	25,789	21,467
	2011	60,368	26,728	22,322
	2012	61,978	27,494	22,752
	2013	60,076	27,269	23,495
Region 2 - Largest city: Owensboro				
	2010	84,776	36,222	48,841
	2011	88,522	35,647	53,597
	2012	91,380	36,465	57,470
	2013	81,698	34,298	51,750
Region 3 - Largest city: Louisville				
	2010	251,742	97,970	109,985
	2011	255,360	88,051	118,104
	2012	244,417	78,915	122,805
	2013	227,109	71,494	121,421
Region 4 - Largest city: Bowling Green				
	2010	124,332	60,445	71,404
	2011	127,278	60,892	72,026
	2012	134,603	63,084	76,872
	2013	126,367	59,661	77,244
Region 5 - Largest city: Lexington				
	2010	148,315	62,924	96,026
	2011	162,617	67,211	101,390
	2012	162,170	71,080	105,482
	2013	150,247	62,085	104,104
Region 6 - Largest city: Covington				
	2010	63,941	44,658	43,460
	2011	66,252	44,331	45,028
	2012	62,889	42,430	48,223
	2013	57,084	37,441	45,266
Region 7 - Largest city: Ashland				
	2010	53,512	26,376	32,075
	2011	56,855	27,106	32,777
	2012	53,877	28,242	33,401
	2013	50,174	25,743	32,311
Region 8 - Largest city: Middlesboro				
	2010	193,056	86,174	121,376
	2011	203,819	92,631	130,436

Region	Fiscal year	Alprazolam	Diazepam	Clonazepam
	2012	210,083	102,680	145,455
	2013	174,840	94,657	148,231
Out-of-state				
	2010	30,144	10,214	13,997
	2011	29,388	10,118	14,291
	2012	31,190	10,621	15,924
	2013	25,247	9,734	14,355
No geography specified				
	2010	23,095	10,557	12,970
	2011	24,020	10,234	14,243
	2012	19,400	8,132	11,328
	2013	4,225	1,978	2,451

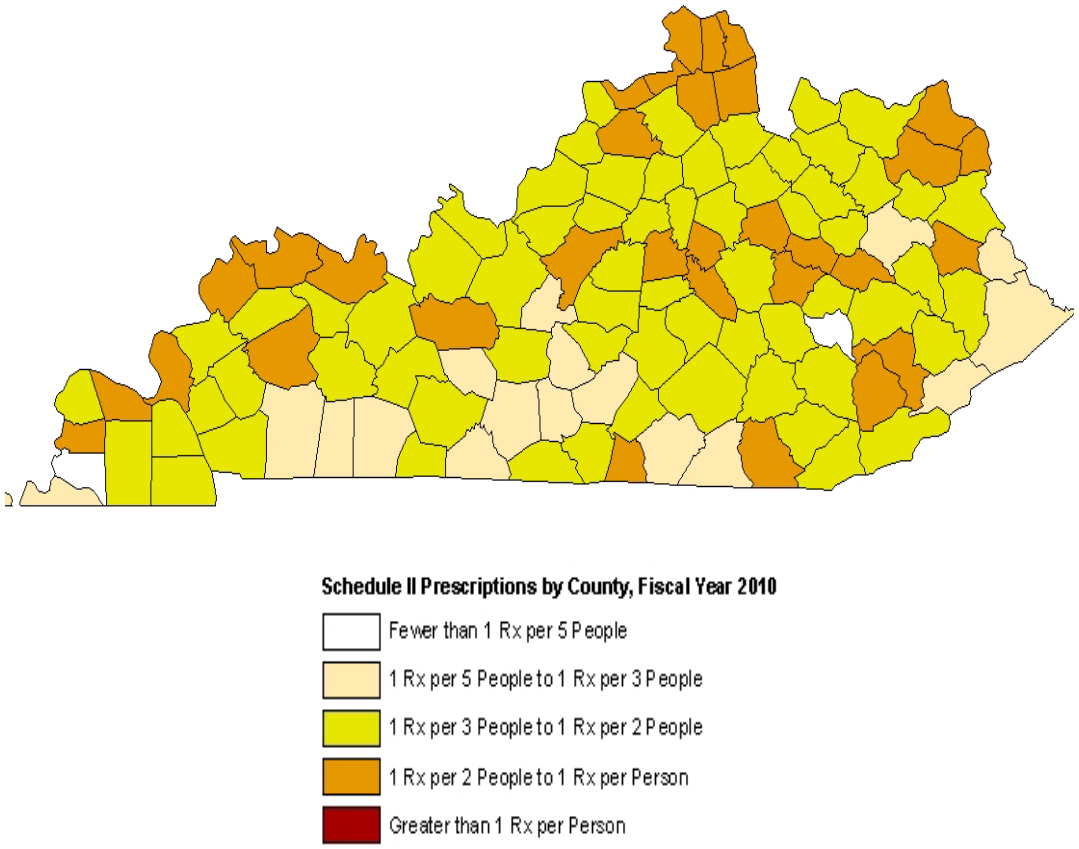
Number of Stimulant Prescriptions by Region of Patient by Selected Drugs: Mixed Salt Amphetamines, Dextroamphetamine, Lisdexamfetamine, Methylphenidate: KASPER, FY 2010 to FY 2013

Region	Fiscal year	Mixed amphetamine salts	Dextro amphetamine	Lisdexamfetamine	Methylphenidate
Region 1 - Largest city: Paducah					
	2010	13,836	773	12,618	20,022
	2011	16,002	802	15,744	19,561
	2012	17,925	657	17,389	19,658
	2013	20,538	572	18,432	21,506
Region 2 - Largest city: Owensboro					
	2010	35,420	1,667	24,295	32,658
	2011	36,364	1,505	27,615	33,266
	2012	39,594	1,221	29,370	34,431
	2013	40,633	961	29,010	35,903
Region 3 - Largest city: Louisville					
	2010	82,129	3,730	46,407	97,376
	2011	90,771	3,908	55,067	101,856
	2012	95,878	3,721	63,284	107,748
	2013	108,302	3,242	69,213	113,979
Region 4 - Largest city: Bowling Green					
	2010	15,551	874	10,983	23,628
	2011	17,195	979	13,179	25,202
	2012	20,868	1,036	13,133	26,390
	2013	24,430	756	12,603	29,541
Region 5 - Largest city: Lexington					
	2010	41,453	2,760	21,057	51,288
	2011	45,355	2,936	25,028	55,160
	2012	50,565	2,586	27,370	60,174
	2013	58,873	2,101	28,702	65,991
Region 6 - Largest city: Covington					
	2010	32,725	1,471	19,020	33,173
	2011	34,776	1,527	21,901	34,273
	2012	38,041	1,415	22,281	35,758
	2013	43,665	1,333	22,206	38,612
Region 7 - Largest city: Ashland					
	2010	9,922	475	3,985	13,564
	2011	9,663	359	4,951	14,372
	2012	11,293	326	4,798	15,491
	2013	13,188	217	5,572	16,987
Region 8 - Largest city: Middlesboro					
	2010	9,370	408	6,272	22,804
	2011	9,553	418	7,397	24,596

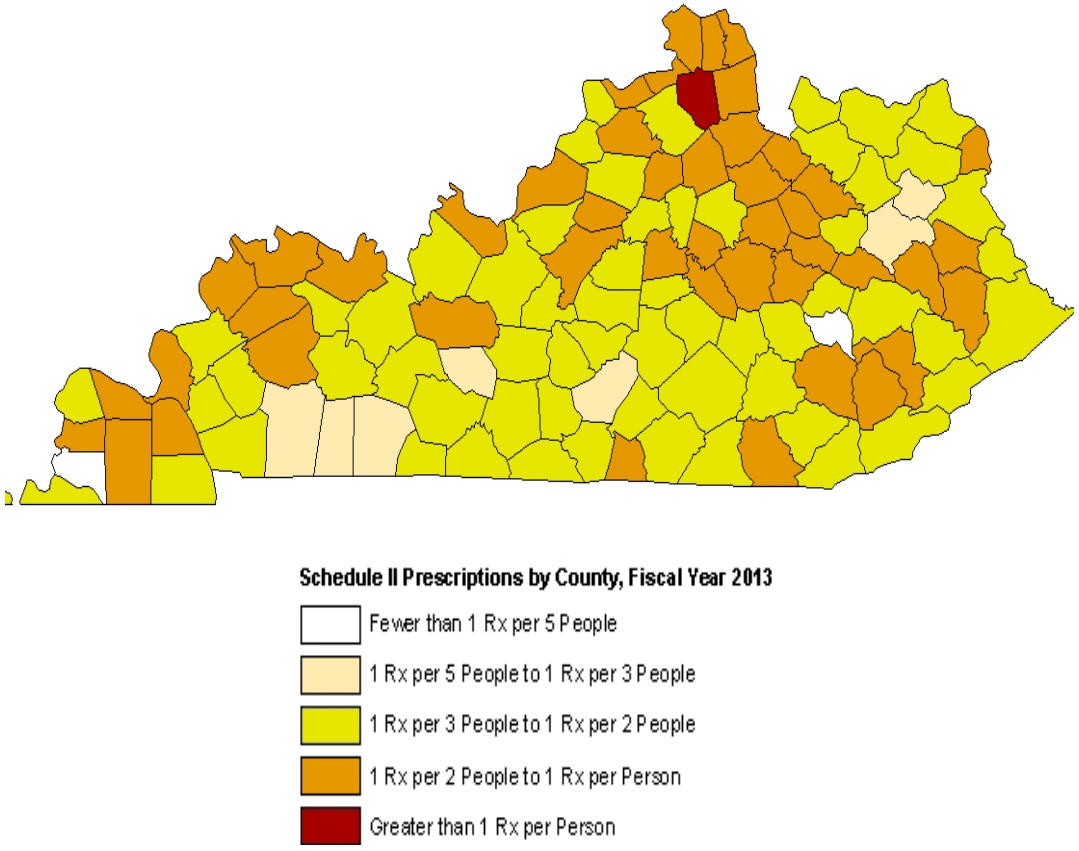
Region	Fiscal year	Mixed amphetamine salts	Dextro amphetamine	Lisdexamfetamine	Methylphenidate
	2012	12,423	396	7,765	27,519
	2013	14,870	341	8,915	29,600
Out-of-state					
	2010	6,113	238	1,950	4,255
	2011	6,942	234	2,543	4,379
	2012	8,324	332	3,104	5,065
	2013	7,875	204	3,171	4,669
No geography specified					
	2010	3,931	300	2,942	6,379
	2011	4,496	274	3,364	6,504
	2012	4,193	221	2,910	2,984
	2013	743	22	476	746

APPENDIX IV: Maps

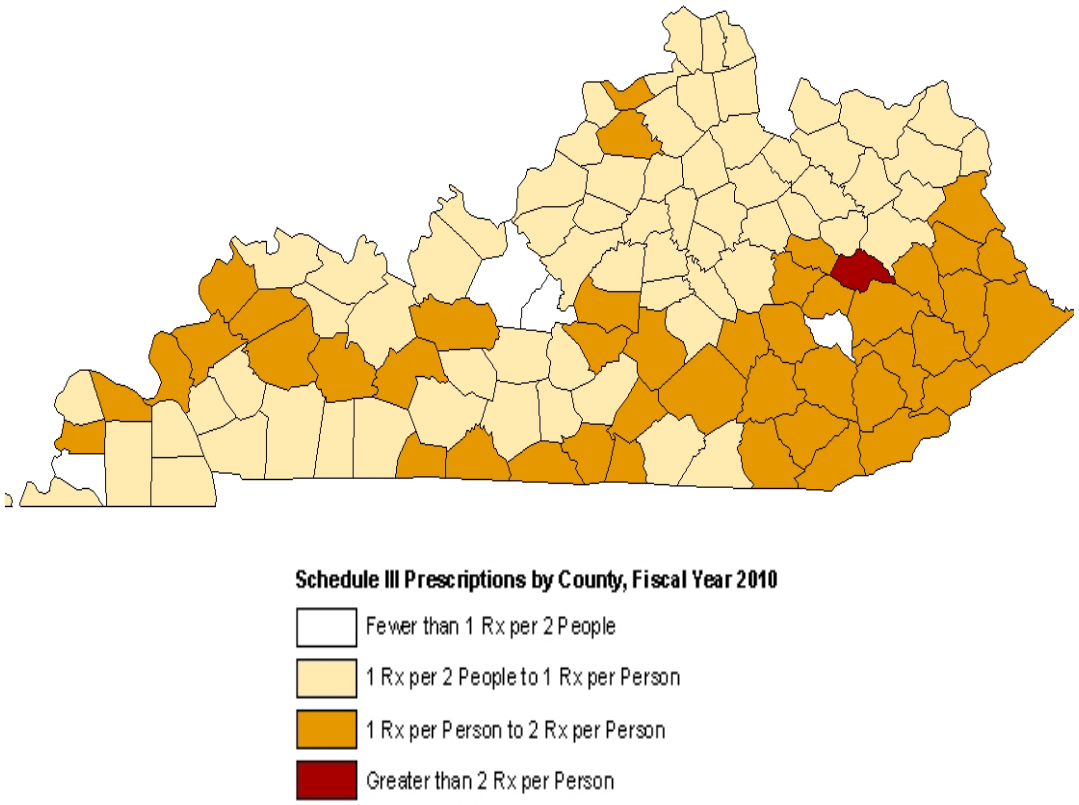
Schedule II Prescriptions by County, Fiscal Year 2010



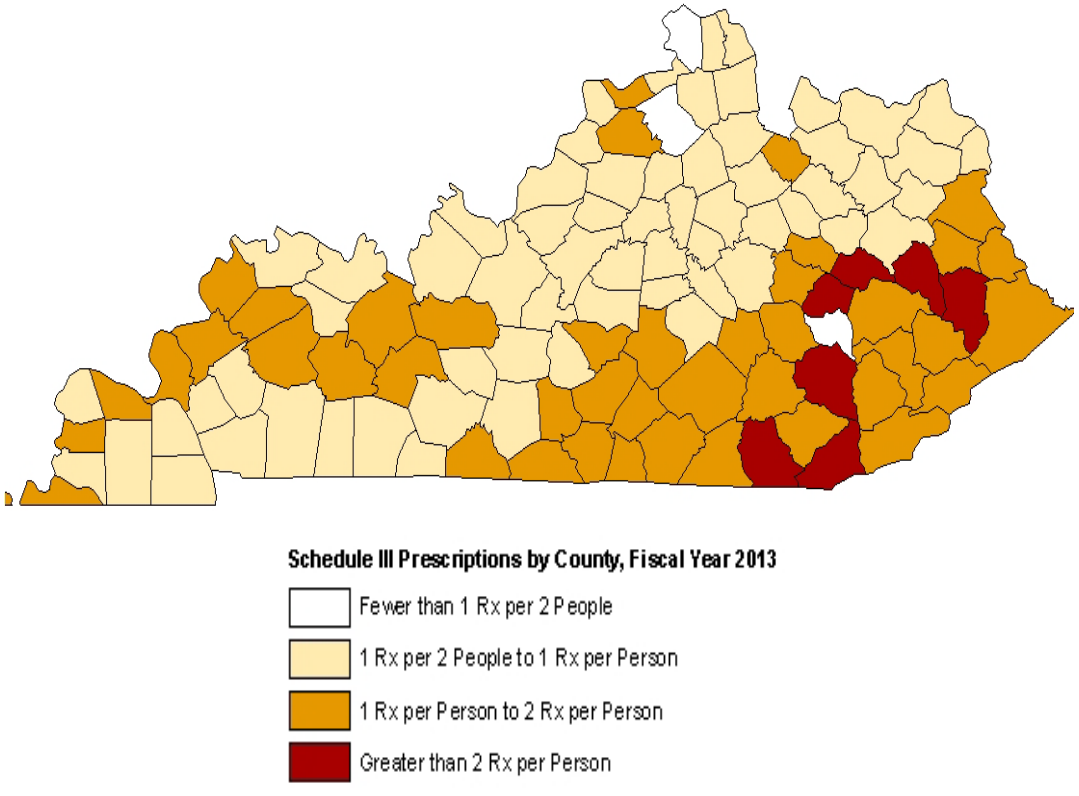
Schedule II Prescriptions by County, Fiscal Year 2013



