



Florida's State Opioid Response Project

ANNUAL REPORT 2019, UPDATED JANUARY 2020

MISSION: To work in partnership with local communities to protect the vulnerable, promote strong and economically self-sufficient families, and advance personal and family recovery and resiliency

Annual Report
Florida's State Opioid Response Project (SOR)
U.S. Department of Health & Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
FOA No. TI-18-015

Agency: Florida Department of Children and Families
Department: Substance Abuse and Mental Health
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Florida's State Opioid Response Project (SOR) is funded by the U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). Administered through the Center for Substance Abuse Treatment, Florida has been awarded a two-year grant (9/30/18 – 9/29/20) under Funding Opportunity Announcement (FOA) No. TI-18-015, State Opioid Response Grants. The program aims to address the opioid crisis by increasing access to medication-assisted treatment using the three FDA-approved medications for the treatment of opioid use disorder, reducing unmet treatment need, and reducing opioid overdose-related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder, including prescription opioids, heroin, and illicit fentanyl and fentanyl analogs. Florida's two-year grant award is \$50,056,851 each year. In March 2019, SAMHSA awarded the Department a \$26,129,676 supplemental award, for a total of \$126,243,378 for the project period. As required by SAMHSA, this Annual Report covers Year 1 of the project period, September 30, 2018 – September 29, 2019.

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Florida's State Opioid Response (SOR) Project is administered through the Office of Substance Abuse and Mental Health (SAMH) in the Department of Children and Families (Department) and has built upon and expanded work implemented under the SAMHSA-funded State Targeted Response Grant (STR). SOR is designed to address the opioid crisis and reduce opioid-related deaths by providing a comprehensive array of evidence-based prevention, medication-assisted treatment (MAT), and recovery support services. Treatment and recovery services target indigent, uninsured, and underinsured individuals with opioid use disorders or opioid misuse. The Department uses SOR grant funds to purchase and distribute naloxone, the life-saving medication that reverses opioid overdoses, and facilitate training on the use of naloxone. Technical assistance is provided to community-based organizations for the development of standing orders, policies, and protocols for community distribution and training.

Florida's SOR Project is multifaceted and funds Behavioral Health Consultants to support child protective investigators and a team of qualified medical professionals to assist with MAT capacity building, training, and technical assistance. The establishment of recovery residences using the Oxford House Model, Recovery Community Organization development, and expansion of the Veterans Support Line have also been implemented under SOR. SOR funds are further allocated to support curricula development for medical schools and buprenorphine induction programs within hospital emergency departments. To ensure timely and accurate data and reporting, the Department has contracted with a vendor to develop and maintain a web-based platform to collect SOR-related client data from community providers for upload to SPARS (SAMHSA's Performance Accountability and Reporting System), as required by SAMHSA.

For core SOR services, the Department contracts with seven Managing Entities (MEs) for the administration and management of regional behavioral health services and supports. MEs are private, non-profit organizations responsible for overseeing contracts with local network service providers for the provision of prevention, treatment, and recovery support services in each respective region. The Department's regional SAMH offices manage ME contracts with support from the SAMH headquarters office.

The annual report covers the first year of the two-year grant award, **9/30/18 – 9/29/19**. This report provides an overview of project goals, objectives, outcomes, and highlights of major activities and accomplishments during the reporting period. The following **Data Highlights** chart provides specific outcome information requested by SAMHSA. Details on each are provided in the report.

| Data Highlights – Year 1 | |
|---|---------------|
| 1. Number of clients who have received treatment services | 7,590 |
| a. Of those, # receiving methadone | 3,145 |
| b. # receiving buprenorphine | 3,364 |
| c. # receiving naltrexone | 602 |
| 2. Number of clients receiving recovery support services | 499 |
| 3. Number of naloxone kits distributed | 17,897 |
| 4. Number of overdose reversals reported* | 3,198 |

Reversals are voluntarily reported by organizations that participate in the Department's Overdose Prevention Program. Cumulatively, **3,198 reversals have been reported since program implementation in 2016. This includes all funding sources, including SOR.*

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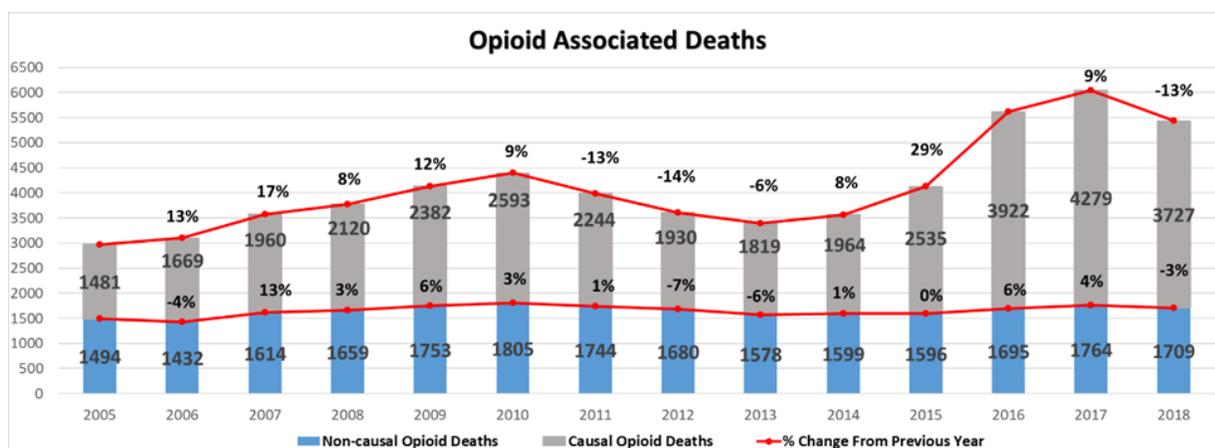
To ensure a comprehensive review of Year 1, the report incorporates information and updates from the mid-year report. Given that the STR grant overlapped with the SOR project period, many providers continued services utilizing STR funding through the end of the STR project period, April 30, 2019; consequently, some providers used little to no SOR funding during the first two quarters (six months) of SOR. Although this impacted implementation of treatment and recovery services under SOR, during the latter months of Year 1, services and resource utilization increased exponentially. The following chart provides an overview of the goals and objectives of Florida's SOR Project. The outcomes show that the program has met or exceeded a number of objectives, including the expansion of MAT treatment. The annual target is to have at least 5,000 clients receiving treatment services. During this first year, 7,590 clients received treatment services, an achievement of 151.8% of the goal. Some outcomes are not available during this reporting period, as SAMHSA's approved reporting tool was released in June 2019, three months before the close of Year 1; therefore, additional time is required to collect a sufficient amount of data for analysis and reporting. Updates will be provided on these measures in the next report.

