

**Recommendations of the Governor's Task Force on  
Prescription Drug and Heroin Abuse**

**Implementation Plan – Update, Fall 2015**

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October 20, 2015

# Implementation Plan of the Governor’s Task Force on Prescription Drug and Heroin Abuse

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# I. Executive Summary

On September 26, 2014, Governor McAuliffe established the Task Force on Prescription Drug and Heroin abuse, a 32-member, multi-disciplinary and bipartisan group of leaders from across the Commonwealth. The Task Force, created through Executive Order 29, was directed to craft policy recommendations in order to respond to the growing opioid and heroin overdose epidemic that has taken the lives of thousands of Virginians. Five supporting workgroups – Education, Treatment, Data and Monitoring, Storage and Disposal, and Enforcement – served to develop and suggest recommendations to the Task Force.

The Task Force ultimately agreed upon and recommended over 50 initiatives to the Governor. These recommendations were submitted, pursuant to the directive of the establishing Executive Order, by the Co-Chairs of the Task Force, Secretary of Health and Human Resources, William A. Hazel, Jr., M.D. and Secretary of Public Safety and Homeland Security, Brian J. Moran, as an Implementation Plan to Governor McAuliffe on June 30, 2015.

As the factors of this epidemic do not remain static, neither must our responses. The Task Force held a final meeting on September 21, 2015, submitting additional recommendations and updates to the Implementation Plan, which are contained herein. The process of implementing these initiatives will continue with both public and private partners moving forward, and subsequent updates will be submitted accordingly.

## II. Introduction

Prescription opioids, which are derived from some of the same sources as the street drug heroin, are used to treat both chronic and acute pain. They, like heroin, can create dependence, and overdosing can cause death. In Virginia, overdose deaths are occurring in all parts of the state and across all walks of life. The number of these fatalities is steadily rising. For some individuals, prescription opioids are just the beginning; what begins as abuse, misuse, or overuse of a prescription opioid can evolve into the use of heroin, which is often cheaper and easier to obtain but has very similar effects.

The Governor's Task Force on Prescription Drug and Heroin Abuse was formed in September 2014 in response to the alarming rise in overdose deaths from both prescription drugs and heroin in Virginia. As part of his *A Healthy Virginia* plan, Governor McAuliffe included an initiative to address and reverse this disturbing, and so often preventable, trend. The Task Force was charged with developing recommendations that would deliver potential solutions to the many factors that have led to the current crisis.

Five Workgroups were defined in the Executive Order:

- Education
- Treatment
- Data and Monitoring
- Storage and Disposal
- Enforcement

The Workgroups, composed of both Task Force members and other subject matter experts, were given subject-specific charges. Each workgroup met and studied the issues independently, reported their findings, and proposed recommendations for Task Force approval. Although each Workgroup had specific areas of focus, several compelling themes emerged as the groups engaged in a total of twenty-five meetings.

*Access to and availability of treatment options.* The lack of access to treatment for drug addiction in Virginia is a major barrier to overcoming prescription opioid and heroin abuse, misuse and overuse.

*Insufficient support for law enforcement.* A common and poignant statement from law enforcement professionals was, "We cannot arrest our way out of this problem." Law enforcement must have access to the training, support, and tools that can help end the costly cycle of incarceration, and increase opportunities for effective treatment without compromising public safety.

*Prevalence of proper prescribing practices.* Providers need focused education on opioid addiction, how to treat pain effectively, and where to refer individuals for treatment if addiction is identified.

These issues, along with many others, are addressed in this Implementation Plan. Leveraging public health data, and data from Virginia's Prescription Monitoring Program (PMP), will be a key component in setting goals and monitoring progress.

## ***Workgroups and charges issued by Governor McAuliffe in Executive Order 29:***

### ***Education***

The Commonwealth cannot make significant strides in decreasing overdose deaths without the investment of legislators, health care providers, law enforcement, community leaders, and the general public. Providing the right informational resources and ensuring continued focus on this issue will arm these groups with the tools they need to be partners in combating abuse, misuse, overuse, and ultimately, overdose.

- Raise public awareness about the dangers of misuse and abuse of prescription drugs.
- Distribute information about appropriate use, secure storage, and disposal of prescription drugs.
- Train health care providers regarding best practices for opioid prescribing, pain management, the use of the PMP, and identification and treatment of individuals at risk of substance abuse through screening, intervention, and referral tools.
- Train first responders to more effectively respond to calls involving overdose, and use evidence-based interventions to reduce overdose deaths.

### ***Treatment***

Treatment is an essential component of the Commonwealth's plan to address the epidemic of prescription drug and heroin addiction. Individuals who receive substance abuse treatment are less likely to engage in criminal activity and more likely to be employed. Substance abuse treatment, when provided at the needed intensity and duration, is just as successful as treatment for diabetes, asthma or hypertension. Moreover, drug treatment is cost-effective, when considering the fiscal impacts on healthcare costs, lost productivity, and incarceration. Studies indicate that every \$1 invested in treatment yields up to \$7 in reduced costs associated with crime, and this return increases to \$12 if health care costs are included.

- Improve access to and availability of treatment services.
- Foster best practices and adherence to standards for treatment of individuals addicted to opioids.
- Strengthen and expand the capacity of Virginia's health workforce to respond to substance abuse treatment needs including encouraging health professions schools and continuing education programs to provide more education about how to identify and treat substance abuse.

### ***Data and Monitoring***

The importance of accurate and timely data cannot be understated as the Commonwealth develops strategies to decrease opioid overdose deaths. Specifically, the PMP is a key tool for both policymakers and practitioners in understanding the nature of prescribing practices in Virginia.

- Share and integrate data among relevant licensing boards, State and local agencies, law enforcement, courts, health care providers and organizations, and programs such as the PMP in order to clarify and address public safety and public health concerns, understand emerging trends, and utilize data-driven decision-making to mitigate harm.

### ***Storage and Disposal***

Per the 2013 National Survey on Drug Use and Health, “Rates averaged across 2012 and 2013 show that more than half of the nonmedical users of pain relievers, tranquilizers, stimulants, and sedatives aged 12 or older got the prescription drugs they most recently used "from a friend or relative for free." Storing prescription drugs in a secure manner and disposing of them properly when no longer medically needed will reduce the opportunity for abuse or misuse of prescription drugs and the potentially harmful effects on the environment.

- Advance effective solutions that lead to safe storage and proper disposal of potentially dangerous prescription drugs.

### ***Enforcement***

Law enforcement officers are often first on the scene of an overdose. Giving law enforcement and first responders the support and resources that they need to help Virginians experiencing overdose and addiction is imperative in reducing overdose deaths. The justice system must be properly prepared to handle the nuanced and complex issues surrounding addiction.

- Identify and promote evidence-based practices and strategies across the criminal justice system to address public safety risks and treatment needs of individuals with opioid addiction, training in the use of life saving interventions, expanded alternatives to incarceration, including drug courts, and cross-system collaboration to improve access and the availability of treatment.

### III. 2015 Legislative Successes and Implemented Recommendations

These 12 recommendations are presented according to subject matter and are not ordered by priority.

#### **A. Expand access to naloxone by lay rescuers and law enforcement to prevent death from overdose.**

Expanding access to naloxone to first responders could save the lives of individuals who are overdosing from an opioid.

*Bill Number:* HB 1458  
*Introduced by:* Delegate John O'Bannon III, M.D.

*Bill Summary:*

The bill provides immunity for anyone who, in good faith, prescribes, dispenses, or administers naloxone or other opioid antagonist used for overdose reversal in an emergency. It also allows pharmacists to dispense naloxone or another opioid antagonist used for overdose reversal pursuant to an oral, written, or standing order, in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and the Virginia Department of Health (VDH). Additionally, firefighters and law-enforcement officers who have completed a training program may possess and administer naloxone in accordance with protocols developed by the Board of Pharmacy in consultation with the Board of Medicine and VDH.

*\*Recommendations of Treatment Workgroup to 1) expand access to naloxone by lay rescuers and law enforcement to prevent death from overdose and 2) increase access to naloxone by allowing pharmacists to dispense naloxone under proper protocols, and Enforcement Workgroup to expand access to naloxone for all first responders as an optional, not mandatory, resource and include immunity from liability.*

#### **B. Expand mandatory PMP registration and amend mandatory use of PMP data.**

Expanding mandatory registration and use of the PMP would prevent and reduce the likelihood of individuals from “doctor-shopping.” Section 54.1-2522.1 of the *Code of Virginia* would be amended to add pharmacists to the mandatory PMP registration requirement. Amending this law would also include the removal of language that could potentially discourage use of treatment agreements.

*Bill Number:* HB 1841  
*Introduced by:* Delegate Charniele Herring

*Bill Summary:*

Requires the Department of Health Professions (DHP) to register every dispenser licensed by the Board of Pharmacy with the PMP and eliminates the requirement that every prescriber who is licensed to treat human patients must be registered upon filing of an application for licensure or renewal of a license. The bill removes the requirement that a treatment agreement be entered into before a prescriber who prescribes benzodiazepine or an opiate must request information from the Director of the DHP PMP to determine what other covered substances are currently prescribed to a patient. The bill also limits the requirement to request information from the PMP to cases in which the course of treatment is anticipated at the onset of treatment to last more than 90 days. The provisions of the bill relating to registration of dispensers and prescribers become effective on January 1, 2016.

*\*Recommendation of Data and Monitoring Workgroup*

**C. Clarify that PMP data shall not be available for use in civil proceedings.**

Preventing PMP data from being used in civil matters would allow prescribers to provide medical assistance to their patients without fear of civil action.

*Bill Number:* HB 1810  
*Introduced by:* Delegate Charniele Herring

*Bill Summary:*

Protects data in the PMP from being used inappropriately in civil proceedings. The PMP is a vital tool for health care providers in making safe treatment and prescribing decisions.

*\*Recommendation of Data and Monitoring Workgroup*

**D. Require hospice to notify pharmacies about the death of a patient.**

Requiring hospice programs, under certain circumstances, to notify pharmacies of the death of a patient who has been dispensed partial quantities of a Schedule II drug will mitigate the diversion and abuse of the quantity of drug remaining on the prescription.

*Bill Number:* HB 1738  
*Introduced by:* Delegate M. Keith Hodges

*Bill Summary:*

Requires every hospice licensed by the Department of Health or exempt from licensure with a hospice patient residing at home at the time of death to notify within 48 hours of the patient's death every pharmacy that has dispensed partial quantities of a Schedule II drug to the hospice patient.

*\*Recommendation of Storage and Disposal Workgroup*

**E. Increase access to naloxone by allowing pharmacists to dispense naloxone under proper protocols.**

The 2015 Session of the General Assembly enacted HB 1458, which allows pharmacists to dispense the medication operating under a protocol from a physician, permits law enforcement and fire fighters to utilize naloxone, and provides civil protections for all those involved.

