REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Sustainability of the Prescription Monitoring Program

REPORT DOCUMENT NO. 156

COMMONWEALTH OF VIRGINIA
RICHMOND
2018

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care.

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Preface

In 2017, Senator Carrico, Sr. requested via SJR 285 that the JCHC study the sustainability of the Prescription Monitoring Program (PMP) and identify potential funding sources for its future operation. SJR 285 was left in the Senate Committee on Rules and agreed to by the Joint Commission on Health Care members at the May 23, 2017 work plan meeting.

With current annual expenditures of approximately $875,000, Virginia's Prescription Monitoring Program (PMP) is used to track Schedule II – IV controlled substances dispensed in the Commonwealth. The study explored three models of sustainable funding in detail:

- Health professional licensing fees: Based on the number of providers and dispensers required to register with the PMP, an annual fee increase of approximately $13 to $19 would be anticipated to support basic PMP functionality on an annual basis.
- Controlled substances sales tax: Based on estimated sales of controlled substances in 2011, a retail sales tax of 0.013% to 0.026% or a flat point-of-sale controlled substances tax of $0.08 to $0.14 would raise approximately $1M to $2M annually.
- Health insurance premium assessment: Based on premiums collected in 2016, an assessment of 0.01% to 0.02% on total health insurance premiums for policies regulated by the Bureau of Insurance would raise approximately $1M to $2M annually.

Additionally, the study described a sustainability plan to implement one or more of the three funding models with the goal of ensuring both sustainable funding and increased use of the PMP.

Six policy options were presented for consideration by members of the Joint Commission on Health Care, who voted to take no action.

Joint Commission members and staff would like to acknowledge and thank those who assisted in this study including representatives from the: Department of Health Professions and associated Boards; Medical Society of Virginia; Virginia Association of Health Plans; Virginia Council for Nurse Practitioners; Virginia Dental Association; Virginia Hospital and Healthcare Association; Virginia Nurses Association; Virginia Optometric Association; Virginia Pharmacists Association; and Virginia Podiatric Medical Association.

The study and this report was assigned to and completed by Andrew Mitchell, Senior Health Policy Analyst at the Joint Commission on Health Care. He may be contacted at amitchell@jchc.virginia.gov.

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Initiated in 2002 as a pilot program in Southwest Virginia and expanded statewide in 2006 based on $20M received from a federal court settlement agreement, Virginia's Prescription Monitoring Program's (PMP) current expenditures of approximately $875,000 are used to track all Schedule II – IV controlled substances dispensed in the Commonwealth. With approximately 72,000 providers and dispensers registered to use the PMP, current programmatic priorities of the Department of Health Professions (DHP) include upgrading the PMP's "basic functionality" – which requires users to step out of their workplace workflow to access PMP data – to "enhanced functionality" – in which PMP data can be automatically integrated into providers' Electronic Health Record or other workflow (i.e., workflow integration). While DHP generates annual statistics on PMP use, it has limited ability to assess impact on prescribing and dispensing practices through routine program data. DHP estimates expenditures to climb to $1M by FY18 and the court settlement agreement funds to run out between 2027 and 2031 to support basic PMP functionality (i.e., PMP access that isn't integrated into users' workflow). DHP estimates the cost to integrate all PMP users to be $1.5M to $2.0M annually for the foreseeable future.

The study explored three models in detail that could support basic functionality of the PMP with funding administered by DHP:

- Health professional licensing fees: Around 50% of State prescription monitoring programs finance the majority of program expenditures through fees assessed on users. In Virginia, based on the number of providers and dispensers required to register with the PMP – just under 79,000 – and DHP's estimates of program costs for basic PMP functionality over the next 5 years, an annual fee increase of approximately $13 to $19 would be anticipated to support basic PMP functionality on an annual basis.
- Controlled substances sales tax: Based on estimated sales of controlled substances in 2011, a retail sales tax of 0.013% to 0.026% would raise approximately $1M to $2M annually. Alternatively, based on the volume of controlled substances dispensed in 2016 (13,847,223 controlled substances tracked by the PMP were dispensed), a flat point-of-sale controlled substances tax of $0.08 to $0.14 would raise approximately $1M to $2M annually.
- Health insurance premium assessment: Based on premiums collected in 2016 from insurers regulated by the Bureau of Insurance, an assessment of 0.01% to 0.02% on total health insurance premiums for policies regulated by the Virginia Bureau of Insurance would raise approximately $1M to $2M annually.