| SOR Goals, Objectives & Outcomes | | |
|---|--|---|
| Objectives | | Outcomes |
| Goal 1. Reduce numbers and rates of opioid-related deaths. | | |
| Objective 1.1 | Distribute at least 40,000 naloxone kits to community providers per year. | 17,897 kits were distributed <i>44.7% of target</i> |
| Objective 1.2 | Train at least 500 individuals on overdose prevention and naloxone per year. | 151 individuals have been trained <i>30.2% of target</i> |
| Objective 1.3 | For individuals engaged in treatment at least 28 days, reduce overdoses by 75% | The new GPRA was released June 2019; therefore, data is not yet available to report on this measure. |
| Goal 2. Prevent prescription opioid misuse among young people. | | |
| Objective 2.1 | Increase the number of evidence-based prevention programs implemented. | 10 evidence-based prevention programs (listed in the narrative portion) have been implemented by 16 providers. 13,522 youth have been served through individual-based and group programs; and 1,159,353 individuals have been reached by media campaigns designed to prevent prescription opioid misuse. |

| Goal 3. Increase access to Medication-Assisted Treatment (MAT) and associated services and supports among individuals with opioid use disorders. | | |
|---|--|--|
| Objective 3.1 | Increase the number of individuals served in certified recovery residences and Oxford Houses. | 14 additional Oxford Houses have opened, for a total of 15 houses with a total 117-bed capacity. <i>46.6% of annual target of 30 houses</i> |
| Objective 3.2 | Increase the number of DATA 2000 waived prescribers in Managing Entities' provider networks. | 182 DATA 2000 waived prescribers are in the Managing Entities' provider networks. This is a 180% increase from 65 prescribers since STR implementation; and an 11.7% increase since the SOR mid-year report. |
| Objective 3.3 | Increase the number of individuals with opioid use disorders treated with buprenorphine. | 3,364 individuals have been treated with buprenorphine; increased from 145 at mid-year. |
| Objective 3.4 | Increase the number of people who receive recovery support services. | 499 people received recovery support services; increased from 1 person at mid-year. |
| Objective 3.5 | Increase retention of individuals in services by 10% | This measure will be adjusted to show increases in successful completion of treatment. Currently, too few clients have completed treatment, successfully or otherwise, to determine this metric. |
| Objective 3.6 | At least 50% of individuals who completed treatment successfully (including no opioid misuse or reduced opioid misuse at discharge) will have eliminated or reduced opioid misuse 3 months and 6 months after discharge (minimum of 3 contact attempts). | Clients have not been engaged in treatment long enough to have 3 and 6-month post discharge figures. The approved GPRR was received in June 2019, and data collection began at that time. |
| Goal 4. Increase the number of individuals and organizations that are trained to provide MAT and recovery support services for opioid use disorders. | | |
| Objective 4.1 | Increase the number of treatment providers trained to provide MAT. | 402 people have been trained in MAT, including 139 physicians and licensed clinicians. SOR-funded MAT training began July 2019. |
| Objective 4.2 | Implement a minimum of 2 accredited Recovery Community Organizations. | 2 Recovery Community Organizations, Rebel Recovery and South Florida Wellness Network, are actively engaged in preparations for the Council on Accreditation of Peer Recovery Support Services (CAPRSS) accreditation. Each is on track for accreditation during the project period. |

Opioid-Caused Deaths in Florida

The overarching goal of SOR is to reduce numbers and rates of opioid-related deaths. According to the Florida Medical Examiners Commission, “*Drugs Identified in Deceased Persons by Florida Medical Examiners 2018 Annual Report*”, opioid-caused deaths decreased by 13% between 2017 and 2018. The number of opioid-caused deaths decreased from 4,279 in 2017 to 3,727 in 2018. Non-causal death decreased by 3%, which indicates that the presence of opioids in decedents has decreased. Fentanyl usage increased by 30%, while all other opioid use decreased by 20%. It should be noted that in 2017, Florida saw the greatest number of opioid-caused deaths since 2005, underscoring the critical need for SOR funding. While this decrease in opioid-caused deaths cannot be exclusively credited to STR and SOR, SAMHSA’s investment in these programs has helped the Department expand access to MAT and other life-saving treatment and prevention services which help to reduce opioid-caused mortality and overdoses in the state.

