COMMONWEALTH of VIRGINIA

PRESCRIPTION DRUG ABUSE REDUCTION STRATEGY

In Conjunction With

THE NATIONAL GOVERNORS ASSOCIATION

Center for Best Practices

Policy Academy

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In September 2012, Virginia was selected by the National Governors Association (NGA) to receive a competitive grant to participate in a yearlong Prescription Drug Abuse Reduction Policy Academy. The goal of the policy academy states: "Reduce prescription drug abuse by helping states develop and implement comprehensive and coordinated strategies that take advantage of all available tools and resources." The NGA's vision of the process was to gather, under the leadership of governors' offices, senior-level teams of advisors, other state policymakers and stakeholders, to participate in a planning process to develop a statewide strategic plan to guide state efforts targeted at reducing prescription drug abuse.

Virginia engaged in an extensive collaborative effort to achieve the NGA goal to develop a state strategic plan. Senior state officials on the front lines in the battle to reduce prescription drug abuse were tapped to lead Virginia's participation in the Policy Academy. Governor McDonnell named the Director of the Department of Health Professions, Dianne L. Reynolds-Cane, M.D., to lead Virginia's team (Team) consisting of the Secretary of Health and Human Resources, William Hazel, M.D.; the Secretary of Public Safety, Marla Decker; Virginia State Police Superintendent, Colonel W. Steven Flaherty; and Commissioner of Behavioral Health and Development Services, James W. Stewart, III. These Team principals were assisted by an expanded Workgroup consisting of additional representatives from relevant state agencies, the General Assembly, and the public.

The Workgroup was further organized into four Subgroups with a focus on each of four key areas: (1) monitoring, (2) education and training, (3) enforcement and (4) disposal. Each Subgroup was tasked with conducting a series of meetings in order to develop a detailed plan for their respective focus area. Each Subgroup had a designated leader and was composed of Workgroup members with an interest or expertise in one of the four focus areas. (Appendix 5 of accompanying document)

The Workgroup issued recommendations based on input from the subgroups. A primary recommendation developed as the Workgroup determined that a great need exists for centralization of training and informational resources specific to prescribers, pharmacists, and other healthcare providers as well as resources for citizens, community organizations, law

enforcement, researchers and others. Consequently, the Workgroup recommends the development of the "Commonwealth Controlled Substances Resource Center" (CCSRC). The CCSRC would be web-based and centrally housed in one agency.

Other recommendations include introduction of legislation to: 1) improve access to data from the Prescription Monitoring Program (PMP) for healthcare providers; 2) provide access to PMP data for criminal courts such as Drug Courts; 3) provide the ability for patients to have their PMP report sent to a destination of their choosing; 4) modify the statute of limitations for §18.2-260.1 Falsifying patient records; 5) expand authority of the PMP to analyze and disseminate information related to indiscriminate prescribing or dispensing to authorized law enforcement and regulatory personnel and; 6) require wholesale distributors to notify the Board of Pharmacy when they cease distribution of controlled substances[1] to dispensers due to suspicious activity.

Critical in the fight to reduce prescription drug abuse is the assurance of a safe, secure, and environmentally responsible means to collect and dispose of unwanted prescription drugs currently stored in home medicine cabinets. Drug take-back events hosted by community organizations and other entities with support by law enforcement are one way to safely collect and dispose of unwanted drugs. Virginia has been participating in the National Drug Take-back Day efforts for several years. These events are generally well attended and useful, but citizens are not inclined or able to travel great distances to participate in these events. Better coordination, communication, and marketing will help to improve the effectiveness and increase utilization of collection events. A second source for safe collection of drugs involves use of secure drug collection boxes. Currently only law enforcement agencies may host drug collection boxes for controlled substances. Law enforcement agencies hosting of drug collection boxes should be encouraged. This activity provides a community service by promoting proper disposal of drugs by citizens. A third method of collecting and disposing of unwanted drugs is by using mail-back envelopes. Under current regulations, only non-controlled substances can be put in the postage paid envelope and mailed to the company for destruction by incineration.

[1] For the purposes of this document, controlled substances refer to those drugs in Schedules II, III, IV, or V in the Drug Control Act.

Prescription drug abuse is a complex problem requiring a long-term strategy and commitment to action by state agencies and stakeholder entities if it is to be solved. For such a plan to be successfully implemented, it must be given a high priority within state government. An entity must exist to facilitate continued coordination across agency boundaries and between the public and private sectors. For those reasons, the Workgroup recommends the creation of a body such as a Statewide Task Force on Prescription Drug Abuse Reduction. This task force would oversee the implementation of the recommendations contained in this strategic plan, refine and add recommendations as necessary, and provide evaluation of efforts undertaken to reduce and prevent prescription drug abuse in the Commonwealth of Virginia.

INTRODUCTION

The Virginia Prescription Drug Abuse Reduction Strategic Plan is the product of the Policy Academy to Reduce Prescription Drug Abuse sponsored and funded by the National Governors Association through a 2012 grant award to Virginia. As a part of this grant, the Commonwealth established an interagency leadership team, convened a working group of stakeholders from the public and private sectors to analyze the problem of prescription drug abuse in Virginia, and developed a plan with solutions to address the problem.

PURPOSE

The purpose of this strategy is to replace fragmented efforts addressing the problem of prescription drug abuse in Virginia with a coordinated, interagency, public-private approach resulting in a statewide plan facilitated by the NGA Policy Academy, whose implementation is focused on specific prescription drug abuse reduction goals addressing monitoring, enforcement, education, and disposal.

THE PROBLEM AND ITS IMPACT

Prescription drug abuse affects every citizen in the Commonwealth of Virginia. Its negative impact is evidenced through 818 overdose deaths in 2011[2], a 55% increase in criminal investigations opened from 2005-2011[3], the burden on health care systems as a result of fraud and illegitimate patients that reaches up to $72.5 billion a year nationally[4], and the ever growing need for substance abuse treatment resources, especially for youth and young adults which show "needing-treatment" percentages above the national average (4.07% and 6.99% respectively)[5]. Without improved intervention and innovative approaches, the resulting effects entail continued personal and financial burdens and an overall reduced quality of life.

[2] 2012 Annual Report of the Office of the Chief Medical Examiner.
[3] Annual reports from Department of State Police 2005-2011.
[4] 2009 National Prescription Drug Threat Assessment: 3. This is an estimate provided by the Coalition Against Insurance Fraud (CAIF), a nongovernment source.
[5] Table C.21 – *Needing But Not Receiving Treatment for Illicit Drug Use in the Past Year*, by Age Group and State: Percentages, Annual Averages, and *P* Values from Tests of Differences between Percentages, 2008-2009 and 2009-2010 NSDUHs.

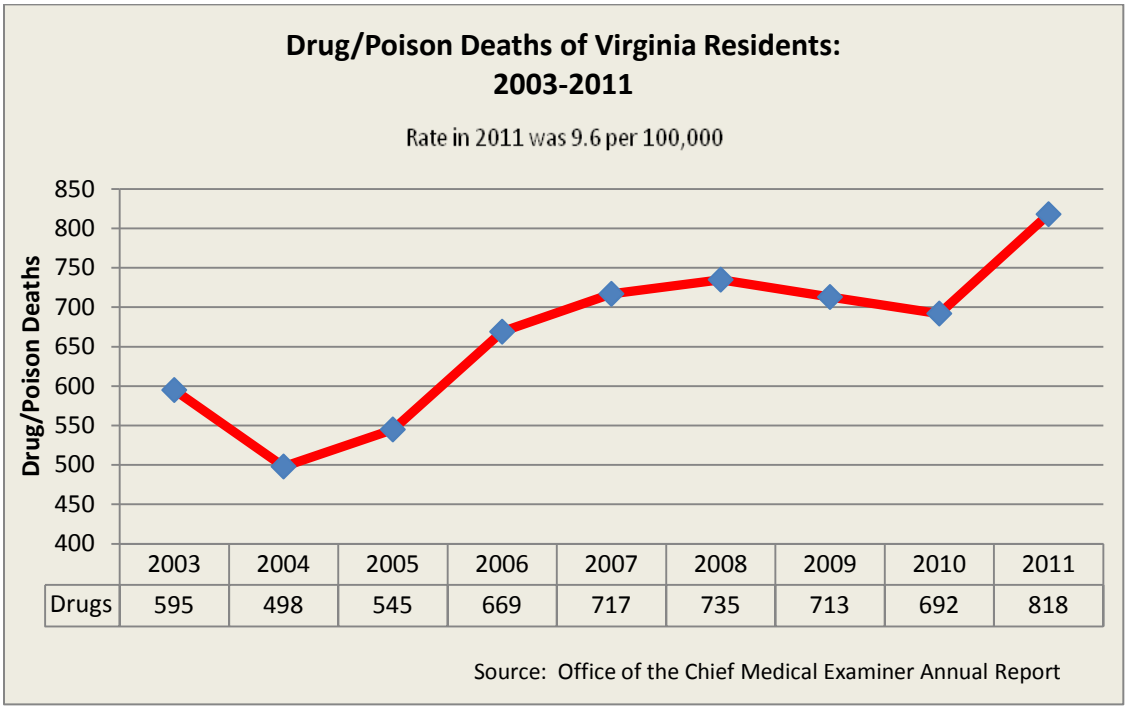

Figure 1

Nationally, The age-adjusted unintentional drug/poison death rate more than doubled, from 4.1 per 100,000 population in 2000 to 9.7 per 100,000 in 2010.[6]

Prescription drug abuse adversely affects Virginia's youth. Data for Chesterfield County in central Virginia from the *2012 Community Youth Survey* shows; "…the past 30-day use of prescription narcotics by high school seniors, at 5.6%, is 50 percent higher than the national average."[7] Across the Commonwealth, young adults aged 18-25 ranked in the second tier nationwide for nonmedical use of pain relievers in the past year at 11.30-12.30% for 2010 and 2011 according to the National Survey on Drug Use and Health (NSDUH).[8]

Many Virginians are unaware of the dangers associated with obtaining drugs, often counterfeit from illegitimate operations. The National Association of Boards of Pharmacy (NABP) reports that of over 10,000 internet sites reviewed, 97% appear to be out of compliance with state and federal laws or NABP patient safety and pharmacy practice standards.[9] The Virginia Board of Pharmacy continues to address this issue; however illegitimate operations remain a threat to public safety.