**Implementation Steps:**

- The DHP Board of Pharmacy will continue to collaborate with the Department of Behavioral Health and Developmental Services (DBHDS) to develop protocols that will permit pharmacists to dispense naloxone under an agreement with a physician to individuals who have been trained to administer the medication
- The DHP Board of Pharmacy will continue to collaborate with DBHDS, the Department of Criminal Justice Services (DCJS) and the Department of Fire Programs (VDFP) to develop protocols that will allow law enforcement officers and fire fighters to access the medication
- DCJS, in consultation with DBHDS, will develop a curriculum to train law enforcement officers to utilize naloxone that will meet its standards for continuing education
- DBHDS will consult with VDFP to explore the development of a curriculum to train fire fighters who are not already certified Emergency Medical Technicians (EMTs) to use naloxone

**Continuing Action Required:** Interagency collaboration; possible funding to procure naloxone for local law enforcement and fire fighters

*\*Recommendation of Treatment Workgroup*

**F. Develop a law enforcement training program regarding naloxone administration.**

Upon the expansion of the naloxone pilot to law enforcement through HB 1458, law enforcement must be given the opportunity to learn how to use the overdose antagonist. The DCJS has taken the lead on this.

On June 4, 2015, DCJS met with Jason Lowe, Manager of the REVIVE! training program, as well as representatives from local police departments, sheriffs' offices, and the Virginia State Police, to modify existing training material for use for law enforcement training. Ongoing trainings are underway.

*\*Recommendation of Education Workgroup*

**G. Add the Morphine Equivalent Doses per Day (MEDD) Score to PMP patient reports to provide prescribers and dispensers with information as to the cumulative amount of opioid medication a patient is currently receiving in order to gauge potential risk of overdose.**

Implemented June 2, 2015.

*\*Recommendation of Data and Monitoring Workgroup.*

**H. Determine preferred methods for disposing of unwanted/needed drugs.**

A survey of Virginia law enforcement was conducted the first week of June, 2015.

*\*Recommendation of Storage and Disposal Workgroup*

**I. Send a letter to all prescribers and dispensers about the PMP, focusing on the urgency of the overdose epidemic.**

This was fulfilled through the “Dear Colleague” letter sent on January 30, 2015.

**Continuing Action Required:** This letter should be posted on the State website.

*\*Recommendation of Education Workgroup*

**J. Determine Virginia’s need to promulgate regulations regarding pharmacy collection and mail-back programs via legal guidance.**

Recently-enacted federal regulations recently enacted authorize pharmacies and certain other facilities to install drug collection boxes and utilize mail-back programs for receiving and disposing of unwanted prescription drugs. There was a question as to whether the Board of Pharmacy must also promulgate regulations on the subject to authorize these allowances in state law. The Office of the Attorney General (OAG) advised the Board that it could not enforce the Federal requirements for these allowances without promulgating regulations on the subject. The Board subsequently adopted a Notice of Intended Regulatory Action (NOIRA) to promulgate regulations similar to the Federal regulations.

**Continuing Action Required:** Monitor status of promulgation of regulation.

*\*Recommendation of Storage and Disposal Workgroup*

**K. Review and update the OAG’s “Take Back Event” document.**

A manual for how to successfully host a drug take-back event was published by the OAG several years ago. It was recommended to review this manual to ensure the information remains current.

The OAG assured the Task Force that the information in the manual was current and that the manual is readily available for law enforcement.

*\*Recommendation of Storage and Disposal Workgroup*

**L. Explore the feasibility of using mobile incinerators for drug disposal.**

In reviewing best methods for disposing of drugs collected by law enforcement, it was recommended to research the possibility of utilizing mobile incinerators. It was determined that while the Environmental Protection Agency (EPA) exempts the use of mobile incinerators from required testing when destroying “contraband or prohibited goods,” the EPA does not consider take-back pharmaceuticals contraband or prohibited goods. Therefore, law enforcement using mobile incinerators to destroy take-back drugs must conduct required testing. Furthermore, the EPA indicated it intends to remove the testing exemption for contraband and prohibited goods in next 2-3 years.

Thus, mobile incinerators do not appear to be a viable or sustainable option for destroying collected medications.

*\*Recommendation of Storage and Disposal Workgroup*

## IV. Recommendations Being Implemented

These eight recommendations are presented according to subject matter and are not ordered by priority.

### **A. Develop a state website as an informational hub on prescription drug and heroin abuse.<sup>1</sup>**

This existing recommendation of the Task Force is underway at the direction of the Department of Health Professions through the Board of Medicine. Funding has been secured and planning has commenced.

#### **Implementation Step:**

- Administrative decisions must be made; DHP and a subgroup of the Education Workgroup are meeting to continue discussions

**Additional Action Required:** DHP has met with relevant agencies; VDH could hold responsibility for main site, DBHDS could hold main content, other info could be under responsibility (SD), Education and resources (DHP), Health professionals (DHP), law enforcement (DCJS). For both public and professionals. Training opportunities. Each agency would have one person who is responsible, but each group would have a person to inform and develop content. Narrow perception of this being an “abuse” issue. Vendors will put out specific proposals for cost and maintenance costs. Easy to use platform to allow for access. Ongoing administration of this website needs to be decided.

*\*Recommendation of the Education and Storage and Disposal Workgroups*

### **B. Create and send “Dear Colleague” letters and stock op-eds.<sup>2</sup>**

This recommendation has been partially fulfilled through a letter sent to prescribers from Secretary Hazel on January 30, 2015.

#### **Implementation Steps:**

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- This recommendation initially included similar communication from the Secretary of Education as well; a more comprehensive approach for K-12 students will be to coordinate with the Department of Education to review existing opioid education and uncover best practices that are replicable for Virginia’s varying educational systems. Specifically, the

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<sup>1</sup> Updated Fall 2015

<sup>2</sup> Updated Fall 2015

Education Workgroup suggests targeting 11<sup>th</sup> and 12<sup>th</sup> grade students in the Commonwealth, as they are at a crucial developmental point and transitioning to young adulthood.

- Op-eds from various angles of this issue will be drafted by the Office of the Secretary of Health and Human Resources and can be placed in media outlets around Virginia at strategic times to coincide with events and earned media.

**Additional Action Required:** Similar communications can continue to be created as necessary; K-12 education will require significant coordination with Department of Education staff.

*\*Recommendation of the Education Workgroup*

### **C. To increase disposal opportunities via drug take-back events held within the community.**

Increase awareness of the public, law enforcement, and community organizations regarding concerns with prescription drug abuse, the importance of properly disposing of unwanted prescription drugs, how to locate drug take-back events within the Commonwealth throughout the year. Identify financial opportunities to assist community organizations in successfully holding drug take-back events, in partnership with law enforcement.

#### **Implementation steps:**

- Letter sent in June 2015 to Superintendent of Education from Secretaries of Public Safety and Health and Human Resources, requesting him to forward the information to school board members, educators, principals, school nurses, and parents emphasizing the importance of properly disposing of leftover drugs at the end of the school year and not disposing of them via toilets and drains, as this potentially causes toxicity spikes in our water ways on or shortly after the last day of the school year.
- Secretaries of Public Safety and Health and Human Resources should send emails to law enforcement and various community organizations to increase their awareness of the concerns with prescription drug abuse, importance of properly disposing of prescription drugs such as through drug take-back events organized by community organizations in partnership with law enforcement held at various times throughout the year, and how to successfully hold a take-back event
- Collaborate with Education Workgroup to develop a state website as an informational hub on prescription drug abuse with resource for alerting public of disposal opportunities and upcoming take-back events, along with lawful opportunities to donate certain qualifying drugs to be re-dispensed to indigent individuals

**Additional Action Required:** DHP, DCJS, and other appropriate agencies, as necessary, to collaborate on: development of draft language for email communications from Secretaries to various audiences to increase awareness of prescription drug abuse; importance of participating in drug take-back events and for community organizations to fund such events; the suggesting of informational resources for state website; and development of a mechanism for receiving notifications regarding upcoming take-back events to include in locator resource on state website

*\*Recommendation of Storage and Disposal Workgroup*

**D. Develop an opioid educational curriculum for law enforcement, corrections, probation and parole, EMTs, Crisis Intervention Team (CIT) officers, and School Resource Officers.**

This existing recommendation is currently being developed by DCJS, VDH, and DBHDS using CIT training as a model. This effort could be furthered by the establishment of a cross-system multi-disciplinary training that needs to focus on awareness, scope of epidemic, and substance abuse recognition for parents and other community members.

**Additional Action Required:** Ongoing oversight by Secretariats

*\*Recommendation of the Education and Enforcement Workgroups*

**E. To reduce stigma and increase access to treatment services, provide education about addiction and Medication Assisted Treatment (MAT) to health care providers, students, community services board (CSB) staff, law enforcement and community leaders.**

The general public lacks understanding that addiction is a brain disease with serious physical, psychological, social, legal and economic consequences. Many continue to view addiction as a moral failing or character flaw that can be addressed by will power or just by “straightening up.”

While some individuals may not require MAT, research indicates that treatment outcomes for opioid addiction are substantially improved when individuals are assisted by medications designed to address cravings, and by engagement in counseling, therapy and support services. However, many treatment providers and key members of the support community do not understand the importance of these medications in the treatment continuum and need additional education and training to learn how to integrate these resources into their communities.

**Implementation Steps:**

- The Task Force has endorsed the summary paragraph of the official consensus statement of the National Association of State Alcohol and Drug Abuse Directors on Medication Assisted Treatment:

*“Individuals seeking treatment for substance use disorders should be educated about all treatment options, including use of medications, so they may make informed decisions about their care. For some people, medication will be unnecessary. For others, it may be a helpful tool for recovery. For still others, medication (such as methadone, buprenorphine, and naltrexone) will be a crucial component of treatment without which the prognosis for recovery is very poor. In all cases, the use of addiction medications should be considered and supported as a viable treatment strategy in conjunction with other evidence-based practices and as a path to recovery for individuals struggling with substance use disorders.*

*In addition, we recommend that public and private health insurance plans cover medication for the treatment of opioid dependence.”*

- Collaborate with Education Workgroup. See Education Workgroup charge regarding training health care providers for information about education for behavioral health care professional school education. Information about assessment and treatment options should be added to these curricula.
- DBHDS will collaborate with the Substance Abuse Council of the Virginia Association of Community Services Boards and other professional organizations to develop and provide training and technical assistance to CSB staff and contract agencies about evidence-based methods of treating opioid addiction and successful methods of implementing MAT in their treatment systems.
- DBHDS will collaborate with DCJS to develop training about addiction as a brain disease and the role of medication in treatment.