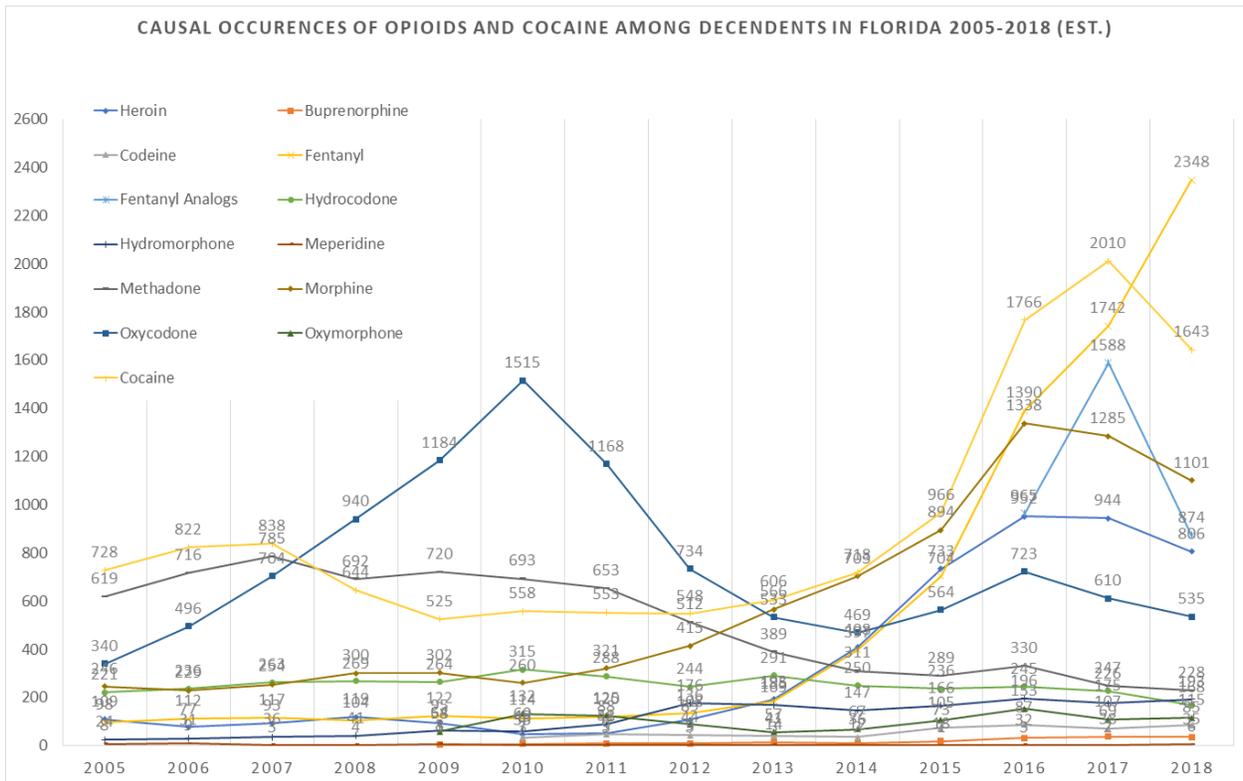


Source: Medical Examiners Commission Annual Report 2018

Additional highlights from the Medical Examiners Commission report follow. All comparisons are made to 2017 calendar year data unless otherwise noted.

- 5,576 opioid-related deaths were reported, which is a **10% decrease** (602 less). The opioids were identified as either the cause of death or merely present in the decedent.
- 3,727 opioid-caused deaths were reported, which is a **13% decrease** (553 less).
- The drugs that caused the most deaths were **fentanyl (2,348)**, cocaine (1,644), benzodiazepines (1,136, including 664 alprazolam deaths), morphine (1,102), fentanyl analogs (874), ethyl alcohol (866), and heroin (806). Fentanyl (87 percent), heroin (86 percent), fentanyl analogs (83 percent), morphine (59 percent), methamphetamine (59 percent), cocaine (58 percent), and methadone (57 percent) were listed as causing death in more than 50 percent of the deaths in which these drugs were found.
- Occurrences of heroin decreased by 11 percent (117 less) and deaths caused by heroin decreased by 15 percent (138 less).

- Occurrences of fentanyl increased by 29.5 percent (615 more) and deaths caused by fentanyl increased by 35 percent (605 more).
- Occurrences of oxycodone decreased by 8 percent (101 less) and deaths caused by oxycodone decreased by 12 percent (75 less).
- Occurrences of amphetamine increased by 29 percent (249 more) and deaths caused by amphetamine increased by 37 percent (95 more). In the body, methamphetamine is metabolized to amphetamine, thus many occurrences of amphetamine likely represent illicit methamphetamine ingestion rather than pharmaceutical amphetamine use.



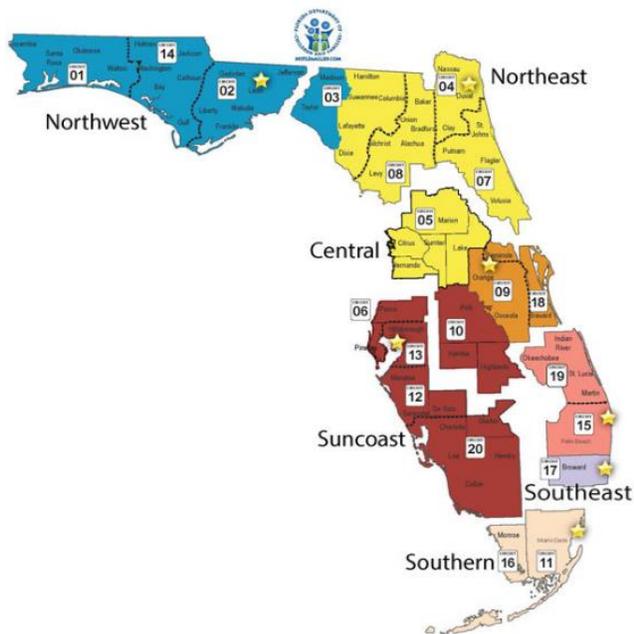
Source: Florida Medical Examiners Commission Annual Report 2018

As illustrated, from 2005 to 2010, there was a dramatic increase in opioid deaths in Florida driven by illegally diverted and nonmedical misuse of pharmaceutical opioids, mainly Oxycodone (e.g., Oxycontin). Actions taken by the State of Florida in 2010 and 2011 included the enactment of laws and regulations to reduce the supply-side of the problem, including the closing of “pill mills”, resulting in a decrease of oxycodone deaths from 2011 to 2014. However, as the number of oxycodone-caused deaths decreased, starting in 2011, other opioid-caused deaths began to increase steadily. After three years of decreasing opioid-caused deaths, Florida began to see another increase in 2014 in deaths driven by heroin, morphine, fentanyl, and illicitly manufactured fentanyl analogs instead of Oxycodone. In comparison to 2017, deaths caused by opioids decreased during 2018 in all drugs except for fentanyl. Deaths caused by fentanyl increased by 35 percent (605 more) (Medical Examiners Commission, 2018 Annual Report). The increase in fentanyl use

and related deaths indicates a need for increased prevention and treatment efforts with a focus on reducing fentanyl use.