[6] National Center for Health Statistics (NCHS), NCHS Data on Drug Poisoning Deaths, December 2012
[7] SAFE of Chesterfield County, 2012 Community Youth Survey.
[8] Source: SAMHSA, Center for Behavioral Health Statistics and Quality, NSDUH, 2010 (Revised March 2012) and 2011.
[9] National Association of Boards of Pharmacy (NABP) website: www.nabp.org.

Prescription drug abuse is a major concern for agencies of state government that address the problem in accordance with their respective missions. The Department of State Police reports that specially trained Drug Diversion Agents continue to open a growing number of prescription drug investigations, with 646 cases opened in 2005 and 1184 opened in 2011. Arrests from these cases rose from 356 to 621 during this time period.[10]

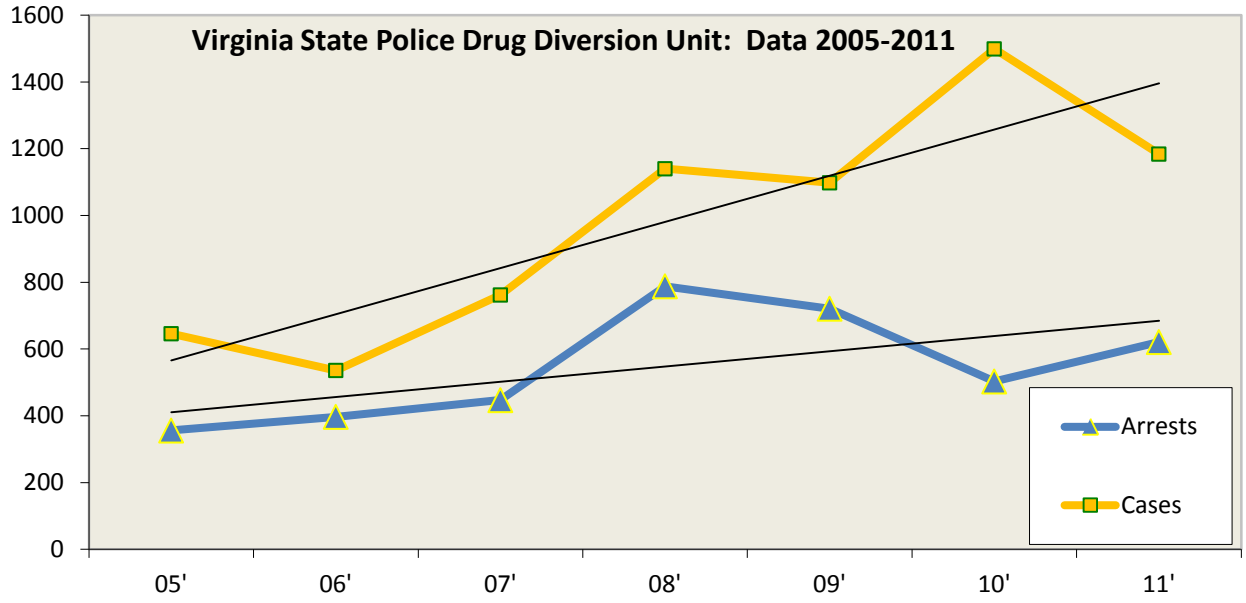

Figure 2

Cases and arrests related to the diversion, prescribing, or dispensing of controlled substances trended higher from 2005-2011 This increase in cases prompted the 2013 General Assembly to pass legislation expanding access to Virginia's Prescription Monitoring Program for drug diversion agents of local law enforcement agencies.

Similarly, the Department of Health Professions experienced an increase in drug related disciplinary cases against licensed healthcare practitioners from 207 in 2005 to 414 in 2011.[11] Since 2003, Virginia's Prescription Monitoring Program (PMP), which is now interoperable with 12 states through PMP InterConnect, has been in the forefront of the national movement toward prescription drug monitoring programs. As Virginia's prescribers and dispensers gain a greater appreciation of the increasingly pervasive nature of prescription drug abuse, they are registering for use of the PMP in an effort to decrease prescription drug fraud, diversion, and abuse with over 1000 new users registering in the first quarter of 2013.[12]

[10] Annual reports from Department of State Police 2005-2011.
[11] Data from Virginia Department of Health Professions.
[12] Virginia's Prescription Monitoring Program 2013 First Quarter Statistics: www.dhp.virginia.gov.

Abusers of prescription drugs often obtain the drugs from the unwanted or unused prescription drugs that remain in the home medicine cabinet of a friend, family member, or acquaintance. Suggested best practices for patients properly disposing of unwanted or unneeded prescriptions drugs varies. Guidance from the Office of National Drug Control Policy (ONDCP) and the Food and Drug Administration (FDA) does not promote flushing of unwanted drugs unless the label or patient information specifically lists flushing as the preferred method of disposal. However, studies have shown that these drugs cannot be totally removed by wastewater treatment processes, often ending up in our drinking water in trace amounts. Virginia's Department of Environmental Quality recommends that unused and unwanted drugs should not be flushed by patients, but instead taken to a collection event/site. The collected drugs can then be taken to an incinerator for unrecoverable destruction which the Environmental Protection Agency (EPA) promotes as the most environmentally responsible method of destruction that technology allows for at this time. Removing unwanted or unused prescription drugs from the home medicine cabinets through safe and convenient methods of drug collection followed by environmentally responsible and unrecoverable destruction can ultimately reduce prescription drug abuse, crime, accidental poisoning of children and pets, and misuse by elderly.

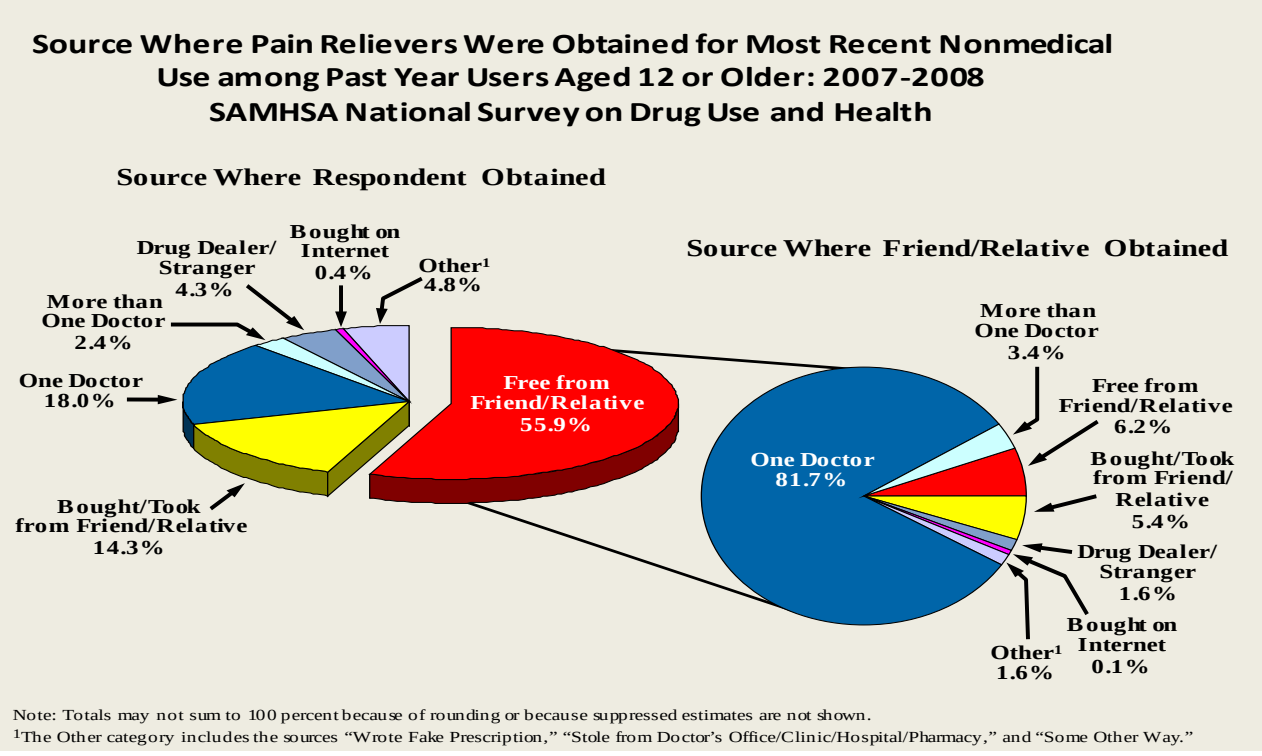

Figure 3

Prescription medications in home medicine cabinets are a major source of abuse, misuse, and diversion. The safe disposal of unused, unwanted prescription medication is a major factor in the fight to reduce prescription drug abuse.