**Addition Action Required:** Collaboration and funding

*\*Recommendation of Treatment Workgroup*

#### **F. Explore and expand use of appropriate peer support services, with necessary oversight.**

The impact of mentoring and coaching by a person with lived experience who has successfully navigated recovery cannot be overstated. The assistance of peer coaches is particularly important for individuals utilizing medication-assisted treatment as these individuals are sometimes ostracized from 12-step groups.

DBHDS has established a certification process for individuals who may wish to pursue the provision of peer services as a career. This process assures that individuals providing peer services are knowledgeable about the science of addiction and mental illness, understand appropriate personal boundaries and possess specific skills necessary to provide peer support to a variety of individuals seeking recovery from addiction and mental illness.

#### **Implementation Steps:**

- DBHDS will continue to implement its peer certification process.
- DBHDS will collaborate with the Department of Medical Assistant Services (DMAS) to establish peer services as a reimbursable service.

**Additional Action Required:** Interagency collaboration with DMAS and peer-service organizations providing training.

*\*Recommendation of Treatment Workgroup*

**G. Ensure health plans are complying with the Mental Health Parity and Addiction Equity Act (MHPAEA) by providing adequate coverage for treatment, including medication-assisted treatment.**

Federal law, enacted in 2008, requires that insurance health plans provide coverage that is equal to that provided for physical health care. However, if providers are not routinely screening for and referring patients with addiction for substance abuse treatment, as they do with other specialty care services, it is possible that the plan may not cover the treatment.

Of note, the 2015 Session of the General Assembly enacted HB 1747, which requires the State Corporation Commission's Bureau of Insurance to develop reporting requirements regarding denied claims complaints and appeals involving coverage for behavioral health benefits, and to compile this information into an annual report beginning in 2017 that will be available to the public.

In June 2015, new Federal provider network adequacy rules were adopted. On and after January 1, 2016, all health carriers must provide up-to-date, accurate and complete provider directories accessible online for plans on the exchange. This requirement applies to Qualified Health Plans in the health benefits exchange. Effective January 1, 2016, all health carriers must provide up-to-date, accurate and complete formularies that can be viewed on the carrier's website via a direct link. Federal rules require the carrier to make the link available in such a way that the individual can easily discern which drug list applies to which plan.

**Implementation Steps:**

- As a part of outreach to and education of the medical community, DBHDS will work with the Medical Society of Virginia and other interested parties to provide information about assessment practices such as Screening, Brief Intervention and Referral to Treatment (SBIRT), the current American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC), and specialty treatment providers to help medical staff improve identification, assessment of and referral for individuals with substance use disorders.
- DBHDS will work with community recovery and advocacy groups to develop information about MHPAEA for distribution to the general public.
- The information required by 45 CFR 156.230 and 45 CFR 156.122 will be linked to the Task Force website.
- DBHDS will work with the Bureau of Insurance to explore opportunities to make provider directories a strong, effective tool for purchasing a health insurance plan and to ensure compliance with sharing of formulary information.
- DBHDS will work with the Bureau of Insurance to ensure that drug formularies accommodate individuals with limited-English proficiency and those with disabilities.

Links to this information will be posted on the Task Force website.

**Additional Action Required:** Collaboration

*\*Recommendation of Treatment Workgroup*

## **H. Examine and enhance Medicaid reimbursement for substance abuse treatment services.**

Currently, Virginia Medicaid reimburses qualified providers for outpatient, intensive outpatient, day treatment, and case management services. Residential services for pregnant women and postpartum women may also be reimbursed. Providers may be reimbursed for medication-assisted treatment, but in the cases of opiate treatment programs, they may not be reimbursed for the cost of the infrastructure required to provide methadone, which can only be administered at a clinic, staffed by a physician, nurses and a pharmacist, and that is equipped to address security concerns. Opiate treatment programs are also required to provide support services and counseling. Due to requirements of the Centers for Medicaid and Medicare Services (CMS), Virginia Medicaid requires that each of these services be billed separately instead of in a “bundle,” which is the way services are actually delivered. Billing practices and policies through Medicaid-contracted plans are not uniform and may discourage utilization.

Further Virginia Medicaid eligibility criteria are extremely restrictive – only pregnant/postpartum women, parents with dependent children and individuals who are aged, blind, or disabled are eligible for Medicaid, further reducing motivation for providers to bill.

### **Implementation Steps:**

- DBHDS will continue to collaborate with DMAS to improve utilization of Medicaid for eligible services and recipients and will assist DMAS in identifying issues with its administrative services organizations.
- DBHDS will collaborate with DMAS to examine its rate structure, which has not been adjusted since 2007 when the State Medical Assistance Plan first began reimbursing for substance abuse treatment services.

**Additional Action Required:** Funding, interagency collaboration.

*\*Recommendation of Treatment Workgroup*

## V. Recommendations Requiring Further Action

These 31 recommendations are presented according to subject matter and are not ordered by priority.

**A. Collaborate with appropriate medical and healthcare school leadership to encourage them to provide curricula in health professional schools (medical, nursing, pharmacy, physician assistants, optometry, and dental) on the safe and appropriate use of opioids to treat pain while minimizing the risk of addiction and substance abuse.**

The Office of the Secretary of Health and Human Resources (OSHHR), with input from the State Counsel of Higher Education for Virginia, VDH, DHP, and DBHDS, should coordinate with leadership at Virginia's six medical schools to develop educational standards for training future providers on identifying and treating addiction, pain management, and proper prescribing of controlled substances.

This modifies and significantly expands an earlier recommendation of the Education Workgroup to send a letter to health professions schools in Virginia regarding development of pain management and addiction training curricula. Further, this recommendation has the endorsement of the Treatment Workgroup, which also proposed a recommendation to *“create training opportunities for health care providers, both in training and in practice, on how to treat addiction and how to diagnose or manage chronic pain.”*

### **Implementation Steps:**

- Reach out to each of Virginia's medical school programs and create a collaborative group to respond to this initiative.
- Leverage existing educational resources from other states.
- Leverage existing best practices in Virginia's agencies and schools.
- Provide ongoing support to schools in classroom education, clinical integration, and Grand Round participation.

**Additional Action Required:** Inter-agency coordination; OSHHR coordination, no budget needs projected

*\*Recommendation of Education Workgroup*

**B. Work with schools of social work to encourage education on addiction, treatment resources, and resource coordination for students going on to work as mental health providers.** – Integrating addiction and treatment education into existing curriculum in a meaningful way for Virginia's future mental health providers and resource coordinators is an essential piece in helping to connect individuals to appropriate treatment. This effort can be coordinated among the OSHHR, DBHDS, and accredited schools of social work in Virginia.

- OSHHR and DBHDS to coordinate with educational leadership in Virginia's four accredited, master's-level social work schools.
- This group will perform a review of current substance abuse course work and field placement options available to clinical and policy students and seek opportunities to expand those options in alignment with the Council on Social Work Education Core Competencies.
- Further, the group will develop strategies to integrate substance abuse and treatment into general, clinical, and policy social work course work where appropriate and in alignment with the National Association of Social Work Code of Ethics.
- A similar approach could be replicated with clinical psychology programs in Virginia.

**Additional Action Required:** OSHHR and agency coordination; no budget needs projected

*\*Recommendation of Education Workgroup*

**C. Establish a loan forgiveness program for medical professionals who agree to participate in a residency program that meets accreditation standards established by either the American Board of Addiction Medicine, the subspecialty certification in addiction medicine of the American Board of Psychiatry and Neurology, or the Board of Osteopathic Specialties Co-Joint Board in Addiction Medicine, and who agree to practice in Virginia for at least five years. Provide additional incentives to individuals who agree to practice in Medically Underserved Areas.**

Relative to many medical specialties, addiction medicine is a less lucrative area of medicine to practice. When facing several years of repaying student loans in excess of \$100,000, medical school graduates are less likely to consider addiction medicine. Meanwhile, there are very few physicians accredited in addiction medicine practicing in Virginia. Very little training is required to qualify to prescribe buprenorphine (about nine hours). Some physicians who are practicing addiction medicine in Virginia have sought continuing medical education through the American Society of Addiction Medicine.

- The DBHDS will research the cost and implementation of such a fellowship in time for consideration by the 2016 Session of the General Assembly.
- Recommend that the OSHHR explore mechanisms, such as a provider assessment, to support or incentivize more graduate medical education in addiction medicine.

**Additional Action Required:** Research, collaboration, and funding.

*\*Recommendation of the Treatment Workgroup*

**D. Evaluate options for continuing medical education (CME), including incentives and consequences to encourage participation in CME of opioids to treat pain while minimizing the risk of addiction and substance abuse.**

In conjunction with the Board of Medicine, develop a mandate for CME in which the Board may require 2 hours of opioid prescribing and/or addiction education for prescribers. This presents several opportunities:

- Tie this initiative to the PMP, and only require providers who meet a specific prescribing threshold to participate. Include benzodiazepine data in reports, as these drugs in concert with opioids pose a heightened overdose risk.
- Require pre-testing of providers who plan to prescribe controlled substances at the initial licensure and then upon subsequent license renewal every 2 years. Passage of this test would exempt a provider from mandated CME on opioid prescribing.
- Allow the Board of Medicine to require subject-specific CME in order to respond to health crises as they come. The Board of Pharmacy has a precedent for this and in 2015 required pharmacists to obtain at least one hour of continuing education in the subject of opioid use or abuse.
- Include a sunset clause on any new mandate.

### **Implementation Steps:**

- Review similar legislation in other states (currently 16+) and seek stakeholder input. The Medical Society of Virginia is currently reviewing options on how to handle provider education.
- Develop appropriate legislation and protocol that reflects intent to allow the Board of Medicine to direct requirements as educational needs arise for Virginia providers.
- Subsequently, seek out or develop free CME courses that offer opioid and addiction education.
- This builds upon previous Task Force discussion and a referred recommendation from Storage and Disposal to provide education for prescribers on prescribing methods designed to limit excess quantities of dispensed medications.

**Additional Action Required:** Potential legislation; stakeholder input; no budget needs projected.

*\*Recommendation of the Education Workgroup*

### **E. Develop individual prescriber feedback reports that describe actual prescribing practices.**

- *Code of Virginia* § 54.1-2523 permits the PMP to send reports to prescribers on “[i]nformation relating to prescriptions for covered substances issued by [the] prescriber, which have been dispensed and reported to the [PMP].”
- Examples of initial prescriber feedback reports include advising each prescriber of the number of patients the prescriber has who are receiving opioid prescriptions, who are on concomitant therapy, who are receiving a specified level of MEDD or who meet other indicators.

- A future goal for this recommendation is to provide individual prescriber feedback reports that compare the prescribing practices of a prescriber with his peers in the same specialty (e.g., cardiologist to cardiologist). The amendments to the regulations governing the Prescription Monitoring Program being implemented through a recommendation of the Data and Monitoring Workgroup (see Section III, B) that adds the NPI and species code to the PMP are required before individual prescriber feedback reports by specialty can be implemented.