MANAGING ENTITIES

The Department contracts with seven Managing Entities (MEs) for the administration and management of regional behavioral health services and supports, including core SOR funded services. MEs are private, non-profit organizations responsible for overseeing contracts with local network service providers for prevention, treatment, and recovery support services in each respective region. The Department’s regional SAMH offices manage ME contracts with support from the SAMH headquarters office. As the map illustrates, there are six Regions: Northwest, Northeast, Central, Suncoast, Southeast, and Southern, and seven MEs: Big Bend Community-Based Care (BBCBC), Broward Behavioral Health Care (BBHC), Central Florida



Behavioral Health Network (CFBHN), Central Florida Cares Health System (CFCHS), Lutheran Services Florida (LSF), South Florida Behavioral Health Network (SFBHN), and Southeast Florida Behavioral Health Network (SEFBHN). For management of regional systems of care, there is one ME located in five of six regions, and two MEs in the Southeast Region. Each ME serves specific counties, as shown in the *Counties Served* chart. See **Attachment 1. Managing Entities Map** (pg.35). SOR implementation and administration are managed through coordination with regional staff, MEs and local service providers. Using an approach similar to SAMHSA’s formula-based allocations to the states which used two equally weighted elements (the state’s proportion

| Counties Served | |
|---|--|
|  | Big Bend Community Based Care Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington |
|  | Broward Behavioral Health Coalition - Broward |
|  | Central Florida Behavioral Health Network Charlotte, Collier, DeSoto, Glades, Hardee, Highlands, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, Polk and Sarasota |
|  | Central Florida Cares Health System Brevard, Orange, Osceola and Seminole |
|  | Lutheran Services Florida Alachua, Baker, Bradford, Citrus, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Hernando, Lake, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Sumter, Suwannee, Union and Volusia |
|  | South Florida Behavioral Health Network Miami-Dade and Monroe |
|  | Southeast Florida Behavioral Health Network Indian River, Martin, Okeechobee, Palm Beach and St. Lucie |

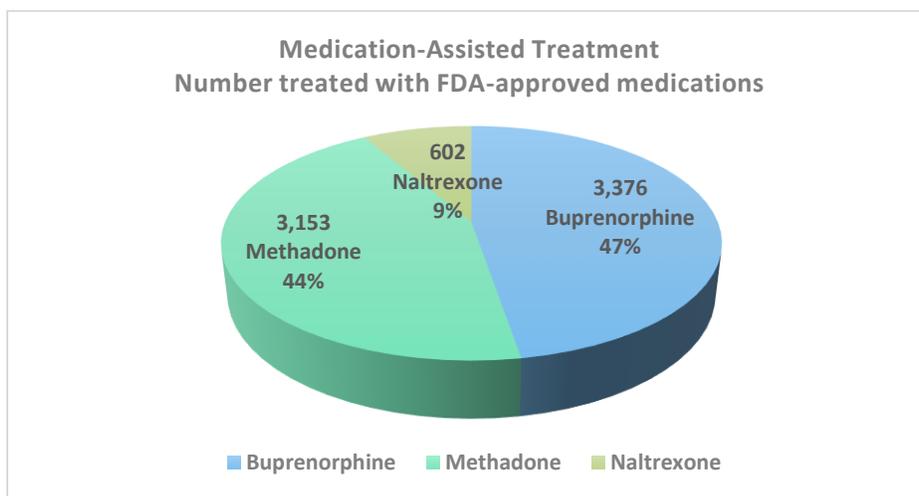
of people with an opioid use disorder who have not received treatment, and the state’s proportion of drug poisoning deaths), the Department allocated the majority of SOR funding to MEs for medication-assisted treatment services in the amount of \$25,059,506; and \$2,300,000 for evidence-based prevention activities. For allocation details, please see **Attachment 1. SOR Funding Methodology (pg.35)**.

MEDICATION-ASSISTED TREATMENT

SOR has expanded Medication-Assisted Treatment (MAT) and associated services using FDA-approved medications statewide. The majority of SOR grant funds are being utilized for methadone maintenance and buprenorphine maintenance because controlled trials demonstrate that these services are most effective at retaining individuals in care, reducing illicit opioid use, and reducing opioid-related mortality. Funds have also been allocated for extended-release naltrexone, which blocks the effects of opioids and is approved for the prevention of relapse to opioid dependence.

During Year 1, \$25,059,406 was allocated for MAT services. Additionally, of the \$26M received in supplemental funding from SAMHSA, \$24,756,429 (94.74% of the award) was allocated to MEs for additional MAT services to support families who are child welfare involved and to implement/expand hospital bridge programs. In addition to paying for FDA-approved medications, buprenorphine, methadone, and naltrexone, funds cover the following services: aftercare, assessment, case management, crisis support, daycare, day treatment, incidental expenses (excluding direct payments to participants), in-home and on-site, medical services, outpatient, outreach (to identify and link individuals with opioid use disorders to MAT providers), recovery support, supported employment, supportive housing/living, detoxification, and residential. If detoxification is provided and it is not a medically necessary precursor to methadone or buprenorphine induction, perhaps due to poly-drug use (particularly alcohol or benzodiazepines), then it must be accompanied by injectable extended-release naltrexone to protect such individuals from an opioid overdose, pursuant to terms of the FOA. Similarly, residential services may only be used to stabilize and treat individuals with opioid use disorders during their transition to MAT. Level of care determinations is reevaluated at least every five days for inpatient detoxification placements and every 14 days for residential placements.