OVERVIEW OF KEY CONCERNS

Expanded Access and Utilization of PMP. Virginia's Prescription Monitoring Program (PMP) is projected to process over 1 million requests in 2013. There is a need for expanded use of the PMP based on protocols and best practices. The program's greatest challenge is to provide information to users in a manner that does not interrupt the PMP user's workflow, is packaged to be quickly and easily understood, and is timely and complete. Legislation passed by the Virginia General Assembly in 2013, expands access to PMP data to authorized local law enforcement agents conducting drug diversion investigations. This legislation provides the same authority for local law enforcement that is currently reserved to drug diversion agents of the Department of State Police. Future consideration should be given to addressing the need for further access to and utilization of PMP data.

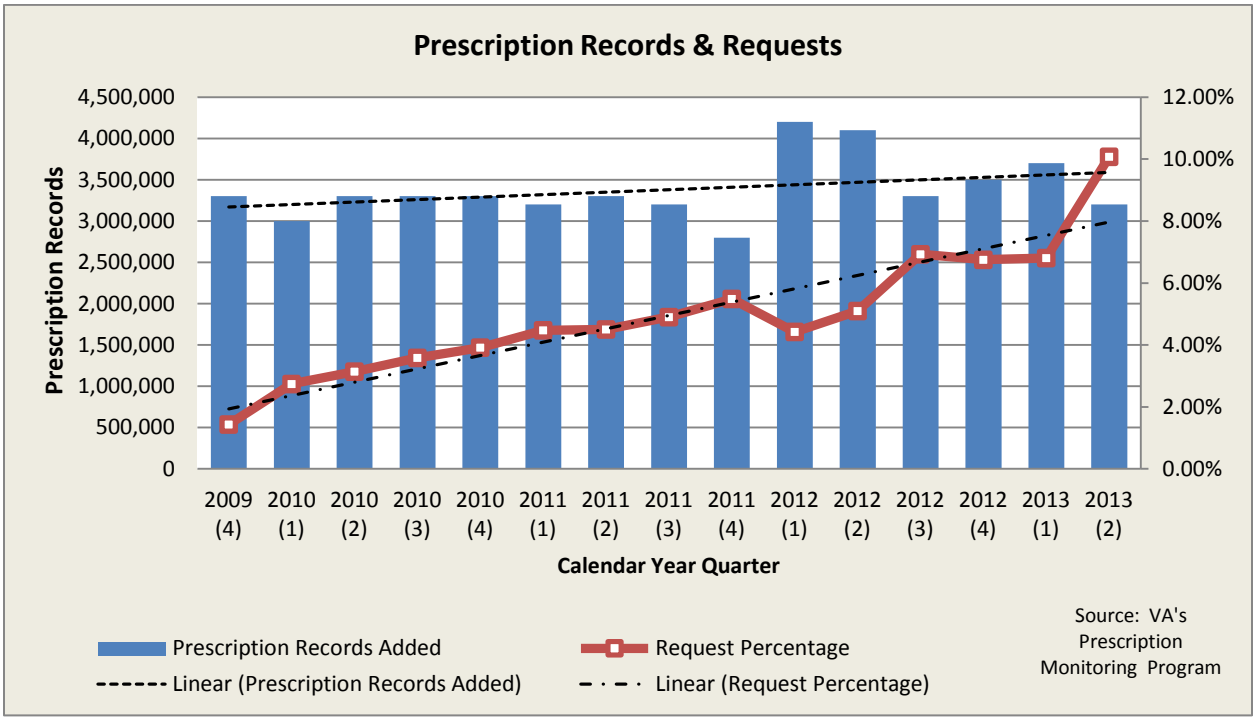

Figure 4

Since 2009, the annual number of requests for information received by the Prescription Monitoring Program increased while the number of prescriptions added remained essentially constant. The increase in requests for PMP information can be attributed to PMP program improvements, outreach to prescribers and dispensers, and the implementation of interoperability with other state PMPs. The advent of integration of prescription data with electronic health record, hospital, state, or federal health information technology systems will significantly increase the number of requests in the future.

Screening in Primary Care Settings. There is a lack of knowledge among health care practitioners in primary care settings related to the availability and use of screening tools designed to assist in determining risk for substance abuse in their patients. The use of screening tools can help determine the need for tighter controls related to prescribing controlled substances, referral to substance abuse treatment, and referral for pain management or other specialized care. Increasing awareness of these tools and providing incentives for use can result in substantial savings of healthcare dollars through early intervention strategies.

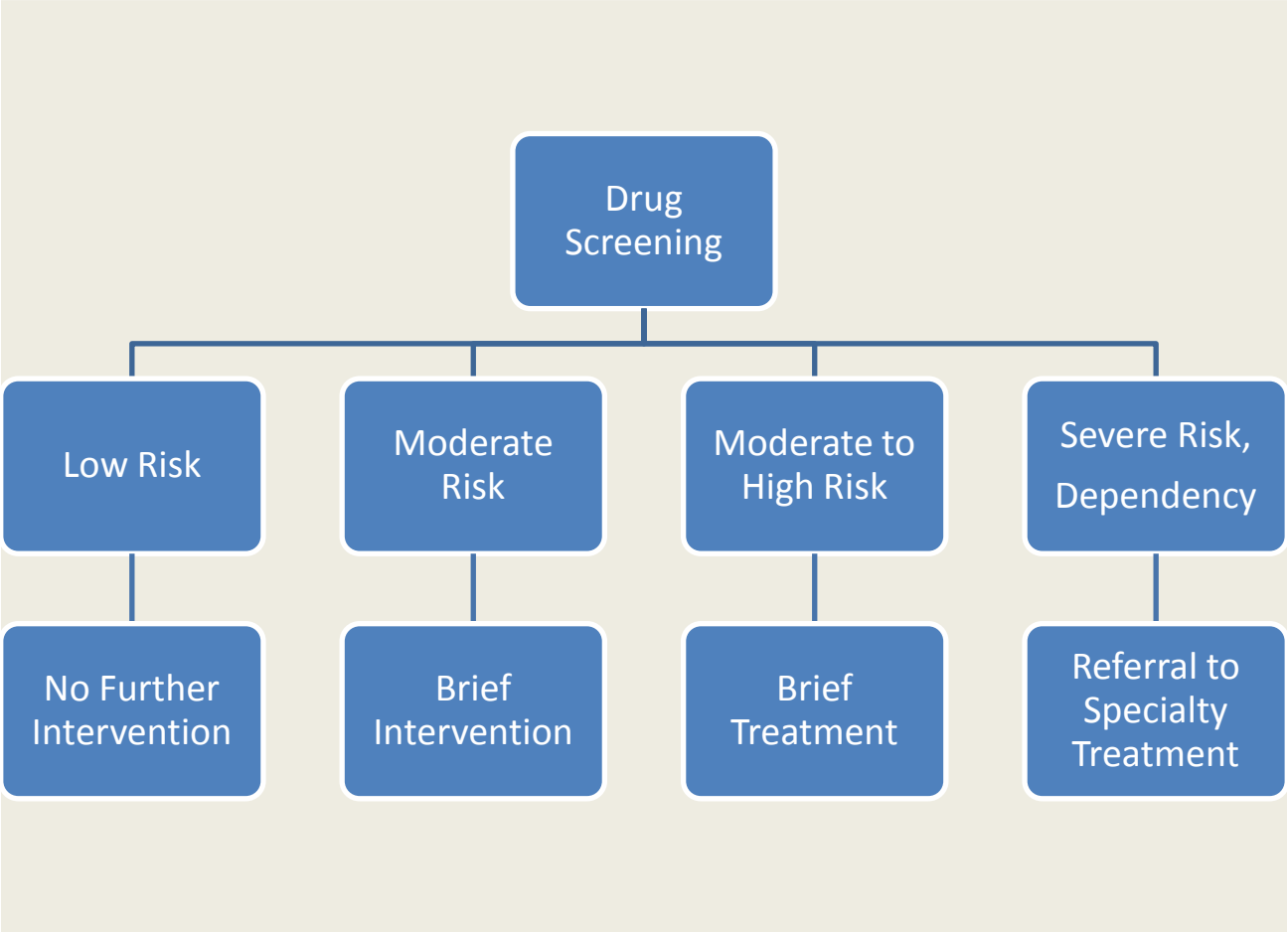

Figure 5

Drug screening tools inform decisions practitioners make in the development of treatment plans that may include prescribing controlled substances. Such tools benefit the practitioner-patient relationship and can result in early intervention leading to cost savings.

Disposal of Unused Prescription Drugs. A task force convened by the Attorney General of Virginia developed a "roadmap" to assist communities in planning and conducting drug disposal events in their localities with the goal of increasing opportunities for the safe and secure disposal of these drugs.