Additionally, the study described a sequenced sustainability plan to implement one or more of the three funding models with the goal of ensuring both sustainable funding and increased use of the PMP. The sustainability plan involved contributions to the PMP from both DHP – supporting enhanced functionality in the short- and medium-term and basic functionality throughout – and PMP users – supporting enhanced functionality in the medium- and long-term.

Six policy options were presented for consideration by members of the Joint Commission on Health Care, who voted to take no action.

SUSTAINABILITY OF THE PRESCRIPTION MONITORING PROGRAM

In 2017, Senator Carrico, Sr. requested via SJR 285 that the JCHC study the sustainability of the Prescription Monitoring Program (PMP) and identify potential funding sources for its future operation. SJR 285 was left in the Senate Committee on Rules and agreed to by the Joint Commission on Health Care members at the May 23, 2017 work plan meeting.

Background

According to the Department of Health Professions (DHP), the goal of the PMP is to promote appropriate use of controlled substances for legitimate medical purposes – including deterrence of misuse, abuse and diversion of controlled substances – by:

- Helping prescribers and pharmacists make safe prescribing and dispensing decisions
- Identifying patients for risk of overdose
- Monitoring patient compliance with treatment plan
- Reducing illicit use of controlled substances

Initiated in 2002 as a pilot program in Southwest Virginia, in 2006 the PMP was established as a statewide program based on $20M received from a federal court settlement agreement with The Purdue Frederick Company. At the current time, the PMP is managed by DHP and collects data on all Schedule II – IV controlled substances dispensed as well as other "drugs of concern" (currently tramadol and gabapentin). Users required to register with the PMP include providers from four Boards – Physicians, Nurse Practitioners, Physician Assistants, Optometrists, Podiatrists, Dentists – and dispensers (pharmacists) from the Board of Pharmacy. Others who also may access the PMP under certain circumstances include officials from law enforcement (for active investigations) and the Office of the Chief Medical Examiner. Dispensers are statutorily required to report filled prescriptions within 24 hours, and prescribers must query the PMP in selected circumstances (e.g., when initiating opioid treatment anticipated to last more than seven days and for opioid addiction therapy).

Currently, Virginia's PMP has a relatively high number of users registered to use the PMP compared to other States (71,950 registered users in 2016, ranking Virginia 3rd-highest compared to other States with available data). This may reflect recent programmatic changes to user registration by DHP to address historically low user registration levels. With DHP authorization of automatic user registration to the PMP upon license renewal, the PMP saw a 163% increase in registered users between October, 2015 and September, 2016.

Workflow integration is a current programmatic priority for the PMP. The current PMP platform requires users to step out of their workplace workflow – such as an Electronic Health Record (EHR) – to log into the PMP platform, and does not provide patient-level analytics that might aid in ensuring safe prescribing and dispensing decisions (this scenario will be referred to as "basic functionality" throughout the remainder of the report). By contrast, "enhanced functionality" involves workflow integration, with PMP data integrated into the user workflow and analytical clinical tools provided, such as patient risk scores. Studies from other States indicate that a lack

of workflow integration has been found to be a barrier to use of Prescription Drug Monitoring Programs (PDMPs) (Poon et al. 2016; Blum et al. 2015). Purdue Pharma is currently supporting the integration of up to 18,000 users and 400 pharmacies through a $3.1M grant. After the grant ends, DHP estimates a cost of $1.5M to $2M annually to integrate all PMP users in the Commonwealth.