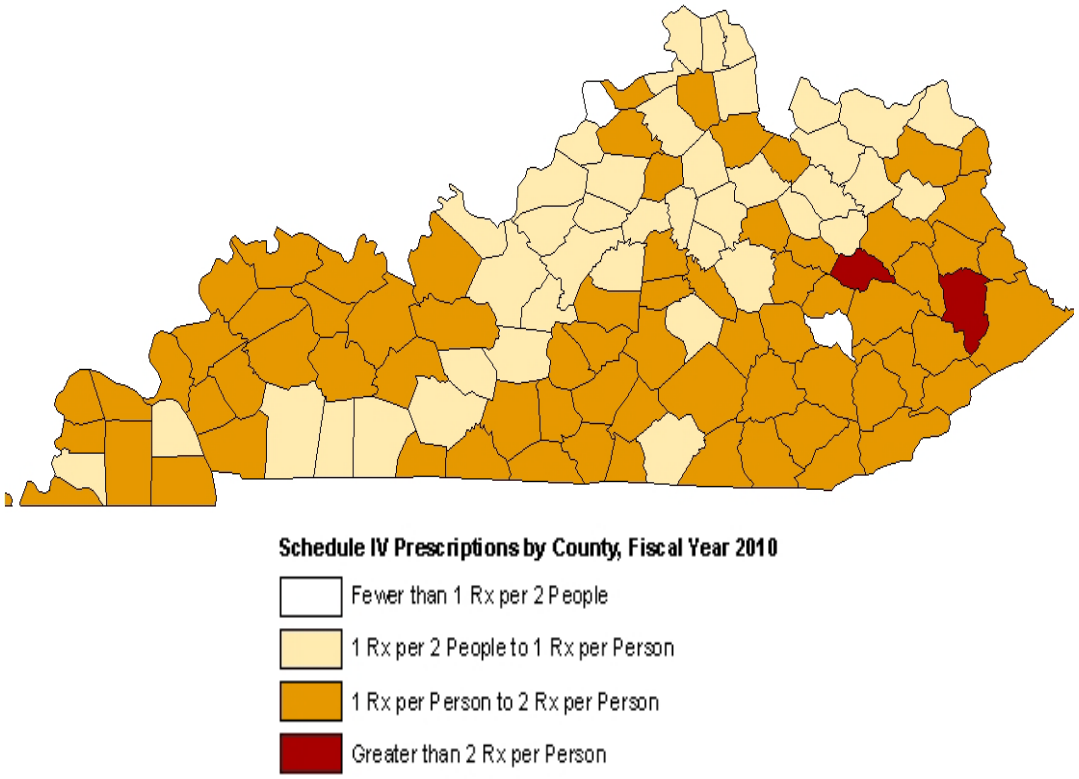
Schedule III Prescriptions by County, Fiscal Year 2010



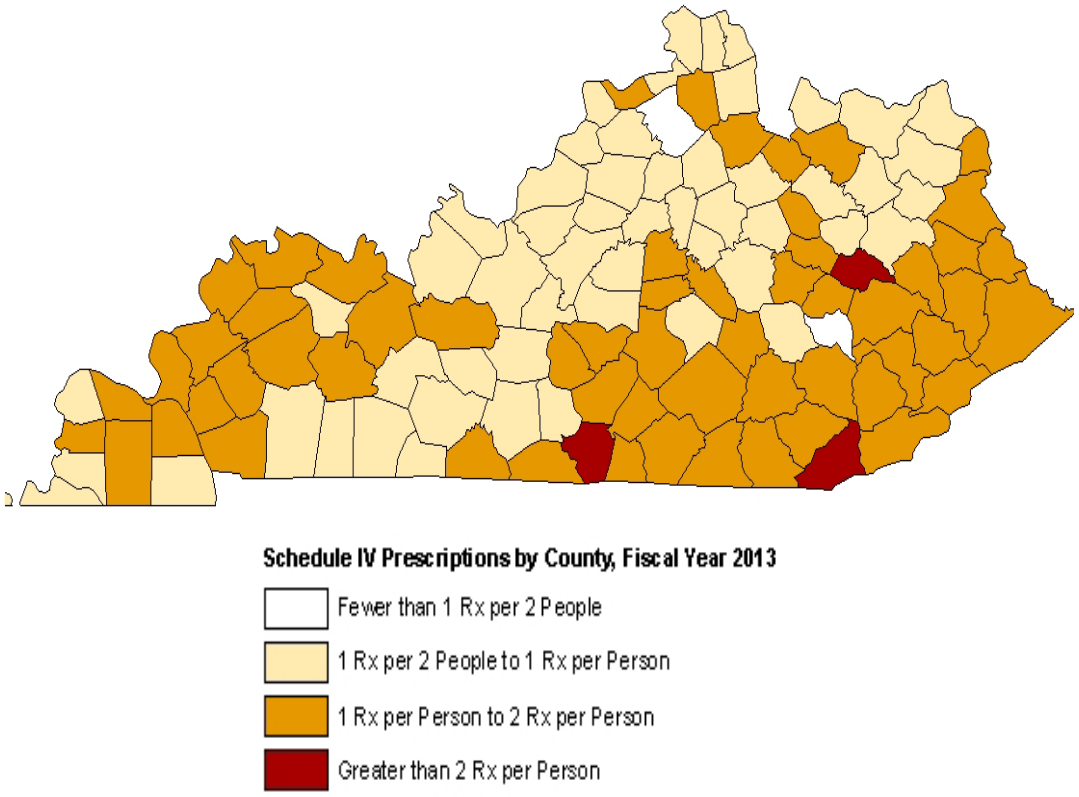
Schedule III Prescriptions by County, Fiscal Year 2013



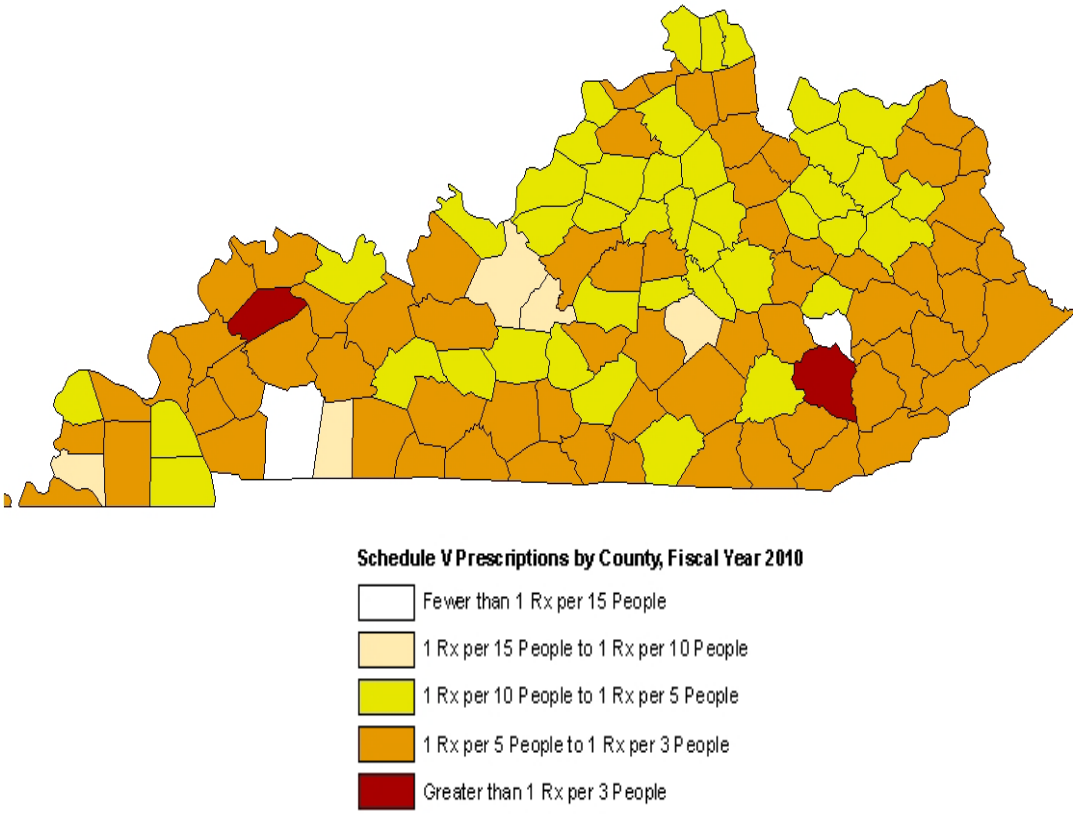
Schedule IV Prescriptions by County, Fiscal Year 2010



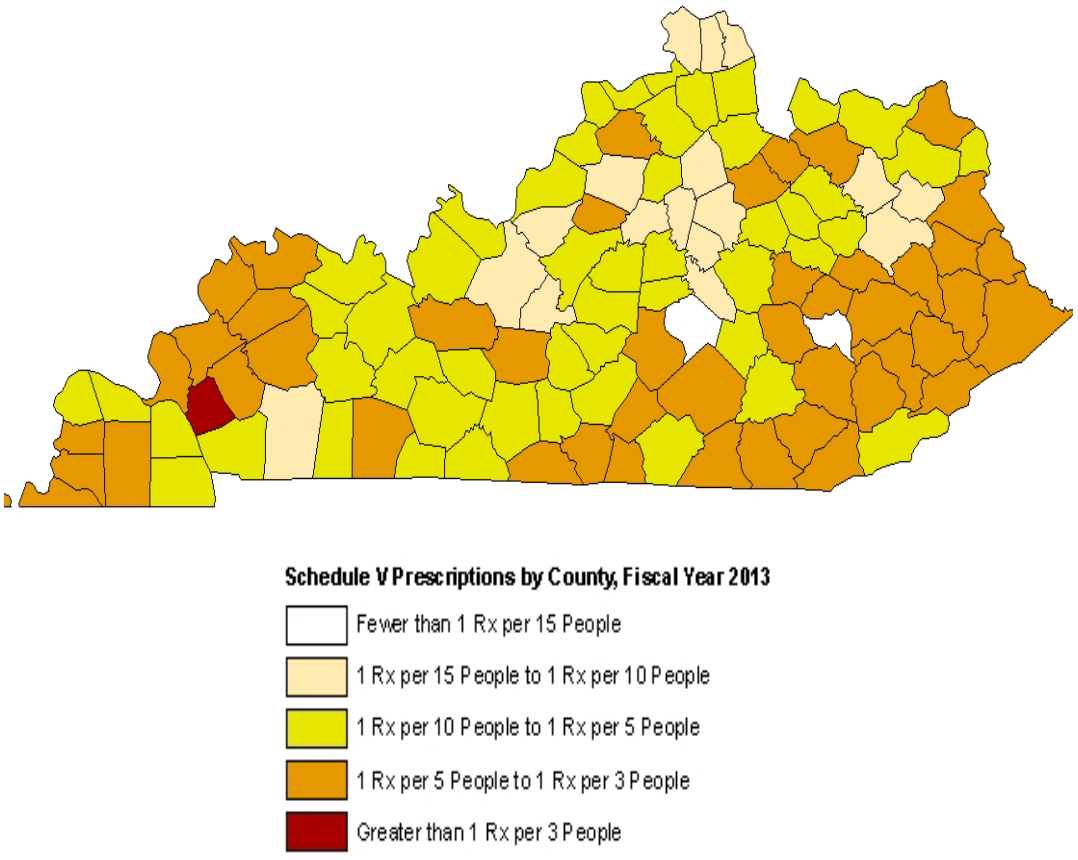
Schedule IV Prescriptions by County, Fiscal Year 2013



Schedule V Prescriptions by County, Fiscal Year 2010



Schedule V Prescriptions by County, Fiscal Year 2013



Confidential

House Bill 1 Evaluation: Prescriber Survey

investigator information:

Patricia Freeman, PhD

Phone: 859-323-1381

Email: trish.freeman@uky.edu

You are invited to participate in a survey collecting information and opinions related to changes in the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system resulting from House Bill 1 passed during the 2012 legislative session. This survey is part of a research project funded by the Kentucky Cabinet for Health and Family Services being conducted at the University of Kentucky Institute for Pharmaceutical Outcomes and Policy.

You have been asked to participate in this survey because you are a prescriber, pharmacist or law enforcement official with a KASPER account. If you voluntarily complete the survey, you will be one of approximately 7,000 KASPER registrants to do so. The survey will take approximately 15 minutes to complete.

The survey asks about your experience using KASPER, your opinions about controlled-substances, and general demographic information. The information generated from this research will assist with the evaluation of the impact of KASPER changes related to House Bill 1.

The only potential risk associated with completing this survey is the very small risk of loss of confidentiality of your responses to the survey items. The research team will not attempt to trace responses back to individuals. Neither the researchers nor the Cabinet for Health and Family Services will know who did, or did not, respond to the survey. There are no known risks associated with disclosure of your opinions about KASPER.

You may receive two additional email invitations to participate in this survey over the next two weeks if you did not initially respond to the survey. If you elect not to respond to the survey, please ignore these additional emails.

Taking part in this research is completely voluntary. If you choose not to participate, there will be no penalty to you. You are free to skip any question that you do not want to answer and you can discontinue the survey at any time. Although you will not personally benefit by completing the survey the information that you provide may help improve the KASPER program.

This study has been reviewed by the University of Kentucky Medical Institutional Review Board. If you have questions

about this study, you may call Patricia Freeman at 859-323-1381. If you have any questions about your rights as a volunteer in this research, you may contact the staff in the Office of Research Integrity at the University of Kentucky at 859-257-9428 or toll free at 1-866-400-9428.

Thank you for your time and we appreciate your consideration in completing this survey.

Sincerely,

Patricia Freeman, PhD

Associate Professor

University of Kentucky College of Pharmacy

Section I: Demographic Information

1 I am licensed to practice as:

- ◯ MD
- ◯ DO
- ◯ DMD
- ◯ DVM
- ◯ APRN

2 Total number of years in practice, including internship and residency: _____ (Number of years)

3 On average, across all practice sites, how many patients do you see a day? _____ (Number of patients)

4a What is the Kentucky county where you currently practice? (If you practice in more than one county, select the county where you practice most often.)

- ◯ Adair
- ◯ Allen
- ◯ Anderson
- ◯ Ballard
- ◯ Barren
- ◯ Bath
- ◯ Bell
- ◯ Boone
- ◯ Bourbon
- ◯ Boyd
- ◯ Boyle
- ◯ Bracken
- ◯ Breathitt
- ◯ Breckenridge
- ◯ Bullitt
- ◯ Butler
- ◯ Caldwell
- ◯ Calloway
- ◯ Campbell
- ◯ Carlisle
- ◯ Carroll
- ◯ Carter
- ◯ Casey
- ◯ Christian
- ◯ Clark
- ◯ Clay
- ◯ Clinton
- ◯ Crittenden
- ◯ Cumberland
- ◯ Daviess
- ◯ Edmonson
- ◯ Elliot
- ◯ Estill
- ◯ Fayette
- ◯ Fleming
- ◯ Floyd
- ◯ Franklin
- ◯ Fulton
- ◯ Gallatin
- ◯ Garrard
- ◯ Grant
- ◯ Graves
- ◯ Grayson
- ◯ Green
- ◯ Greenup
- ◯ Hancock
- ◯ Hardin
- ◯ Harlan
- ◯ Harrison
- ◯ Hart
- ◯ Henderson
- ◯ Henry
- ◯ Hickman
- ◯ Hopkins
- ◯ Jackson
- ◯ Jefferson
- ◯ Jessamine
- ◯ Johnson
- ◯ Kenton
- ◯ Knott
- ◯ Knox
- ◯ Larue
- ◯ Laurel
- ◯ Lawrence
- ◯ Lee
- ◯ Leslie
- ◯ Letcher
- ◯ Lewis
- ◯ Lincoln
- ◯ Livingston

- ◯ Logan
- ◯ Lyon
- ◯ Madison
- ◯ Magoffin
- ◯ Marion
- ◯ Marshall
- ◯ Martin
- ◯ Mason
- ◯ McLean
- ◯ McCracken
- ◯ McCreary
- ◯ Meade
- ◯ Menifee
- ◯ Mercer
- ◯ Metcalfe
- ◯ Monroe
- ◯ Montgomery
- ◯ Morgan
- ◯ Muhlenberg
- ◯ Nelson
- ◯ Nicholas
- ◯ Ohio
- ◯ Oldham
- ◯ Owen
- ◯ Owsley
- ◯ Pendleton
- ◯ Perry
- ◯ Pike
- ◯ Powell
- ◯ Pulaski
- ◯ Robertson
- ◯ Rockcastle
- ◯ Rowan
- ◯ Russell
- ◯ Scott
- ◯ Shelby
- ◯ Simpson
- ◯ Spencer
- ◯ Taylor
- ◯ Todd
- ◯ Trigg
- ◯ Trimble
- ◯ Union
- ◯ Warren
- ◯ Washington
- ◯ Wayne
- ◯ Webster
- ◯ Whitley
- ◯ Wolfe
- ◯ Woodford

4b What is the zip code of the Kentucky address where you currently practice? (If you practice at more than one address, select the zip code where you practice most often.)