### **Implementation Steps:**

- The PMP will explore various options to implement the initial prescriber feedback reports, including in-house resources, expanding capabilities of the PMP application, and contracting for services.
- The Director of the Department of Health Professionals, in consultation with the PMP Advisory Panel, will recommend the information to be included in the prescriber feedback reports.
- The PMP will disseminate information about the individual prescriber feedback reports to all PMP registered users and interested entities prior to their implementation.
- Once the Regulations Governing the Prescription Monitoring Program are amended to require reporting of the NPI and species code, the PMP will develop individual provider feedback reports based on the prescriber's specialty.

**Additional Action Required:** Appropriations language may be necessary to authorize the PMP to expend funds to make enhancements to the PMP software application or utilize contracted services (PMP is a non-general fund entity).

*\*Recommendation of the Data and Monitoring Workgroup*

**F. Create a Health and Criminal Justice Data Committee, comprised of data analysts from applicable agencies within the Secretariats of Public Safety & Homeland Security (PSHS) and Health & Human Resources (HHR), to study data for the purpose of better understanding the ways in which criminal justice and public health issues intersect, with the goal of improving government responses to crises, as well as identifying and responding to concerns before they become crises.**

This Committee should function in a manner similar to the Technical Committee for the Offender Population Forecast, which meets multiple times a year to share information on relevant trends that might impact the correctional populations, and then produces an annual report on behalf of the Secretary of PSHS.

The Health and Criminal Justice Data Committee's format, membership, and meeting schedule should be structured according to what the Committee determines best allows it to achieve the goals of identifying important trends in criminal justice and public health related issues.

### **Implementation Steps:**

- A Subcommittee of the Task Force's Data and Monitoring Workgroup, which included representatives from the Office of the Chief Medical Examiner, DCJS, the PMP, the Department of Forensic Science, the Virginia State Police, VDH, and Virginia Health Information, a non-governmental agency, should serve as a transitional working group that identifies agencies and analysts that should participate in the Health and Criminal Justice Data Committee or provide data to the Committee.
- The membership of the Health and Criminal Justice Data Committee should be finalized by August 1, 2015. Once formed, the Committee should select a Chair, who will serve as the point of contact for all participating agencies and as the liaison to the Offices of the Secretaries of PSHS and HHR.
- The Health and Criminal Justice Data Committee may request relevant de-identified, aggregated, locality-level data from agencies and other entities. Data should be provided to the Committee Chair electronically, on a periodic basis, as requested, and no less than quarterly. The Chair will combine the data from various agencies and share it with the Committee.
- Analysts serving on the Health and Criminal Justice Data Committee will analyze the data, identify trends or concerns, and share their preliminary findings with the Committee. The Committee should meet multiple times during the year, according to the schedule that best suits the Committee's needs.
- The Health and Criminal Justice Data Committee should provide an annual trends report to the Secretaries of PSHS and HHR. Preliminary findings of the Committee should be shared with the Secretaries independent of the annual report. A copy of the annual report should be shared with the Center for Behavioral Health and Justice. The initial report from the Committee should be submitted by January 15, 2016. Subsequent annual reports should be submitted annually by October 15.
- The Health and Criminal Justice Data Committee's initial focus should be on gathering and analyzing appropriate up-to-date data to mitigate harm from prescription drug and heroin abuse.
- The Health and Criminal Justice Data Committee will require cooperation from multiple agencies. To ensure an efficient data-sharing process, the Secretaries of PSHS and HHR should direct agencies to share, to the extent possible, up-to-date data requested by the Committee.
- To the extent possible, the Health and Criminal Justice Data Committee should monitor data-sharing improvement initiatives within the Secretaries of PSHS and HHR, and work to make any data sharing improvements developed by the Committee available to assist these initiatives.

**Additional Action Required:** No legislation, regulatory change or appropriation required.  
Coordination of Offices of HHR and PSHS

*\*Recommendation of Data and Monitoring Workgroup*

**G. Reduce the timeframe in which dispensers must report to the PMP from within 7 days of dispensing to within 24 hours of dispensing.**

Daily reporting provides prescribers and dispensers access to more timely information. Data from the PMP for the first six months of 2014 showed the following:

- 4,537 individuals received prescriptions from two or more prescribers within a 24-hour period (an average of 25 individuals per day);
  - 21,661 individuals received prescriptions from two or more prescribers within 0-3 days (an average of 120 individuals per day); and
  - 43,708 individuals received prescriptions from two or more prescribers within 0-7 days (an average of 243 per day).
- As of January 1, 2016, 21 states will have implemented a requirement for reporting to their prescription monitoring programs within 24 hours of dispensing.
  - There are currently three bills being considered in Congress to authorize grant funding for prescription monitoring programs that will make reporting within 24 hours an eligibility requirement or a preference element for receiving grant funding.
  - This recommendation has been adopted by the PMP Advisory Panel.

**Implementation Steps:**

- This recommendation should be implemented through legislation that amends *Code of Virginia* §54.1-2521 and has a delayed effective date of January 1, 2017.
- Once the legislation passes:
  - The PMP will disseminate information regarding the new reporting timeframe to all PMP registered users and other interested entities (e.g., Virginia Pharmacists Association, application vendors).
  - The PMP will update its reporting manual to reflect this change upon approval of the legislation.
  - Dispensers will need to update their systems and processes to ensure reporting occurs within the new 24-hour time period by the legislation's effective date.

**Additional Action Required:** Legislation to amend *Code of Virginia* §54.1-2521 recommended, with a delayed effective date of January 1, 2017.

*\*Recommendation of Data and Monitoring Workgroup*

**H. Expand access to PMP information on a specific patient to clinical pharmacists and consulting prescribers practicing on healthcare teams treating that specific patient.**

- Currently, the authority for access to PMP information is strictly limited to the prescribing and dispensing functions of prescribers and pharmacists, and it does not reflect the common practice in healthcare where “team care” is utilized.
- This suggested change aims to improve patient outcomes by making PMP information available to all appropriate healthcare providers.
- This recommendation has also been adopted by the PMP Advisory Panel.

**Implementation Steps:**

- Legislation to amend Subsection C of *Code of Virginia* §54.1-2523 is required to implement this recommendation.
- The PMP will disseminate information about this change to all PMP registered users and interested entities prior to the legislation’s effective date.

**Additional Action Required:** Legislation to amend Subsection C of *Code of Virginia* §54.1-2523 required.

*\*Recommendation of Data and Monitoring Workgroup*

**I. Clarify that PMP reports may be placed in the medical record.**

Although the Virginia PMP has previously advised that PMP reports may be placed in the medical record, existing statutory language creates uncertainty, and the information is not generally kept in the medical record.

**Implementation Steps:**

- Legislation to amend *Code of Virginia* §54.1-2525 is necessary to implement this recommendation.
- The PMP will disseminate information advising that PMP reports may be placed in medical records to all PMP registered users and interested entities prior to the legislation’s effective date.

**Additional Action Required:** Legislation to amend *Code of Virginia* §54.1-2525 required.

*\*Recommendation of Data and Monitoring Workgroup*

**J. Develop clinically oriented criteria for unsolicited reports to prescribers on specific patients.**

- *Code of Virginia* §54.1-2523.1 permits the PMP to send unsolicited reports to prescribers when PMP data indicates “potential misuse . . . of covered substances” by patients. The

Director of the Department of Health Professionals is required to develop the criteria for these reports in consultation with the PMP Advisory Panel.

- Currently, the unsolicited reports sent to prescribers on specific patients address doctor shopping behavior.
- Examples of clinically oriented criteria for these reports include patients who have MEDD scores over a specified level, who are on concomitant therapy of opioids and benzodiazepines, or who meet other criteria that may indicate increased risk for abuse and/or overdose.
- This recommendation is endorsed by the Education Workgroup, which also recommended conducting annual outreach to opioid prescribers, based on PMP data, regarding appropriate prescribing of controlled substances.

### **Implementation Steps:**

- The PMP Advisory Panel will review possible criteria and make recommendations to the Director of the Department of Health Professions for specified clinically oriented criteria.
- The PMP will explore various options to implement this reporting, including utilization of in-house resources, expanding capabilities of the PMP application, and contracting for services.
- The PMP will disseminate information to all PMP registered users and interested entities about any clinically oriented criteria adopted for these unsolicited reports.

**Additional Action Required:** No legislation or regulatory change required. Appropriations language may be necessary to authorize the PMP to expend funds to make enhancements to the PMP software application or utilize contracted services (PMP is a non-general fund entity).

*\*Recommendation of Data and Monitoring Workgroup*

**K. Enable the PMP to determine in what specialty the prescriber is practicing by requiring the reporting of (i) the prescriber National Provider Identifier (NPI) for prescriptions for human patients, and (ii) the species code.**

Capturing the NPI and species code will assist the PMP in sending individual prescriber feedback reports based on specialty.

### **Implementation Steps:**

- The PMP will add the reporting of the National Provider Identifier (NPI) and species code as required data elements through the regulatory process.
- The PMP will disseminate information about this new requirement to all PMP registered users and interested entities prior to the regulation's effective date.
- The PMP will update its PMP reporting manual to reflect these changes prior to the regulation's effective date.

**Additional Action Required:** Amendments to the Regulations Governing the Prescription Monitoring Program (18 VAC 76-20-10 et seq.) required. Appropriations language may be necessary to authorize the PMP to expend funds to make enhancements to the PMP software application or utilize contracted services (PMP is a non-general fund entity).

*\*Recommendation of Data and Monitoring Workgroup*

#### **L. Expand the use of the PMP.**

Physicians at opiate treatment programs are required to check the PMP when a new patient is admitted to services, annually, and if the patient appears noncompliant. They are strongly encouraged to routinely check it at six month intervals. However, there is no requirement that physicians prescribing buprenorphine in an office practice use it if the prescription is for less than 90 days. In addition, there is no designation for professionals who are not prescribers who are providing substance abuse treatment to access the PMP.

#### **Implementation Steps:**

- Consider legislation that requires prescribers of buprenorphine in office-based practices to document use of the PMP for every patient at admission, for cause, and on a monthly basis.

**Additional Action Required:** Possible statutory or regulatory action.

*\*Recommendation of the Treatment Workgroup*

#### **M. Provide further education for judges, prosecutors, and defense attorneys on the nature and causes of addiction and alternatives to incarcerations, particularly Drug Courts, and continue all avenues of support that currently exist.<sup>3</sup>**

Individuals often face criminal penalty for behaviors and activities associated with their addictions.

#### **Implementation Steps:**

- Leadership from Public Safety, Commonwealth's Attorneys, the Virginia Bar Association and public defenders can create an educational program or handbook that would act as a resource for the judiciary and attorneys in handling cases in which individuals are experiencing addiction. Presentations to Commonwealth's Attorneys, indigent Defense Commission, and judiciary through the Office of the Executive Secretary.
- Include these professional groups in a planned opioid education conference to be held Spring 2016.