The PMP has limited ability to assess impact on prescribing and dispensing practices through routine program data. While the PMP routinely collects data on the number and characteristics of both users and prescriptions, PMP data are not combined with other data sources to assess PMP implementation impact on outcomes. Although two analyses examined Virginia's PMP in relation to prescriptions of opioids and the use of the PMP by the Office of the Chief Medical Examiner (Prescription Behavior Surveillance System 2016; Prescription Monitoring Program Center of Excellence at Brandeis 2011), those analyses did not attempt to determine what role the PMP or PMP requirements themselves may have played in findings. The PMP's relatively limited use of analytics to evaluate the impact of the program in relation to its goals appears to be similar to that of other States in terms of use of program data. An exception is Tennessee, which conducts relatively sophisticated analyses that combine PMP data with other patient-level databases to perform epidemiological analyses and report findings to the State (Tennessee Health Licensure & Regulation Controlled Substance Monitoring Database Committee 2017).

While use of programmatic data to assess impact remains limited, academic research indicates that PDMP implementation may be related to changes in a variety of provider and patient behaviors and health outcomes, such as improved prescribing practices, reductions in drug overdose or mortality, and reductions in "doctor shopping" (Ali et al. 2016; Baehren et al. 2009; Bao et al. 2016)(Delcher et al. 2014; Haegerich et al. 2013; Li et al. 2014)(Rutkow et al. 2015; Patrick et al. 2016)(Rasubala et al. 2015; Yarbrough 2017). However, methodological challenges – such as difficulty in establishing causality, limited generalizability of PDMPs across States, and uncertainty in magnitude of associations – limit the ability to attribute changes in outcomes to use of PDMPs.

PMP funding

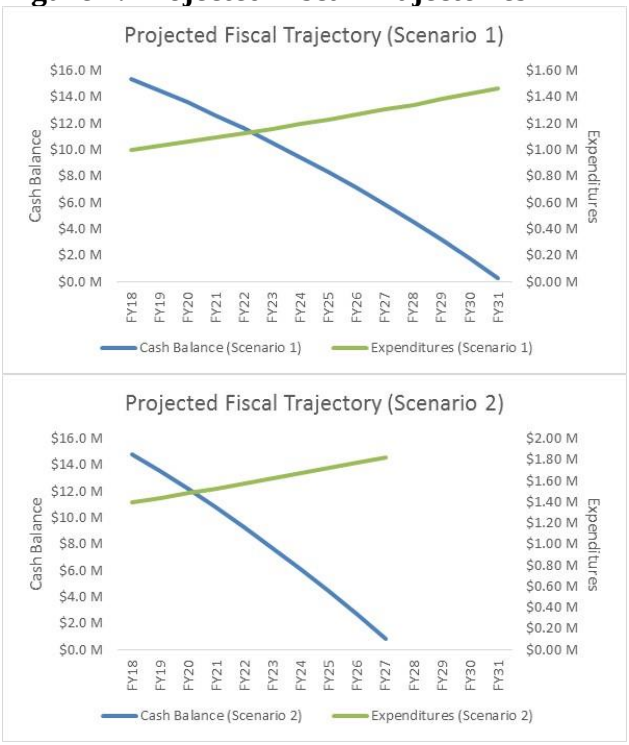
The Virginia PMP's current budget is around $875,000, which is expected to climb to at least $1M by FY18. The current level of funding is 7th highest among the 38 State PDMPs from which data were able to be collected. As indicated in Table 1, below, the Purdue Frederick Company court settlement agreement funds support basic functionality, while there are currently additional sources of funds supporting time-limited initiatives.

Table 1. Current PMP Funding Sources

Basic functionality		Additional Initiatives	
Purpose	**Source**	**Purpose/amount**	**Source**
PMP operational costs	Remaining funds in Purdue Frederick Company court settlement agreement	Prescriber reports ($50,000 for FY16 – FY18)	VDH
		Advanced analytics ($30,000 for FY16 – FY18)	VDH
		Strategic planning / resource allocation ($130,000 for FY18)	DBHDS
		Integration of up to 18,000 users/400 pharmacies ($3.1M for FY17 – FY18)	Purdue Pharma LP grant

The current reserves of the Purdue Frederick Company court settlement agreement funds are approximately $16M. Going forward, the PMP projects that the remaining settlement agreement funds will be run down between 2027 and 2031 to support basic functionality. The longer expenditure trajectory until 2031 assumes that expenditures beginning in FY18 are $1M, with annual increases due to inflation thereafter. The shorter expenditure trajectory assumes that expenditures beginning in FY18 will be somewhat higher than current expenditures – for example if future legislative requirements for the PMP require a higher level of resources than currently are needed, with increases thereafter for inflation.

