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House Committee on Veteran's Affairs

Subcommittee on Health

Is the U.S. Department of Veterans Affairs (VA) Meeting the Pharmaceutical Needs of Veterans? An Examination of the VA National Formulary, Issues of Patient Safety, and Management of the Pharmacy Benefits Program

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Good afternoon Mr. Chairman and members of the subcommittee. I am Ray Bullman, Executive Vice President of the National Council on Patient Information and Education (NCPIE). I've been asked to testify this afternoon relative to NCPIE patient medication safety efforts and best practices or innovative means that NCPIE coalition members utilize to enhance medication safety.

I would note at the outset that NCPIE does not focus specifically on formulary issues. Yet, recognizing the role and impact that formulary decision-making ultimately plays downstream on patient – healthcare provider communication, informed decision-making about therapy choice and what medication is prescribed or recommended and why, and ultimately -- to what extent patients effectively self manage their medication therapy, NCPIE is pleased to help support the work of the Subcommittee this afternoon and moving forward. Additionally, I would point out that NCPIE educational messages and materials are motivated by what we refer to as the “**3Rs**” for **Safe Medicine Use**. They are:

-- **Risk** - recognize that all medicines (prescription and nonprescription) have risks as well as benefits; and you need to weigh these risks and benefits carefully for every medicine you take.

-- **Respect** - respect the power of your medicine and the value of medicines properly used.

-- **Responsibility** - take responsibility for learning about how to take each medication safely. Being responsible also means following this important rule: when in doubt, ask first. Your healthcare professional can help you get the facts you need to use medicines correctly.

These “**3 Rs**” are likely similar to motivators for healthcare providers within the VA as they make evidence-based formulary decisions and VA pharmacists, as they collaborate with members of the VA's interdisciplinary healthcare team, and as they counsel patients about safe and appropriate medicine use. As such, NCPIE is pleased to help support VA pharmacists, a subset of the nation's medication experts, as they work collaboratively within the VA pharmacy system on what NCPIE refers to as the “**Medicine Education Team,**” to help optimize medication therapy and to minimize patient risks.

About NCPIE

NCPIE was established in October 1982 as a non-profit organization. Its founding Chair was Congressman Paul G. Rogers (who served 24 years in the U.S. House of Representatives representing West Palm Beach, FL, and during his tenure was referred to as “Mr. Health” for his leading role in passing dozens of measures promoting health care and the environment). The late Honorable Congressman Rogers served as NCPIE's Chair for 16 years.

NCPIE is a diverse coalition of organizations working to stimulate and improve communication of information on the appropriate use of medicines to consumers and healthcare professionals. NCPIE develops programs, provides educational resources, issues research reports, conducts special issues meetings and multi-media campaigns, such as our annual “**Talk About Prescriptions**” Month every October. As such, NCPIE’s activities are guided by three common values: 1) to represent a wide spectrum of organizations serving the public health through educational and advocacy programs; 2) to empower consumers to be more informed about and active in decisions affecting their use of medicines; and 3) to be a catalyst and convener for the development of new, useful, and scientifically accurate information about medicine use that is disseminated in multiple formats to a wide range of audiences.

What makes NCPIE unique, besides its long-term focus on the appropriate use of medicines, is the depth and breadth of its national coalition of nearly 100 organizations committed to providing patients with useful and appropriate medicine information. The NCPIE coalition includes: consumer organizations; patient advocacy groups, and voluntary health agencies; organizations representing health care professionals and health educators; schools of pharmacy; state and federal government agencies; health-related trade associations; national and international private sector companies including pharmaceutical manufacturers, patient information/database companies, and managed care organizations.

NCPIE is based in Bethesda, Maryland. J. Leonard Lichtenfeld, M.D., representing the American Cancer Society, currently serves as NCPIE’s Chairperson.