During this reporting period, **7,602** people received MAT and associated services supported by SOR funding. Of those reported, 7,131 received FDA-approved medications; 3,153 (44%) received methadone treatment; 3,376 (47%) received buprenorphine; and 602 (9%) were treated with naltrexone.

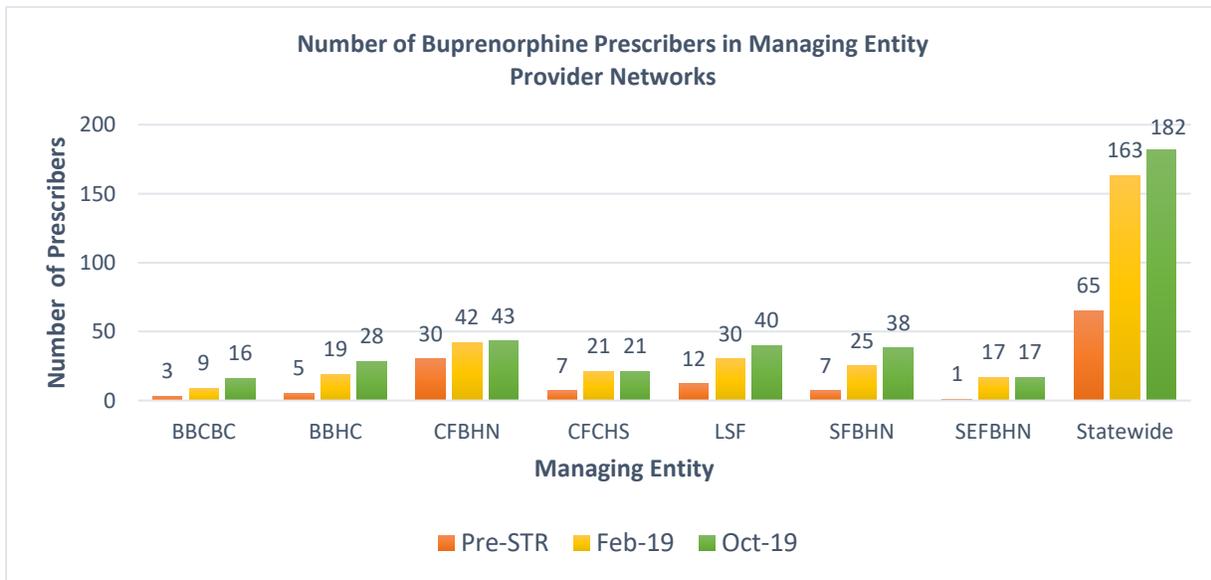


The Department contracts with the Florida Alcohol and Drug Abuse Association (FADAA) for the distribution and associated medical costs of Vivitrol® (naltrexone extended-release injectable medication) to treat opioid use disorders. FADAA contracts with treatment providers for delivery of these services. In addition to, \$4,653,337 in SOR funding for Vivitrol®, FADAA received \$5.6 million from a Florida legislature appropriation during this reporting period. The agency continued expending STR funding through most of this reporting period. SOR-funded services began July 2019. FADAA reports that of the 510 clients served since that time, 230 (45%) were funded by SOR. The agency has 46 enrolled service providers for the administration of screening, assessment, and Vivitrol administration. See Attachment.

Of the other allowable treatment and recovery support services, providers report that 2,570 individuals received case management, and 952 participated in outpatient groups. A reported 1,377 clients were supported through incidental expenses (temporary expenses incurred to facilitate continuing treatment and community stabilization when no other resources are available), which include transportation, childcare, housing assistance, clothing, medical care, and vocational services.

Data-Waived Practitioners

A primary objective of SOR is to expand access to MAT in Florida through increased DATA 2000-waived prescribers. The Department conducted surveys to determine the number of DATA waived practitioners in Managing Entities’ provider networks; Big Bend Community-Based Care (BBCBC), Broward Behavioral Health Care (BBHC), Central Florida Behavioral Health Network (CFBHN), Central Florida Cares Health System (CFCHS) Lutheran Services Florida (LSF), South Florida Behavioral Health Network (SFBHN), and Southeast Florida Behavioral Health Network (SEFBHN).



The first survey was administered during Year 1 of the STR grant. Prior to receiving STR funds, there were 65 DATA waived prescribers in the Managing Entities’ provider networks. After receiving STR funds, 37 prescribers were added for a total of 102 prescribers, representing a 56.9% increase. The next survey was conducted in February 2019, which showed a total of 163 prescribers, representing a total increase of 150.77%. The most recent survey was conducted at the end of the SOR Year 1 project period. ME’s reported that there are now 182 buprenorphine prescribers across their networks. This represents an approximate

12% increase since the SOR mid-year report. Since implementation of STR, an overall 180% increase in the capacity of publicly-funded service providers to prescribe buprenorphine to treat opioid use disorders across the state.

Hospital Bridge Programs

SOR funding is allocated to support hospital bridge programs that initiate buprenorphine treatment for individuals with opioid use disorders who have overdosed or experienced other medical problems due to opioid misuse. The goal is to utilize the time spent in the hospital to engage the individual in treatment and, if possible, immediately begin buprenorphine induction, and provide access to maintenance treatment and recovery support services to keep the individual from experiencing withdrawal symptoms upon release. Where available, these programs use peer specialists to assist with engagement; provide linkage to a maintenance provider; and other community support resources; and provide peer support until individuals are linked with community-based care. Emergency departments with DATA 2000 waived practitioners who can initiate buprenorphine induction, and peer-organizations with peer specialists who can serve multiple emergency departments, are prioritized for funding. Providers expended STR funding to support hospital bridge programs through the end of the STR grant period and began implementation or expansion of hospital bridge programs using SOR fund in July 2019. During Year 1, ME’s report that 765 individuals have been screened in emergency departments and 45 were inducted with buprenorphine prior to discharge. The majority of people seen in the emergency department (520 or 67.9%) were referred to community providers, and of those referred, 318 (61.1%) were confirmed to be linked to care.