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<sup>3</sup> Updated Fall 2015

**Additional Action Required:** Several similar recommendations and conversations have arisen on the Task Force and in other Workgroups in regards to Drug Courts. Consolidation of a comprehensive education plan for justice-oriented professionals may be necessary, and this work will most likely need to happen as a joint effort of the Enforcement and Education Workgroups. This recommendation requires that sufficient alternatives to incarceration are available throughout the Commonwealth.

*\*Recommendation of Education Workgroup*

**N. Explore ways to enhance MAT through CSBs, Drug Treatment Courts, and jail-based treatment.**

Fewer than half of the CSBs currently utilize medication to assist treatment for individuals seeking recovery from opioid addiction. Barriers to providing MAT include limited funding, lack of access to a qualified physician or opiate treatment program, and lack of staff knowledge about how medication can assist recovery. Judges may lack awareness of the critical role that MAT can play in helping drug treatment court participants achieve success and instead insist on a “drug-free” model that is not supported by evidence. In addition, most Drug Treatment Courts are not adequately funded to provide medication. Sheriffs and jail administrators also lack up-to-date information, access to qualified physicians, and funding to support necessary staff and purchase medication.

**Implementation Steps:**

- DBHDS will collaborate with the Substance Abuse Council of the Virginia Association of Community Services Boards to develop and provide training and technical assistance to CSB staff and contract agencies about evidence-based methods of treating opioid addiction and successful methods of implementing MAT in their treatment systems. Necessary resources and infrastructure will be identified.
- DBHDS will collaborate with the Virginia Supreme Court Drug Treatment Court Office and its advisory council, and the Virginia Association of Drug Treatment Courts to develop information, training and technical assistance to improve the use of MAT in drug treatment courts.
- DBHDS will collaborate with the Substance Abuse Council of the Virginia Association of Community Services Boards, the Virginia Sheriffs Association and the Department of Criminal Justice Services to explore methods of increasing access to medication assisted treatment for individuals incarcerated in local jails.

**Additional Action Required:** Collaboration and funding.

*\*Recommendation of the Treatment Workgroup*

**O. Pursue opportunities to increase the number and the capacity of Drug Treatment Courts operating in Virginia.**

Drug Treatment Courts, administered by the Supreme Court of Virginia, employ several models of adjudication that provide individuals charged with drug-related crimes an opportunity to access substance abuse treatment and other support services with the goals of:

- Reducing drug addiction and drug dependency among offenders;
- Reducing recidivism;
- Reducing drug-related court workloads;
- Increasing personal, familial, and societal accountability; and
- Promoting effective planning and use of resources among criminal justice system and community agencies. (*Code of Virginia* §18.2-254.1).

Currently, 37 Drug Treatment Courts are operating in Virginia, and serve specific populations, such as adults, juveniles, families and DUI offenders. Funding for Drug Treatment Courts is not consistent. A few are funded by state general funds, some receive time-limited Federal grants, and some cobble together local resources. Given that the benefits of Drug Treatment Courts clearly outweigh the costs, Drug Treatment Courts should be available in more communities.

**Implementation Steps:**

- DBHDS will encourage CSBs to actively participate in providing treatment support to local Drug Treatment Courts and will explore potential incentives.

**Additional Action Required:** Possible funding.

*\*Recommendation of the Treatment Workgroup*

**P. Evidence-based practices should be used to provide the criminal justice system with viable alternatives to incarceration for all drug abusers.**

House Joint Resolution 622 (HJR622), which failed in the 2015 General Assembly session due to anticipated fiscal impact, would have accomplished this recommendation. This legislation should be re-introduced or another entity should conduct the study.

**Implementation Steps:**

- Option to re-introduce.
- Option to research another entity to conduct the study, particularly academic research institutions.
- Explore feasibility of utilizing asset forfeiture to fund the study.

**Additional Action Required:** Budget allocation is necessary to fund the study described in HJR622, which is approximately \$23,000 in direct costs. If another entity conducts the study, the cost would likely be higher to account for indirect costs.

*\*Recommendation of Enforcement Workgroup*

**Q. As a matter of policy, if the state determines that incarceration is an appropriate punishment for addicts who have continued contact with the criminal justice system, treatment options should be made available during their periods of confinement.**

The lack of treatment for individuals with addiction while incarcerated can unwittingly lead to fatal overdoses when the inmate is released, based on physiological reactions to the re-introduction of opioids after a prolonged absence. Treatment options should be made available to addicts during periods of incarceration to prevent future fatal overdoses from occurring and to prevent recidivism.

**Additional Action Required:** Additional funding for alternative treatment options at local and state facilities is necessary.

*\*Recommendation of Enforcement Workgroup*

**R. Make evidence-based substance abuse treatment, including the use of medication assisted treatment, available in local jails, focusing especially on providing the skills necessary to maintain sobriety and live successfully in the community.**

Local and regional jails, which hold the majority of incarcerated individuals, vary considerably in the programs provided to inmates. Inmates who were using opioids prior to entering jail are at high risk for overdose upon release. Of 73 jails contacted in a 2013 survey, 37 responded; of these, 34 indicated that they provided some level of substance abuse programming, ranging from 12-step groups provided by volunteers (27 facilities) to group treatment (16 facilities) to therapeutic communities (six facilities). Available space was a consistent factor in the extent of available programs. Currently, services are funded by either local jails, funds from local government, state or Federal funds allocated to the CSBs by DBHDS, or limited competitive Federal grant funds from DCJS.

**Implementation Steps:**

- DCJS, DBHDS, Department of Corrections (DOC), the Office of the Attorney General (OAG), and representatives from Virginia Sheriffs Association and the Virginia Association of Regional Jails will collaborate to expand access to evidence-based treatment and support programs that will prepare individuals to successfully re-enter the community from local and regional jails.
- DCJS, DBHDS, DOC, OAG, the Virginia Sheriffs Association and the Virginia Association of Regional Jails will collaborate to seek funding to support these services.
- DCJS, DBHDS, DOC, OAG, the Virginia Sheriffs Association and the Virginia Association of Regional Jails will collaboratively develop an educational DVD that will provide inmates with information about overdose risk and accessing treatment services once released from jail.

- DBHDS will explore methods to incentivize CSBs to provide evidence-based treatment services in local jails and to provide priority case management and access to community treatment once an individual is released.

**Additional Action Required:** Collaboration and funding.

*\*Recommendation of the Treatment Workgroup*

**S. Enhance and enforce a standard of care for treatment with office-based buprenorphine.**

The Federal government allows physicians who have completed an eight-hour on-line training course to prescribe buprenorphine, a medication which is very effective in reducing the physical discomfort of withdrawal and cravings often experienced by individuals seeking recovery from addiction to opioids. However, unlike opiate treatment centers, there is no requirement that counseling or additional support services be provided, or that these physicians utilize practices that will mitigate diversion of buprenorphine. As a result, individuals are paying significant sums for poor quality care or may be selling this medication on the street. Promulgating regulatory standards through the DHP Board of Medicine would communicate a clear expectation to all physicians utilizing this medication and would protect their patients and the public from misuse and diversion.

**Implementation Steps:**

- The Virginia Board of Medicine, in collaboration with DBHDS, will convene a workgroup of physicians experienced with utilizing this medication to review standards of care from a variety of sources, and develop recommendations for evidence-based treatment with buprenorphine for the Board of Medicine to consider for promulgation.

**Additional Action Required:** Interagency collaboration and regulatory action.

*\*Recommendation of the Treatment Workgroup*

**T. Support pregnant women and women with dependent children by coordinating responses among providers of substance abuse treatment, health care, social services and law enforcement to effectively address their substance abuse treatment needs.**

Research demonstrates that women experience addiction differently from men, for reasons that are physiological, psychological and social. Women also face unique barriers to accessing treatment. Women experience additional stigma and are often afraid of losing custody of their dependent children if they acknowledge their illness and seek help.

More work is needed to identify at-risk pregnant women and mothers, to provide treatment and monitor cases in which a newborn shows signs of being exposed in utero to drugs or alcohol, and to ensure reporting of those exposure cases to social services and the local CSBs.

### **Implementation Steps:**

- Request that the DBHDS “Handle with Care” project specifically identify issues and make recommendations regarding hospitals failing to refer women to CSBs for treatment as required by *Code of Virginia* §32.1-127.
- Recommend funding to support the addition of sites to Project Link, a program of coordinated intensive care run by DBHDS.
- Recommend funding to support additional residential treatment capacity specifically designed to support pregnant women and women with dependent children.

**Additional Action Required:** Policy work in progress; requires funding for treatment.

*\*Recommendation of the Treatment Workgroup*

### **U. Increase capacity to treat adolescents who are abusing or are dependent on opioids.**

Many communities are reporting significant increases in opioid addiction among adolescents and among young adults who started using as adolescents. Treatment of adolescents and young adults requires special knowledge and skills to address addiction using cognitive-based therapies that are developmentally appropriate for individuals who are still struggling with adolescent impulsivity and poor judgment even when sober, who may have additional family problems, and who may struggle to find support from their peer group for sober living. The 2012 Session of the General Assembly amended the *Code of Virginia* to require CSBs to provide information to hospitals about substance abuse services available to minors. DBHDS created a template for CSBs to use to assist hospitals in providing this information to families.

### **Implementation Steps:**

- DBHDS will continue to provide technical assistance to CSBs and other providers of addiction treatment services to improve knowledge and skill about providing treatment services to adolescents and young adults, and will strategically seek funding to support expansion of capacity to provide evidence-based treatment for these youth.
- DBHDS will collaborate with the State Council on Higher Education to explore the development of Recovery Housing for students in Virginia colleges who are seeking recovery through treatment and active participation in appropriate peer recovery support groups.
- DBHDS will encourage CSBs to develop referral relationships with local community colleges to assist in providing access to treatment, support and sponsorship of college-based recovery activities.

**Additional Action Required:** Collaboration and funding.

*\*Recommendation of the Treatment Workgroup*

**V. Enact legislation allowing prosecutors to criminally charge predatory dealers who distribute drugs which directly cause fatal overdoses:**

Legislative efforts to enact such a law failed in 2015. The Task Force recommends reintroducing similar legislation to the General Assembly in 2016. It is difficult for prosecutors to hold predatory dealers criminally liable for their actions which lead to fatal overdoses, and thus some cases are handled in Federal courts. Any statutory language enacted should be broad enough to encompass any distributed controlled substance, and not just heroin.

**Additional Action Required:** Enact legislation allowing for enhanced punishment during the penalty phase of criminal cases where a predatory dealer caused a fatal overdose.