Patient Medication Safety Issues / Current and Ongoing NCPIE Programs

NCPIE is one of the original patient safety organizations, addressing safe and appropriate medicine use through the identification, development, and dissemination of educational messages and resources to promote safe and appropriate medicine use. NCPIE also convenes and participates in ongoing and ad-hoc external collaborations and issues-driven project partnerships, striving to address a wide range of potential medication safety (safe use) issues, as described below:

Safety Issues Related to Communicating Risk via Written Consumer Medicine Information

– NCPIE, in 1996, at the request of then HHS Secretary Shalala, participated in the development of a **10-Year Action Plan for the Provision of Useful Prescription Medicine Information**. The **Action Plan**, which included criteria for quality improvements for both clinical content and the design, layout, and readability of written medicine information leaflets conveyed by community pharmacies with every retail prescription, sunset in December 2006. The Food and Drug Administration as the lead agency responsible for assessing to what extent **Action Plan** quality improvements were achieved by the private sector during this 10-year period, is conducting a two-day workshop later this week to obtain key stakeholder input on proposed new prototypes for such useful written information and to seek input on a research agenda to ensure consumer input on the development, design, and testing of such written information. NCPIE is participating in the workshop as a reactor panelist.

Safety Issues Related to Medication Nonadherence

– Although the challenge of poor adherence has been discussed and debated for at least three decades, these problems have, until recently, generally been overlooked as a major health care priority. NCPIE has since 1995 called for national action to address this major public health problem that has recently been estimated to cost the U.S. economy over \$290 billion annually – or 13% of total healthcare expenditures (New England Health Care Institute, July 2009). Consider:

- Nearly 3/4 of Americans report they don't take their medications as directed;
- One in three never fill their prescriptions;

- For common chronic conditions such as diabetes and hypertension, proper adherence averages only 50-65 percent;
- 3-69% of medication-related hospital admissions are linked to poor adherence.

Failure to follow medication regimes is especially harmful to people with chronic health conditions. When those with chronic conditions fail to follow their medication regimen, they risk decreased productivity, a lesser quality of life, a more rapid progression of their condition, complications, hospitalization, and even death. Employers are seeing billions of dollars lost to chronic condition-related absenteeism and *presenteeism* (when employees report for work, but do not function at full capacity). It is estimated that diabetes accounts for 120 million work days lost every year to presenteeism.

In 1995, NCPPIE released the referenced report, “**Prescription Medicine Compliance: A Review of the Baseline of Knowledge,**” which outlined the health consequences of nonadherence and defined key factors contributing to poor medication adherence. The report included an overview of strategies to enhance adherence, along with implementation tools and materials.

In August 2007, NCPPIE released its second report, “**Enhancing Prescription Medicine Adherence: A National Action Plan.**” This referenced report was released as a renewed nationwide call to action for improving medication adherence through patient information and education, health professional intervention, expanded research, and supportive government policies. The report includes 10 recommendations for action that cross-cut the continuum of care – from diagnosis through treatment and follow-up patient care and monitoring. The report is available for download at www.talkaboutrx.org.

1. Elevate patient adherence as a critical health care issue.
2. Agree on a common adherence terminology that will unite all stakeholders.
3. Create a public/private partnership to mount a unified national education campaign to make patient adherence a national health priority.
4. Establish a multidisciplinary approach to compliance education and management.
5. Immediately implement professional training and increase the funding for professional education on patient medication adherence.
6. Address the barriers to patient adherence for patients with low health literacy.
7. Create the means to share information about best practices in adherence education and management.
8. Develop a curriculum on medication adherence for use in medical schools and allied health care institutions.
9. Seek regulatory changes to remove roadblocks for adherence assistance programs.
10. Increase the federal budget and stimulate rigorous research on medication adherence.

Safety Issues Related to Prevention of Medication Abuse Among Teens -- While the use of tobacco, alcohol and illicit drugs is declining overall, a new threat is emerging; more teens are abusing prescription drugs than any illicit drug, except marijuana. The misuse and abuse of prescription medications - the very same drugs used to legitimately relieve pain, and treat conditions like anxiety, depression, sleep disorders, or ADHD in some people - is a growing and under-recognized problem that puts young lives at risk.

- 1 in 5 teens (or 4.5 million) has deliberately abused these drugs.
- 1 in 3 teens surveyed says there is “nothing wrong” when using prescription drugs “every once and a while.”
- Every day, 2,500 youth (12-17) abuse a prescription pain reliever for the very first time.