| SOR Hospital Bridge Program | | | | |
|------------------------------------|---|--|--|--|
| July 2019 - September 2019 | | | | |
| Managing Entity | Number of individuals screened in the Emergency Department | Individuals inducted with buprenorphine in the ED/hospital prior to discharge | Individuals referred to treatment providers | Individuals linked to treatment providers |
| CFBHN | 420 | 5 | 258 | 171 |
| CFCHS | 216 | 9 | 150 | 107 |
| LSF | 88 | 5 | 74 | 13 |
| SFBHN | 41 | 26 | 38 | 27 |
| TOTAL | 765 | 45 | 520 | 318 |

During Year 1, four MEs reported information on screening and linkage to treatment. Hospitals and providers in three ME networks had not fully implemented hospital-based services funded by SOR during this reporting period. Providers and hospitals are at various stages of implementation; staffing peers, developing contracts/MOU’s, and creating protocols and procedures.

Child Welfare

To support families involved in the child welfare system in accessing treatment and support services, Behavioral Health Consultants (BHC’s) are collocated with Child Protective Investigators (CPI). Through SOR funding, twelve BHC’s have been hired, with two staffing each of the six regions. The BHC’s are licensed or certified behavioral health professionals who provide technical assistance and consultation to CPI’s and child welfare case managers on the identification of behavioral health conditions, their effects on parenting

capacity, and engagement techniques. Consultants also assist investigative staff and dependency case managers in understanding the signs and symptoms of opioid use disorders and the best practices to engage and treat, including the use of MAT; provide clinical expertise and assist with the identification of parents with opioid disorders in the child welfare system. To help ensure coordination of services, their role is also to develop contacts, facilitate referrals, and assist investigative staff with engaging clients in recommended services and improving timely access to treatment.

Many BHC's have served as a liaison between the Department, child welfare, Community Based Care Organizations, and providers. Overall the consensus from the regions is that having the support of a BHC has helped to expedite the referral and linkage process. During Year 1, the Department has worked with the regions to develop a more streamlined process for integrating the BHC's across the state, including comprehensive reporting, which began in July 2019. The following highlights services provided during this period, as reported by BHC's and regional staff. Given that formal reporting began in July 2019, this is not a comprehensive list of activities; however, it illustrates that a significant number of families are being assisted by BHC's and CPI's through this more coordinated and collaborative process.

- BHC's provided services in 10 of the 20 circuits in Florida
- BHC's assisted 505 different CPI's (Child Protective Investigators) with 893 investigations:
 - 654 consultations;
 - 176 joint visits with both the CPI and BHC;
 - 174 brief assessments; and
 - 280 other ancillary support services provided (e.g., case staffings, training)
- BHC's reported 717 (80.2%) cases involved substance use. Opioids were reported as the primary substance of choice in 242 cases.
- There were 505 cases with children under the age of five in the household; of which, 283 (56%) cases involved substance exposed infants (children under the age of one year old that was prenatally exposed to substances).

Since BHC's have been staffed, feedback from the Regions has been very encouraging, as some have reported that BHC's have brought tremendous value to the child welfare assessment, engagement, and service linkage processes. BHC's have accompanied CPI's in the field to assist with family support and safety planning. Regions have reported that agencies utilizing a BHC have better quality assessments through participation in multi-disciplinary staffing, which help engage both Case Managers and service providers. Utilizing supplemental funding from SAMHSA, the Department allocated additional monies to Regions to hire eight (8) more BHC's to be collocated with CPI's, bringing the total to 20 with the intent of staffing each of the 20 circuits in Florida. As of this report, fifteen of twenty BHC's are currently staffed.

In addition to expanding the cohort of BHC's, the Department has allocated \$8M of SOR supplemental funds to each Region to address the treatment needs of families who are involved in the child welfare system. The objective is to expand and/or implement MAT, and associated services using all FDA approved medications targeting parents and caregivers with an opioid use disorder or opioid misuse involved with child welfare. Implemented in July 2019, the Department worked with the Office of Child Welfare (OCW) to develop an allocation methodology using prevalence data specific to child welfare and provide funds to all seven MEs for services provided to this population. The Department set guidance for Regions in

developing plans in coordination with the OCW and local community-based care organizations (CBC's). Plans had to address essential components to ensure coordinated service delivery, including: means of identification of individuals that meet grant criteria; referral processes; how services will be explained to individuals (including all FDA approved medications); current or planned access to MAT in all clinical settings; support services to be offered; and a sustainability plan. Multiple plans were received from the regions, and preliminarily, the plans indicate that the OCW and CBC's are working towards improved communication and collaboration in serving these families who are child-welfare involved and require critical treatment and recovery support services. Given that implementation began in July, few services have been implemented under this allocation, updates and outcomes will be provided in the next SOR report.

PREVENTION

Primary Prevention

SOR funds allocated for prevention are intended to be used for evidence-based services that are effective at preventing opioid misuse, opioid dependence, or opioid deaths. During Year 1, Managing Entities (ME's) received \$2.3M in funding to work with local prevention coalitions and service providers to implement and/or expand primary prevention services in each respective area. A pre-approved list of evidence-based prevention programs was provided to ensure implementation of school and family-based prevention programs proven to effectively reduce prescription drug misuse and prevent the initiation of prescription drug and opioid use. Selection of these programs was based on several factors, including SAMHSA's Center for Application of Prevention Technologies (CAPT) review of studies of a broad array of relevant prevention programs and strategies and identified controlled trials of Botvin Life Skills Training (LST), which demonstrate significant reductions in prescription opioid misuse.