Besides promoting participation at these take-back events, there is a need for continuous access to disposal sites such as drop boxes hosted by local law enforcement.

Community Involvement. Virginia has 18 community-based "Drug Free Organizations". One Care of Southwest Virginia, SAFE in central Virginia, and Concerned in the Winchester/northern Virginia area are just three examples. Energizing community organizations to take ownership of this public health and safety issue, through the development of messages and through the offer of statewide coordinated support, will provide valuable assistance as they determine solutions to prescription drug abuse that make sense for their locality.

NATIONAL GOVERNORS ASSOCIATION POLICY ACADEMY

In July 2012, the National Governors Association (NGA) announced a request for applications from states to participate in its Prescription Drug Abuse Reduction Policy Academy. The goal of the NGA Policy Academy was stated as: "reduce prescription drug abuse by helping states develop and implement comprehensive and coordinated strategies that take advantage of all available tools and resources." The NGA's vision of the process was to gather, under the leadership of governors' offices, senior-level teams of advisors, other state policymakers and stakeholders to participate in a well coordinated planning process to develop a statewide strategic plan to guide state efforts targeted at reducing prescription drug abuse. In September 2012, Virginia was selected by the NGA to receive a year-long $45,000 competitive grant to participate in an NGA sponsored Prescription Drug Abuse Reduction Policy Academy. Other states selected for the important policy development effort were Alabama, Arkansas, Colorado, Kentucky, New Mexico and Oregon.

The Policy Academy consisted of two NGA-conducted sessions—one in Montgomery, AL and another in Denver, CO—for representatives of all the grantee states and an intensive strategic planning effort conducted in-state. Virginia's in-state effort involved extensive outreach to, and participation by, interested stakeholders from the state and Federal government, and representatives of a variety of private sector groups. All involved stakeholders have a direct interest in reducing the abuse of prescription drugs.

Policy Academy Organization for Planning

Virginia's Policy Academy leadership team envisioned an extensive, collaborative effort to develop a state strategic plan. Senior state officials on the front lines in the battle to reduce prescription drug abuse were tapped to lead Virginia's participation in the Police Academy. Governor Robert F. McDonnell named the Director of the Department of Health Professions, Dianne L. Reynolds-Cane, M.D., to lead Virginia's team (TEAM) consisting of Secretary of Health and Human Resources William Hazel, M.D.; Secretary of Public Safety Marla Decker; Virginia State Police Superintendent Colonel W. Steven Flaherty; and Commissioner of Behavioral Health and Development Services James W. Stewart, III. Assisting the TEAM principals was an expanded Workgroup consisting of other representatives of state agencies, the General Assembly and the public.

Virginia's interagency, public-private Workgroup was charged with developing a comprehensive statewide strategy to guide efforts to reduce prescription drug abuse throughout the Commonwealth. The strategic planning approach included developing goals in specific focus areas and crafting objectives for achieving those goals. Planning then proceeded to the development of recommendations for actions to be undertaken to reach the various objectives, as well as the identification of existing and future resources required for implementation of the plan to reduce prescription drug abuse.

The Workgroup was further organized into four Subgroups with a focus on each of four key areas: monitoring, education and training, enforcement, and disposal. Each Subgroup was tasked with conducting a series of meetings in order to develop a detailed plan for each focus area. Each Subgroup had a designated leader(s) with expertise in the respective focus area, and was composed of Workgroup members who also had an interest or expertise in the focus areas (Appendix 5). The Subgroups were organized around the following focus areas and responsibilities:

- **Monitoring Subgroup:** Review and develop recommendations to improve and increase the use of Virginia's Prescription Monitoring Program (PMP) to include: integration of PMP data into Electronic Health Record (EHR) systems, increase interoperability with other state PMPs, and mapping of PMP and other state data to align education, enforcement, and treatment services to allocate resources across the Commonwealth.
- **Training/Education Subgroup:** Review and develop recommendations for educational resources to include: guidance for controlled substance prescribing and dispensing; identifying educational resources for public educators, employers, and community organizations; educating consumers on the dangers of purchasing prescription drugs online; and training for health care providers to introduce them to comprehensive approaches to identification of substance use

issues, early intervention and referral that can be integrated with health care, such as SBIRT (Screening, Brief Intervention and Referral to Treatment).

- **Enforcement Subgroup:** Review and develop recommendations to include: ensuring enforcement of laws, regulations and other actions to improve management of "at risk" patients, explore prosecutor and Drug Court access to PMP data, explore the need for increases in law enforcement drug diversion personnel, and strengthening or updating existing laws.
- **Disposal Subgroup:** Review and develop recommendations to develop a statewide strategic plan for drug disposal, identify funding resources for collection and disposal, and identify educational resources to educate the public, health care providers, law enforcement, and policymakers about safe and effective drug disposal methods.

Policy Academy Workgroup Core Planning

Prescription drug abuse has wide ranging effects on economic activity, individual health and the quality of life in communities throughout Virginia. The effects are reflected by the impact and cost of crime; impact on workforce availability and development; the crippling effects of addiction on individuals, families, friends, and communities; and the high cost of healthcare resulting from the nonmedical use of controlled substances. Virginia's Prescription Drug Abuse Reduction Policy Academy Workgroup and its four Subgroups met in person and via teleconference over a three-month period and developed goals, objectives, and specific recommendations for action, which form the basis of this plan.

Overarching GOAL

Although each Subgroup's goal is specific to that particular Subgroup's focus area, an overarching goal for the Workgroup emerged during the planning process:

"Promote the appropriate use of controlled substances for legitimate medical purposes to prevent and reduce the misuse, abuse, and diversion of these substances."

Focus Area Goals, Objectives AND RECOMMENDATIONS

Monitoring Subgroup

GOAL: Promote the appropriate use of controlled substances for legitimate medical purposes to prevent and reduce the misuse, abuse, and diversion of these substances.

OBJECTIVE 1: Develop widespread and systematic use of the Prescription Monitoring Program by appropriate healthcare providers**.**

OBJECTIVE 2: Expand the use of PMP data for research, evaluation, and investigative purposes and assist the development of policy decisions.

OBJECTIVE 3: Provide training and education on the use of Prescription Monitoring Program.

OBJECTIVE 4: Explore mechanisms to share data and information as allowed by law to other states' regulatory boards or law enforcement.

OBJECTIVE 5: Identify data issues to enhance the value of information in the PMP database to users.

Virginia's Prescription Monitoring Program (PMP) was first implemented as a pilot program covering parts of southwest Virginia in September 2003. Based on an evaluation of that pilot, legislation was passed in 2005 to expand the program statewide and a web-based program was implemented in 2006. In 2009, new software provided 24/7 access with auto-response software to prescribers and pharmacists and in 2011, Virginia's PMP became one of the first 3 states nationwide to become interoperable with another state's program. The PMP is now interoperable with 12 states with several additional programs preparing to start sharing.

RECOMMENDATIONS: (APPENDIX 1)

Leverage Health Information Technology. In 2012, over 850,000 requests for prescription information were processed with 90% of requests coming from prescribers, 8% from pharmacists and the remaining from law enforcement and regulatory personnel. Dispensers report an average of 1.1 million prescription records to the PMP database every month.[13] In order to fully support the reduction of

[13] 2012 Program Statistics, Prescription Monitoring Program Website: www.dhp.virginia.gov.

prescription drug abuse, PMP data must be made available to authorized healthcare practitioners within existing workflow patterns. The PMP must implement mechanisms to improve and increase the use of the program by leveraging health information technologies and through integration of PMP data with VirginiaConnect, the state's Health Information Exchange (HIE), health systems electronic medical records systems, e-prescribing platforms, and pharmacy systems.

Integrate PMP Registration with License Renewal. The PMP is housed in the Department of Health Professions (DHP), an umbrella agency containing 13 health regulatory boards, including all the boards for prescribers and pharmacists (Board of Medicine, Board of Nursing, Board of Pharmacy, Board of Dentistry, Board of Veterinary Medicine and Board of Optometry). One single automated licensing system serves all 13 boards. To achieve 100% PMP registration of Virginia prescribers and pharmacists, DHP will utilize the licensing renewal process and information technology assets to automate the PMP registration process for these licensees.

Develop Data Sets. The PMP holds over 90 million prescription records which are primarily used to provide prescription history reports to authorized users. The Monitoring Subgroup identified as a critical need the use of this data for policy and research: specifically to develop data sets from the PMP to identify trends and assist policy makers in making resource allocation decisions, to assist law enforcement and regulatory investigations, and develop de-identified data sets of PMP prescription data for use by researchers.

Develop PMP Training. Another need is the development of training for prescribers and dispensers on the use of PMP data, starting with basic information as to gaining access, the proper and lawful use of the PMP, and detailed discussion of PMP reports

Other Recommendations. Other recommendations of the Monitoring Subgroup include: add authority for pharmacists to designate delegates; review statutory language for delegates to insure language does not impede access and utilization of PMP data; coordinate future use of PMP by Veterans Health Administration Medical Centers in Virginia and advocate use of PMP by Department of Defense Medical Facilities; identify or develop specific training tools on use of PMP for registered users; and develop a mechanism for "drugs of concern" to be added as "covered substances" requiring reporting of dispensing to PMP.