NCPPIE, with contract support from the Substance Abuse and Mental Health Services Administration (SAMHSA), and input from a project advisory team of over a dozen national organizations involved in drug abuse prevention and teen health, has developed two collaborative educational campaigns to promote prevention of prescription medicine abuse among teenagers:

- **“Not Worth the Risk – Even If It’s Legal,”** consisting of English and Spanish language television and radio spots, a newspaper article (English and Spanish distributions) and two educational brochures, one targeting teens and one targeting parents. All of the campaign elements are posted for viewing on www.talkaboutrx.org.
- **“Maximizing Your Role as a Teen Influencer: What You Can Do To Help Prevent Teen Prescription Drug Abuse,”**-- turn-key educational workshop materials (Power Point presentation with presenter’s notes and a comprehensive Presenter’s Guide) to equip teen influencers (e.g., parents, teachers, school administrators, coaches, community leaders, physicians and pharmacists) with the knowledge and skills to communicate with teens and help curb prescription drug abuse.
- NCPPIE has begun development of a third resource, an online **“Tool Kit for Curbing Prescription Medicine Abuse on America’s College Campuses,”** in October 2009.

Safety Issues Related to Proper Disposal of Pharmaceuticals - Proper disposal of unused medications has become a visible and sensitive public health and environmental issue. Goals of proper disposal programs include: 1) Prevent environmental exposures and impacts from improper pharmaceutical disposal, especially to the aquatic ecosystem; 2) Minimize accidental overdoses by people, pets and wildlife; 3) Limit opportunities for drug-related crime and subsequent abuse; 4) Provide a safe alternative to drug stockpiling in homes; 5) Preclude outdated drug donations; and 6) Facilitate pharmacoeconomic assessments of waste and prescriptions, insurance, and reimbursement and dispensing policies and practices.

NCPPIE distributes a handout for consumers on proper disposal entitled, **“Tips on Safe Storage and Disposal of Your Prescription Medicines.”** (www.talkaboutrx.org). NCPPIE is also a collaborative partner and participant in **The Safe Medicine Disposal for Maine**. NCPPIE is represented on the project advisory team for this statewide pilot disposal program developed in Maine with grant support from the U.S. Environmental Protection Agency (EPA). The program provides a safe and anonymous method of drug disposal for Maine residents and is the first of its kind in the country. For additional information see: <http://www.safemeddisposal.com/>.

Safety Issues Related to the Prevention of Medication Errors - NCPPIE is a member of the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP), a coalition of over two dozen leading national health care organizations who work collaboratively to address the interdisciplinary causes of medication errors and to promote the safe use of medications. The U.S. Pharmacopeia spearheaded the formation of NCC MERP and is a founding member and Secretariat for NCC MERP. The Department of Veterans Affairs is also a member of NCC MERP. Currently, 14 NCC MERP Recommendations reside on the NCC MERP web site at: <http://www.nccmerp.org/councilRecs.html>. Select sample titles include: *Recommendations to Enhance Accuracy of Prescription Writing*; *Recommendations for Health Care Organizations to Reduce Medication Errors Associated with the Label, Labeling, and Packaging of Pharmaceutical (Drug) Products and Related Devices*; and *Reducing Medication Errors Associated with At-risk Behaviors by Healthcare Professionals*.

Safety Issues Related to Safe and Appropriate Use of Acetaminophen Products --- NCPPIE is currently participating in two coalitions (Maryland Acetaminophen Coalition and the American Pharmacists Multi-Stakeholder Coalition) addressing the safe use of OTC and prescription medicines containing the active ingredient acetaminophen. Acetaminophen is sold under several brand names and is also available in over 600 cough and cold products, sleep aids, and prescription pain relievers.

The wide spread utilization of acetaminophen by patients may increase the incidence and prevalence of misuse, which can lead to severe health care outcomes. Many cases of overdose are caused by patients inadvertently taking more than the current recommended dose of a particular product, or by taking more than one product containing acetaminophen (e.g., an over-the-counter product and a prescription drug containing acetaminophen).

Safety Issues Related to Older Adults and Medication Use/Misuse -- NCPIE, in 2007, developed and launched **The Medication Use Safety Training for Seniors™** program (**MUST for Seniors™**). This turn-key, online educational program for older adult medicine users, caregivers, and community-based programs that address older adult health and wellness includes a complete menu of video vignettes, Power Point presentations with accompanying scripts and a range of supporting educational handouts for individuals or group participants. See: www.mustforseniors.org.

The following patient medication safety issues were first described by NCPIE in a forward-looking **October 1987 referenced report, “Priorities and Approaches for Improving Prescription Medicine Use by Older Americans.”** The report summarized the problem of improper medication use among older adults, its consequences, and factors contributing to the problem; identified priorities for resolving factors leading to medication misuse; and suggested practical approaches to program developers for taking action in the following key priority areas: 1) Poor Communication Between Older Patients And Health Professionals; 2) Polypharmacy (the use of multiple medicines); 3) Multiple Health Care Providers 4) Altered Drug Action and Response With Advancing Age; 5) Inability To Take The Medication As Prescribed, and 6) Deliberate Nonadherence.