_____
(Zip code)

5 What best describes your specialty?

- ◯ Internal Medicine
- ◯ Neurology
- ◯ Emergency Medicine
- ◯ Palliative/Hospice Care
- ◯ Pediatrics
- ◯ Family Practice
- ◯ Orthopedics
- ◯ Surgery
- ◯ Psychiatry
- ◯ Other

If "Other" specialty, please describe: _____

Section II: Questions about Your Practice

6 Did you have a KASPER account prior to the House Bill 1 mandate, which was effective as of July 2012?
- ◯ Yes
- ◯ No

6a If yes, how long prior to the mandate in July 2012 had you held a KASPER account?
- ◯ Less than one year
- ◯ Between one and two years
- ◯ Between three and five years
- ◯ Between six and ten years
- ◯ Longer than ten years

7 Who usually requests KASPER reports at your office?
- ◯ I request reports myself.
- ◯ My delegate requests reports.
- ◯ The delegate for the practice or facility requests reports.
- ◯ Other

If "Other" requests reports, then please describe: _____

8 How often do you discuss KASPER reports with patients?
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

8a How has this changed since the implementation of House Bill 1 in July 2012?
- ◯ I discuss KASPER reports with my patients more frequently since House Bill 1
- ◯ I discuss KASPER reports with my patients less frequently since House Bill 1
- ◯ No change

9 How often do you discuss KASPER reports with other practitioners?
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

9a How has this changed since the implementation of House Bill 1 in July 2012?
- ◯ I discuss KASPER reports with other practitioners more frequently since House Bill 1
- ◯ I discuss KASPER reports with other practitioners less frequently since House Bill 1
- ◯ No change

10 How often do you discuss KASPER reports with pharmacists?
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

10a How has this changed since the implementation of House Bill 1 in July 2012?
- ◯ I discuss KASPER reports with pharmacists more frequently since House Bill 1
- ◯ I discuss KASPER reports with pharmacists less frequently since House Bill 1
- ◯ No change

11 Approximately how many KASPER reports have you utilized in the past one (1) week? (If none, enter 0.)
_____ (Total number)

11a Of these reports, how many confirmed your decision to prescribe a controlled substance?
_____ (Number of cases)

11b Of these reports, how many changed your decision such that you did NOT prescribe a controlled substance?
_____ (Number of cases)

11c Of these reports, how many changed your decision on the TYPE of controlled substance to prescribe?
_____ (Number of cases)

11d Of these reports, how many did NOT impact your prescribing decision?
_____ (Number of cases)

12 I am confident in the accuracy of the information in a KASPER report.
- ◯ Strongly agree
- ◯ Somewhat agree
- ◯ Neutral
- ◯ Somewhat disagree
- ◯ Strongly disagree

13 Since implementation of House Bill 1 in July 2012, how many patients have your referred to substance abuse treatment as a result of KASPER reports?
- ◯ None
- ◯ 1 - 5
- ◯ 6 - 20
- ◯ >20

13a How has this changed since implementation of House Bill 1 in July 2012?
- ◯ I am referring more patients to treatment since House Bill 1
- ◯ I am referring fewer patients to treatment since House Bill 1
- ◯ No change

13a If "None", how has this changed since the implementation of House Bill 1 in July 2012?
- ◯ I am referring fewer patients to treatment since House Bill 1
- ◯ No change

14 Since implementation of House Bill 1 in July 2012, how many patients have you suspected of doctor shopping and/or diverting controlled substances as a result of information contained in KASPER reports?
- ◯ None
- ◯ 1 - 5
- ◯ 6 - 20
- ◯ >20

14a How has this changed since implementation of House Bill 1 in July 2012?
- ◯ I see more patients I suspect of doctor shopping since implementation of House Bill 1
- ◯ I see fewer patients I suspect of doctor shopping since implementation of House Bill 1
- ◯ No change

14a If "None", how has this changed since the implementation of House Bill 1 in July 2012?
- ◯ I see fewer patients I suspect of doctor shopping since House Bill 1
- ◯ No change

15 Since implementation of House Bill 1 in July 2012, how many patients have you dismissed from your practice as a result of information contained in KASPER reports?
- ◯ None
- ◯ 1 - 5
- ◯ 6 - 20
- ◯ >20

15a How has this changed since implementation of House Bill 1 in July 2012?
- ◯ The number of patients dismissed from my practice has increased since House Bill 1
- ◯ The number of patients dismissed from my practice has decreased since House Bill 1
- ◯ No change

15a If "None", how has this changed since implementation of House Bill 1 in July 2012?
- ◯ The number of patients dismissed from my practice has decreased since House Bill 1
- ◯ No change

16 Since implementation of House Bill 1 in July 2012, how many times have you contacted law enforcement to report a case of possible doctor shopping or diversion?
- ◯ None
- ◯ 1 - 5
- ◯ 6 - 20
- ◯ >20

16a How has this changed since implementation of House Bill 1 in July 2012?
- ◯ I contact law enforcement more frequently since House Bill 1
- ◯ I contact law enforcement less frequently since House Bill 1
- ◯ No change

16a If "None", how has this changed since implementation of House Bill 1 in July 2012?
- ◯ I contact law enforcement less frequently since House Bill 1
- ◯ No change

17 Since implementation of House Bill 1, do you believe that your controlled substance prescribing behaviors are being monitored more closely by regulatory agencies?
- ◯ Yes
- ◯ No

17a Why? _____

18 On average, how many Schedule II controlled substance prescriptions (such as Oxycontin, hydrocodone, and hydromorphone) do you prescribe per week?
- ◯ None
- ◯ 1 - 10
- ◯ 11 - 20
- ◯ 21 - 30
- ◯ >30

19 Since the implementation of House Bill 1 in July 2012, my Schedule II controlled substance prescribing has...
- ◯ Not changed
- ◯ Increased
- ◯ Decreased

20 On average, how many Schedule III and/or IV controlled substance prescriptions (such as Tylenol #3, tramadol, carisoprodol, or alprazolam) do you prescribe per week?
- ◯ None
- ◯ 1 - 10
- ◯ 11 - 20
- ◯ 21 - 30
- ◯ >30

21 Since implementation of House Bill 1 in July 2012, my Schedule II and/or IV controlled substance prescribing has...
- ◯ Not changed
- ◯ Increased
- ◯ Decreased

22 Prior to House Bill 1, did you DISPENSE controlled substance prescriptions from your office?
- ◯ Yes
- ◯ No

22a If yes, on average, how many controlled substance prescriptions did you dispense from your office per week? _____ (Number of prescriptions dispensed)

23 Thinking about your general prescribing patterns since implementation of House Bill 1 in July 2012, which of the following best describes your controlled substance prescribing:
- ◯ My controlled substance prescribing has not changed
- ◯ My controlled substance prescribing has increased
- ◯ My controlled substance prescribing has decreased
- ◯ I no longer prescribe controlled substances because of House Bill 1

23a My controlled substance prescribing has increased because:
- ☐ I feel more confident in making controlled substance prescribing decisions
- ☐ Mandatory use of KASPER has increased patient referrals to my practice
- ☐ My patient population has changed
- ☐ Other

((Select all that apply))

If "Other", please describe: _____

23a My controlled substance prescribing has decreased because:

- ☐ I refer more patients to pain management specialists
- ☐ Stigma created by media coverage of prescription drug abuse and diversion
- ☐ Implementation of House Bill 1 requiring mandatory use of KASPER has created a burden on my practice
- ☐ Implementation of House Bill 1 requiring mandatory use of KASPER has allowed me to more easily identify possible doctor shoppers
- ☐ Concern about increased law enforcement activity related to prescription drug abuse and diversion and law enforcement investigation of my practice
- ☐ Concern over licensing board investigation of my practice
- ☐ My patient population has changed
- ☐ Other

((Select all that apply))

If "Other", please describe: _____

23b If your prescribing has changed since the implementation of House Bill 1 in July 2012, has it impacted your ability to manage your patients' conditions?

- ◯ Yes, there has been a positive impact on my ability to help my patients manage their conditions.
- ◯ Yes, there has been a negative impact on my ability to help my patients manage their conditions.
- ◯ No, there has been no impact on my ability to help my patients manage their conditions.

Section III: Perceptions about Controlled Substance Prescribing Regulations and Controlled Substance Prescribing

I am confident in my understanding of each of the following...

		Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
24a	...when to request an initial KASPER report.	○	○	○	○	○
24b	...prescribing standards for controlled substances.	○	○	○	○	○
24c	...assessment and treatment standards for conditions requiring controlled substances.	○	○	○	○	○
24d	...obtaining written consent for treatment.	○	○	○	○	○
24e	...how often to order KASPER reports during continuing therapy.	○	○	○	○	○
24f	...exit strategies for long-term treatment with controlled substances.	○	○	○	○	○

		Strongly agree	Somewhat agree	Neutral	Somewhat disagree	Strongly disagree
25	I am confident in my ability to make prescribing decisions for the treatment of chronic pain that are in line with current guidelines and recommendations.	○	○	○	○	○
26	I am confident in my ability to interpret information found in a KASPER report.	○	○	○	○	○
27	I am confident in my decisions on when to order urine drug screenings.	○	○	○	○	○
28	I am confident in my ability to interpret urine drug screen results for treatment decisions.	○	○	○	○	○

Effectiveness is often defined as producing a desired result. To what extent do you feel KASPER is an effective tool to:

		Not effective at all	Somewhat ineffective	Neutral	Somewhat effective	Very effective
29a	Reduce drug abuse and diversion in Kentucky?	◯	◯	◯	◯	◯
29b	Reduce doctor shopping in Kentucky?	◯	◯	◯	◯	◯

30 Please provide any additional information on KASPER, impact of House Bill 1, or your licensure board's prescribing regulations that you would like to share. _____

House Bill 1 Evaluation: Pharmacist Survey

investigator information:

Patricia Freeman, PhD

Phone: 859-323-1381

Email: trish.freeman@uky.edu

You are invited to participate in a survey collecting information and opinions related to changes in the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system resulting from House Bill 1 passed during the 2012 legislative session. This survey is part of a research project funded by the Kentucky Cabinet for Health and Family Services being conducted at the University of Kentucky Institute for Pharmaceutical Outcomes and Policy.

You have been asked to participate in this survey because you are a prescriber, pharmacist or law enforcement official with a KASPER account. If you voluntarily complete the survey, you will be one of approximately 7,000 KASPER registrants to do so. The survey will take approximately 15 minutes to complete.

The survey asks about your experience using KASPER, your opinions about controlled-substances, and general demographic information. The information generated from this research will assist with the evaluation of the impact of KASPER changes related to House Bill 1.

The only potential risk associated with completing this survey is the very small risk of loss of confidentiality of your responses to the survey items. The research team will not attempt to trace responses back to individuals. Neither the researchers nor the Cabinet for Health and Family Services will know who did, or did not, respond to the survey. There are no known risks associated with disclosure of your opinions about KASPER.

You may receive two additional email invitations to participate in this survey over the next two weeks if you did not initially respond to the survey. If you elect not to respond to the survey, please ignore these additional emails.

Taking part in this research is completely voluntary. If you choose not to participate, there will be no penalty to you. You are free to skip any question that you do not want to answer and you can discontinue the survey at any time. Although you will not personally benefit by completing the survey the information that you provide may help improve the KASPER program.

This study has been reviewed by the University of Kentucky Medical Institutional Review Board. If you have questions about this study, you may call Patricia Freeman at 859-323-1381. If you have any questions about your rights as a volunteer in this research, you may contact the staff in the Office of Research Integrity at the University of Kentucky at 859-257-9428 or toll free at 1-866-400-9428.

Thank you for your time and we appreciate your consideration in completing this survey.

Sincerely,

Patricia Freeman, PhD

Associate Professor

University of Kentucky College of Pharmacy

Section I: Demographic Information

1 My terminal degree is:

- ◯ BSPharm
- ◯ PharmD

2 Total number of years in practice, including residency:

_____
(Number of years)

3 My practice site is:

- ◯ Independent pharmacy
- ◯ Chain pharmacy
- ◯ Supermarket/mass merchandiser pharmacy
- ◯ Hospital pharmacy
- ◯ Long-term care pharmacy
- ◯ Other

If "Other" practice site, please describe: _____

4 On average, how many prescriptions are dispensed DAILY at your pharmacy?

_____
(Number of prescriptions)

4a Of these, how many are controlled substances?

_____
(Number of prescriptions)

5a What is the Kentucky county where you currently practice? (If you practice in more than one county, select the county where you practice most often.)

- ◯ Adair
- ◯ Allen
- ◯ Anderson
- ◯ Ballard
- ◯ Barren
- ◯ Bath
- ◯ Bell
- ◯ Boone
- ◯ Bourbon
- ◯ Boyd
- ◯ Boyle
- ◯ Bracken
- ◯ Breathitt
- ◯ Breckenridge
- ◯ Bullitt
- ◯ Butler
- ◯ Caldwell
- ◯ Calloway
- ◯ Campbell
- ◯ Carlisle
- ◯ Carroll
- ◯ Carter
- ◯ Casey
- ◯ Christian
- ◯ Clark
- ◯ Clay
- ◯ Clinton
- ◯ Crittenden
- ◯ Cumberland
- ◯ Daviess
- ◯ Edmonson
- ◯ Elliot
- ◯ Estill
- ◯ Fayette
- ◯ Fleming
- ◯ Floyd
- ◯ Franklin
- ◯ Fulton
- ◯ Gallatin
- ◯ Garrard
- ◯ Grant
- ◯ Graves
- ◯ Grayson
- ◯ Green
- ◯ Greenup
- ◯ Hancock
- ◯ Hardin
- ◯ Harlan
- ◯ Harrison
- ◯ Hart
- ◯ Henderson
- ◯ Henry
- ◯ Hickman
- ◯ Hopkins
- ◯ Jackson
- ◯ Jefferson
- ◯ Jessamine
- ◯ Johnson
- ◯ Kenton
- ◯ Knott
- ◯ Knox
- ◯ Larue
- ◯ Laurel
- ◯ Lawrence
- ◯ Lee
- ◯ Leslie
- ◯ Letcher
- ◯ Lewis
- ◯ Lincoln
- ◯ Livingston

- ◯ Logan
- ◯ Lyon
- ◯ Madison
- ◯ Magoffin
- ◯ Marion
- ◯ Marshall
- ◯ Martin
- ◯ Mason
- ◯ McLean
- ◯ McCracken
- ◯ McCreary
- ◯ Meade
- ◯ Menifee
- ◯ Mercer
- ◯ Metcalfe
- ◯ Monroe
- ◯ Montgomery
- ◯ Morgan
- ◯ Muhlenberg
- ◯ Nelson
- ◯ Nicholas
- ◯ Ohio
- ◯ Oldham
- ◯ Owen
- ◯ Owsley
- ◯ Pendleton
- ◯ Perry
- ◯ Pike
- ◯ Powell
- ◯ Pulaski
- ◯ Robertson
- ◯ Rockcastle
- ◯ Rowan
- ◯ Russell
- ◯ Scott
- ◯ Shelby
- ◯ Simpson
- ◯ Spencer
- ◯ Taylor
- ◯ Todd
- ◯ Trigg
- ◯ Trimble
- ◯ Union
- ◯ Warren
- ◯ Washington
- ◯ Wayne
- ◯ Webster
- ◯ Whitley
- ◯ Wolfe
- ◯ Woodford

5b What is the zip code of the Kentucky address where you currently practice? (If you practice at more than one address, select the zip code where you practice most often.)