Given SAMHSA's findings, SOR prevention funds are authorized to implement LST, which is a school-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. LST is based on both the social influence and competence enhancement models of prevention. Consistent with this theoretical framework, LST addresses multiple risk and protective factors and teaches personal and social skills that build resilience and help youth navigate developmental tasks, including the skills necessary to understand and resist prodrug influences.

Regarding standards for evidence, the Department looked for statistically significant reductions in opioid misuse (or the use of other illicit drugs), relative to comparison or control groups, as documented in peer-reviewed publications reporting on experimental or quasi-experimental program evaluation designs. Since the most effective prevention programs tend to demonstrate effects across multiple substances, the Department authorized the use of SOR funds for the following prevention programs that have evidence of effectiveness at preventing any illicit drug use:

1. Strengthening Families Program - for Parents and Youth 10-14
(if done in combination with Botvin Life Skills Training)
2. Caring School Community
3. Guiding Good Choices
4. InShape Prevention Plus Wellness
5. PAX Good Behavior Game

6. Positive Action
7. Project SUCCESS
8. Project Towards No Drug Abuse
9. SPORT Prevention Plus Wellness
10. Teen Intervene

The SOR FOA calls for states to implement “evidence-based strategic messaging” as part of community-based prevention efforts. CAPT summarized evaluation findings from a selection of media campaigns designed to prevent prescription drug misuse. The only study that measured SOR-related outcomes was an evaluation of *Use Only as Directed: Utah Prescription Pain Medication Program*.

- According to SAMHSA’s summary, during campaign implementation, the number of unintentional prescription drug-related overdose deaths decreased. Additionally, about half of participants said they were less likely to share their prescriptions than before seeing the campaign. About half also said they were less likely to use prescription drugs not prescribed to them.
- The only other CAPT resource on media campaigns to prevent prescription opioid misuse is a list of campaigns without any evaluation findings. For these reasons, SOR prevention funds in Florida can be used for media campaigns based on the *Use Only as Directed* initiative.

Finally, the Department also allows Managing Entities to request permission to implement evidence-based programs not listed above, subject to Department approval. To date, only two such requests have been received. The Department’s rationale and determination for each are as follows:

- EVERFI’s “Prescription Drug Safety Course” for High School Students. After reviewing descriptive and promotional materials for the program, it appears that there is currently no evidence that this program effectively reduces prescription opioid misuse (or other illicit drug use). With regard to standards for evidence, the Department is looking for statistically significant reductions in opioid misuse (or the use of other illicit drugs), relative to comparison or control groups, as documented in peer-reviewed publications reporting on experimental or quasi-experimental program evaluation designs. If evidence of this nature is produced in the future, then we can revisit this determination.
- I Can Problem Solve (ICPS). A review of the research and evaluation studies that were provided identified only one controlled trial of ICPS that measured illicit drug use as an outcome. In this evaluation, ICPS was implemented as part of a multicomponent initiative, and lifetime illicit drug use was measured in 1985 and 1993. No significant differences were found between intervention and control groups for any of the measures of drug use (including illicit drugs). For this reason, SOR prevention funds cannot be used to implement ICPS. If any additional studies are provided later, we will revisit this determination.

During Year 1, 16 providers have implemented evidence-based prevention (EBP) programs across Florida. There are twelve approved EBP programs, of which ten have been implemented. During Year 1, **13,522** youth have been engaged in prevention programs, of which 9,842 or 73% participated in Botvin LifeSkills Training (LST). Other prevention programs implemented during this reporting period are: Caring School Community, Guiding Good Choices, InShape Prevention Plus Wellness, PAX Good Behavior Game, Project

SUCCESS, Project Towards No Drug Abuse, SPORT Prevention Plus Wellness, Strengthening Families and Teen Intervene.

Use Only as Directed was also implemented during this reporting period. This media campaign provides information and strategies for safely using, storing, and disposing of prescription painkillers. The program offers video, audio, and print ads that communities can use to inform the public and begin conversations about prescription pain medication misuse and abuse. Prevention providers report impressions (the number of people who have seen or heard the campaign), and during Year 1, an estimated **1,159,353** impressions have been reported; 259,730 youth and 899,623 adults.

The following illustrates the number served through evidence-based prevention programs in schools and community settings including the *Use Only as Directed* media campaign, which provides information and strategies for safe use, storage, and disposal for prescription pain medications.

| School and Community Evidence-Based Prevention Programs | | | |
|--|----------------|----------------|------------------|
| | Numbers Served | | |
| Program | Youth | Adults | Total |
| Caring School Community | 0 | 11 | 11 |
| Guiding Good Choices | 0 | 241 | 241 |
| InShape Prevention Plus Wellness | 22 | 0 | 22 |
| Botvin Life Skills Training | 9,842 | 608 | 10,450 |
| PAX Good Behavior Game (PAX GBG) | 20 | 0 | 20 |
| Project SUCCESS | 3,099 | 97 | 3196 |
| Project Towards No Drug Abuse | 227 | 8 | 235 |
| SPORT Prevention Plus Wellness | 273 | 1 | 274 |
| Strengthening Families | 10 | 22 | 32 |
| Teen Intervene | 29 | 17 | 46 |
| TOTAL | 13,522 | 1,005 | 14,527 |
| The <i>Use Only as Directed</i> media campaign reach is measured and reported as impressions (the number of people who have seen or heard the campaign). There have been over 1.1M impressions during this report period. | | | |
| Media Campaign | Youth | Adults | Total |
| <i>Use Only as Directed</i> | 259,730 | 899,623 | 1,159,353 |
| Total Served: Prevention Programs and Media Campaign | 273,252 | 900,628 | 1,173,880 |
| <i>Source: Performance Based Prevention System (PBPS)</i> | | | |

Overdose Prevention

Implemented in 2016, the Department's Overdose Prevention Program aims to increase access to naloxone, the life-saving medication that reverses opioid overdoses, among individuals in the community at risk of experiencing an opioid-related overdose and to family/friends that may witness an overdose. The program provides the medication to community organizations who, in turn, distribute take-home naloxone kits (Narcan®) directly to those in the community at risk of experiencing or witnessing an overdose. The Department uses SOR grant funds to purchase and distribute naloxone; facilitate training on the use of naloxone; and provide technical assistance to community-based organizations for the development of standing orders, policies, and protocols for community distribution and training.