Safety Issues Related to Children and Improper Medicine Use --In 1989 NCPIE produced a referenced report entitled, **“Children and America’s Other Drug Problem: Guidelines for Improving Prescription Medicine Use Among Children and Teenagers.** Key findings from the report included the finding that improper medicine use among children is a widespread problem. Adolescents are even more likely not to take medicine as prescribed than children under age 13. Four types of improper medicine misuse commonly occur: 1) Stopping a medicine too soon; 2) Not taking enough of a medicine; 3) Refusing to take a medicine; 4) Taking too much of a medicine. The consequences of such improper medicine use are serious: 1) Dangerous health outcomes; 2) Inadvertent treatment errors; 3) Life-threatening adverse effects; 4) Unpleasant side effects; 5) Unnecessary diagnostic and treatment costs; and 6) Greater risk of accidental poisoning.

Select Best Practices, Programs or Policies that NCPIE Member Organizations Employ to Enhance Medication and Patient Safety

NCPIE is pleased to share best practices, programs, or policies that select member organizations employ to enhance safe and appropriate medicine use and patient safety. The following represents only a partial list of such members’ work products:

- American Pharmacists Association
- American Society of Health System Pharmacists
- Academy of Managed Care Pharmacy
- Health Resources and Services Administration, Office of Pharmacy Affairs
- Institute of Safe Medication Use (ISMP)
- Pharmacy Coalition Work Product

American Pharmacists Association (APhA)

-- **Medication Therapy Management (MTM) Central** – APhA web content; comprehensive information about MTM) including links to:

- MTM Certificate Program
- MTM Services Continuing Education Programs
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- APhA MTM Digest.
- 100 MTM Tips for the Pharmacist

<http://www.pharmacist.com/AM/Template.cfm?Section=MTM&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=87&ContentID=19154>

-- **“Pharmacist Clinical Services Improve Health Care Quality, Lower Health Care Costs - Potential Medication Therapy Management Impact: ~ \$30 Billion in Savings”**

Information presented by APhA to demonstrate possible savings if pharmacist clinical services were more widely available for the following diseases: Diabetes, Cardiovascular Disease, and Asthma. Includes the following data from the Department of Veterans Affairs (VA): By extrapolating the average salary data for a pharmacist, the VA expects to see an annual \$368,000 in savings from each pharmacist by providing clinical pharmacy services. (Schumock OT, Butler M6, Meek PD, Vermeulen LC, Arondeker BV, Bauman JL. *Evidence of the Economic Benefit of Clinical Pharmacy Services: 1996-2000* Pharmacotherapy 2003; 23(1):113-132)

American Society of Health-System Pharmacists (ASHP)

ASHP supports all pharmacists being able to play a leadership role in medication-use safety. In larger hospitals, a dedicated position is necessary to oversee the management of medication safety initiatives. This new position has emerged to provide leadership in medication-use quality and safety: the Medication Safety Officer (MSO). The MSO is a practitioner who serves as an authoritative leader within the organization on safe medication use. While an MSO can be a nurse or physician, this role is usually filled by a pharmacist or pharmacy manager in the Department of Pharmacy. To become an MSO, requirements include formal training in medication safety and quality best practices. Pharmacists who choose to specialize in medication-use safety undergo 10 years of educational training, including an accredited postdoctoral residency training program. Job responsibilities of an MSO include, but are not limited, to the following:

- 1) Managing information on patients and medication
- 2) Overseeing processes for prescribing and monitoring use of medication
- 3) Optimizing communication methods to minimize risk for errors
- 4) Minimizing potential for error in medication labeling, packaging, and nomenclature
- 5) Standardizing administration, dosing, and storage of medication
- 6) Overseeing preparation, distribution, dispensing, and administration of medication
- 7) Evaluating and oversee acquisition, use, and monitoring of medication delivery devices
- 8) Maintaining safe environmental conditions for patients and staff
- 9) Ensuring health care staff competence, education, and proficiency
- 10) Ensuring patient education
- 11) Maintaining quality processes and oversee risk management
- 12) Ensuring legal and regulatory compliance
- 13) Serving as a liaison to the public for the organization and management
- 14) Evaluating integration of technology, automation, and clinical information systems
- 15) Promoting Best Practices for safe medication use
- 16) Collaborating with other healthcare disciplines and hospital leadership to coordinate system-wide medication safety initiatives.