_____

(Zip code)

Section II: Questions about Your Practice

6 Did you have a KASPER account prior to the House Bill 1 mandate, which was effective as of July 2012?
- ◯ Yes
- ◯ No

6a If yes, how long prior to the mandate in July 2012 had you held a KASPER account?
- ◯ Less than one year
- ◯ Between one and two years
- ◯ Between three and five years
- ◯ Between six and ten years
- ◯ Longer than ten years

7 Who usually requests KASPER reports at your practice?
- ☐ I request reports myself
- ☐ My technician requests reports
- ☐ Another pharmacist at the practice requests reports
- ☐ Other

((Select all that apply))

If "Other", please describe: _____

8 How often do you discuss KASPER reports with patients?
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

8a How has this changed since the implementation of House Bill 1 in July 2012?
- ◯ I discuss KASPER reports with my patients more frequently since House Bill 1
- ◯ I discuss KASPER reports with my patients less frequently since House Bill 1
- ◯ No change

9 How often do you discuss KASPER reports with prescribers?
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

9a How has this changed since implementation of House Bill 1 in July 2012?
- ◯ I discuss KASPER reports with prescribers more frequently since House Bill 1
- ◯ I discuss KASPER reports with prescribers less frequently since House Bill 1
- ◯ No change

10 How often do you discuss KASPER reports with other pharmacists?
- ◯ Frequently
- ◯ Sometimes
- ◯ Rarely
- ◯ Never

10a How has this changed since implementation of House Bill 1 in July 2012?
- ◯ I discuss KASPER reports with other pharmacists more frequently since House Bill 1
- ◯ I discuss KASPER reports with other pharmacists less frequently since House Bill 1
- ◯ No change

11 Approximately how many KASPER reports have you utilized in the past one (1) week? _____ (Total number)

11a Of these reports, how many confirmed your decision to dispense a controlled substance? _____ (Number of cases)

11b Of these reports, how many changed your decision such that you did NOT dispense a controlled substance? _____ (Number of cases)

11c Of these reports, how many did NOT impact your dispensing decision? _____ (Number of cases)

12 I am confident in the accuracy of the information in a KASPER report.

- ◯ Strongly agree
- ◯ Somewhat agree
- ◯ Neutral
- ◯ Somewhat disagree
- ◯ Strongly disagree

13 I am confident in my ability to interpret information found in a KASPER report.

- ◯ Strongly agree
- ◯ Somewhat agree
- ◯ Neutral
- ◯ Somewhat disagree
- ◯ Strongly disagree

14 Since implementation of House Bill 1 in July 2012, how many times have you contacted a prescriber to discuss a patient's potential substance abuse issue or problem?

- ◯ None
- ◯ 1 - 5
- ◯ 6 - 20
- ◯ >20

14a How has this changed since implementation of House Bill 1?

- ◯ I contact prescribers more frequently since House Bill 1
- ◯ I contact prescribers less frequently since House Bill 1
- ◯ No change

14a If "none", how has this changed since the implementation of House Bill 1?

- ◯ I contact prescribers less frequently since House Bill 1
- ◯ No change

15 Since implementation of House Bill 1 in July 2012, how many patients have you referred to substance abuse treatment as the result of KASPER reports?

- ◯ None
- ◯ 1 - 5
- ◯ 6 - 20
- ◯ >20

15a How has this changed since implementation of House Bill 1 in July 2012?

- ◯ I refer more patients to treatment since House Bill 1
- ◯ I refer fewer patients to treatment since House Bill 1
- ◯ No change

15a If "none", how has this changed since implementation of House Bill 1?

- ◯ I refer fewer patients to treatment since House Bill 1
- ◯ No change

16 Since implementation of House Bill 1 in July 2012, how many patients have you suspected of doctor shopping and/or diverting controlled substances as a result of information contained in KASPER reports?

- ◯ None
- ◯ 1 - 5
- ◯ 6 - 20
- ◯ >20

16a How has this changed since implementation of House Bill 1 in July 2012?

- ◯ I see more patients I suspect of doctor shopping since implementation of House Bill 1
- ◯ I see fewer patients I suspect of doctor shopping since implementation of House Bill 1
- ◯ No change

16a If "none", how has this changed since implementation of House Bill 1?

- ◯ I see fewer patients I suspect of doctor shopping since implementation of House Bill 1
- ◯ No change

17 Since implementation of HB1 in July 2012, how many patients have you refused to fill controlled substance prescriptions for as a result of information contained in KASPER reports?

- ◯ None
- ◯ 1 - 5
- ◯ 6 - 20
- ◯ >20

17a How has this changed since implementation of House Bill 1 in July 2012?

- ◯ I refuse to fill for more patients since House Bill 1
- ◯ I refuse to fill for fewer patients since House Bill 1
- ◯ No change

17a If "none", how has this changed since implementation of House Bill 1?
- ◯ I refuse to fill for fewer patients since House Bill 1
- ◯ No change

18 Since implementation of House Bill 1 in July 2012, how many times have you contacted law enforcement to report a case of possible doctor shopping or diversion?
- ◯ None
- ◯ 1 - 5
- ◯ 6 - 20
- ◯ >20

18a How has this changed since implementation of House Bill 1 in July 2012?
- ◯ I contact law enforcement more frequently since House Bill 1
- ◯ I contact law enforcement less frequently since House Bill 1
- ◯ No change

18a If "none", how has this changed since implementation of House Bill 1?
- ◯ I contact law enforcement less frequently since House Bill 1
- ◯ No change

19 Since implementation of House Bill 1, do you believe that your controlled substance dispensing behaviors are being monitored more closely by regulatory agencies?
- ◯ Yes
- ◯ No

19a Why? _____

20 On average, how many Schedule II controlled substance prescriptions (such as Oxycontin, hydrocodone, and hydromorphone) do you dispense per week? _____ (Number prescriptions dispensed)

21 Since the implementation of House Bill 1 in July 2012, my Schedule II controlled substance dispensing has...
- ◯ Not changed
- ◯ Increased
- ◯ Decreased

22 On average, how many Schedule III and/or IV controlled substance prescriptions (such as Tylenol #3, tramadol, carisoprodol, or alprazolam) do you dispense per week? _____ (Number prescriptions dispensed)

23 Since the implementation of House Bill 1 in July 2012, my Schedule III and/or IV controlled substance dispensing has...
- ◯ Not changed
- ◯ Increased
- ◯ Decreased

24 Thinking about your general dispensing patterns since implementation of House Bill 1, which of the following best describes your controlled substance dispensing:
- ◯ My controlled substance dispensing has not changed
- ◯ My controlled substance dispensing has increased
- ◯ My controlled substance dispensing has decreased
- ◯ I no longer dispense controlled substances because of House Bill 1

24a My controlled substance dispensing has increased because:
- ☐ I feel more confident in making controlled substance dispensing decisions
- ☐ Mandatory use of KASPER has increased patient referrals to my pharmacy
- ☐ My practice site has changed
- ☐ Other

((Select all that apply))

If "Other", please describe: _____

24a My controlled substance dispensing has decreased because:

- ☐ Policy changes within my pharmacy
- ☐ We receive fewer controlled substance prescriptions from prescribers
- ☐ Stigma created by media coverage of prescription drug abuse and diversion
- ☐ Implementation of House Bill 1 requiring mandatory use of KASPER
- ☐ Concern over increased law enforcement activity related to prescription drug abuse and diversion and law enforcement investigation of my pharmacy/practice
- ☐ Concern over licensing board investigation of my pharmacy/practice
- ☐ My practice site has changed
- ☐ Other

((Select all that apply))

If "Other", please describe: _____

24b If your dispensing has changed since the implementation of House Bill 1 in July 2012, has it impacted your ability to manage your patients' conditions?

- ◯ Yes, there has been a positive impact on my ability to help my patients manage their conditions.
- ◯ Yes, there has been a negative impact on my ability to help my patients manage their conditions.
- ◯ No, there has been no impact on my ability to help my patients manage their conditions.

Effectiveness is often defined as producing a desired result. To what extent do you feel KASPER is an effective tool to:

		Not effective at all	Somewhat ineffective	Neutral	Somewhat effective	Very effective
25a	Reduce drug abuse and diversion in Kentucky?	◯	◯	◯	◯	◯
25b	Reduce doctor shopping in Kentucky?	◯	◯	◯	◯	◯

26 Please provide any additional information on KASPER, impact of House Bill 1, or the Board of Pharmacy KASPER regulations that you would like to share.

House Bill 1 Evaluation: Law Enforcement Survey

investigator information:

Patricia Freeman, PhD

Phone: 859-323-1381

Email: trish.freeman@uky.edu

You are invited to participate in a survey collecting information and opinions related to changes in the Kentucky All Schedule Prescription Electronic Reporting (KASPER) system resulting from House Bill 1 passed during the 2012 legislative session. This survey is part of a research project funded by the Kentucky Cabinet for Health and Family Services being conducted at the University of Kentucky Institute for Pharmaceutical Outcomes and Policy.

You have been asked to participate in this survey because you are a prescriber, pharmacist or law enforcement official with a KASPER account. If you voluntarily complete the survey, you will be one of approximately 7,000 KASPER registrants to do so. The survey will take approximately 15 minutes to complete.

The survey asks about your experience using KASPER, your opinions about controlled-substances, and general demographic information. The information generated from this research will assist with the evaluation of the impact of KASPER changes related to House Bill 1.

The only potential risk associated with completing this survey is the very small risk of loss of confidentiality of your responses to the survey items. The research team will not attempt to trace responses back to individuals. Neither the researchers nor the Cabinet for Health and Family Services will know who did, or did not, respond to the survey. There are no known risks associated with disclosure of your opinions about KASPER.

You may receive two additional email invitations to participate in this survey over the next two weeks if you did not initially respond to the survey. If you elect not to respond to the survey, please ignore these additional emails.

Taking part in this research is completely voluntary. If you choose not to participate, there will be no penalty to you. You are free to skip any question that you do not want to answer and you can discontinue the survey at any time. Although you will not personally benefit by completing the survey the information that you provide may help improve the KASPER program.

This study has been reviewed by the University of Kentucky Medical Institutional Review Board. If you have questions about this study, you may call Patricia Freeman at 859-323-1381. If you have any questions about your rights as a volunteer in this research, you may contact the staff in the Office of Research Integrity at the University of Kentucky at 859-257-9428 or toll free at 1-866-400-9428.

Thank you for your time and we appreciate your consideration in completing this survey.

Sincerely,

Patricia Freeman, PhD

Associate Professor

University of Kentucky College of Pharmacy

Section I: Demographic Information

1 What best describes your professional role?

- ◯ City/County Law Enforcement
- ◯ State Law Enforcement
- ◯ Sheriff
- ◯ Drug Enforcement Administration (DEA)
- ◯ Regulatory Agency (Licensing Board, Medicaid, Drug Control, etc.)
- ◯ Prosecutor
- ◯ Other

If "other", please describe: _____

2 What is the Kentucky county in which you currently work? (If you have jurisdiction in more than one county, please report the one in which you spend the majority of your time.)

- ◯ Adair
- ◯ Allen
- ◯ Anderson
- ◯ Ballard
- ◯ Barren
- ◯ Bath
- ◯ Bell
- ◯ Boone
- ◯ Bourbon
- ◯ Boyd
- ◯ Boyle
- ◯ Bracken
- ◯ Breathitt
- ◯ Breckenridge
- ◯ Bullitt
- ◯ Butler
- ◯ Caldwell
- ◯ Calloway
- ◯ Campbell
- ◯ Carlisle
- ◯ Carroll
- ◯ Carter
- ◯ Casey
- ◯ Christian
- ◯ Clark
- ◯ Clay
- ◯ Clinton
- ◯ Crittenden
- ◯ Cumberland
- ◯ Daviess
- ◯ Edmonson
- ◯ Elliot
- ◯ Estill
- ◯ Fayette
- ◯ Fleming
- ◯ Floyd
- ◯ Franklin
- ◯ Fulton
- ◯ Gallatin
- ◯ Garrard
- ◯ Grant
- ◯ Graves
- ◯ Grayson
- ◯ Green
- ◯ Greenup
- ◯ Hancock
- ◯ Hardin
- ◯ Harlan
- ◯ Harrison
- ◯ Hart
- ◯ Henderson
- ◯ Henry
- ◯ Hickman
- ◯ Hopkins
- ◯ Jackson
- ◯ Jefferson
- ◯ Jessamine
- ◯ Johnson
- ◯ Kenton
- ◯ Knott
- ◯ Knox
- ◯ Larue
- ◯ Laurel
- ◯ Lawrence
- ◯ Lee
- ◯ Leslie
- ◯ Letcher
- ◯ Lewis
- ◯ Lincoln
- ◯ Livingston

- ◯ Logan
- ◯ Lyon
- ◯ Madison
- ◯ Magoffin
- ◯ Marion
- ◯ Marshall
- ◯ Martin
- ◯ Mason
- ◯ McLean
- ◯ McCracken
- ◯ McCreary
- ◯ Meade
- ◯ Menifee
- ◯ Mercer
- ◯ Metcalfe
- ◯ Monroe
- ◯ Montgomery
- ◯ Morgan
- ◯ Muhlenberg
- ◯ Nelson
- ◯ Nicholas
- ◯ Ohio
- ◯ Oldham
- ◯ Owen
- ◯ Owsley
- ◯ Pendleton
- ◯ Perry
- ◯ Pike
- ◯ Powell
- ◯ Pulaski
- ◯ Robertson
- ◯ Rockcastle
- ◯ Rowan
- ◯ Russell
- ◯ Scott
- ◯ Shelby
- ◯ Simpson
- ◯ Spencer
- ◯ Taylor
- ◯ Todd
- ◯ Trigg
- ◯ Trimble
- ◯ Union
- ◯ Warren
- ◯ Washington
- ◯ Wayne
- ◯ Webster
- ◯ Whitley
- ◯ Wolfe
- ◯ Woodford

3 What is the zip code of the Kentucky city/county in which you currently work? (If you have jurisdiction in more than one city/county, please report the one in which you spend the majority of your time.)

_____
(zip code)

4 How many years have you served in your present position?

_____
(Number of years)

Section II: Questions about Your Use of KASPER

5 Do you request reports from KASPER?

◯ Yes, I request reports from KASPER myself
◯ Yes, but someone else requests reports on my behalf
◯ No, I do not request reports from KASPER

5a What is the primary reason you have not requested KASPER reports?

◯ I am not assigned to drug diversion cases
◯ I do not believe it is a useful tool for my cases

5b Why do you find KASPER is not a useful tool?

_____

Section III: Utilization and Value of Individual KASPER Reports

6 Approximately how many KASPER reports have you utilized in the past one (1) month? (If none, enter 0.)

_____
(Number of reports)

6a In general, I use the information in KASPER reports:

☐ To confirm/support my decisions to pursue investigations
☐ To confirm/support my decisions to close or dismiss pursuit of investigations
☐ In some other way
((Select all that apply))

If you use reports in some other way, please describe:

_____

7 I am confident in the accuracy of the information in a KASPER report.

◯ Strongly agree
◯ Somewhat agree
◯ Neutral
◯ Somewhat disagree
◯ Strongly disagree

8 I am confident in my ability to interpret information found in a KASPER report.

◯ Strongly agree
◯ Somewhat agree
◯ Neutral
◯ Somewhat disagree
◯ Strongly disagree

Section IV: Impact and Effectiveness of House Bill 1

House Bill 1 (HB1) was a law effective as of July 2012 that required prescribers and pharmacists to register with KASPER, and required prescribers to query the KASPER system for reports on their patients before prescribing for certain conditions.