*\*Recommendation of Enforcement Workgroup*

**W. Data on overdoses should be reported to a non-law enforcement agency whereby certain people, such as law-enforcement, would have limited access to the information (similar to the PMP).**

**Additional Action Required:** Legislation or new regulation is likely necessary to require reporting and to establish guidelines for securing and accessing the data.

*\*Recommendation of Enforcement Workgroup*

**X. Expand access to naloxone by lay rescuers and law enforcement to prevent death from overdose.**

**Additional Action Required:** Funding for purchase of naloxone by law enforcement.

*\*Recommendation of the Treatment Workgroup*

**Y. Encourage distribution of lock boxes with controlled substances when dispensed.** While providing lock boxes for prescribed medications alongside all dispensed narcotics may not be feasible, providing information about proper storage as well as the potential for diversion of these drugs is possible. Possible partners include VDH and DHP.

**Implementation Steps:**

- Create a brochure or insert that can be distributed to pharmacies statewide explaining that proper storage is imperative to maintaining safety in the home.
- Include information on how easily diverted prescription pills are, as well as how addiction often begins with legitimate prescriptions that are diverted.
- Print and distribute to pharmacies.

**Additional Action Required:** Funding for printing and shipment. This would most likely come out of an agency and would need to be included in budget.

*\*Recommendation of Education Workgroup*

**Z. Encourage placement of collection boxes in every locality and subsequently inform Virginians of their locations.**

Increase disposal opportunities via mail-back programs and collection boxes, with a minimum goal of one disposal container in every locality.

**Implementation Steps:**

- As work continues to place collection boxes in every locality, those that are already placed will be noted on the state website and new containers will be added as they become available.
- The state website should have a dedicated page, clearly noted on the homepage, which lists up-to-date disposal locations in an easy-to-use and direct format.
- The link to this page should be used in social media by localities and state agencies and officials when take-back days and events occur.
- The link should also be posted to applicable state agencies' sites.

**Additional Action Required:** Collection boxes must be purchased and placed (See Storage and Disposal)

*\*Recommendation of Education Workgroup. Coincides with Storage and Disposal recommendation.*

**AA. To increase disposal opportunities via drug take-back events within the law enforcement agencies (LE), increase number of law enforcement agencies participating as drug collection sites.<sup>4</sup>**

Since 2010, the Drug Enforcement Administration (DEA) has held national take-back events semi-annually. During the last event in November 2014, 309 tons of unwanted prescription drugs were collected and destroyed. . To continue providing opportunities for the public to dispose of unwanted prescription drugs, it is important to continue holding statewide take-back events semi-annually and increase voluntary participation of law enforcement agencies installing drug collection boxes, with the goal of having at least one collection box in every locality in Virginia.

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<sup>4</sup> Updated Fall 2015

### **Implementation steps:**

- State leadership to encourage law enforcement and public participation in semi-annual state-wide take-back events. Events could be combined with existing holidays for recognizing the environment, recycling efforts, tax-free holidays, etc.
- Survey of law enforcement agencies was conducted by the Storage and Disposal Workgroup in June 2015 to determine willingness to participate in take-back events and install collection boxes, and to identify location of current collection boxes.
- Continue encouraging law enforcement agencies to obtain free collection boxes from an identified source. For example, CVS/pharmacy and The Partnership at Drugfree.org has approximately 150 collection boxes available for free through an application process.
- Provide funding for purchasing any additionally needed collection boxes to reach the goal of one collection box per locality.
- Provide (or pursue) ongoing funding for disposal efforts, giving localities the flexibility to determine the best method of using those funds.

**Additional Action Required:** Identify funding resources to offset costs, if any, associated with purchasing collection boxes and drug disposal. Designate someone to coordinate take-back events.

*\*Recommendation of Storage and Disposal Workgroup*

### **BB. Increase disposal opportunities via mail-back programs and collection boxes provided by pharmacies.**

Recently enacted Federal regulations authorize pharmacies to install collection boxes for the public to dispose of unwanted prescription drugs and to participate in mail back programs, wherein patients receive envelopes from the pharmacies for directly mailing prescription drugs back to reverse distributors for destruction. Drugs collected via collection boxes must be returned by the pharmacy to a reverse distributor for destruction.

**Additional Action Required:** Meet with interested stakeholders to evaluate feasibility of increasing voluntary participation of pharmacies installing drug collection boxes or participating in mail-back programs.

*\*Recommendation of Storage and Disposal Workgroup*

### **CC. Determine ongoing funding sources for drug disposal.**

Law enforcement survey and other Workgroup discussions reveal that additional funding and resources are needed for both local and state law enforcement in order to increase participation in drug collection and disposal efforts.

**Additional Action Required:** Consider use of grants from the OAG via asset forfeiture for disposal efforts and costs associated with take-back events, equipment grants from DCJS for the purchasing of collection boxes, and/or legislative action for a state appropriation from the General Assembly.

*\*Recommendation of Storage and Disposal Workgroup*

**DD. Coordinate with stakeholders and other agencies to develop Public Service Announcements (PSAs) and collateral marketing materials.** Reach multiple audiences simultaneously by placing PSAs on television in media markets statewide. Depending on funding, this could also include other marketing materials, such as corresponding messaging via radio and out-of-home advertising.<sup>5</sup>

**Implementation steps:**

- Education public outreach subgroup can select an existing advertising campaign, several of which have been reviewed by the Task Force. Proper permissions would need to be obtained.
- These should be posted to the state website being developed by the Task Force.
- Collateral materials can be developed with funding if necessary.

**Additional Action Required:** Funding for a media campaign may be necessary, as PSAs are not optimal messaging mechanisms. Major media buys, depending on reach and length of advertising, require significant funding. PSAs are purchased differently and cost nothing for airtime, but they also air less frequently, and competition for PSA slots is fierce.

*\*Recommendation of Education Workgroup*

**EE. The Executive Branch should publicize the passage of Senate Bill 892/House Bill 1500, which provides a ‘safe harbor’ affirmative defense for an individual who calls 911 or notifies emergency personnel that someone in his presence is suffering from an overdose.**

**Additional Action Required:** Governor directs all state agencies to notify constituents and stakeholders; solicit media coverage; and post on state and local websites.

*\*Recommendation of Enforcement Workgroup*

**FF. Expand mandatory requests to the PMP to include the initial prescribing of an opiate or benzodiazepine and periodic reports thereafter, not to exceed 90 days, with limited exceptions.<sup>6</sup>**

Exceptions to the expanded mandatory requests:

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<sup>5</sup> Updated Fall 2015

<sup>6</sup> Added Fall 2015

1. The opiate or benzodiazepine is prescribed to a patient currently receiving hospice or palliative care;
2. The opiate or benzodiazepine is prescribed to a patient as part of treatment for a surgical procedure and such prescription is not refillable; and
3. The PMP is not operational or available due to temporary technological or electrical failure or natural disaster.

**Implementation steps:**

- Legislation to amend Code § 54.1-2522.1 is required to implement this recommendation expanding mandatory requests to the PMP
- The PMP will disseminate information about this change to all PMP registered users and interested entities prior to the legislation's effective date

*\*Recommendation of Data and Monitoring Workgroup*

**GG. Grant authority to the PMP, through the Director of the Department of Health Professions (DHP), to send unsolicited reports on egregious outlier prescribing and dispensing behavior to the Enforcement Division of DHP and/or to law enforcement, based on criteria developed by the PMP Advisory Panel in consultation with applicable licensing boards<sup>7</sup>**

**Implementation Steps:**

- Legislation to amend Code § 54.1-2523.1 is required to implement this recommendation addressing unsolicited reports on outlier prescribing and dispensing
- The PMP Advisory Panel, in consultation with the applicable licensing boards, will need to develop the outlier criteria
- The PMP will disseminate information about this change to all PMP registered users and interested entities prior to the legislation's effective date

*\*Recommendation of Data and Monitoring Workgroup*

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<sup>7</sup> Added Fall 2015

## Special Thanks

The members, co-chairs, and staff of the Education and Treatment Workgroups would like to extend special thanks to the following providers who served on a Provider Education Panel at a joint meeting on May 12, 2015. Their expertise and experience in educating medical students, residents, and current prescribers significantly informed the direction of the Workgroups in developing recommendation proposals for the Task Force.

- **Carol Forster, M.D.**, Physician Director, Pharmacy & Therapeutics/Medication Safety Mid-Atlantic Permanente Medical Group
- **Robin Hamill-Ruth, M.D.**, Associate Professor, Anesthesiology and Critical Care Medicine; Director, Clinical Pain Research, University of Virginia Health System
- **Dan Harrington, M.D.**, Vice President for Academic Affairs for Carilion Clinic
- **Mary McMasters, M.D.**, FASAM, Addictionologist, Comprehensive Behavioral Health
- **Hughes Melton, M.D.**, Vice President, Medical Education for Northeast and Northwest Markets of Mountain States Health Alliance
- **Gerard Moeller, M.D.**, Professor of Psychiatry, Pharmacology and Toxicology, and Neurology; Division Chair for Addiction Psychiatry; Director of the Institute for Drug and Alcohol Studies and Director of Addiction Medicine, Virginia Commonwealth University
- **Kent Norman, Ed.D.**, AGPCNP-BC, Nurse Practitioner, Pain SCAN-ECHO, McGuire Veteran's Administration Medical Center, Richmond, VA

## VI. Appendices

### Appendix A: Task Force Members

**The Honorable William Hazel, Jr., MD, Co-Chair**  
Secretary of Health and Human Resources

**The Honorable Brian Moran, Co-Chair**  
Secretary of Public Safety and Homeland Security

**Craig Branch**

Chief of Police  
Germanna Community College Police  
Department  
2130 Germanna Highway  
Locust Grove, Virginia 22508  
(540) 891-3007  
[cbranch@germanna.edu](mailto:cbranch@germanna.edu)

**James Cervera**

Chief of Police  
Virginia Beach Police Department  
2509 Princess Anne Road  
Virginia Beach, Virginia 23456  
(757) 385-4141  
[jcervera@vbgov.com](mailto:jcervera@vbgov.com)

**David Brown, DC**

Director  
Virginia Department of Health Professions  
9960 Mayland Drive, Suite 300  
Henrico, Virginia 23233  
(804) 367-4648  
[david.brown@dhp.virginia.gov](mailto:david.brown@dhp.virginia.gov)

**Lillian Chamberlain**

Substance Abuse Services Team Leader  
Norfolk Community Services Board  
7460 Tidewater Drive  
Norfolk, Virginia 23505  
(757) 664-6682  
[lillian.chamberlain@norfolk.gov](mailto:lillian.chamberlain@norfolk.gov)

**Jan Brown**

Founder & Executive Director  
SpiritWorks Foundation  
5800 Mooretown Road  
Williamsburg, Virginia 23188  
(757) 903-0000  
[janmbrown@mac.com](mailto:janmbrown@mac.com)