Training and Education Subgroup

GOAL: Develop educational strategies to promote the appropriate use of controlled substances for legitimate medical purposes and to reduce misuse, abuse and diversion.

OBJECTIVE 1: Develop an online Resource Center for posting information for practitioners, community organizations, citizens, and enforcement and regulatory entities.

OBJECTIVE 2: Provide information and training for practitioners to improve their knowledge about addiction and pain management.

OBJECTIVE 3: Promote the development and use of clinical support tools by healthcare providers through integration with Electronic Health Records and other healthcare software applications.

OBJECTIVE 4: Provide contextual information to law enforcement agencies, prosecutors and courts about the appropriate use of controlled substances for legitimate medical purposes and the misuse, abuse and diversion of prescription drugs.

OBJECTIVE 5: Develop or identify community education and resource tools to enable communities to reduce the critical public health and safety hazard of prescription drug abuse.

RECOMMENDATIONS: (APPENDIX 3)

Resource Center. The need for education, training, and awareness of the issues surrounding the prescribing, dispensing, proper use and storage, and the proper disposal of controlled substances is great. Policy makers, researchers, media, and other interested stakeholders also need access to data and tools that are comprehensive and accessible to meet their specific requirements. To meet these needs the Workgroup suggests the development of the "Commonwealth Controlled Substances Resource Center" (CCSRC). The CCSRC would be web-based and allow for training resources and curriculum specific for prescribers, pharmacists, and other healthcare providers to be housed in one location along with resources for citizens, community organizations, law enforcement, researchers and others. The CCSRC would be housed at the Department of Health Professions, the umbrella agency for both the PMP and the Board of Pharmacy (the state's controlled substance authority).

Training On Pain Management and Addiction. Healthcare professionals are the front line for preventing prescription drug abuse but receive limited training on the prescribing and dispensing of controlled substances, as well as the treatment of pain, substance abuse, and addiction. With prescription

drug abuse at an epidemic level throughout the United States and in the Commonwealth, it is imperative that students preparing for professional careers in healthcare, receive adequate training in these areas as part of their base curriculum or in a residency rotation as appropriate. Therefore, all healthcare teaching institutions in Virginia are encouraged to develop and require competency requirements in their curriculum on these subjects. Furthermore, professional healthcare organizations are encouraged to promote the inclusion of these subjects as a requirement for accreditation of curriculum for teaching institutions.

Continuing Education. Due to the limited amount of training available at teaching institutions and given that new information becomes available on a continuing basis, healthcare professionals need to receive specific continuing education on requirements for the prescribing and dispensing of controlled substances, pain management approaches, assessment for risk of substance abuse/addiction, and development of treatment/referral recommendations if abuse/addiction is identified on a routine and continuous basis. Continuing education is required by health regulatory boards as a mechanism to ensure healthcare professionals remain current in their knowledge and skills. Generally, boards do not mandate specific continuing education topics, although some boards may have the authority to do so. Organizations representing healthcare professionals are a source for continuing education as well as other private and public entities and are an important element in reducing prescription drug abuse. Entities that are sources for continuing education for healthcare professionals are encouraged to develop and make training on these topics available.

Screening Tools. There is a great need to identify screening tools related to the prescribing and dispensing of controlled substances appropriate for use by healthcare professionals and to promote their use as part of risk management procedures. Such tools include SBIRT (Screening, Brief Intervention, and Referral for Treatment) and other screening approaches to include those specifically developed for pregnant women and women of childbearing age as well as for adolescents and other adults.

Community Assistance. Communities directly experience the effects of prescription drug abuse. It is therefore important to develop/identify community education and resource tools to enable communities to reduce the critical public health and safety hazard of prescription drug abuse. Examples of assistance to community groups include providing resources designed to alert and educate consumers on the dangers of purchasing prescription drugs online, reviewing programs in use by Veterans Services to determine if they can be used by communities throughout the Commonwealth, and reviewing products

from entities such as Partnership@drugfree.org and Virginia-based community coalitions for use by community organizations.

Sharing Best Practices/Prescribing and Dispensing Guidelines. Across the Commonwealth prescribing and dispensing guidelines currently being used by health systems, independent practices, and pharmacies should be identified and shared as best practices. Other best practice items include best practices for preventing the theft of controlled substances at healthcare facilities, practices, and pharmacies; identify and promote the use of clinical support tools, especially those that can be integrated with electronic health records and other health information technology; and consumer education related to the safeguarding, storing, and proper disposal of drugs.

Drug Screening. There is a significant need in the Commonwealth for the identification of guidelines, training, and resources for the urine drug screen practices of healthcare providers. The technical information needed to develop this resource requires additional time. Therefore, the Subgroup recommends the formation of an ad hoc committee to examine the issue.

Enforcement Subgroup

GOAL: To strengthen the capacity of law enforcement to reduce prescription drug abuse in Virginia.

OBJECTIVE 1: Improve the ability of law enforcement and regulatory agencies to utilize information held by the Prescription Monitoring Program.

OBJECTIVE 2: Identify possible changes in laws and regulations to aid and enhance drug diversion investigations.

Law enforcement and regulatory actions are essential to protecting public health and safety. The Drug Diversion Section of the Department of State Police is currently the primary law enforcement entity in the Commonwealth with the authority to request and receive data from the PMP. The PMP has expanded access to federal law enforcement agents and, beginning July 1, 2013, access will be expanded to local law enforcement agents with drug diversion investigation authority. While this is an expansion of access to PMP information, it is important to review current law and regulations to discover language that

unnecessarily impedes drug diversion investigations or does not take advantage of information now available.

RECOMMENDATIONS: (APPENDIX 3)

Expanded Access to Disseminate Prescribing/Dispensing Information. The PMP holds over 90 million prescription records. The authority to allow the development of data sets to assist law enforcement and regulatory investigations is a crucial need when allocating law enforcement resources. The PMP is currently authorized to send unsolicited reports related to doctor-shopping and forgeries by recipients to the State Police, but there is an additional need for the PMP to be given authority to analyze and disseminate information related to indiscriminate prescribing and dispensing to law enforcement and regulatory personnel authorized access to the PMP.

Drug Court Access to PMP Information. Drug Courts in Virginia need access to data from the PMP. The PMP also receives requests periodically from probation or parole officers about access to the program. The authority of the PMP should be expanded to allow information relevant to a criminal proceeding to be provided to a court of competent jurisdiction for the purpose of the administration of criminal justice as defined in §9.1-101. This would ultimately permit dissemination to courts as well as probation and parole.

Reports to Third Parties. The PMP is currently authorized to provide a patient's own prescription history report to a person over the age of eighteen. In order to prevent improper access to PMP data, the person must fill out the required form, have it notarized and provide a copy of a government issued identification card. By regulation, the prescription history report may only be sent to the address on the identification card or the report may be picked up in person. In order to accommodate situations where a person desires to have their Prescription History Report sent directly to a third party legislation is needed to authorize this choice. This is identical to current practices for requesting and receiving criminal background checks from the Department of the State Police.

Statute of Limitations. One of the charges for the Enforcement Subgroup was to review the code for possible changes to enhance investigations. The Subgroup specifically identified §18.2-260.1, where the statute of limitations needs to be adjusted to account for the length of time needed to complete investigations. The criminal penalty for this section is a misdemeanor with a generic one year statute of

limitations applied to it. Typically the investigation related to this section of code requires over a year to complete the investigation. The recommendation is to extend the statute of limitations to five years.

Notification to Board of Pharmacy and Virginia State Police. Wholesale distributors of controlled substances are regulated by Drug Enforcement Administration (DEA) and the Virginia Board of Pharmacy. DEA requires wholesale distributors to have policies and procedures in place to prevent diversion and abuse of controlled substances. This includes policies to review procurement history and compare procurement of controlled substances with other customer activity. Recently, actions by DEA against some wholesale distributors have intensified scrutiny of pharmacy procurement of controlled substances and in some cases resulted in pharmacies being suspended from procuring or possessing certain controlled substances. Currently, there is no requirement for wholesale distributors to notify the Board of Pharmacy and Virginia State Police when they cease distribution of controlled substances to a dispenser due to suspicious activity. It is recommended that this requirement be added to the Drug Control Act §54.1 Chapter 34.

Disposal Subgroup

GOAL: Reduce prescription drug abuse by identifying mechanisms to assist patients and facilities to properly dispose of unwanted/unused drugs through methods that are environmentally responsible, convenient, fiscally achievable, and compliant with legal requirements.

OBJECTIVE 1: Increase opportunities for patients to dispose of unwanted/unused drugs via drug take-back programs.

OBJECTIVE 2: Increase opportunities for patients to dispose of unwanted/unused drugs via prescription drug collection sites.

OBJECTIVE 3: Identify opportunities to implement mail-back programs and collection boxes subsequent to Drug Enforcement Administration's regulatory final rule.