Figure 1. Projected Fiscal Trajectories



Source: DHP

Sustainable Funding Models

Nationally, around one-half of States finance their PDMPs in whole or in part with fees assessed on users, including health professional licensing fees, controlled substances registration fees, or through regulatory Board funds. Another 20% use General Funds, and the rest, including Virginia, rely on other sources.

The following analytic framework was used to inform recommendations for sustainable funding options for Virginia's PMP:

- The overarching goal of sustainability is to maintain benefits of PMP use and potential benefits of increased PMP use to the Commonwealth

- The focus is placed on options that do not incur additional costs to the Commonwealth
- The Commonwealth, PMP users and beneficiaries share interests, and potential responsibilities in, sustaining the PMP in terms of:
    - Basic functionality: stand-alone/login-based platform providing descriptive patient-level data
    - Enhanced functionality: platform integrated into provider/dispenser workflow (e.g., EHRs) providing patient-level analytics (e.g., patient risk scores)
- A transition period may be required to sustainably transition from the current model of financing to a longer-term solution

Based on the analytic framework and as characterized in Table 2, below, three models were explored in detail related to health professionals licensing fees, a health insurance premium assessment, and a tax on controlled substances.

Table 2. Sustainable funding models examined

Model	Used by any PDMP?	Sustainability time horizon	Primary cost burden
Health professional licensing fees	Yes	Long-term	Users
Health insurance premium assessment	No	Long-term	Patients
Tax on controlled substances sales	No	Long-term	Patients

Additional models reviewed – and reasons for which those models are not recommended – are listed in Table 3, below.

Table 3. Additional sustainable funding models reviewed

Model	In use?	Sustainability time horizon	Primary cost burden	Reason(s) not recommended
Provider controlled substance registration fees	Yes	Long-term	PMP Users	Similar/identical in impact to professional licensing fees
General Funds (directly to PMP or via DHP)	Yes	Long-term	General Public	Incurs additional costs to Commonwealth
Medicaid Fraud Control Unit (MFCU) funds	Yes	Short-term / uncertain	Plan members	Variability in resource availability; MFCU funds already allocated to DMAS

Model 1: Health Professional Licensing Fees

Use of professional fees assessed on health providers and/or dispensers to support PDMPs is one of the most common models used by States. Where possible to quantify the annual dollar amount of health professional licensing or controlled substances registration fees – which are similar or identical in impact – most States using this model levied fees of $20 annually or less (ranging from $3 to $40; see Table 4, right). Based on the number of providers and dispensers required to register with the PMP – just under 79,000 – and DHP's estimates of program costs for basic PMP functionality over the next 5 years, an annual fee increase of approximately $13 to $19 would be anticipated to support basic PMP functionality (see Table 5, left). As a point of reference, current license fee renewal levels for Virginia physicians and pharmacists – the two professions that make up 71% of users required to register with the PMP in Virginia – are 3rd–lowest and at the median, respectively, compared to neighboring States.

Table 4. Annual fees on professionals for other PDMPs

State(s)	Fee type	Amount
CA, KS, TX	Licensing	≤ $10
AL	CS* registration	
CO	Licensing	$11-$20
NJ	CS registration	
AK	Licensing	>$20
LA, NV	CS registration	

* CS: Controlled Substance

Table 5. Licensing fee scenarios

Scenario	PMP Expenditures	Increased Annual Fee / Licensee
FY16 (actual)	$874,683	$11.13
FY18-FY22 average (low end)	$1.06M	$13.51
FY18-FY22 average (high end)	$1.49M	$19.09

* CS: Controlled Substance

Model 2: Controlled Substances Sales Tax

Across the US, only Illinois currently taxes prescription medicines, and in Virginia in 2014, the Joint Subcommittee on Tax Preferences recommended continued exemption of prescription medicines. As part of a study conducted in 2011, it was estimated that tax exemptions for controlled substances resulted in approximately $32M in foregone revenue that year. Based on estimated sales of controlled substances in 2011 (the latest year for which sales data are available), a retail sales tax of 0.013% to 0.026% would raise approximately $1M - $2M. A flat point-of-sales tax could be an alternative approach to a retail sales tax. Based on the volume of controlled substances dispensed in 2016 (13,847,223 controlled substances tracked by the PMP were dispensed), a flat point-of-sale controlled substances tax of $0.08 to $0.14 would raise approximately $1M to $2M. The Virginia Department of Taxation (VATAX) anticipates a one-time cost of around $83,400 and annual costs of around $21,600 to administer either tax.