ASHP compiles its policy positions, statements, guidelines, technical assistance bulletins, therapeutic position statements, therapeutic guidelines, and selected ASHP-endorsed documents in **ASHP's *Best Practices for Hospital & Health-System Pharmacy***. This compilation is updated annually, and provides guidance and direction to ASHP members and pharmacy practitioners and to other audiences who affect pharmacy practice.

Academy of Managed Care Pharmacy (AMCP)

The Framework for Quality Drug Therapy (<http://www.fmcenet.org/index.cfm?p=132D8447>)

This uniquely designed self-assessment tool is intended to be used by individual pharmacists and other health care practitioners and by organizations of virtually any size, from a physician's office to a large corporate health plan. The interactive tool provides individual practitioners and organizations with an online step-by-step process to identify, evaluate and improve upon specific task, skills and functions that contribute to effective medication therapy management. By answering a series of questions contained in the interactive self-assessment tool, the program helps identify drug therapy management areas ripe for improvement. The program then populates any one of three action plan templates chosen by the user. The action plan template provides a format for defining measurable goals, assigning responsibilities, identifying available resources, and tracking progress, thus beginning a continuous quality improvement process.

Health Resources and Services Administration, Office of Pharmacy Affairs

“Patient Safety and Clinical Pharmacy Services Collaborative Change Package,” (PSCS; version 11, August 1, 2008). The *“Patient Safety and Clinical Pharmacy Services Collaborative Change Package,”* is organized into strategies. Each strategy includes change concepts, each of which is accompanied by action items (e.g., “assess organizational needs for quality...”). The *Change Package* also denotes links to current corresponding national initiatives, helpful tools and resources, and definitions relevant to the proposed material. The following is one illustrative strategy:

Strategies to Achieve Accountability for Results

IV. Safe Medication Use Systems: Develop and operate by safe medication-use practices

Key Change Concepts for Improved Patient Safety and Clinical Pharmacy Systems

J. Systematically introduce and institutionalize safe medication-use practices and monitoring procedures.

Suggested Action Items (Range from J1. – J11; Representative sample below).

- J1. Eliminate the practice of providing free samples, or establish a strict set of guidelines for acceptance and monitoring of samples based on a rational formula for the organization.
- J2. Require double-checking, especially during the times when pharmacist is unavailable (e.g., develop and utilize policies requiring two nurses to verify the right drug when nurses access medication storage).
- J3. Write notes in a standardized way based on locally developed guidelines shared among providers; for example, list “do not use” abbreviations on the medication form

Institute for Safe Medication Practices (ISMP)

ISMP Self-Assessments

The Institute for Safe Medication Practices (ISMP) makes available to healthcare organizations several ISMP Medication Safety Self Assessments®. These tools are designed to help healthcare organizations assess the medication safety practices in their respective institution surrounding the use of medication therapy, identify opportunities for improvement, and compare individual organizational experience with the aggregate experience of demographically similar organizations.

The self-assessments contain items that address the use of medications in the clinical setting, many of which are on the ISMP list of high-alert medications. Many of the items included represent system improvements and safeguards that ISMP has recommended in response to analysis of medication errors reported to the USP – ISMP Medication Errors Reporting Program, problems identified during on-site consultations with healthcare organizations, and guidelines in the medical literature. Available Self Assessments include:

- Acute Care - ISMP Medication Safety Self Assessment® for Hospitals
[2004 Self-assessment](#)
[2000 Self-assessment](#)
- [Antithrombotic Therapy](#)
- [Bar Coding Assessment](#)
- [Community/Ambulatory Pharmacy](#)
- [Physician Practices](#)
- ISMP Medication Safety Self Assessment® for Automated Dispensing Cabinets

Pharmacy Coalition Work Product

1. Principles of a Sound Drug Formulary System

A coalition of national organizations representing health care professionals, government, and business leaders formed a working group (Including the Department of Veterans Affairs. See Appendix III) to develop a set of principles specifying the essential components that contribute to a sound drug formulary system. The Coalition was formed in September 1999 in response to the widespread use of drug formularies in both inpatient and outpatient settings and the lack of understanding about formularies among the public. The passage of federal legislation providing a prescription drug benefit for Medicare beneficiaries also brought increased attention to the appropriate role and management of drug formulary systems within drug benefit programs. This document contains “*Guiding Principles*” that the Coalition believes must be present for a drug formulary system to appropriately serve the patients it covers.