According to the 2011 National Survey on Drug Use and Health (NSDUH) produced by the federal Substance Abuse and Mental Health Services Administration, 54.2 percent of non-medical users of pain relievers obtained the drugs they most recently used from a friend or relative for free. Another 12.2 percent bought them from a friend or relative, while 4.4 percent took pain relievers from a friend or

relative without asking.[14] This data demonstrates that Americans have a lot of unused/unwanted drugs in their medicine cabinets. However, it is not necessarily easy to responsibly dispose of unused/unwanted drugs. Under current federal law, controlled substances once dispensed to a patient may not be returned to the pharmacy, prescriber, or any other healthcare professional for disposal. Additionally, there is conflicting federal guidance as to how consumers should dispose of drugs.

Congress passed the Safe Drug Disposal Act of 2010 requiring the DEA to promulgate regulations to broaden the ability of patients to return and dispose of unused/unwanted controlled substances more easily while maintaining controls designed to prevent diversion of these substances. DEA has issued proposed regulations and requested comments which are now being reviewed with final regulations not expected to be available until 2014. Therefore, recommendations from the Disposal Subgroup reflect the conditions that currently exist and not what may be possible once final regulations are put in place.

RECOMMENDATIONS: (APPENDIX 4)

Drug Take-back Days. A small study conducted in southwest Virginia during one of the first DEA sponsored National Drug Take-back Days revealed the great majority of citizens participating in the event traveled no more than 10 miles.[15] Therefore it is imperative to take advantage of and enhance the capabilities of community organizations to conduct and publicize drug take-back events in their communities. Law enforcement organizations should promote to their membership the necessity and importance of law enforcement participation. Healthcare providers and facilities can also be a conduit for increasing awareness of the proper storage and disposal of prescription drugs. The *Hosting A Successful Prescription Drug Take-Back Event—A Roadmap for Local Communities in Virginia* developed by the Attorney General of Virginia's task force in 2011 should be reviewed and updated as necessary to reflect current and future requirements.

Drug Collection Boxes. One of the biggest needs related to disposal is the continuous availability of locations for citizens to safely and securely dispose of their unwanted/unused drugs. While drug take-back events may be hosted by community organizations in cooperation with law enforcement, these are intermittent events. Law enforcement agencies are currently the only locations that may host drug collection boxes for controlled substances that are available on a continuous basis. Law enforcement

[14] 2011 National Survey on Drug Use and Health (NSDUH).
[15] Online First: Prescription Drug Abuse and DEA-Sanctioned Take-Back Events: Characteristics and Outcomes in Rural Appalachia. Jeffrey Gray, PharmD; Nicholas E. Hagemeirer, PharmD, PhD Published online June 25, 2012.

agency-hosting of drug collection boxes provides a community service that should be encouraged. DEA's proposed regulations will expand the use of drug collection box locations to entities other than law enforcement, providing a means of disposal to be explored in the future.

Mail Back Programs. Mail back programs for non-controlled drugs are already available today at local pharmacies. Typically a citizen pays for the envelope in which to place the unwanted drugs, seals the envelope and mails the postage paid package via the Post Office. The package is sent to a disposal/destruction site for safe, secure and environmentally responsible destruction. DEA's proposed regulations expand the use of mail back programs to include controlled substances; providing a means of disposal to be explored in the future.

Other recommendations related to the publishing of disposal regulations by DEA are: In the event DEA no longer sponsors National Drug Take-back Day events, Virginia should encourage the continuation of Drug Take-back Day events in the Commonwealth. When the DEA regulations become final, there will be a need to review them and develop a statewide coordinated effort to take advantage of new avenues for disposal.

SUBSTANCE ABUSE TREATMENT

The Workgroup did not address specific recommendations related to substance abuse treatment. It was widely recognized that reduction of prescription drug abuse must also include considerations for providing adequate and appropriate substance abuse treatment capability.

The benefits of adequate and appropriate treatment capacity to address the clinical care of those who become addicted to prescription pain medication cannot be overstated. Many prescription pain relievers are opioid-based, and evidence is emerging suggesting that people addicted to these pain drugs may progress to using illegal street drugs such as heroin. Effective treatment is available, however, and it may include medication assisted treatment such as Suboxone® or methadone. Suboxone® is a drug that combines two chemicals (buprenorphine and naltrexone) to address the brain's craving and to block the effects of opiates. Suboxone ® can be provided by a physician who is specially trained and credentialed. The training can be obtained online in about eight hours. Methadone also treats craving but must be administered in a clinic setting regulated by both the state and federal government. Although both these drugs designed to treat opiate addiction, they are not interchangeable.

Recent data specific to the southwestern part of Virginia, where the rates of death due to prescription pain medication have been highest, demonstrate that access to appropriate treatment can dramatically lower the death rate. Project REMOTE (Rural Enhanced Model for Opioid Treatment Expansion) was funded by the federal Substance Abuse and Mental Health Services Administration as a Treatment Capacity Expansion grant for three years, from 2006 to 2009, receiving $500,000 for each of the three years. During this period, the grant served 229 adults, and deaths were reduced from 75 in 2006 to 44 in 2009. Participants chose whether to receive "drug free" treatment or whether to receive Suboxone ® or methadone. A key part of the program focused on educating local physicians and pharmacists about the use of opioid-based drugs and local treatment services available in the community and involved conducting 13 events which provided training to 476 health care professionals. Staff from the PMP played an active role in this training. The project also provided physician mentoring to support physicians providing Suboxone® treatment services. An existing community coalition was strengthened by engaging the local health district director, as well as leadership from a pharmacy school. Support services led by people in recovery were also established.

Project Remote and other evidence clearly illustrates that improved access to treatment is a key part of a successful strategy to combat the effects of prescription drug abuse.

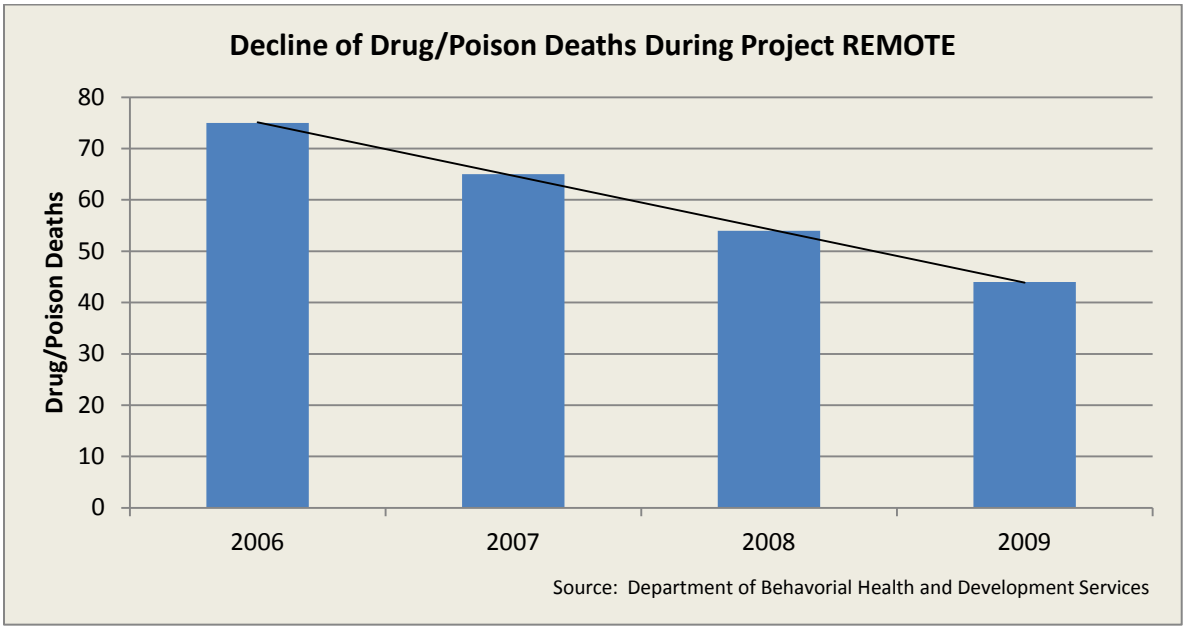

Figure 6

Between 2006 and 2009 Project Remote contributed to the decline in drug/poison deaths in the communities where it was piloted.

In 2011, the Department of Behavioral Health and Developmental Services and eight other state agencies, in concert with public and private providers and advocacy organizations, developed a strategic plan that described successful treatment services in Virginia and made recommendations concerning the types of resources that will be necessary to expand capacity. This plan, *Creating Opportunities for People in Need of Substance Abuse Services* (www.dbhds.virginia.gov/documents/omh-sa-InteragencySAReport.pdf), provides a blueprint for expanding capacity to improve access, fill gaps in the needed array of services, and provide services and supports to necessary to sustain recovery. The Joint Legislative Audit and Review Commission found that, in 2006, Virginia spent $613 million addressing untreated substance abuse, mostly in public safety costs.[16] Cost-benefit information from other states indicates that as much as $7 can be saved for every $1 spent on treatment.[17] Finding resources to address these needs, while beyond the scope of the NGA Project, must become a part of the Commonwealth's strategy to prevent death and injury associated with abuse of prescription drugs.