9 Since House Bill 1 (HB1) became effective, do you utilize KASPER reports...
- ◯ More often than before HB1
- ◯ Less often than before HB1
- ◯ No change in how often I utilize KASPER reports since HB1

10 On average, how many cases dealing with prescription drug abuse and diversion do you investigate annually?
_____
(Number of cases investigated annually)

11 Since implementation of HB1 in July 2012, the total number of drug abuse and diversion cases I investigate has:
- ◯ Increased
- ◯ Decreased
- ◯ No change

12 Since implementation of HB1 in July 2012, the number of drug abuse and diversion cases I investigate related to individual patients has:
- ◯ Increased
- ◯ Decreased
- ◯ No change

13 Since implementation of HB1 in July 2012, the number of drug abuse and diversion cases I investigate related to inappropriately prescribing physicians has:
- ◯ Increased
- ◯ Decreased
- ◯ No change

14 Since implementation of HB1 in July 2012, the number of drug abuse and diversion cases I investigate related to inappropriately prescribing dentists has:
- ◯ Increased
- ◯ Decreased
- ◯ No change

15 Since implementation of HB1 in July 2012, the number of drug abuse and diversion cases I investigate related to inappropriately prescribing nurse practitioners has:
- ◯ Increased
- ◯ Decreased
- ◯ No change

16 Since implementation of HB1 in July 2012, the number of drug abuse and diversion cases I investigate related to inappropriately dispensing pharmacists/pharmacies has:
- ◯ Increased
- ◯ Decreased
- ◯ No change

17 In your experience, do you believe some pharmacies have altered their stocking and/or dispensing of controlled prescription drugs (Schedule II-V) as a result of HB1?
- ◯ Yes
- ◯ No

17a Why do you believe some pharmacies have altered their stocking and dispensing of controlled prescription drugs (Schedule II-V) as a result of HB1?
_____

17a Why do you believe some pharmacies have not altered their stocking and dispensing of controlled prescription drugs (Schedule II-V) as a result of HB1?
_____

18 In your experience, do you believe some prescribers have altered their prescribing of controlled prescription drugs (Schedule II-V) as a result of HB1?
- ◯ Yes
- ◯ No

18a Why do you believe some prescribers have altered their prescribing of controlled prescription drugs (Schedule II-V) as a result of HB1?
_____

18a Why do you believe some prescribers have not altered their prescribing of controlled prescription drugs (Schedule II-V) as a result of HB1?
_____

19 Since implementation of HB1 in July 2012, how many prescribers (doctors, dentists, APRNs) have contacted you to report a patient they suspect is doctor-shopping or diverting controlled substances?

- ◯ None
- ◯ 1 - 5
- ◯ 6 - 20
- ◯ Greater than 20

19a How has this changed since implementation of House Bill 1 in July 2012?

- ◯ I am contacted by prescribers more frequently since HB1
- ◯ I am contacted by prescribers less frequently since HB1
- ◯ No change

19a If "none", how has this changed since the implementation of HB1?

- ◯ I am contacted by prescribers less frequently since HB1
- ◯ No change

20 Since implementation of HB1, how many pharmacists have contacted you to report a patient they suspect is doctor-shopping or diverting controlled substances?

- ◯ None
- ◯ 1 - 5
- ◯ 6 - 20
- ◯ Greater than 20

20a How has this changed since implementation of House Bill 1 in July 2012?

- ◯ I am contacted by pharmacists more frequently since HB1
- ◯ I am contacted pharmacists less frequently since HB1
- ◯ No change

20a If "none", how has this changed since implementation of HB1?

- ◯ I am contacted by pharmacists less frequently since HB1
- ◯ No change

Section V: Effectiveness of KASPER

Effectiveness is often defined as producing a desired result. To what extent do you feel KASPER is an effective tool to...

		Not effective at all	Somewhat ineffective	Neutral	Somewhat effective	Very effective
21a	Reduce doctor shopping in Kentucky?	◯	◯	◯	◯	◯
21b	Reduce prescription drug abuse and diversion in Kentucky?	◯	◯	◯	◯	◯

22 How has doctor shopping changed since HB1 took effect July 2012?

- ◯ Significant increase in doctor shopping
- ◯ Slight increase in doctor shopping
- ◯ No change in doctor shopping
- ◯ Slight decrease in doctor shopping
- ◯ Significant decrease in doctor shopping

23 Please provide any additional feedback on KASPER or the impact of HB1 you would like to share.

_____

APPENDIX VI: Survey Results

PRESCRIBER SURVEY RESULTS

Total E-mails Sent:	17,440
Total Responses:	1,479
Bounced & inappropriate e-mails:	
Final Response Rate:	8.480504587

SECTION I: Demographic Information

1. I am licensed to practice as:

Response	*Frequency*	*%*
MD	1,040	73.76%
DO	86	6.10%
DMD	276	19.57%
DVM	0	0.00%
APRN	8	0.57%
Total	1,410	100%

2. Total number of years in practice, including internship and residency

Mean years (Standard Deviation)	22.92 years	SD= 12.04
Range	0 minimum	68 maximum
Median years (Interquartile Range)	23 years	IQR= 13 to 33

3. On average, across all practice sites, how many patients do you see a day?

Mean patients (SD)	22.82 patients	SD=17.31
Range	0 minimum	350 maximum
Median patients (IQR)	20 patients	IQR=15 to 30

4. What is the Kentucky county where you currently practice?

*Collapsed to region

Region	*Frequency*	*%*
1		
2		
3		
4		
5		
6		
7		
8		
Total		

4b. What is the zip code of the Kentucky address where you practice?

Summary:

1,324 responses

13 zip codes from outside of Kentucky

5. What best describes your specialty?

Response	*Frequency*	*%*
Internal Medicine	136	9.66%
Neurology	13	0.92%
Emergency Medicine	151	10.72%
Palliative/Hospice Care	8	0.57%
Pediatrics	86	6.11%
Family Practice	260	18.47%
Orthopedics	41	2.91%
Surgery	102	7.24%
Psychiatry	61	4.33%
Other	550	39.06%
Total	**1,408**	**99.99%**

"Other" specialties:

537 text responses

Section II: Questions about Your Practice

6. Did you have a KASPER account prior to the HB1 mandate, which was effective as of July 2012?

Response	*Frequency*	*%*
Yes	712	55.71%
No	566	44.29%
Total	**1,278**	**100%**

6a. If yes, how long prior to the mandate in July 2012 had you held a KASPER account?

Response	*Frequency*	*%*
Less than one year	91	12.87%
Between one and two years	164	23.20%
Between three and five years	216	30.55%
Between six and ten years	158	22.35%
Longer than ten years	78	11.03%
Total	**707**	**100%**

7. Who usually requests KASPER reports at your office?

Response	*Frequency*	*%*
I request reports myself	550	42.90%
My delegate requests reports	459	35.80%
The delegate for the practice or facility requests reports	199	15.52%
Other	74	5.77%
Total	**1,282**	**100%**

If "other" requests reports, please describe:

70 text responses were entered

Most frequent response: "I do not prescribe CS"

8. How often do you discuss KASPER reports with patients?		
Response	*Frequency*	*%*
Frequently	302	23.59%
Sometimes	434	33.91%
Rarely	360	28.13%
Never	184	14.38%
Total	**1,280**	**100%**

8a. How has this changed since implementation of HB1?		
Response	*Frequency*	*%*
I discuss KASPER reports with my patients more frequently since HB1	527	41.43%
I discuss KASPER reports with my patients less frequently since HB1	20	1.57%
No change	725	57%
Total	**1,272**	**100%**

9. How often do you discuss KASPER reports with other practitioners?		
Response	*Frequency*	*%*
Frequently	132	10.39%
Sometimes	400	31.47%
Rarely	491	38.63%
Never	248	19.51%
Total	1,271	100%

9a. How has this changed since implementation of HB1?		
Response	*Frequency*	*%*
I discuss KASPER reports with other practitioners more frequently since HB1	322	25.56%
I discuss KASPER reports with other practitioners less frequently since HB1	16	1.27%
No change	922	73.17%
Total	1,260	100%

10. How often do you discuss KASPER reports with pharmacists?		
Response	*Frequency*	*%*
Frequently	47	3.68%
Sometimes	284	22.24%
Rarely	535	41.90%
Never	411	32.18%
Total	**1,277**	**100%**

10a. How has this changed since implementation of HB1?

Response	*Frequency*	*%*
I discuss KASPER reports with pharmacists more frequently since HB1	210	16.84%
I discuss KASPER reports with pharmacists less frequently since HB1	23	1.84%
No change	1,014	81.32%
Total	**1,247**	**100%**

11. Approximately how many KASPER reports have you utilized in the past one (1) week?

Mean (SD)	13.42 reports	SD=87.47
Range	0 minimum	3,000 maximum
Median (IQR)	3 reports	IQR= 0 to 240

11a. Of these reports, how many confirmed your decision to prescribe a controlled substance?

Mean (SD)	14.92 reports	SD=105.61
Range	0 minimum	2,900 maximum
Median (IQR)	5 reports	IQR=0 to 200

11b. Of these reports, how many changed your decision such that you did NOT prescribe a controlled substance?

Mean (SD)	1.41 reports	SD=5.22
Range	0 minimum	100 maximum
Median (IQR)	0 reports	IQR=0 to 30

11c. Of these reports, how many changed your decision on the TYPE of controlled substance to prescribe?

Mean (SD)	1.54 reports	SD=19.01
Range	0 minimum	515 maximum
Median (IQR)	0 reports	IQR=0 to 45

11d. Of these reports, how many did NOT impact your prescribing decision?

Mean (SD)	14.46 reports	SD=106.98
Range	0 minimum	2,900 maximum
Median (IQR)	4 reports	IQR=0 to 221

12. I am confident in the accuracy of the information in a KASPER report.

Response	*Frequency*	*%*
Strongly agree	467	36.83%
Somewhat agree	507	39.98%
Neutral	200	15.77%
Somewhat disagree	74	5.84%
Strongly disagree	20	1.58%
Total	**1,268**	**100%**

13. Since implementation of HB1 in July 2012, how many patients have you referred to substance abuse treatment as a result of KASPER reports?

Response	*Frequency*	*%*
None*	903	71.78%
1 to 5	233	18.52%
6 to 20	67	5.33%
>20	55	4.37%
Total	**1,258**	**100%**

*If "none" is selected, respondent is re-directed to 13a (alt).

13a. How has this changed since implementation of HB1 in July 2012?

Response	*Frequency*	*%*
I am referring more patients to treatmer	125	10.04%
I am referring fewer patients to treatme	19	1.53%
No change	1,101	88.43%
Total	**1,245**	**100%**

14. Since implementation of HB1 in July 2012, how many patients have you suspected of doctor shopping and/or diverting controlled substances as a result of information contained in KASPER reports?

Response	*Frequency*	*%*
None*	384	30.40%
1 to 5	470	37.21%
6 to 20	214	16.94%
>20	195	15.44%
Total	**1,263**	**100%**

*If "none" is selected, respondent is re-directed to 14a (alt).

14a. How has this changed since implementation of HB1 in July 2012?

Response	*Frequency*	*%*
I see more patients I suspect of doctor sl	190	15.14%
I see fewer patients I suspect of doctor s	197	15.70%
No change	868	69.16%
Total	**1,255**	**100%**

15. Since implementation of HB1 in July 2012, how many patients have you dismissed from your practice as a result of information contained in KASPER reports?

Response	*Frequency*	*%*
None*	883	70.19%
1 to 5	265	21.07%
6 to 20	65	5.17%
>20	45	3.58%
Total	**1,258**	**100%**

*If "none" is selected, respondent is re-directed to 15a (alt).

15a. How has this changed since implementation of HB1 in July 2012?

Response	*Frequency*	*%*
The number of patients dismissed from	152	12.21%
The number of patients dismissed from	28	2.25%
No change	1,065	85.54%
Total	**1,245**	**100%**

16. Since implementation of HB1 in July 2012, how many times have you contacted law enforcement to report a case of possible doctor shopping or diversion?

Response	*Frequency*	*%*
None*	1,020	80.82%
1 to 5	218	17.27%
6 to 20	19	1.51%
>20	5	0.40%
Total	**1,262**	**100%**

*If "none" is selected, respondent is re-directed to 16a (alt).

16a. How has this changed since implementation of HB1 in July 2012?

Response	*Frequency*	*%*
I contact law enforcement more frequer	63	5.04%
I contact law enforcement less frequentl	41	3.28%
No change	1,147	91.69%
Total	**1,251**	**100%**

17. Since implementation of HB1, do you believe that your controlled substance prescribing behaviors are being monitored more closely by regulatory agencies?

Response	*Frequency*	*%*
Yes	923	73.66%
No	320	26.34%
Total	**1,253**	**100%**

17a. Why?

909 text responses were submitted

18. On average, how many Schedule II CS prescriptions (such as Oxycontin, hydrocodone, and hydromorphone) do you prescribe per week?

Response	*Frequency*	*%*
None	360	28.64%
1 to 10	583	46.38%
11 to 20	187	14.88%
21 to 30	67	5.33%
>30	60	4.77%
Total	**1,257**	**100%**

19. Since the implementation of HB1 in July 2012, my Schedule II CS prescribing has…

Response	*Frequency*	*%*
Not changed	830	66.24%
Increased	29	2.31%
Decreased	394	31.44%
Total	**1,253**	**100%**

20. On average, how many Schedule III and/or IV CS prescriptions (such as Tylenol #3, tramadol, carisoprodol, or alprazolam) do you prescribe per week?

Response	*Frequency*	*%*
None	392	31.21%
1 to 10	618	49.20%
11 to 20	151	12.02%
21 to 30	50	3.98%
>30	45	3.58%
Total	**1,256**	**100%**

21. Since the implementation of HB1 in July 2012, my Schedule III and/or IV CS prescribing has…

Response	*Frequency*	*%*
Not changed	909	72.43%
Increased	91	7.25%
Decreased	255	20.32%
Total	**1,255**	**100%**

22. Prior to HB1, did you DISPENSE CS prescriptions from your office?

Response	*Frequency*	*%*
Yes	155	12.36%
No	1,099	87.64%
Total	**1,254**	**100%**

22a. If yes, on average, how many CS prescriptions did you dispense from your office per week?

Mean (SD)	10.89 prescription	SD=17.69
Range	0 minimum	150 maximum
Median (IQR)	5 prescriptions	IQR=0 to 60

23. Thinking about your general prescribing patterns since implementation of HB1, which of the following best describes your CS prescribing:

Response	*Frequency*	*%*
My CS prescribing has not changed	761	60.78%
My CS prescribing has increased	28	2.24%
My CS prescribing has decreased	418	33.39%
I no longer prescribe CS because of HB1	45	3.59%
Total	**1,252**	**100%**

23a. (alt: increased) My CS prescribing has increased because:

Response	*Frequency*	*%*
I feel more confident in making CS presc	5	14.71%
Mandatory use of KASPER has increased	10	29.41%
My patient population has changed	12	35.29%
Other	7	20.59%
Total	**34**	**100%**

If increased due to "Other":
7 text responses were collected

23a. (alt: decreased) My CS prescribing has decreased because:

Response	*Frequency*	*%*
I refer more patients to pain manageme	135	15.50%
Stigma created by media coverage of pr	72	8.27%
Implementation of HB1 requiring manda	193	22.16%
Implementation of HB1 requiring manda	150	17.22%
Concern about increased law enforceme	107	12.28%
Concern over licensing board investigati	107	12.28%
My patient population has changed	54	6.20%
Other	53	6.09%
Total	**871**	**100.00%**

If decreased due to "other", please describe:
51 text responses were submitted

23b. If your prescribing has changed since the implementation of HB1 in July 2012, has it impacted your ability to manage your patients' conditions?

Response	*Frequency*	*%*
Yes, there has been a positive impact on	92	18.93%
Yes, there has been a negative impact or	209	43.00%
No, there has been no impact on my abi	185	38.07%
Total	**486**	**100%**

Section III: Perceptions about CS Prescribing Regulations and CS Prescribing

I am confident in my understanding of each of the following….

24a. …when to request an initial KASPER report.

Response	*Frequency*	*%*
Strongly disagree	97	8.04%
Somewhat disagree	53	4.39%
Neutral	108	8.96%
Somewhat agree	338	28.03%
Strongly agree	610	50.58%
Total	**1,206**	**100%**

24b. …prescribing standards for controlled substances.

Response	*Frequency*	*%*
Strongly disagree	93	7.70%
Somewhat disagree	57	4.72%
Neutral	107	8.89%
Somewhat agree	433	35.84%
Strongly agree	518	42.88%
Total	**1,208**	**100%**

24c. …assessment and treatment standards for conditions requiring controlled substances.