**Rick Clark, Jr.**

Chief of Police  
Galax Police Department  
353 N. Main Street  
Galax, Virginia 24333  
(276) 236-8101  
[rclark@galaxva.com](mailto:rclark@galaxva.com)

**The Honorable Charles 'Bill' Carrico, Sr.**

Senate of Virginia, District 40  
P O. Box 1100  
Galax, Virginia 24333  
(276) 236-0098  
[district40@senate.virginia.gov](mailto:district40@senate.virginia.gov)

**Karl Colder**

Special Agent in Charge  
U.S. Department of Justice  
Drug Enforcement Administration  
Washington Division Office  
800 K Street NW, Suite 500  
Washington, DC 20001

(202) 305-8120  
[karl.c.colder@usdoj.gov](mailto:karl.c.colder@usdoj.gov)

**Kim Craig, MSN, RN**  
Executive Director, Staunton-Augusta  
County Rescue Squad  
Vice President, Virginia Association of  
Volunteer Rescue Squads  
1601 N. Coalter Street  
Staunton, Virginia 24401  
(540) 885-3444  
[kcraig@stauntonrescue.org](mailto:kcraig@stauntonrescue.org)

**Terry Dickinson, DDS**  
Executive Director  
Virginia Dental Association  
3460 Mayland Court  
Henrico, Virginia 23233  
(804) 523-2191  
[dickinson@vadental.org](mailto:dickinson@vadental.org)

**Francine Ecker**  
Director  
Virginia Department of Criminal Justice  
Services  
1100 Bank Street  
Richmond, Virginia 23219  
(804) 786-8718  
[fran.ecker@dcjs.virginia.gov](mailto:fran.ecker@dcjs.virginia.gov)

**Debra Ferguson, PhD**  
Commissioner  
Virginia Department of Behavioral Health &  
Developmental Services  
1220 Bank Street  
Richmond, Virginia 23219  
(804) 783-3921  
[debra.ferguson@dbhds.virginia.gov](mailto:debra.ferguson@dbhds.virginia.gov)

**Don Flattery**  
5427 Grist Mill Woods Way  
Alexandria, Virginia 22309  
(202) 564-4677  
[dflatter@cox.net](mailto:dflatter@cox.net)

**Carol Forster, MD**  
Physician Director, Pharmacy &  
Therapeutics/Medication Safety  
Mid-Atlantic Permanente Medical Group  
2101 E. Jefferson Street  
Rockville, Maryland 20852  
(301) 816-7194  
[carol.a.forster@kp.org](mailto:carol.a.forster@kp.org)

**Mary Gavin**  
Chief of Police  
Falls Church Police Department  
300 Park Avenue  
Falls Church, Virginia 22046  
(703) 248-5069  
[mgavin@fallschurchva.gov](mailto:mgavin@fallschurchva.gov)

**The Honorable Charniele Herring**  
Minority Whip  
Virginia House of Delegates, 46th District  
P.O. Box 11779  
Alexandria, Virginia 22312  
(703) 606-9705  
[delcherring@house.virginia.gov](mailto:delcherring@house.virginia.gov)

**The Honorable David Hines**  
Sheriff  
Hanover County  
7522 County Complex Road  
Hanover, Virginia 23069  
(804) 365-6249  
[drhines@hanovercounty.gov](mailto:drhines@hanovercounty.gov)

**The Honorable M. Keith Hodges, RPh**  
Virginia House of Delegates, 98th District  
P.O. Box 928  
Urbanna, Virginia 23175  
(804) 277-9801  
[delkhodges@house.virginia.gov](mailto:delkhodges@house.virginia.gov)

**Cynthia Hudson**

Chief Deputy Attorney General  
Commonwealth of Virginia  
900 East Main Street  
Richmond, Virginia 23219  
(804) 786-2435  
[chudson@oag.state.va.us](mailto:chudson@oag.state.va.us)

**Major Rick Jenkins**

Deputy Director, Bureau of Criminal  
Investigation  
Virginia Department of State Police  
7700 Midlothian Turnpike  
Richmond, Virginia 23235  
(804) 674-2051  
[rick.jenkins@vsp.virginia.gov](mailto:rick.jenkins@vsp.virginia.gov)

**The Honorable Jerrauld Jones**

Presiding Judge  
Norfolk Circuit Court  
100 St. Paul's Blvd  
Norfolk, Virginia 23510  
(757) 664-4580  
[jjones@circuitcourtnva.us](mailto:jjones@circuitcourtnva.us)

**Marissa Levine, MD, MPH**

State Health Commissioner  
Virginia Department of Health  
109 Governor Street  
Richmond, Virginia 23219  
(804) 864-7009  
[marissa.levine@vdh.virginia.gov](mailto:marissa.levine@vdh.virginia.gov)

**Mary McMasters, MD, FASAM**

Addictionologist  
Comprehensive Behavioral Health  
9 Pinnacle Lane, Ste 105  
Fishersville, Virginia 22939  
(540) 688-2646  
[mmcmasters@chsonline.net](mailto:mmcmasters@chsonline.net)

**Sarah Tollison Melton, PharmD**

Chair, One Care of Southwest Virginia  
23104 Virginia Trail  
Bristol, Virginia 24202  
(276) 971-6097  
[meltonst@etsu.edu](mailto:meltonst@etsu.edu)

**The Honorable John O'Bannon III, MD**

Virginia House of Delegates, 73rd District  
P.O. Box 70365  
Richmond, Virginia 23255  
(804) 282-8640  
[deljobannon@house.virginia.gov](mailto:deljobannon@house.virginia.gov)

**The Honorable Nancy Parr**

Commonwealth's Attorney, City of  
Chesapeake  
President, Virginia Association of  
Commonwealth's  
Attorneys  
307 Albemarle Drive, Suite 200A  
Chesapeake, Virginia 23322  
(757) 382-3200  
[nparr@cityofchesapeake.net](mailto:nparr@cityofchesapeake.net)

**The Honorable Anthony Roper**

Sheriff  
Clarke County  
100 N. Church Street  
Berryville, Virginia 22611  
(540) 955-5153  
[troper@clarkecounty.gov](mailto:troper@clarkecounty.gov)

**Juan Santacoloma**

Chesterfield County Multicultural Liaison  
P.O. Box 40  
Chesterfield, Virginia 23832  
(804) 796-7085  
[santacolomaj@chesterfield.gov](mailto:santacolomaj@chesterfield.gov)

**Patricia Shaw**  
Administrator, Henrico County Drug  
Treatment Court  
President, Virginia Drug Court Association  
P. O. Box 90775  
Henrico, Virginia 23273-0775

(804) 501-2301  
[sha66@henrico.us](mailto:sha66@henrico.us)  
**The Honorable Jennifer Wexton**  
Senate of Virginia, 33rd District  
20 W. Market Street  
Leesburg, Virginia 20176  
(703) 672-3696  
[district33@senate.virginia.gov](mailto:district33@senate.virginia.gov)

**Task Force Staff:**

**Laura Rothrock**  
Virginia Department of Health Professions

**Jessica Smith**  
Virginia Department of Criminal Justice Services

**Karen Sullivan**  
Virginia Department of Criminal Justice Services

# **Appendix B: Workgroup Membership**

## **Education Workgroup**

Sarah Melton, PharmD, Co-Chair  
Victoria Cochran, Co-Chair  
David Brown, DC  
Terry Dickinson, DDS  
Don Flattery  
Chief Craig Branch  
Juan Santacoloma  
First Sergeant John Welch  
Jane Chambers  
Gail Taylor, M.Ed.  
Maria Jankowski

Eden Freeman  
Sterling Ransone, Jr., MD  
Danny Saggese  
Lisa Wooten, BSN, RN  
Nassima Ait-Daoud, MD  
Carolyn Weems

STAFF: Jodi Manz, MSW (OSHR)

## **Treatment Workgroup**

Delegate John O'Bannon III, MD, Co-Chair  
Jennifer Lee, MD, Co-Chair  
Chuck Adcock, LCSW  
Jaime Areizaga-Soto  
Jan Brown  
Lillian Chamberlain  
Duffy Ferguson  
Nancy Finch  
Chief Mary Gavin  
Cynthia Kirkwood, PharmD

Sheriff Gabriel Morgan  
Patricia Shaw  
Art Van Zee, MD  
Senator Jennifer Wexton  
Debra Ferguson, Ph.D.  
Dana Schrad  
Mary McMasters, MD  
Samuel Hughes Melton, MD

STAFF: Mellie Randall (DBHDS)

## **Data and Monitoring Workgroup**

Carol Forster, MD, Co-Chair  
Katya Herndon, Co-Chair  
Baron Blakely  
Greg Cherundolo  
Timothy Coyne, Esq.  
Delegate Charniele Herring  
Sheriff Brian Hieatt  
Rosie Hobron, MPH  
Major Rick Jenkins  
Rusty Maney, RPh  
Lisa Miller, DVM

Amanda Wahnich, MPH  
Anne Zehner, MPH  
Deborah Waite  
Marty Mooradian  
David Sarrett, DMD, MS  
Marissa Levine, MD, MPH  
  
STAFF: Ralph Orr (DHP)

## **Storage and Disposal Workgroup**

Chief Rick Clark, Jr., Co-Chair  
Caroline Juran, RPh, Co-Chair  
Delegate M. Keith Hodges, RPh  
Cynthia Hudson  
Kevin Carroll  
Regina Whitsett  
Sheriff Steve Draper  
Karl Colder  
Amy Woods, RN  
Deborah DeBiasi  
Kristina Morris

Kathy Sullivan  
Sam Catron  
Regina Sayers  
Mickey Blazer  
Terry Talbott  
Gill Abernathy, RPh  
Tim Jennings

STAFF: Teresa Gooch (DCJS)

## **Enforcement Workgroup**

Chief James Cervera, Co-Chair  
Michael Herring, Co-Chair  
Kenneth Alger II, Esq.  
Shawn Buckner  
Senator Charles 'Bill' Carrico, Sr.  
Trevar Chapmon, MD  
Kim Craig, MSN, RN  
Francine Ecker  
Colonel David Hines  
Judge Jerrauld Jones  
Anna Powers

Carole Pratt, DDS  
Tonya Vincent  
Honesty Liller  
John Jones  
Nancy Parr  
Sheriff Tony Roper  
Chief Alfred Durham  
Chief (Ret.) Ray Tarasovic

STAFF: Shannon Dion (DCJS)