FUTURE ACTION

Prescription drug abuse is a complex problem requiring a long-term strategy and commitment to action by state agencies and stakeholder entities if it is to be solved. For such a plan to be successfully implemented, it must be given a high priority within state government. An entity must exist to facilitate continued coordination across agency boundaries and between the public and private sectors. For those reasons, the Workgroup recommends the creation of a body such as a Statewide Task Force on Prescription Drug Abuse Reduction. This task force may be co-chaired by the Secretary of Public Safety and the Secretary of Health and Human Resources. The membership may include representatives from the existing Workgroup membership and others as needed. The task force would oversee the implementation of the recommendations contained in this strategic plan, refine and add recommendations as necessary,

[16] Report of the Joint Legislative Audit and Review Commission to the Governor and The General Assembly of Virginia. Mitigating the Costs of Substance Abuse in Virginia. House Document No. 19, 2008.
[17] Gerstein, Dean R., et. Al. Evaluating recovery services: the California Drug and Alcohol Treatment Assessment (CALDATA) submitted to the state of California, Department of Alcohol and Drug Programs by the National Opinion Research Center and Lewis-VHI, Inc., 1994.

and provide an evaluation report with further recommendations on a biennial schedule to the Governor.

Access to treatment for substance abuse is a critical component of prescription drug abuse reduction, but addressing this topic was not included in the scope of the current Workgroup efforts. The task force could also be charged with reviewing updates to the 2011 report described above to be proposed by DBHDS (charged with planning for substance abuse services under COV §37.2-310) to ensure that the plan remains comprehensive, including goals of increasing access to treatment, describing the types and capacity of treatment currently available in the publicly-funded system, identifying existing resources and additional needs, making optimal use of local groups such as peer support organizations, community-level coalitions and proposes recommendations.

Appendix 1: Monitoring Subgroup

Goal: Promote the appropriate use of controlled substances for legitimate medical purposes and reduce/prevent the misuse, abuse, and diversion of these substances.

Objectives	Recommendations	Strategies
1. Develop widespread and systematic use of the Prescription Monitoring Program by appropriate healthcare providers.	a. Add authority for pharmacists to designate delegates under their supervision to access the Prescription Monitoring Program on their behalf. Review broader expansion of delegate authority to take advantage of integration with health system applications and Health Information Exchange (HIE)	1) Draft language to amend §54.1-2526.
	b. Integrate license renewal for prescribers and dispensers to automate registration with the Prescription Monitoring Program.	2) Coordinate an interface between the DHP licensing system and the Virginia PMP.
	c. Achieve electronic access to information by expanding use of PMP InterConnect to 3rd party entities.	3) Partnership with NABP's PMPi to achieve this goal.
	d. Achieve electronic access to information by exploring use of web services and use of statewide Health Information Exchange tools.	4) DHP and VITA to perform the research and planning for statewide HIE tools.
	e. Highlight the benefits of routine use of the PMP as part of overall marketing plan to reduce Prescription Drug Abuse.	5) Stories from stakeholders should be included in the marketing plan.
	f. Advocate the use of the PMP by Virginia VAMCs and DOD Medical Facilities.	6) Coordinate with Veterans Services.
2. Expand the use of PMP data for research, evaluation, and investigative purposes and assist the development of policy decisions.	a. Develop data sets from the PMP to identify trends and assist policy makers in making resource allocation decisions.	1) Determine trends by regions as it relates to the increase in drug usage in terms of pockets of prescribers as well as geographic separation of same.
	b. Develop data sets from the PMP to assist law enforcement and regulatory investigations.	2) Develop data sets by prescriber, by pharmacy, by early prescription refills as

		well as dispensing and prescribing patterns.
	c. Develop de-identified data sets from the PMP for use by researchers.	3) Develop data sets that may be accessed and used for research purposes.
3. Provide training and education on the use of the Prescription Monitoring Program.	a. Identify or develop specific training for prescribers on the use of the PMP.	1) Provide links on Board newsletters, websites and other available tools.
	b. Identify or develop specific training for pharmacists on the use of the PMP.	2) Add a "splash" page after login. Add a "splash" page at periodic bases: after 30 logins, after 90 days, etc.
	c. Identify or develop specific training for investigators on the use of the PMP.	3) Coordinate with NADDI or other organizations to develop this resource.
	d. Identify or develop specific training for researchers on the use of the PMP.	4) Develop description of data elements available for research and how to request data
4. Explore mechanisms to share data and information as allowed by law to other states' regulatory boards or law enforcement.	a. Identify existing state laws or regulations allowing sharing of PMP data via solicited or unsolicited reports.	1) Collect information on existing laws and develop a criteria report.
5. Identify data issues to enhance the value of information in the PMP database to users.	a. Develop mechanism for "drugs of concern" to be added as "covered substances" requiring reporting of dispensing to PMP.	1) Develop legislative proposal to authorize collection of "drugs of concern".

Appendix 2: Training and Education Subgroup

Goal: Develop educational strategies to promote the appropriate use of controlled substances for legitimate medical purposes and to reduce misuse, abuse and diversion.

Objectives	Recommendations	Strategies
1. Develop an online Resource Center for posting information for practitioners, community organizations, citizens, and enforcement and regulatory entities.	a. Develop a Resource Center web page to assist practitioners in the management of patients using controlled substances.	1) Compile page content, as discussed throughout this document.
	b. Develop a Resource Center web page on the proper storage and disposal of drugs.	2) Utilize other forms of social media to promote the Resource Center, such as Twitter and Facebook.
	c. Develop a Resource Center web page to assist practitioners in the use of urine drug screens.	
	d. Develop a Resource Center web page to assist practitioners in the use of approaches to screening for substance misuse, abuse and dependence.	
	e. Develop a Resource Center web page to educate consumers about the dangers of using online pharmacies.	
2. Provide information and training for practitioners to improve their knowledge about addiction and pain management.	a. Identify evidence-based screening tools to help practitioners screen patients for substance misuse, abuse and dependence. Utilize the Resource Center and other online media to disseminate information about how and when to use these tools.	1) Promote and make available information on Screening, Brief Intervention and Referral to Treatment (SBIRT).
		2) Promote and make available behavioral health risks screening tools, including those appropriate for specific populations (e.g., pregnant women and women of childbearing age, adolescents, and older

		adults).
		3) Make information available to prescribers about appropriate pain management for persons with a history of substance abuse/addiction.
	b. Review existing prescribing and dispensing guidelines to identify those that can be shared as best practices in the Commonwealth.	1) Compile input from a variety of sources including major health provider systems and associations.
	c. Develop and disseminate competency expectations for the training of healthcare providers on the prescribing and dispensing of controlled substances, pain management, and substance abuse and addiction.	1) Promote the requirement of a competency area in addiction as a part of the accreditation of teaching facilities, residency programs and other applicable healthcare training programs to include etiology, assessment, diagnosis and intervention.
		2) Promote the requirement of a competency area in pain management as a part of the accreditation of teaching facilities, residency programs and other applicable healthcare programs.
	d. Explore the need, availability and scope of continuing education on pain management, the prescribing and dispensing of controlled substances, and substance abuse and addiction.	1) Address the specific needs of health care practitioners, including prescribers, nurses and pharmacists.
	e. Identify guidelines, training and resources for urine drug screen practices for use by healthcare	1) Appoint an *ad hoc* committee to examine the use of urine drug screens in healthcare settings for

	providers and post to Resource Center web page.	the clinical management of pain medication and for employment purposes when performed by a healthcare professional. Explore liability and confidentiality issues and develop recommendations.
3. Promote the development and use of clinical support tools by healthcare providers through integration with Electronic Health Records and other healthcare software applications.	a. Identify or develop and promote algorithms to guide prescribers when considering the use of controlled substances in a treatment plan.	1) Circulate algorithms for testing to major health care systems for testing and comment.
	b. Identify substance abuse risk assessment tools that can be integrated into Electronic Health Records and other health information technology applications.	1) Post risk-assessment tools to Resource Center. 2) Use hyperlink to connect risk assessment tools to Electronic Health Record.
4. Provide contextual information to law enforcement agencies, prosecutors and courts about the appropriate use of controlled substances for legitimate medical purposes and the misuse, abuse and diversion of prescription drugs.	a. Promote use of Resource Center web page for this purpose.	1) Develop information to provide context for law enforcement concerning the legitimate use of pain medication and post to Resource Center.
5. Develop or identify community education and resource tools to enable communities to reduce the critical public health and safety hazard of prescription drug abuse.	a. Develop or identify tools to support the development of community organizations to conduct outreach and education for communities, to include: (a) dangers of purchasing prescription drugs online; (b) dangers of misusing prescription drugs; (c) safety precautions to be taken when appropriately using prescription drugs, including storing and	1) Review programs in use by Veterans Services to determine suitability for communities. 2) Review products from organizations such as Partnership@drugfree.org and Virginia-based coalitions for use by communities in Virginia.

	disposal; (d) tools to help communities form cohesive organizations, to include input from a variety of stakeholders (e.g., schools, parents, businesses, physical and behavioral health care providers, law enforcement, and recovery community); promote through the Resource Center.	

Appendix 3: Enforcement Subgroup

Goal: To strengthen the capacity of law enforcement to reduce prescription drug abuse in Virginia.