Response	*Frequency*	*%*
Strongly disagree	91	7.56%
Somewhat disagree	63	5.23%
Neutral	130	10.80%
Somewhat agree	419	34.80%
Strongly agree	501	41.61%
Total	**1,204**	**100%**

24d. …obtaining written consent for treatment.

Response	*Frequency*	*%*
Strongly disagree	99	8.22%
Somewhat disagree	96	7.97%
Neutral	215	17.84%
Somewhat agree	337	27.97%
Strongly agree	458	38.01%
Total	**1,205**	**100%**

24e. …how often to order KASPER reports during continuing therapy.

Response	*Frequency*	*%*
Strongly disagree	95	7.92%
Somewhat disagree	115	9.59%
Neutral	234	19.52%
Somewhat agree	358	29.86%
Strongly agree	397	33.11%
Total	**1,199**	**100%**

24f. …exit strategies for long-term treatment with controlled substances.

Response	*Frequency*	*%*
Strongly disagree	115	9.66%
Somewhat disagree	169	14.20%
Neutral	370	31.09%
Somewhat agree	300	25.21%
Strongly agree	236	19.83%
Total	**1,190**	**100%**

25. I am confident in my ability to make prescribing decisions for the treatment of chronic pain that are in line with current guidelines and recommendations.

Response	*Frequency*	*%*
Strongly disagree	195	16.33%
Somewhat disagree	155	12.98%
Neutral	326	27.30%
Somewhat agree	262	21.94%
Strongly agree	256	21.44%
Total	**1,194**	**100%**

26. I am confident in my ability to interpret information found in a KASPER report.

Response	*Frequency*	*%*
Strongly disagree	260	21.56%
Somewhat disagree	99	8.21%
Neutral	81	6.72%
Somewhat agree	244	20.23%
Strongly agree	522	43.28%
Total	**1,206**	**100%**

27. I am confident in my decisions on when to order urine drug screenings.

Response	*Frequency*	*%*
Strongly disagree	205	17.20%
Somewhat disagree	175	14.68%
Neutral	293	24.58%
Somewhat agree	231	19.38%
Strongly agree	288	24.16%
Total	**1,192**	**100%**

28. I am confident in my ability to interpret urine drug screen results for treatment decisions.

Response	*Frequency*	*%*
Strongly disagree	217	18.19%
Somewhat disagree	157	13.16%
Neutral	258	21.63%
Somewhat agree	236	19.78%
Strongly agree	325	27.24%
Total	1,193	100%

Effectiveness is often defined as producing a desired result. To what extent do you feel KASPER is an effective tool to:

29a. Reduce drug abuse and diversion in Kentucky?

Response	*Frequency*	*%*
Not effective at all	161	13.41%
Somewhat ineffective	121	10.07%
Neutral	198	16.49%
Somewhat effective	521	43.38%
Very effective	200	16.65%
Total	**1,201**	**100%**

29b. Reduce doctor shopping in Kentucky?		
Response	*Frequency*	*%*
Not effective at all	70	5.87%
Somewhat ineffective	100	8.39%
Neutral	191	16.02%
Somewhat effective	541	45.39%
Very effective	290	24.33%
Total	**1,192**	**100%**

30. Please provide any additional information on KASPER, the impact of HB1, or your licensure board's prescribing regulations that you would like to share.

608 comments were submitted

Comments are compiled and summarized in another sheet.

PHARMACIST SURVEY RESULTS

Total E-mails Sent:	5,521
Total Responses:	534
Bounced & inappropriate e-mails:	
Final Response Rate:	9.67216084

SECTION I: Demographic Information

1. My terminal degree is:

Response	*Frequency*	*%*
BSPharm	198	38.82%
PharmD	312	61.18%
Total	510	100%

2. Total number of years in practice, including residency:

Mean (SD)	17.30 years	SD=13.48
Range	0.5 minimum	57 maximum
Median (IQR)	14 years	IQR=1 to 54

3. My practice site is:

Response	*Frequency*	*%*
Independent pharmacy	137	26.81%
Chain pharmacy	146	28.57%
Supermarket/mass merchandiser pharmacy	55	10.76%
Hospital pharmacy	100	19.57%
Long-term care pharmacy	22	4.31%
Other	51	9.98%
Total	511	100%

If "Other" practice site, please describe:

49 responses submitted to other

4. On average, how many prescriptions are dispensed DAILY at your pharmacy?

Mean (SD)	496.70 prescr	SD=916.45
Range	0 minimum	10,000 maximum
Median (IQR)	300 prescrip-t	IQR=160 to 467.5

4a. Of these, how many are controlled substances?

Mean (SD)	97.08 prescri	SD=170.70
Range	0 minimum	2,000 maximum
Median (IQR)	50 prescriptio	IQR=30 to 100

5a. What is the Kentucky county where you currently practice?

**Collapsed to region*

Response	*Frequency*	*%*
1		
2		
3		
4		
5		
6		
7		
8		
Total	482	

5b. What is the zip code of the Kentucky address where you currently practice?

478 total zip codes reported

3 are outside of Kentucky

Section II: Questions about Your Practice

6. Did you have a KASPER account prior to the HB1 mandate, which was effective as of July 2012?

Response	*Frequency*	*%*
Yes	222	57.81%
No	162	42.19%
Total	384	100%

6a. If yes, how long prior to the mandate in July 2012 had you held a KASPER account?

Response	*Frequency*	*%*
Less than one year	34	15.53%
Between one and two years	60	27.40%
Between three and five years	61	27.85%
Between six and ten years	49	22.37%
Longer than ten years	15	6.85%
Total	219	100%

7. Who usually requests KASPER reports at your practice? *May select all that apply*

Response	*Frequency*	*%*
I request reports myself	297	64.15%
My technician requests reports	18	3.89%
Another pharmacist at the practice requests reports	87	18.79%
Other	61	13.17%
Total	463	100%

If "Other", please describe:

59 responses submitted

Most common response: "a physician"

8. How often do you discuss KASPER reports with patients?

Response	*Frequency*	*%*
Frequently	9	2.32%
Sometimes	71	18.30%
Rarely	172	44.33%
Never	136	35.05%
Total	388	100%

8a. How has this changed since the implementation of HB1 in July 2012?

Response	*Frequency*	*%*
I discuss KASPER reports with my patients more frequently since HB1	62	16.40%
I discuss KASPER reports with my patients less frequently since HB1	2	0.53%
No change	314	83.07%
Total	378	100%

9. How often do you discuss KASPER reports with prescribers?

Response	*Frequency*	*%*
Frequently	31	8.07%
Sometimes	198	8.07%
Rarely	125	32.55%
Never	30	7.81%
Total	384	100%

9a. How has this changed since the implementation of HB1 in July 2012?

Response	*Frequency*	*%*
I discuss KASPER reports with prescribers more frequently since HB1	130	34.30%
I discuss KASPER reports with prescribers less frequently since HB1	4	1.63%
No change	245	64.64%
Total	379	100%

10.How often do you discuss KASPER reports with other pharmacists?

Response	*Frequency*	*%*
Frequently	38	9.90%
Sometimes	142	36.98%
Rarely	149	38.80%
Never	55	14.32%
Total	384	100%

10a. How has this changed since the implementation of HB1 in July 2012?

Response	*Frequency*	*%*
I discuss KASPER reports with other pharmacists more frequently since HB1	72	19.35%
I discuss KASPER reports with other pharmacists less frequently since HB1	5	1.34%
No change	295	79.30%
Total	372	100%

11. Approximately how many KASPER reports have you utilized in the past one (1) week?

Mean (SD)	3.09 reports	SD=6.75
Range	0 minimum	50 maximum
Median (IQR)	1 report	IQR=0 to 45

11a. Of these reports, how many confirmed your decision to dispense a controlled substance?

Mean (SD)	4.76 reports	SD=7.47
Range	0 minimum	50 maximum
Median (IQR)	2 reports	IQR=0 to 35

11b. Of these reports, how many changed your decision such that you did NOT dispense a controlled substance?

Mean (SD)	0.64 reports	SD=1.31
Range	0 minimum	10 maximum
Median (IQR)	0 reports	IQR=0 to 5

11c. Of these reports, how many did NOT impact your dispensing decision?

Mean (SD)	1.73 reports	SD=6.50
Range	0 minimum	50 maximum
Median (IQR)	0 reports	IQR=0 to 22

12. I am confident in the accuracy of the information in a KASPER report.

Response	*Frequency*	*%*
Strongly agree	159	41.09%
Somewhat agree	180	46.51%
Neutral	29	7.49%
Somewhat disagree	15	3.88%
Strongly disagree	4	1.03%
Total	387	100%

13. I am confident in my ability to interpret information found in a KASPER report.

Response	*Frequency*	*%*
Strongly agree	308	79.79%
Somewhat agree	56	14.51%
Neutral	20	5.18%
Somewhat disagree	0	0%
Strongly disagree	2	0.52%
Total	386	100%

14. Since implementation of HB1 in July 2012, how many times have you contacted a prescriber to discuss a patient's potential substance abuse issue or problem?

Response	*Frequency*	*%*
None*	87	22.83%
1 to 5	166	43.57%
6 to 20	90	23.62%
>20	38	9.97%
Total	381	100%

*If "none" is selected, respondent is re-directed to 14a (alt).

14a. How has this changed since implementation of HB1?

Response	*Frequency*	*%*
I contact prescribers more frequently si	96	25.53%
I contact prescribers less frequently sin	18	4.79%
No change	262	69.68%
Total	376	100%

15. Since implementation of HB1 in July 2012, how many patients have you referred to substance abuse treatment as the result of KASPER reports?

Response	*Frequency*	*%*
None*	352	92.15%
1 to 5	24	6.28%
6 to 20	2	0.52%
>20	4	1.05%
Total	382	100%

*If "none" is selected, respondent is re-directed to 15a (alt).

15a. How has this changed since implementation of HB1?

Response	*Frequency*	*%*
I refer more patients to treatment since HB1	12	3.17%
I refer fewer patients to treatment since HB1	3	0.79%
No change	363	96.03%
Total	378	100%

16. Since implementation of HB1 in July 2012, how many patients have you suspected of doctor shopping and/or diverting CS as a result of information contained in KASPER reports?

Response	*Frequency*	*%*
None*	82	21.64%
1 to 5	178	46.97%
6 to 20	74	19.53%
>20	45	11.87%
Total	379	100%

*If "none" is selected, respondent is re-directed to 16a (alt).

16a. How has this changed since implementation of HB1?

Response	*Frequency*	*%*
I see more patients I suspect of doctor shopping since implementation of HB1	57	15.36%
I see fewer patients I suspect of doctor shopping since implementation of HB1	97	26.15%
No change	217	58.49%
Total	371	100%

17. Since implementation of HB1 in July 2012, how many patients have you refused to fill CS prescriptions for as a result of information contained in KASPER reports?

Response	*Frequency*	*%*
None*	112	29.71%
1 to 5	150	39.79%
6 to 20	78	20.69%
>20	37	9.81%
Total	377	100%

*If "none" is selected, respondent is re-directed to 17a (alt).

17a. How has this changed since implementation of HB1?

Response	*Frequency*	*%*
I refuse to fill for more patients since HB1	87	23.39%
I refuse to fill for fewer patients since HB1	28	7.53%
No change	257	69.09%
	372	100%

18. Since implementation of HB1 in July 2012, how many times have you contacted law enforcement to report a case of possible doctor shopping or diversion?

Response	*Frequency*	*%*
None*	274	73.07%
1 to 5	95	25.33%
6 to 20	4	1.07%
>20	2	0.53%
Total	375	100%

*If "none" is selected, respondent is re-directed to 18a (alt).

18a. How has this changed since implementation of HB1?

Response	*Frequency*	*%*
I contact law enforcement more frequently since HB1	19	5.14%
I contact law enforcement less frequently since HB1	23	6.22%
No change	328	88.65%
Total	370	100%

19. Since implementation of HB1, do you believe that your CS dispensing behaviors are being monitored more closely by regulatory agencies?

Response	*Frequency*	*%*
Yes	223	59.79%
No	150	40.21%
Total	373	100%

19a. Why?

258 responses were submitted (summarized in supplemental documents)

20. On average, how many Schedule II CS prescriptions (such as Oxycontin, hydrocodone, and hydromorphone) do you dispense per week?

Mean (SD)	153.00 prescr	SD=247.10
Range	0 minimum	2,000 maximum
Median (IQR)	75 prescriptio	IQR=30 to 1,250

21. Since the implementation of HB1 in July 2012, my Schedule II CS dispensing has…

Response	*Frequency*	*%*
Not changed	215	59.56%
Increased	88	24.38%
Decreased	58	16.07%
Total	361	100%

22. On average, how many Schedule II and/or IV CS prescriptions (such as Tylenol #3, tramadol, carisoprodol, or alprazolam) do you dispense per week?

Mean (SD)	165.07 prescr SD=224.09
Range	0 minimum 2,000 maximum
Median (IQR)	100 prescripti IQR=0 to 1,000

23. Since the implementation of HB1 in July 2012, my Schedule III and/or IV CS dispensing has…

Response	*Frequency*	*%*
Not changed	261	72.50%
Increased	40	11.11%
Decreased	59	16.39%
Total	360	100%

24. Thinking about your general dispensing patterns since implementation of HB1, which of the following best describes your CS dispensing:

Response	*Frequency*	*%*
My CS dispensing has not changed	250	68.49%
My CS dispensing has increased	38	10.41%
My CS dispensing has decreased	76	20.82%
I no longer dispense CS because of HB1	1	0.27%
Total	365	100%

24a. (increased-alt.) My CS dispensing has increased because:

Response	*Frequency*	*%*
I feel more confident in making CS dispensing decisions	17	37.78%
Mandatory use of KASPER has increased patient referrals to my pharmacy	5	11.11%
My practice site has changed	8	17.78%
Other	15	33.33%
Total	45	100%

24a. (increased-alt) If "Other", please describe:

14 responses were submitted

24a. (decreased-alt.) My CS dispensing has decreased because:

Response	*Frequency*	*%*
Policy changes within my pharmacy	26	18.18%
We receive fewer CS prescriptions from prescribers	52	36.36%
Stigma created by media coverage of prescription drug abuse and diversion	10	6.99%

Implementation of HB1 requiring mandatory use of KASPER	28	19.58%
Concern over increased law enforcement activity related to prescription drug abuse and diversion and law enforcement investigation of my pharmacy/practice	10	6.99%
Concern over licensing board investigation of my pharmacy/practice	7	4.90%
My practice site has changed	6	4.20%
Other	4	2.80%
Total	143	100%

24a. (decreased- alt.) If "Other", please describe:
4 responses were submitted

24b. If your dispensing has changed since the implementation of HB1 in July 2012, has it impacted your ability to manage your patients' conditions?

Response	*Frequency*	*%*
Yes, there has been a positive impact on my ability to help my patients manage their conditions.	44	39.64%
Yes, there has been a negative impact on my ability to help my patients manage their conditions.	16	14.41%
No, there has been no impact on my ability to help my patients manage their conditions.	51	45.95%
Total	111	100%

Effectiveness is often defined as producing a desired result. To what extent do you feel KASPER is an effective tool to:

25a. Reduce drug abuse and diversion in Kentucky?

Response	*Frequency*	*%*
Not effective at all	15	4.07%
Somewhat ineffective	23	6.23%
Neutral	46	12.47%
Somewhat effective	218	59.08%
Very effective	67	18.16%
Total	369	100%

25b. Reduce doctor shopping in Kentucky?

Response	*Frequency*	*%*
Not effective at all	5	1.37%

Somewhat ineffective	24	6.58%
Neutral	37	10.14%
Somewhat effective	190	52.05%
Very effective	109	29.86%
Total	365	100%

26. Please provide any additional information on KASPER, the impact of HB1, or the Board of Pharmacy KASPER regulations that you would like to share.