## Appendix C: Task Force Schedule

<b>November 12, 2014:</b>	Task Force Meeting Education Workgroup Meeting Treatment Workgroup Meeting Data and Monitoring Workgroup Meeting Storage and Disposal Workgroup Meeting Enforcement Workgroup Meeting
<b>December 1, 2014:</b>	Data and Monitoring Workgroup Meeting
<b>December 2, 2014:</b>	Enforcement Workgroup Meeting
<b>December 4, 2014:</b>	Storage and Disposal Workgroup Meeting
<b>December 5, 2014:</b>	Education Workgroup Meeting Treatment Workgroup Meeting
<b>December 16, 2014:</b>	Task Force Meeting Data and Monitoring Workgroup Meeting Treatment Workgroup Meeting
<b>January 9, 2015:</b>	Education Workgroup Meeting
<b>February 25, 2015:</b>	Data and Monitoring Workgroup Meeting
<b>March 19, 2015:</b>	Task Force Meeting Treatment Workgroup Meeting Education Workgroup Meeting Data and Monitoring Workgroup Meeting
<b>March 31, 2015:</b>	Date and Monitoring DataSet Subcommittee Meeting
<b>April 13, 2015:</b>	Storage and Disposal Workgroup Meeting
<b>April 14, 2015:</b>	Education Workgroup Meeting Data and Monitoring Workgroup Meeting Data and Monitoring DataSet Subcommittee Meeting Enforcement Workgroup Meeting
<b>April 29, 2015:</b>	Data and Monitoring Workgroup Meeting
<b>May 1, 2015:</b>	Treatment Workgroup Meeting
<b>May 12, 2015:</b>	Task Force Meeting

Joint Meeting of Education and Treatment Workgroups

**June 10, 2015:**

Treatment Workgroup Meeting

**June 16, 2015:**

Task Force Meeting

**Summer 2015:**

Workgroups May Meet at Co-Chair discretion

**September 21, 2015:**

Task Force Meeting

**September 26, 2015:**

Executive Order Expired

# **Appendix D:**

## **List of Recommendations by Workgroup**

### **Education Workgroup**

1. Develop a State website as an informational hub on prescription drug and heroin abuse. (p. 18; Sec IV, A)
2. Create and send “Dear Colleague” letters and stock op-eds. (p. 18; Sec IV, B)
3. Encourage placement of stationary disposal containers in every locality and subsequently inform Virginians of their locations. (p. 33; Sec V, Z)
4. Encourage the distribution of lock boxes with controlled substance prescriptions when dispensed. (p. 32; Sec V, Y)
5. Send a letter to all prescribers and dispensers about the PMP, focusing on the urgency of the overdose epidemic. (p. 10; Sec III, I)
6. Annual outreach to opioid prescribers (based on PMP data) regarding appropriate prescribing of controlled substances. (p. 24; Sec V, J)
7. Send a letter to health professions schools in Virginia regarding development of pain management and addiction training curricula. (p. 12; Sec IV, B)
8. Develop an educational curriculum for law enforcement, corrections, corrections, probation and parole, EMTs, CIT officers, and School Resource Officers. (p. 14; Sec IV, D)
9. Develop a law enforcement training program regarding naloxone administration if the existing pilot is expanded to include law enforcement (coinciding recommendation referred from the Enforcement Workgroup). (p. 9; Sec III, F)
10. Referral from the Storage and Disposal Workgroup: Education for doctors on how to prescribe medication in proper doses to limit excess quantities of drugs. (p. 19; Sec V, D)
11. Collaborate with appropriate medical and healthcare school leadership to encourage them to provide curricula in health professional schools (medical, nursing, pharmacy, physician assistants, optometry, and dental) on the safe and appropriate use of opioids to treat pain while minimizing the risk of addiction and substance abuse. (p. 18; Sec V, A)
12. Work with schools of social work to encourage education on addiction, treatment resources, and resource coordination for students going on to work as mental health providers. (p. 18; Sec V, B)
13. Evaluate options for continuing medical education (CME), including incentives and consequences to encourage participation in CME of opioids to treat pain while minimizing the risk of addiction and substance abuse. (p. 19; Sec V, D)
14. Provide further education for judges, prosecutors, and defense attorneys on the nature and causes of addiction and alternatives to incarcerations, particularly Drug Courts. (p. 26; Sec V, M)
15. Develop Public Service Announcements and collateral marketing materials. (p. 35; Sec V, DD)

## **Storage and Disposal Workgroup**

1. Increase disposal opportunities via drug take-back events held within communities. (p. 13; Sec IV, C)
2. To increase disposal opportunities via drug take-back events within law enforcement agencies, increase number of law enforcement agencies participating as drug collection sites. (p. 33; Sec V, AA)
3. Increase disposal opportunities via mail-back programs and collection boxes provided by pharmacies. (p. 34; Sec V, BB)
4. Determine preferred methods for disposing of unwanted/needed drugs; determine federal rule impact of existing drug disposal/take-back programs. (p. 17; Sec III, H)
5. Require hospice to notify pharmacies about the death of a patient. (p. 14; Sec III, D)
6. Determine ongoing funding sources for drug disposal. (p. 34; Sec V, CC)
7. Determine Virginia's need to promulgate regulations regarding pharmacy collection and mail back programs via legal guidance. (p. 10; Sec III, J)
8. Review and update the OAG's "Take Back Event" document. (p. 11; Sec III, K)
9. Explore the feasibility of using mobile incinerators for drug disposal. (p. 11; Sec III, L)

## **Treatment Workgroup**

1. To reduce stigma and increase access to treatment services, provide education about addiction and MAT to health care providers, students, Community Service Boards, law enforcement, and communities. (p. 14; Sec IV, E)
2. Explore ways to enhance access to MAT through CSBs, Drug Treatment Course, and jail-based treatment. (p. 27; Sec V, N)
3. Increase training opportunities for health care professionals, both in training and in practice, on how to treat addiction and how to diagnose or manage chronic pain. (p. 18 & 19; Sec V; A, D)
4. Enhance and enforce a standard of care for treatment with office-based buprenorphine. (p. 30; Sec V, S)
5. Ensure health plans are complying with the Mental Health Parity and Addiction Equity Act by providing adequate coverage for treatment, including MAT. (p. 16; Sec IV, G)
6. Examine and enhance Medicaid reimbursement for substance abuse treatment services. (p. 17; Sec IV, H)
7. Expand access to naloxone by lay rescuers and law enforcement to prevent death from overdose. (p. 7; Sec III, A) (p. 32; Sec V, X)
8. Explore and expand use of appropriate peer support services, with necessary oversight. (p. 15; Sec IV, F)
9. Expand use of the PMP. (p. 26; Sec V, L)
10. Increase access to naloxone by allowing pharmacists to dispense naloxone under proper protocols. (p. 9; Sec III, E)
11. Establish a loan forgiveness program for medical professionals who agree to participate in a residency program that meets accreditation standards established by either the

American Board of Addiction Medicine, the subspecialty certification in addiction medicine of the American Board of Psychiatry and Neurology, or the Board of Osteopathic Specialties Co-Joint Board in Addiction Medicine, and who agree to practice in Virginia for at least five years. Provide additional incentives to individuals who agree to practice in Medically Underserved Areas. (p. 19; Sec V, C)

12. Pursue opportunities to increase the number and the capacity of drug treatment courts operating in Virginia. (p. 27; Sec V, O)
13. Make evidence-based substance abuse treatment, including the use of medication assisted treatment, available in local jails, focusing especially on providing the skills necessary to maintain sobriety and live successfully in the community. (p. 29; Sec V, R)
14. Support pregnant women and women with dependent children by coordinating responses among providers of substance abuse treatment, health care, social services and law enforcement to effectively address their substance abuse treatment needs. (p. 30; Sec V, T)
15. Increase capacity to treat adolescents who are abusing or are dependent on opioids. (p. 31; Sec V, U)

### **Data and Monitoring Workgroup**

1. Expand mandatory PMP registration and amend mandatory use of PMP data. (p. 7; Sec III, B)
2. Require reporting of prescriber National Provider Identifier for prescriptions for human patients and “Species Code” as a required data element. (p. 25; Sec V, K)
3. Clarify that PMP data shall not be available for use in civil proceedings. (p. 8; Sec III, C)
4. Add Morphine Equivalent Doses per Day information to PMP patient reports to provide prescribers with information as to the cumulative amount of opioid medication a patient is currently receiving in order to gauge potential risk of overdose. (p. 10; Sec III, G)
5. Develop clinically-oriented criteria for unsolicited reports to prescribers on specific patients. (p. 24; Sec V, J)
6. Develop individual prescriber feedback reports that describe actual prescribing practices. (p. 20; Sec V, E)
7. Direct applicable agencies to share data on prescription drug and heroin abuse, overdoses, drug seizures, arrest information, etc. to analyze information to mitigate harm. (p. 21; Sec V, F)
8. Create a Health and Criminal Justice Data Committee, comprised of data analysts from applicable agencies within the Secretariats of Public Safety & Homeland Security and Health & Human Resources, to study data for the purpose of better understanding the ways in which criminal justice and public health issues intersect, with the goal of improving government responses to crises, as well as identifying and responding to concerns before they become crises. (p. 21; Sec V, F)
9. Reduce the timeframe in which dispensers must report to the PMP from within 7 days of dispensing to within 24 hours of dispensing. (p. 23; Sec V, G)

10. Expand access to PMP information on a specific patient to clinical pharmacists and consulting prescribers practicing on healthcare teams treating that specific patient. (p. 23; Sec V, H)
11. Clarify that PMP reports may be placed in the medical record. (p. 24; Sec V, I)
12. Expand mandatory requests to the PMP to include the initial prescribing of an opiate or benzodiazepine and periodic reports thereafter, not to exceed 90 days, with limited exceptions. (p. 35; Sec V, FF)
13. Grant authority to the PMP, through the Director of the Department of Health Professions (DHP), to send unsolicited reports on egregious outlier prescribing and dispensing behavior to the Enforcement Division of DHP and/or to law enforcement, based on criteria developed by the PMP Advisory Panel in consultation with applicable licensing boards. (p. 36; Sec V, GG)

### **Enforcement Workgroup**

1. Evidence-based practices should be used to provide the criminal justice system with viable alternatives to incarceration for all drug abusers. (p. 28; Sec V, P)
2. Enact legislation allowing prosecutors to criminally charge predatory dealers who distribute drugs which directly cause fatal overdoses. (p. 32; Sec V, V)
3. Expand access to naloxone for all first responders as optional, not mandatory, resource and include immunity from liability. (p. 7; Sec III, A)
4. As a matter of policy, if the state determines that incarceration is an appropriate punishment for addicts who have continued contact with the criminal justice system, treatment options should be made available during their periods of confinement. (p. 29; Sec V, Q)
5. Data on overdoses should be reported to a non-law enforcement agency whereby certain people, such as law-enforcement, would have limited access to the information (similar to the PMP). (p. 32; Sec V, W)
6. The Executive Branch should publicize the passage of Senate Bill 892/House Bill 1500, which provides a 'safe harbor' affirmative defense for an individual who calls 911 or notifies emergency personnel that someone in his presence is suffering from an overdose. (p. 35; Sec V, EE)