Objectives	Recommendations	Strategies
1. Improve the ability of law enforcement and regulatory agencies to utilize information held by the PMP.	a. Develop data sets from the PMP to assist law enforcement and regulatory investigations.	1) Agencies: DHP and VSP Mechanism: Legislation
2. Identify possible changes in laws and regulations to aid and enhance drug diversion investigations.	a. Expand authority of the PMP to analyze and disseminate information related to indiscriminate prescribing or dispensing to law enforcement and regulatory personnel authorized access to PMP data.	1) DHP and VSP Legislation to permit creation of target list and dissemination of target info to VSP and DHP Enforcement Division.
	b. Expand authority of the PMP to allow the providing of information relevant to a criminal proceeding to a court of competent jurisdiction for the purpose of the administration of criminal justice as defined in §9.1-101.	1) DHP and VSP Legislation to permit dissemination to courts, re 54.1-2523
	c. Expand authority to allow a person to direct the further dissemination of his prescription history from the PMP to a third party as he deems appropriate.	1) DHP and VSP Legislation re 54.1-2523
	d. Identify statutes, such as §18.2-260.1, where the statute of limitations may need to be adjusted to account for length of time investigations.	1) VSP Legislation to increase statute of limitations for 18.2-260.1 to five years

	e. Require wholesalers to notify Board of Pharmacy and VSP whenever they cut off a dispenser for reasons other than nonpayment.	1) DHP and VSP Legislation

Appendix 4: Disposal Subgroup

Goal: Reduce prescription drug abuse by identifying mechanisms to assist patients and facilities to properly dispose of unwanted/unused drugs through methods that are environmentally responsible, convenient, fiscally achievable, and compliant with legal requirements.

Objectives	Recommendations	Strategies
3. Increase opportunities for patients to dispose of unwanted/unused drugs via drug take-back programs.	a. Increase awareness with law enforcement of the importance of holding or assisting drug take-back events.	1) Communicate with Virginia Sheriffs' Association, Virginia State Police, and Virginia Association of Chiefs of Police to encourage them to sponsor or assist with take-back events. 2) Update and provide the OAG's guidance for hosting a drug take-back event. ~~3)~~ Provide list of resources – state web page on drug abuse and drug disposal options, list of approved incinerators for disposal, diversion information, links to DEA and other Diversion Prevention groups, Poison Control, Governors Office for Substance Abuse Prevention (GOSAP); provide relevant links, e.g., The Partnership at Drugfree.org, SAAVY Initiative; develop mechanism

		to send notifications via social media to reach teens. 4) Provide resources to help law enforcement properly dispose of evidentiary drugs that are no longer needed, and the documentation required by the Board of Pharmacy. Encourage law enforcement to develop guidance and training for their staff. 5) Encourage presentations by law enforcement that held successful take-back events to share lessons learned.
	b. Increase awareness with large groups that could benefit from a partnership with law enforcement to hold drug-take back events. Health care providers, communities, (public utilities, civic organizations, environmental organizations) long term care facilities, hospice programs, and funeral homes to partner with law enforcement to hold drug take-back events.	1) Reach out to health care providers to provide information to patients on how to properly dispose of unwanted drugs and to provide guidance on hosting a drug-take back event. This could include medical centers, LTC facilities, hospice programs, funeral homes, veterinary offices, poison control centers, etc. Work with EPA and DEA to identify and address obstacles potentially created by the Resource

		Recovery and Conservation Act (RCRA) for residents in LTC facilities to dispose of drugs via take-back events 2) Communicate with associations representing government groups, religious groups, schools, colleges, communities, AARP, public utilities, and environmental organizations to inform them of take-back events and how to hold them, provide OAG's guidance for hosting a take-back event, provide links to helpful resources. Find PSA's on the problems associated with diversion, and make them available to the groups who want to hold a take-back event. Suggest combining collection events in communities with recycling day; recommend use of news media, community organizations, and schools to promote event.
	c. Increase awareness with the public of the importance of responsible	1) Encourage funeral homes, hospitals, and long term care

	drug disposal at take-back events.	facilities to educate families of decedents about take-back events and importance of proper disposal of drugs. 2) Develop online resource page for any person or entity to learn about prescription drug abuse and importance of proper disposal of drugs. This could be done through the GOSAP; provide relevant links, e.g., The Partnership at Drugfree.org, SAAVY Initiative; develop mechanism to send notifications via social media to reach teens
	d. Promote the development of a mechanism for alerting the public of upcoming drug collection events.	1) Within the developed online resource page, build in "locator" search capability to identify upcoming take-back events throughout Virginia. Encourage hosts of events to post event information on resource page. 2) Encourage community

		organizations and schools to promote upcoming local take-back events. 3) Notify media of upcoming events.
	e. Identify any financial assistance available for programs.	1) Identify organizations, corporations, and businesses who might subsidize part of costs as service to community. 2) Offer Governor recognition of corporation and individual involvement.
	f. Review OAG's document, "Hosting a Successful Prescription Drug Take-Back Event" for possible revisions to best practices.	1) Encourage participating groups who initially developed the document to review for possible revisions
4. Increase opportunities for patients to dispose of unwanted/unused drugs via drug collection sites.	a. Increase number of law enforcement agencies participating as drug collection sites.	1) Contact Washington state and NADDI to learn of collection site best practices and costs. 2) Identify any currently participating law enforcement agencies in Virginia, identify best practices and costs. 3) Communicate best

		practices and projected costs with law enforcement agencies and encourage participation.
5. Identify opportunities to implement mail back programs and collection boxes after DEA's proposed rules become final.	a. Reconvene Subgroup members after rules are final to identify opportunities to implement mail back programs and collection boxes.	1) Monitor promulgation of DEA's regulations and reconvene Subgroup when regulations final.

Appendix 5: Workgroup Membership

MEMBER	ORGANIZATION	NOTES
Dianne Reynolds-Cane, M.D.	Director, Department of Health Professions	TEAM Leader
William Hazel, M.D.	Secretary, Health and Human Resources	TEAM Member
Marla Decker	Secretary, Department of Public Safety	TEAM Member
Jim Stewart	Commissioner, Department of Behavioral Health and Developmental Services	TEAM Member
COL Steven Flaherty	Superintendent, Virginia Department of State Police	TEAM Member
Arne Owens	Chief Deputy Director, Department of Health Professions	Chair, Workgroup
Caroline Juran, RPh	Executive Director, Board of Pharmacy, Department of Health Professions	Co-Chair-Disposal
Deborah DeBiasi	State Coordinator for Whole Effluent Toxicity Program, Pretreatment Program, and Microconstituents, Office of VPDES Permits, Virginia Department of Environmental Quality	Co-Chair Disposal
Mellie Randall	Director, Office of Substance Abuse Services, Department of Behavioral Health and Development Services	Chair, Training-Education
Ralph Orr	Director, Prescription Monitoring Program, DHP	Chair, Monitoring
LTC Robert Kemmler	Director, Bureau of Administrative and Support Services, Virginia Department of State Police	Chair, Enforcement
1SGT John Welch	Drug Diversion Unit, Virginia Department of State Police	
Andrew Molloy	Chief Deputy Director, Department of Criminal Justice Services	
Bob Bushnell	Virginia Commonwealth Attorney Association	
Catherine Wilson	Executive Director, Wounded Warrior Program, Department of Veterans Services	
Dana Schrad	Executive Director, Virginia Association of Chiefs of Police	
Dave Kozera, RPh	Chair, Board of Pharmacy	
Delegate Keith Hodges	Virginia House of Delegates	
Mary McMasters, M.D.	Addictionologist, Representative of MSV	
Nadeem Ahmed, PhD	Crossroads Community Service Board	
Terry Dickinson, DDS	Executive Director, Virginia Dental Association	
Elizabeth Carter, PhD	Executive Director, Board of Health Professions	

Enrique Cancel	Group Supervisor, Richmond Office, DEA	
Gail Jaspen	Deputy Director, Department of Forensic Science	
Gwen Mason	Office of US Attorney Western District, Virginia	
John Beckner, RPh	Retail Pharmacist, Martins	
Kathy Miller	Director of Programs, Department of Aging and Rehabilitative Services	
Kim Barnes	Office Information Management, Virginia Department of Health	
Lauren Rowley	Vice-President, Government Affairs, CVS Caremark	
Leslie Blackhall, MD	Palliative Care, University of Virginia	
Lindsey Jones, CPhT	Pharmacy Operations, CVS Caremark	
LTC Neal Edmonds	Virginia National Guard	
Mark Blackwell	Executive Director, Substance Abuse and Addiction Recovery Alliance	
Mary Johnson-Rochee	Diversion Program Manager, DEA	
Matthew Wade	Regional Director, Region 3, Department of Veterans Services	
Mike Jurgensen	Executive Director, Medical Society of Virginia	
R. Neal Graham	Virginia Association of Community Health Centers	
Richard Vaughan	Sheriff, Grayson County, Virginia Sheriffs Association	
Robert Bradley	Director of Membership Support, Virginia Association of Free Clinics	
Sandy McCleaf	Executive Director, ConnectVirginia	
Sarah Melton, PharmD	President, OneCare of Southwest Virginia	
Senator Barbara Favola	Senate of Virginia	
Sharyl Adams	Substance Abuse Prevention Specialist, SAFE of Chesterfield	
Susan Ward	Vice-President and General Counsel, Virginia Hospital and Healthcare Association	
Tim Musselman, PharmD	Executive Director, Virginia Pharmacists Association	
Wayne Frith	Executive Director, SAFE of Chesterfield	