122 comments were submitted (summarized in supplemental documents)

LAW ENFORCEMENT SURVEY RESULTS

Total E-mails Sent:	1,729
Total Responses:	232
Bounced & inappropriate e-mails:	
Final Response Rate:	13.4181608

SECTION I: Demographic Information

1. What best describes your professional role?

Response	*Frequency*	*%*
City/County Law Enforcement	90	40.00%
State Law Enforcement	58	25.78%
Sheriff	13	5.78%
Drug Enforcement Administration (DEA)	3	1.33%
Regulatory Agency (Licensing Board, Medicaid, Drug Control, etc.)	7	3.11%
Prosecutor	6	2.67%
Other	48	21.33%
Total	**225**	**100%**

If "Other", please describe:

47 responses were submitted, mostly parole and probation officers

2. What is the Kentucky county in which you currently work?

**Grouped by region*

Response	*Frequency*	*%*
1		
2		
3		
4		
5		
6		
7		
8		
Total	**215**	**100%**

3. What is the zip code of the Kentucky city/county in which you currently work?

219 zip codes were submitted

1 zip code was outside of Kentucky

4. How many years have you served in your present position?

Mean (SD)	10.97 years	SD=7.30
Range	0 minimum	32 maximum
Median (IQR)	10 years	IQR=1 to 28

Section II: Questions about Your Use of KASPER

5. Do you request reports from KASPER?

Response	*Frequency*	*%*
Yes, I request reports from KASPER myself	186	83.04%
Yes, but someone else requests reports on my behalf	20	8.93%
No, I do not request reports from KASPER	18	8.04%
Total	**224**	**100%**

5a. What is the reason you have not requested KASPER reports?

Response	*Frequency*	*%*
I am not assigned to drug diversion cases	15	93.75%
I do not believe it is a useful tool for my cases	1	6.25%
Total	**16**	**100%**

5b. Why do you find KASPER is not a useful tool?

1 response submitted, summarized in supplemental documents

Section III: Utilization and Value of Individual KASPER Reports

6. Approximately how many KASPER reports have you utilized in the past one (1) month?

Mean (SD)	2.50 reports	SD=7.99
Range	0 minimum	100 maximum
Median (IQR)	1 report	IQR=0 to 26

6a. In general, I use the information in KASPER reports:

Response	*Frequency*	*%*
To confirm/support my decisions to pursue investigations	99	60.00%
To confirm/support my decisions to close or dismiss pursuit of investigations	49	29.69%
In some other way	17	10.31%
Total	**165**	**100%**

If you use reports in some other way, please describe:

17 responses submitted, summarized in a supplemental documents

7. I am confident in the accuracy of the information in a KASPER report.

Response	*Frequency*	*%*
Strongly agree	134	60.36%
Somewhat agree	74	33.33%
Neutral	9	4.05%
Somewhat disagree	2	0.90%
Strongly disagree	3	1.35%
Total	**222**	**100%**

8. I am confident in my ability to interpret information found in a KASPER report.

Response	*Frequency*	*%*
Strongly agree	158	71.17%
Somewhat agree	56	25.23%
Neutral	6	2.70%
Somewhat disagree	1	0.45%
Strongly disagree	1	0.45%
Total	**222**	**100%**

Section IV: Impact and Effectiveness of HB1

HB1 was a law effective as of July 2012 that required prescribers and pharmacists to register with KASPER and required prescribers to query the KASPER system for reports on their patients before prescribing for certain conditions.

9. Since HB1 became effective, do you utilize KASPER reports…

Response	*Frequency*	*%*
More often than before HB1	39	20.97%
Less often than before HB1	13	6.99%
No change in how often I utilize KASPER reports sin	134	72.04%
Total	**186**	**100%**

10. On average, how many cases dealing with prescription drug abuse and diversion do you investigate annually?

Mean (SD)	38.77 cases	SD=121.15
Range	0 minimum	1,200 maximum
Median (IQR)	12 cases	IQR=0 to 202

11. Since implementation of HB1 in July 2012, the number of drug abuse and diversion cases I investigate has:

Response	*Frequency*	*%*
Increased	40	21.74%
Decreased	29	15.76%
No change	115	62.50%
Total	**184**	**100%**

12. Since implementation of HB1 in July 2012, the number of drug cases I investigate related to individual patients has:

Response	*Frequency*	*%*
Increased	33	18.64%
Decreased	31	17.51%
No change	113	63.84%
Total	**177**	**100%**

13. Since implementation of HB1 in July 2012, the number of drug cases I investigate related to inappropriately prescribing physicians has:

Response	*Frequency*	*%*
Increased	17	9.50%
Decreased	31	17.32%
No change	131	73.18%
Total	**179**	**100%**

14. Since implementation of HB1 in July 2012, the number of drug cases I investigate related to inappropriately prescribing dentists has:

Response	*Frequency*	*%*
Increased	6	3.49%
Decreased	17	9.88%
No change	149	86.63%
Total	**172**	**100%**

15. Since implementation of HB1 in July 2012, the number of drug cases I investigate related to inappropriately prescribing nurse practitioners has:

Response	*Frequency*	*%*
Increased	11	6.29%
Decreased	17	9.71%
No change	147	84.00%
Total	**175**	**100%**

16. Since implementation of HB1 in July 2012, the number of drug cases I investigate related to inappropriately dispensing pharmacists/pharmacies has:

Response	*Frequency*	*%*
Increased	7	3.93%
Decreased	22	12.36%
No change	149	83.71%
Total	**178**	**100%**

17. In your experience, do you believe some pharmacies have altered their stocking and/or dispensing of controlled prescription drugs (Schedule II-V) as a result of HB1?

Response	*Frequency*	*%*
Yes	75	44.64%
No	93	55.36%
Total	**168**	**100%**

17a. (if yes) Why do you believe some pharmacies have altered their stocking and dispensing of controlled prescription drugs (Schedule II-V) as a result of HB1?

60 responses submitted, summarized elsewhere

17a. (if no) Why do you believe some pharmacies have NOT altered there stocking and dispensing of controlled prescription drugs (Schedule II-V) as a result of HB1?

51 responses submitted, summarized elsewhere

18. In your experience, do you believe some prescribers have altered their prescribing of controlled prescription drugs (Schedule II-V) as a result of HB1?

Response	*Frequency*	*%*
Yes	107	61.85%
No	66	38.15%
Total	**173**	**100%**

18a. (if yes) Why do you believe some prescribers have altered their prescribing of controlled prescription drugs (Schedule II-V) as a result of HB1?

87 responses submitted, summarized elsewhere

18a. (if no) Why do you believe some prescribers have altered their prescribing of controlled prescription drugs (Schedule II-V) as a result of HB1?

36 responses submitted, summarized elsewhere

19. Since implementation of HB1 in July 2012, how many prescribers (doctors, dentists, APRNs) have contacted you to report a patient they suspect is doctor shopping or diverting CS?

Response	*Frequency*	*%*
None*	111	62.01%
1 to 5	51	28.49%
6 to 20	10	5.59%
>20	7	3.91%
Total	**179**	**100%**

*If "none" is selected, respondent is re-directed to 19a (alt).

19a. How has this changed since the implementation of HB1?

Response	*Frequency*	*%*
I am contacted by prescribers more frequently since HB1	25	14.12%
I am contacted by prescribers less frequently since HB1	12	6.78%
No change	140	79.10%
Total	**177**	**100%**

20. Since implementation of HB1 in July 2012, how many pharmacists have contacted you to report a patient they suspect is doctor shopping or diverting CS?

Response	*Frequency*	*%*
None*	128	70.33%
1 to 5	44	24.18%
6 to 20	5	2.75%
>20	5	2.75%

Total	**182**	**100%**

*If "none" is selected, respondent is re-directed to 20a (alt).

20a. How has this changed since the implementation of HB1?

Response	*Frequency*	*%*
I am contacted by pharmacists more frequently since HB1	23	12.92%
I am contacted by pharmacists less frequently since HB1	6	3.37%
No change	149	83.71%
Total	**178**	**100%**

Section V: Effectiveness of KASPER

Effectiveness is often defined as producing a desired result. To what extent do you feel KASPER is an effective tool to:

21a. Reduce doctor shopping in Kentucky?

Response	*Frequency*	*%*
Not effective at all	4	2.16%
Somewhat ineffective	5	2.70%
Neutral	20	10.81%
Somewhat effective	100	54.05%
Very effective	56	30.27%
Total	**185**	**100%**

21b. Reduce prescription drug abuse and diversion in Kentucky?

Response	*Frequency*	*%*
Not effective at all	9	4.89%
Somewhat ineffective	14	7.61%
Neutral	32	17.39%
Somewhat effective	93	50.54%
Very effective	36	19.57%
Total	**184**	**100%**

22. How has doctor shopping changed since HB1 took effect July 2012?

Response	*Frequency*	*%*
Significant increase in doctor shopping	5	2.84%
Slight increase in doctor shopping	6	3.41%
No change in doctor shopping	42	23.86%
Slight decrease in doctor shopping	88	50.00%
Significant decrease in doctor shopping	35	19.89%
Total	**176**	**100%**

23. Please provide any additional feedback on KASPER or the impact of HB1 you would like to share.

58 responses submitted, summarized in supplemental documents

APPENDIX VII: Data Description, Linkage and Limitations

KASPER data

The data for this study came from the KASPER database maintained by the Kentucky Cabinet of Health and Family Services (CHFS). Each record of this database is one prescription dispensed in Kentucky. Within each record there is information about the drug dispensed, the patient receiving the drug, the practitioner who prescribed the drug and the pharmacy where the drug was dispensed. By law the records need to include:

> *Data for each controlled substance that is dispensed shall include but not be limited to the following:*
> *(a) Patient identifier;*
> *(b) National drug code of the drug dispensed;*
> *(c) Date of dispensing;*
> *(d) Quantity dispensed;*
> *(e) Prescriber; and*
> *(f) Dispenser.*[1]

In the database each patient is assigned an identification code (ID) created by CHFS. CHFS developed an algorithm to match patients across records so they could assign a unique ID to each patient. CHFS reports that two people being assigned the same ID is rare, and as such, was not listed as a point of concern in our analysis. The database contains patient characteristics: age, gender and address of residence.

Each drug dispensed was assigned a date dispensed, quantity dispensed, the number of days supplied and the national drug code (NDC). In our analysis we assigned fiscal year to each record based on date of dispensation. There were outliers identified in the data for quantity dispensed and days of supply which we did not adjust for in our analysis; however, we identified where the days of supply maximum changed from 999 days to less than 999 days and found that, on average, these outliers did not affect the results. We matched each NDC to a Medispan database to classify the drugs by Schedule and to translate NDC to a uniform generic drug name. The KASPER drug names were replaced with a Medispan name if they were missing. We classified the drugs by drug type and groups of individual drugs by using a Medispan code for opioids and searching the drug name for key words. In Table 1, 1.2 percent of the prescriptions could not be assigned to a Schedule. This number decreased over the fiscal years, which was due, in part, to using an updated version of Medispan meaning some retired NDC codes did not match. There were also rare instances of other prescriptions that had no drug name, no Medispan code or the drug name was abbreviated making it impossible to assign it to a drug class.

Each opioid drug had a standardizing factor called morphine milligram equivalent (MME) applied to it to better summarize opioid use across a variety of drugs. The quantity prescribed and an MME conversion table from the Center for Disease Control and

[1] Kentucky statute, 2012

Prevention (CDC) were used to calculate the MMEs. The conversion table was matched to KASPER by NDC. Less than one percent of the opioid prescriptions had no MME because they did not match the MME conversion file. In the tables to adjust for extreme outliers we deleted any calculated MME greater than four standard deviations from the mean. The origin of these outliers is not clear.

The geography in the KASPER database originates from the address of the patient. The data administrator assigned the patients' 3-digit zip code to a county. About 1.5 percent of the patients could not be assigned to a county. This number declined from 2 percent in fiscal year 2010 to 0.4 percent in fiscal year 2013 as the geography records in KASPER improved. From our earlier work with aggregate data summarized to the zip code level we know that there are many zip code errors in the file and 3-digit zip codes may cross county lines. These would be possible sources of error in classifying patients to a county. About 3 percent of the records across the years are assigned to an out-of-state county. The largest percentages are from neighboring states.

We found large increases and decreases in some monthly statistics, which may be indicative of data quality problems. We worked with CHFS to correct one major reporting error. Further review of the data needs to be done to test whether the changes that we observe are true changes in the data or data anomalies due to the processing of the data. Fiscal year 2011 appears to be most problematic.

In order to complete our study we needed to link outside data to KASPER. The largest set was the Drug Enforcement Administration (DEA) registrant data. The DEA file contains all prescribers (called practitioners in the DEA file) registered to prescribe controlled substances. It does not contain very much detail on practitioner type, where the definition of practitioner type is predominately limited to physicians, dentists, veterinarians, podiatrist, nurse practitioners, hospital and clinic practitioners, physician assistants[2] and optometrists. Physician specialty and/or degree type is not included in DEA registrant data. About 16 percent of the prescribers could not be classified by type, which represents three percent of the prescriptions in KASPER. The DEA number in the KASPER dataset did not match to the DEA file mostly because our DEA file started in January 2014 or the KASPER file had incorrect or incomplete DEA numbers. We supplemented our DEA file with older data from an earlier study at IPOP and from information provided to us by CHFS. The DEA records were used to assign practitioner county in Kentucky if the practitioner was in-state. Otherwise they were labeled out-of-state. We are also able to identify pharmacies from the DEA file. As with the practitioners we assigned county codes to the pharmacy.

One last data quality issue is the lack of data for exempt groups from reporting to KASPER. Patients being prescribed data by an exempt group such as Veterans Affairs Hospitals, dispensations during inpatient stay, or dispensations that occurred as part of a substance abuse treatment regimen will not show up in our data. As a result, we do not have the complete prescribing history for these patients.

[2] Physician assistants are only from out-of-state. PAs are not allowed to prescribe CS in Kentucky.

APPENDIX VIII: Number of Prescribers by Prescriber Type and Region of Prescriber: KASPER, FY 2010 to FY 2013

Region	Fiscal year	Practitioners	Nurse practitioners	Other prescribers	NEC	Total
Region 1 - Largest city: Paducah						
	2010	557	68	43	17	685
	2011	577	86	37	15	715
	2012	586	102	36	16	740
	2013	572	117	33	21	743
Region 2 - Largest city: Owensboro						
	2010	804	94	49	20	967
	2011	821	102	41	20	984
	2012	852	129	43	19	1,043
	2013	869	143	42	18	1,072
Region 3 - Largest city: Louisville						
	2010	4,140	312	87	166	4,705
	2011	4,230	365	86	158	4,839
	2012	4,282	418	87	155	4,942
	2013	4,352	509	69	139	5,069
Region 4 - Largest city: Bowling Green						
	2010	938	116	70	34	1,158
	2011	958	128	71	37	1,194
	2012	980	151	61	41	1,233
	2013	1,004	169	58	30	1,261
Region 5 - Largest city: Lexington						
	2010	2,866	152	82	98	3,198
	2011	2,938	186	78	117	3,319
	2012	3,019	223	65	140	3,447
	2013	3,077	254	66	142	3,539
Region 6 - Largest city: Covington						
	2010	1,063	46	33	28	1,170
	2011	1,092	57	27	30	1,206
	2012	1,123	75	27	30	1,255
	2013	1,139	90	26	25	1,280
Region 7 - Largest city: Ashland						
	2010	602	58	29	25	714
	2011	623	62	28	27	740
	2012	641	75	29	29	774
	2013	641	80	23	23	767
Region 8 - Largest city: Middlesboro						
	2010	1,005	115	72	60	1,252
	2011	1,024	140	66	51	1,281

Region	Fiscal year	Practitioners	Nurse practitioners	Other prescribers	NEC	Total
	2012	1,048	161	66	74	1,349
	2013	1,079	181	69	64	1,393
Out-of-state						
	2010	32,231	1,999	1,118	459	35,807
	2011	37,890	2,909	1,423	439	42,661
	2012	38,146	3,386	1,551	364	43,447
	2013	31,243	2,995	1,418	217	35,873
No geography specified						
	2010	0	0	0	8,768	8,768
	2011	0	0	0	7,631	7,631
	2012	0	0	0	6,702	6,702
	2013	0	0	0	4,688	4,688

Appendix IX: Total and Mean Numbers of CS Prescriptions Dispensed by Prescriber Type and Select Drugs

Number of Opioid Prescriptions Dispensed by Selected Prescriber Type and Selected Drugs: Hydrocodone, Oxycodone, Hydromorphone, Oxymorphone: KASPER, FY 2010 to FY 2013