Model 3: Health Insurance Premium Assessment

Virginia's State Corporation Commission's (SCC) Bureau of Insurance currently assesses premiums on several types of insurers' to support four funds, including insurance related to fire, dam safety and flood prevention/protection, automobile theft and insurance fraud. While the Bureau of Insurance regulates health insurers in the Commonwealth, the Bureau's regulatory scope extends only to the fully-insured markets – which covers an estimated 30% of health insurance policies in the State across the individual, small employer, and large employer markets (the remaining 70% of health insurance policies are self-insured policies regulated by the US Department of Labor and would not be subject to an assessment by the Bureau of Insurance). A premium assessment would therefore apply only to policyholders in those markets. Based on premiums collected in 2016 from insurers regulated by the Bureau of Insurance, an assessment of 0.01% to 0.02% on total health insurance premiums for policies regulated by the Virginia Bureau of Insurance would raise approximately $1M to $2M (see Table 6, below). As context, if the premium assessment were spread evenly across policyholders, this would equate to between $1 and $2 per policy per year.

Table 6. Health Insurance Premium Assessment

Description	Plan Type			All Plans
	Individual	Small Employer	Large Employer	
Total Premium*	$2,120,515,890	$1,854,759,912	$6,079,306,553	$10,054,582,355
# certificates or policies	312,790	210,134	599,511	1,122,435
# covered lives	468,593	374,977	1,134,959	1,978,529

* Total premium collected in FY16 Source: Bureau of Insurance

Summary of Models 1 – 3

A comparison of funding models is presented in Table 7, below. As an example, each of the following would generate enough revenue to support low-end estimates of basic PMP functionality expenditures over the next 5 years (i.e., $1.06M):

- A $14 increase in health professional license fee; OR
- A controlled substances sales tax of 0.014% of retail price or $0.07 flat point-of-sale; OR
- A health insurance premium assessment of 0.011%

Table 7. Comparison of Funding Models

Funding Source	Amount needed to support PMP Functionality					
	Basic alone*		Enhanced alone**		Basic + Enhanced	
	Low end ($1.06M)	High end ($1.49M)	Low end ($1.5M)	High end ($2M)	Low end ($2.56M)	High end ($3.49M)
Licensing fee increase	$14	$19	$19	$25	$33	$44
Controlled substances sales tax						
% retail price	0.014%	0.02%	0.02%	0.026%	0.036%	0.046%
Flat point-of-sale	$0.08	$0.11	$0.11	$0.14	$0.19	$0.25
Health insurance premium assessment						
% total premium	0.011%	0.015%	0.015%	0.02%	0.025%	0.035%
Average $ / policy***	$0.95	$1.32	$1.34	$1.78	$2.29	$3.10

* Based on projected FY18-FY22 average ** Based on estimates for FY19
*** Informational only

Sustainability plan

Because an abrupt model transition in PMP funding might disrupt or deter use of the PMP and create barriers in achieving the PMP's goals, a sequenced sustainability plan can be considered with the goal of ensuring both sustainable funding and increased use of the PMP. Characterized in Table 8, below, is an illustrative sustainability plan intended to maximize ongoing and future use/benefits of Virginia's PMP while ensuring its long-term financing. To summarize that sustainability plan:

- Basic functionality costs would be supported through Model 1, 2 and/or 3
- Purdue Frederick Company court settlement agreement funds would be used for a limited period of time to support integration (i.e., enhanced functionality) for all PMP users
- At a predetermined time, health systems, hospitals, practices, etc. would absorb the cost of supporting workflow integration either in part (Short-term Phase) or in whole (Long-term Phase)