See: <http://www.amcp.org/amcp.ark?p=AA8CD7EC>

How The NCPIE Coalition Works to Meet its Mission

NCPIE works to meet its mission to “stimulate and improve communication of information on the appropriate use of medicines to consumers and health care professionals,” through both in-house development and implementation of educational products or programs and through convening or participating in collaborative programs with both member and non-member organizations. Examples of both approaches include:

Dedicated / Recurring Event of Observance

- In October 1986, NCPIE conducted its first annual “**Talk About Prescriptions**” Month. The purpose of “**Talk About Prescriptions**” Month (TAP Month) is to help ensure that safe and appropriate medicine use through high-quality medicine communication is positioned as an important public health issue. TAP Month also provides NCPIE a regularly- scheduled platform for announcing new educational products, programs or services to promote its organizational mission. The theme for NCPIE’s upcoming, 24th annual TAP Month, October 2009 is, **Talk About Prescriptions: “Communication is Key.”**

Establish Key Partnerships

- In-house development, January 2002 launch, and ongoing implementation of “**Be MedWise**” to **Promote Safe Use of Over-the-Counter Medicines** (www.bemedwise.org). NCPIE conceptualized this ongoing, web-based public education campaign and invited the Food and Drug Administration and the American Pharmacists Association to participate in its launch at a National Press Club media briefing. Dr. Richard Carmona, M.D., MPH, FACS, U.S. Surgeon General, participated in a subsequent media briefing in September 2003 to expand the scope of the campaign. NCPIE also licenses content from the campaign to support two state-wide collaborative programs, “**Be MedWise**” Tennessee, and “**Be MedWise**” Arkansas. Lead state organizations are the Universities of Tennessee and Arkansas’ Cooperative Extension Services, the University of TN College of Pharmacy and the Univ. of Arkansas College of Pharmacy.

Convene Expert Project Advisory Team

- Formulation of an external Project Advisory Team (PAT) to assist in the development, promotion, and dissemination of a turn-key educational workshop kit, “**Maximizing Your Role as a Teen Influencer: What You Can Do To Help Prevent Teen Prescription Drug Abuse.**”. The PAT for this project, which will launch in October 2009 in conjunction with NCPIE’s annual “Talk About Prescriptions” Month campaign includes representatives from 14 organizations.

NCPIE also convened an external Project Advisory Team for the development, promotion, and 2007 launch of its ongoing online NCPIE program, “**Medication Use Safety Training for Seniors™ (MUST for Seniors™)**.”

Participate in External Coalitions

- NCPIE currently participates in the following external coalitions or special projects:
 - * National Coordinating Council for Medication Reporting and Prevention (NCC MERP)
 - * National Consumers League / Agency for Health Care Research and Quality National Medication Adherence Public Awareness Campaign
 - * Safe Medication Disposal for ME (Maine) Program – member of project advisory team
 - * “*Follow Directions: How to Use Methadone Safely*” Campaign Partner
 - * New England Health Care Institute (NEHI) medication adherence improvement project
 - * Maryland State Board of Pharmacy Acetaminophen Safety Campaign
 - * American Pharmacists Association Safe Use of Acetaminophen Products Coalition

Use the Internet and (Pending) Use of Social Media

- NCPIE currently maintains or promotes four educational web sites:

www.talkaboutrx.org – primary site; home for “Talk About Prescriptions” Month;

www.bemedwise.org – safe use of over-the-counter (OTC) medicines;

www.mustforseniors.org – targeting older adults and caregivers;

www.learnaboutrxsafety.org – targeting families, including older adults, caregivers, parents and children; developed collaboratively for The Center for Improving Medication Management (SureScripts) who own / maintain the site.

- Upcoming campaign (online Tool Kit to address medicine abuse on college campuses) will include outreach via social media, including Facebook and Twitter).

I would once again like to thank you for inviting me to testify before this Subcommittee. I appreciate the work of this Subcommittee on Oversight and Investigations of the House Committee on Veterans' Affairs. On behalf of all NCPIE member organizations I thank you for your trust in our ability to assist you with this important work. I look forward to answering any questions you might have.