Type	Drug class	FY 2010	Percent change (FY10-11)	FY 2011	Percent change (FY11-12)	FY 2012	Percent change (FY12-13)	FY 2013
Practitioner								
	Hydrocodone	3,376,093	2.57%	3,462,975	0.57%	3,482,809	-14.21%	2,987,971
	Oxycodone	883,505	12.90%	997,481	7.40%	1,071,338	-11.71%	945,849
	Hydromorphone	25,088	9.98%	27,591	8.50%	29,937	-0.34%	29,836
	Oxymorphone	15,726	39.50%	21,937	24.54%	27,321	-36.21%	17,428
Nurse practitioner								
	Hydrocodone	111,883	33.26%	149,090	45.45%	216,858	13.72%	246,609
	Oxycodone	6,637	36.39%	9,052	40.37%	12,706	4.40%	13,265
	Hydromorphone	127	28.35%	163	99.39%	325	6.15%	345
	Oxymorphone	23	260.87%	83	42.17%	118	6.78%	126
Other practitioner								
	Hydrocodone	7,614	-4.41%	7,278	4.59%	7,612	6.79%	8,129
	Oxycodone	5,188	4.07%	5,399	0.15%	5,407	10.30%	5,964
	Hydromorphone	111	-16.22%	93	26.88%	118	11.86%	132
	Oxymorphone	15	-20.00%	12	233.33%	40	-20.00%	32

Mean Number of Opioid Prescriptions Dispensed per Prescriber by Selected Prescriber Type and Selected Drugs: Hydrocodone, Oxycodone, Hydromorphone, Oxymorphone: KASPER, FY 2010 to FY 2013

Type	Drug class	FY 2010	Percent change (FY10-11)	FY 2011	Percent change (FY11-12)	FY 2012	Percent change (FY12-13)	FY 2013
Practitioner								
	Hydrocodone	134.54	-1.02%	133.17	-0.41%	132.62	-7.06%	123.26
	Oxycodone	58.68	8.96%	63.94	5.25%	67.30	-4.29%	64.41
	Hydromorphone	9.11	3.29%	9.41	1.70%	9.57	15.57%	11.06
	Oxymorphone	24.38	-2.63%	23.74	5.98%	25.16	-11.41%	22.29
Nurse practitioner								
	Hydrocodone	66.76	10.93%	74.06	21.81%	90.21	7.25%	96.75
	Oxycodone	8.69	15.65%	10.05	11.44%	11.20	-6.34%	10.49
	Hydromorphone	1.74	-4.60%	1.66	53.01%	2.54	21.26%	3.08
	Oxymorphone	1.53	59.48%	2.44	-5.33%	2.31	51.52%	3.50
Other practitioner								
	Hydrocodone	8.89	-9.67%	8.03	-0.37%	8.00	7.13%	8.57
	Oxycodone	17.41	9.99%	19.15	-12.58%	16.74	16.43%	19.49
	Hydromorphone	4.63	-35.21%	3.00	27.00%	3.81	-21.26%	3.00
	Oxymorphone	3.00	-50.00%	1.50	105.33%	3.08	-45.45%	1.68

Notes: The number of prescribers includes those practitioners who had at least one prescription dispensed in the fiscal year for the drug type.

Number of Opioid Prescriptions Dispensed by Selected Prescriber Type and Selected Drugs: Fentanyl, Morphine, Buprenorphine, Buprenorphine/Naloxone: KASPER, FY 2010 to FY 2013

Type Drug class	FY 2010	Percent change (FY10-11)	FY 2011	Percent change (FY11-12)	FY 2012	Percent change (FY12-13)	FY 2013
Practitioner							
Fentanyl	90,691	-0.88%	89,891	5.71%	95,027	-3.67%	91,544
Morphine	118,104	2.87%	121,498	10.48%	134,231	2.46%	137,530
Buprenorphine-Total	166,405	23.40%	205,338	38.15%	283,683	41.52%	401,465
Buprenorphine and naloxone combination only	157,243	20.80%	189,957	36.02%	258,378	39.35%	360,037
Nurse practitioner							
Fentanyl	329	5.17%	346	42.49%	493	-8.72%	450
Morphine	434	35.94%	590	55.25%	916	32.10%	1,210
Buprenorphine-Total	143	48.25%	212	308.49%	866	38.45%	1,199
Buprenorphine and naloxone combination only	88	-19.32%	71	228.17%	233	20.17%	280
Other practitioner							
Fentanyl	147	-25.85%	109	25.69%	137	25.55%	172
Morphine	403	-8.93%	367	-11.72%	324	48.77%	482
Buprenorphine-Total	216	-27.78%	156	93.59%	302	31.46%	397
Buprenorphine and naloxone combination only	213	-33.33%	142	97.89%	281	36.30%	383

Mean Number of Opioid Prescriptions Dispensed per Prescriber by Selected Prescriber Type and Selected Drugs: Fentanyl, Morphine, Buprenorphine, Buprenorphine/Naloxone: KASPER, FY 2010 to FY 2013

Type Drug class	FY 2010	Percent change (FY10-11)	FY 2011	Percent change (FY11-12)	FY 2012	Percent change (FY12-13)	FY 2013
Practitioner							
Fentanyl	22.64	-1.24%	22.36	1.12%	22.61	9.60%	24.78
Morphine	28.21	-0.28%	28.13	4.16%	29.30	14.10%	33.43
Buprenorphine-Total	185.51	-8.67%	169.42	3.87%	175.98	31.41%	231.26
Buprenorphine and naloxone combination only	186.97	10.92%	207.38	21.32%	251.59	22.94%	309.31
Nurse practitioner							
Fentanyl	3.02	-13.91%	2.60	0.38%	2.61	-0.38%	2.60
Morphine	3.06	0.98%	3.09	20.39%	3.72	30.65%	4.86
Buprenorphine-Total	11.00	-53.00%	5.17	139.26%	12.37	4.20%	12.89
Buprenorphine and naloxone combination only	8.00	-55.63%	3.55	162.54%	9.32	-11.59%	8.24
Other practitioner							
Fentanyl	4.20	-31.67%	2.87	-2.44%	2.80	53.57%	4.30
Morphine	7.90	-26.20%	5.83	-14.58%	4.98	46.59%	7.30
Buprenorphine-Total	9.82	-33.81%	6.50	32.77%	8.63	17.96%	10.18
Buprenorphine and naloxone combination only	9.68	-33.37%	6.45	74.26%	11.24	17.53%	13.21

Notes: The number of prescribers includes those practitioners who had at least one prescription dispensed in the fiscal year for the drug type.

Number of Opioid Prescriptions Dispensed by Selected Prescriber type and Selected Drugs: Methadone, Codeine, Tramadol: KASPER, FY 2010 to FY 2013

Type	Drug class	FY 2010	Percent change (FY10-11)	FY 2011	Percent change (FY11-12)	FY 2012	Percent change (FY12-13)	FY 2013
Practitioner								
	Methadone	79,030	0.09%	79,102	4.42%	82,599	-6.95%	76,860
	Codeine	322,947	-3.43%	311,858	-13.04%	271,182	-1.59%	266,875
	Tramadol	518,460	11.10%	575,994	4.44%	601,571	-12.97%	523,537
Nurse practitioner								
	Methadone	122	24.59%	152	67.11%	254	-6.69%	237
	Codeine	21,925	27.93%	28,049	-0.33%	27,957	11.72%	31,234
	Tramadol	39,847	22.44%	48,787	26.56%	61,747	-1.00%	61,130
Other practitioner								
	Methadone	162	19.14%	193	-29.02%	137	29.20%	177
	Codeine	1,992	-14.81%	1,697	5.19%	1,785	-9.13%	1,622
	Tramadol	1,303	19.03%	1,551	11.15%	1,724	-8.99%	1,569

Mean Number of Opioid Prescriptions Dispensed per Prescriber by Selected Prescriber type and Selected Drugs: Methadone, Codeine, Tramadol: KASPER, FY 2010 to FY 2013

Type	Drug class	FY 2010	Percent change (FY10-11)	FY 2011	Percent change (FY11-12)	FY 2012	Percent change (FY12-13)	FY 2013
Practitioner								
	Methadone	34.29	4.11%	35.70	2.89%	36.73	4.96%	38.55
	Codeine	28.35	-4.59%	27.05	-9.54%	24.47	4.13%	25.48
	Tramadol	45.54	-4.39%	43.54	-1.31%	42.97	-4.79%	40.91
Nurse practitioner								
	Methadone	2.35	9.79%	2.58	6.98%	2.76	-9.78%	2.49
	Codeine	25.29	8.86%	27.53	-11.99%	24.23	0.25%	24.29
	Tramadol	38.31	1.23%	38.78	6.01%	41.11	-11.48%	36.39
Other practitioner								
	Methadone	5.79	51.47%	8.77	-34.89%	5.71	47.64%	8.43
	Codeine	7.84	-22.96%	6.04	17.72%	7.11	-9.42%	6.44
	Tramadol	3.91	-1.02%	3.87	14.47%	4.43	-9.03%	4.03

Notes: The number of prescribers includes those practitioners who had at least one prescription dispensed in the fiscal year for the drug type.

Number of Benzodiazepine Prescriptions Dispensed by Selected Prescriber Type and Selected Drugs: Alprazolam, Diazepam, Clonazepam: KASPER, FY 2010 to FY 2013

Type	Drug class	FY 2010	Percent change (FY10-11)	FY 2011	Percent change (FY11-12)	FY 2012	Percent change (FY12-13)	FY 2013
Practitioner								
	Alprazolam	985,309	4.05%	1,025,238	-1.73%	1,007,524	-11.71%	889,554
	Diazepam	433,013	-0.22%	432,044	0.46%	434,038	-10.63%	387,905
	Clonazepam	539,169	4.54%	563,630	3.85%	585,344	-5.07%	555,650
Nurse practitioner								
	Alprazolam	29,838	24.71%	37,212	50.75%	56,097	13.76%	63,817
	Diazepam	14,103	36.45%	19,243	52.75%	29,394	13.93%	33,488
	Clonazepam	20,016	43.87%	28,797	61.33%	46,459	31.76%	61,216
Other								
	Alprazolam	921	-0.11%	920	9.78%	1,010	5.45%	1,065
	Diazepam	1,008	5.36%	1,062	1.79%	1,081	17.11%	1,266
	Clonazepam	891	18.97%	1,060	0.75%	1,068	10.30%	1,178

Mean Number of Benzodiazepine Prescriptions Dispensed per Prescriber by Selected Prescriber Type and Selected Drugs: Alprazolam, Diazepam, Clonazepam: KASPER, FY 2010 to FY 2013

Type	Drug class	FY 2010	Percent change (FY10-11)	FY 2011	Percent change (FY11-12)	FY 2012	Percent change (FY12-13)	FY 2013
Practitioner								
	Alprazolam	81.33	-5.78%	76.63	-2.14%	74.99	2.83%	77.11
	Diazepam	39.57	-4.85%	37.65	0.19%	37.72	-5.06%	35.81
	Clonazepam	63.07	-7.17%	58.55	2.80%	60.19	7.31%	64.59
Nurse practitioner								
	Alprazolam	28.69	0.94%	28.96	24.00%	35.91	13.42%	40.73
	Diazepam	19.53	10.86%	21.65	24.34%	26.92	1.37%	27.29
	Clonazepam	25.15	7.83%	27.12	26.51%	34.31	32.35%	45.41
Other								
	Alprazolam	3.97	-8.31%	3.64	0.82%	3.67	19.89%	4.40
	Diazepam	6.15	5.37%	6.48	-17.44%	5.35	20.19%	6.43
	Clonazepam	5.03	6.36%	5.35	4.49%	5.59	27.01%	7.10

Notes: The number of prescribers includes those practitioners who had at least one prescription dispensed in the fiscal year for the drug type.

Number of Stimulant Prescriptions Dispensed by Selected Prescriber Type and Selected Drugs: Mixed Salt Amphetamines, Dextroamphetamine, Lisdexamfetamine, Methylphenidate: KASPER, FY 2010 to FY 2013

Type	Drug class	FY 2010	Percent change (FY10-11)	FY 2011	Percent change (FY11-12)	FY 2012	Percent change (FY12-13)	FY 2013
Practitioner								
	Mixed amphetamine salts	237,062	8.35%	256,867	9.32%	280,807	10.06%	309,044
	Dextroamphetamine	12,100	2.48%	12,400	-7.94%	11,415	-18.58%	9,294
	Lisdexamfetamine	141,273	17.68%	166,253	7.93%	179,435	2.69%	184,262
	Methylphenidate	292,412	4.61%	305,895	4.07%	318,357	5.46%	335,739
Nurse practitioner								
	Mixed amphetamine salts	9,684	22.46%	11,859	37.90%	16,354	38.80%	22,700
	Dextroamphetamine	328	17.99%	387	1.81%	394	0.25%	395
	Lisdexamfetamine	6,120	48.48%	9,087	18.88%	10,803	24.76%	13,478
	Methylphenidate	8,616	25.20%	10,787	36.97%	14,775	37.32%	20,289
Other								
	Mixed amphetamine salts	394	-16.50%	329	47.11%	484	-9.92%	436
	Dextroamphetamine	10	140.00%	24	-45.83%	13	-7.69%	12
	Lisdexamfetamine	263	18.63%	312	22.76%	383	-31.07%	264
	Methylphenidate	557	-7.54%	515	2.52%	528	22.54%	647

Mean Number of Stimulant Prescriptions Dispensed per Prescriber by Selected Prescriber Type and Selected Drugs: Mixed Salt Amphetamines, Dextroamphetamine, Lisdexamfetamine, Methylphenidate: KASPER, FY 2010 to FY 2013

Type	Drug class	FY 2010	Percent change (FY10-11)	FY 2011	Percent change (FY11-12)	FY 2012	Percent change (FY12-13)	FY 2013
Practitioner								
	Mixed amphetamine salts	43.33	-2.45%	42.27	-0.28%	42.15	26.29%	53.23
	Dextroamphetamine	10.19	-0.49%	10.14	-7.50%	9.38	-4.37%	8.97
	Lisdexamfetamine	45.28	3.89%	47.04	-2.66%	45.79	6.27%	48.66
	Methylphenidate	57.47	-4.07%	55.13	5.97%	58.42	14.82%	67.08
Nurse practitioner								
	Mixed amphetamine salts	35.87	-14.80%	30.56	-3.24%	29.57	44.84%	42.83
	Dextroamphetamine	6.31	11.57%	7.04	-17.76%	5.79	-2.59%	5.64
	Lisdexamfetamine	37.32	6.81%	39.86	-14.50%	34.08	18.75%	40.47
	Methylphenidate	33.92	-9.91%	30.56	22.71%	37.5	29.44%	48.54
Other								
	Mixed amphetamine salts	5.47	-18.65%	4.45	-0.22%	4.44	16.89%	5.19
	Dextroamphetamine	3.33	-19.82%	2.67	-46.07%	1.44	18.75%	1.71
	Lisdexamfetamine	6.92	28.76%	8.91	-17.28%	7.37	-14.65%	6.29
	Methylphenidate	8.98	-18.04%	7.36	-0.41%	7.33	35.74%	9.95

Notes: The number of prescribers includes those practitioners who had at least one prescription dispensed in the fiscal year for the drug type.

APPENDIX X: MME Conversion

Each opioid drug had a standardizing factor called morphine milligram equivalent (MME) applied to it to better summarize opioid use across a variety of drugs. The quantity prescribed and an MME conversion table from the Centers for Disease Control and Prevention (CDC) were used to calculate the MMEs. The conversion table was matched to KASPER by NDC. Less than one percent of the opioid prescriptions had no MME because the NDC did not match the MME conversion file. Below is the equation used to calculate the MMEs and the origin of the variables:

MME per prescription = Prescription metric quantity (KASPER) * Strength per unit (CDC) * MME conversion factor (CDC)

MME per day = MME per prescription / Days of supply of prescription

APPENDIX XI: Concurrent Prescribing of OAC

For the purposes of this evaluation, an instance of concurrent prescribing of OAC was defined as a patient receiving prescriptions for an opioid (either hydrocodone or oxycodone) alprazolam and carisoprodol, dispensed in Kentucky and reported in KASPER, within a one-month period. The months are defined by calendar months. One patient receiving OAC in two separate months in a fiscal year is counted as two instances of concurrent prescribing in that year. The drugs are identified as OAC if the main drug name is somewhere in the generic drug name provided in KASPER.