Table 8. Illustrative Sustainability Plan

Phase	Revenue source for PMP functionality		# years	Notes
	Basic	Enhanced		
Short-term	• License fees AND/OR • Tax on Controlled Substances AND/OR • Health insurance premium assessment	• DHP at 100%	• 2-3 years	• Enhanced functionality supported by DHP using Purdue Frederick Company court settlement agreement funds • Begins when Purdue Pharma LP $3.1M integration grant funds spent (anticipated end FY18)
Medium-term		• DHP at 50%; health systems / hospitals / provider practices at 50%	• 2-4 years	• 50% enhanced functionality supported by DHP using court settlement agreement funds • Ends when court settlement agreement funds reach pre-determined floor (e.g., $5M)
Long-term		• Health systems / hospitals / provider practices at 100%	• Indefinite	• Remaining court settlement agreement funds allocated by DHP to respond to program needs

Policy Options and Public Comment

Comments were received from the following 2 organizations:

- Ralston King, Assistant Vice President of Government Affairs, **Medical Society of Virginia (MSV)**
- Richard Grossman, on behalf of the **Virginia Council for Nurse Practitioners (VCNP)**

Policy Option	Stakeholder position:	
	In Support	Opposed
☑ 11-5 Option 1: Take No Action	▪ Medical Society of Virginia (MSV) ▪ Virginia Council for Nurse Practitioners (VCNP)	
Introduce legislation to amend the Code of Virginia authorizing the:		
Option 2: Department of Health Professions (DHP) to increase, by up to $30, licensing fees of health professions required to register with the Prescription Monitoring Program (PMP), provided that: • Annual fees/fee increases to support the PMP are deposited		

Policy Option	Stakeholder position:	
	In Support	Opposed
into a Virginia PMP fund, established by DHP and for the purpose of financing expenditures for basic PMP functionality • An enactment clause delays the effective date until the funds from the $3.1M Purdue Pharma integration grant have been distributed		
Option 3: Department of Taxation to administer a retail sales or point-of-sale tax of 0.02% OR $0.10, respectively, on controlled substances, provided that: • Tax revenues to support the PMP are deposited into a Virginia PMP fund, established by the Department and for the purpose of financing expenditures for basic PMP functionality • An enactment clause delays the effective date until the funds from the $3.1M Purdue Pharma integration grant have been distributed		
Option 4: Bureau of Insurance to assess health insurers 0.015% of the total premium of health plans in the individual, small employer and large employer markets, provided that: • Premium assessments to support the PMP are deposited into a Virginia PMP fund, established by DHP and for the purpose of financing expenditures for basic PMP functionality • An enactment clause delays the effective date until the funds from the $3.1M Purdue Pharma integration grant have been distributed		

Policy Option	Stakeholder position:	
	In Support	Opposed
Option 5: Introduce budget amendment authorizing DHP to use, after funds from the $3.1M Purdue Pharma LP grant have been distributed, Purdue Frederick Company settlement agreement funds to support the integration of up to 100% of PMP users*		
Option 6: Authorize a Non-General Fund appropriations increase of $110,000 for 1 Full-Time Equivalent position at the DHP to lead analyses drawing on PMP and other patient-level data sources that help the PMP meet its program goals of promoting appropriate use of controlled substances for legitimate medical purposes, including deterrence of misuse, abuse and diversion of controlled substances		

*Regarding Option 5: If the proposed sustainability plan described in Table 3 is used, the intent is for DHP to use the court settlement agreement funds for integration until that fund reaches a predetermined floor (e.g. $5M). Also, please note that this option was added after discussions with DLS indicated that this policy could be adopted in the upcoming session even if it didn't take effect until a future budget session.

Summary of Comments

Both MSV and VCNP feel that there is not a need to take action at this time given the amount of money remaining in the Purdue Frederick Company court settlement agreement funds. However, both recommend the formation of a stakeholder workgroup to identify the future needs and functionality of the PMP.

Subsequent Actions by the Joint Commission on Health Care

During the Joint Commission's 2017 Decision Matrix meeting, JCHC members voted to take no action.

JCHC Staff for this Report

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Citations

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