Naloxone Kits and Distribution

The Overdose Prevention Program had 114 organizations enrolled by the end of Year 1. Enrolled providers range from substance use mental health treatment facilities, harm reduction programs, peer recovery organizations, HIV/AIDS service organizations, homeless shelters, street outreach teams, and other community-based organizations. Organizations enrolled in the program receive the medication to distribute take-home naloxone kits directly to people who use drugs, people with a history of drug use, others at risk of experiencing an overdose, and to friends/family that may witness an overdose. The SOR Grant has allowed the Department to maintain naloxone supplies for current providers, as well as to expand and conduct outreach to enroll additional organizations that provide services to people who use drugs (PWUD).

The Overdose Prevention Program began in August 2016 and has been a key component in addressing the opioid epidemic in Florida. Since implementation to date, 3,198 overdose reversals have been reported. Throughout the STR grant (5/1/17 – 4/30/19), a total of 56,595 naloxone kits were purchased and distributed to organizations enrolled in the program, and 2,647 reversals were reported. This work has continued with the implementation of SOR.

People who use drugs (PWUD) are often the first responders in overdose situations and reverse an overwhelming majority of overdoses in the community. In fact, studies show that PWUD administer naloxone to reverse overdoses at a rate 10 times greater than people who do not use drugs – emphasizing the importance of ensuring that PWUD have continuous access to naloxone to save lives. In order to meet the needs of PWUD in Florida, more low-barrier naloxone distribution programs must be established in settings where PWUD may feel more comfortable and be more likely to frequent. Although many SAMH and other health care providers in Florida offer naloxone to anyone, not just to individuals already enrolled in services, PWUD are less likely to visit these providers to get naloxone. Many factors play a role in determining why PWUD are less likely to visit traditional health care providers to receive naloxone kits, including negative encounters they may have experienced when receiving services from similar organizations in the past, or stigma they often face when attempting to continuously access naloxone from these providers. Recognizing the significant barriers to naloxone access PWUD often encounter in traditional health care settings, the Department is focusing Year 2 outreach efforts on establishing more low-threshold distribution programs within peer recovery organizations, syringe exchange programs, homeless shelters, harm reduction programs, and other community organizations engaged in street outreach services.

While syringe exchange programs (SEPs) are one of the most effective types of organizations at providing large quantities of naloxone to PWUD through low-barrier distribution models, there is only one legal SEP in Florida - the IDEA Exchange in Miami-Dade County. Since the IDEA Exchange began distributing naloxone in April of 2017, the program has provided almost 3,000 naloxone kits directly to PWUD, and participants have reversed over 1,500 overdoses in the community. Miami's exchange was initially authorized as a 5-year pilot program. Still, state paraphernalia laws prevented the establishment of SEPs in any other counties - leaving many PWUD in Florida without access to life-saving harm reduction services. During the 2019 session, however, the legislature passed a law to expand SEPs statewide (F.S. 381.0038 Education; sterile needle and syringe exchange programs), contingent upon approval by county commissions. Four counties have already approved local ordinances to authorize SEPs, including Broward, Palm Beach, Manatee, and Leon – but it is unclear when these programs will be operational. If new SEPs are established during Year 2, the Department will provide naloxone to these organizations to meaningfully increase access among PWUD. The Department will also continue to establish naloxone distribution programs in other targeted settings, such as within hospital emergency departments, SAMH providers, and EMS/Fire leave behind programs.

The Department allocated \$3,498,750 of SOR Year 1 funds to purchase naloxone for the program. Prior to utilizing any SOR dollars for the program, the Department spent all STR naloxone funds. Due to this overlap in project periods, the first SOR naloxone purchase was made in May 2019, after all STR funds were expended. \$1,575,312 of SOR dollars were used to purchase naloxone during Year 1, providing the Department with 22,175 Narcan® Nasal Spray kits, at the cost of \$71.04 per 2-dose kit. Of this amount, 17,897 kits were shipped to providers for community-based distribution during Year 1. The remaining Year 1 naloxone funds (\$1,923,438) will be requested to be carried over and expended during Year 2 for continued maintenance and expansion of the program.

One of the main challenges experienced during Year 1 has been shipping out naloxone to providers in a timely manner. The Department's Overdose Prevention Coordinator is working closely with the Florida State Hospital pharmacy staff to improve this process and ensure providers receive naloxone supplies within one week after submitting orders.

RECOVERY SUPPORT

Recovery Community Organizations

Faces & Voices of Recovery (FAVOR) is an accredited Recovery Community Organization (RCO) that works to support individuals in long-term recovery from drug and alcohol addiction and their family members, friends, and allies in a variety of ways. Services include capacity building in support of the national recovery movement, fighting the stigma of addiction, and creating recovery messaging trainings. In collaboration with the Department, Florida Alcohol and Drug Abuse Association (FADAA), and the Peer Support Coalition of Florida, FAVOR coordinates efforts to build the capacity of RCOs through training and technical assistance. Activities under SOR began in January. During the first quarter, the organization conducted planning activities, including coordinating staffing, developing administrative processes, modifying training materials, creating tools for this project, and establishing relationships with the Florida recovery community. Two full-time project coordinators were hired and tasked with developing a strategic project implementation plan. FAVOR researched ARCO (Association of Recovery Community Organizations) applicants from the last five years who may not have met eligibility criteria at the time to discover which

are based in Florida. Contact was made with several applicants, and progress has been made toward informally assessing organizational readiness for ARCO membership.

FAVOR has developed the RCO Boot Camp and tailored the content to the needs of Florida. The boot camps are designed to orient organizations to RCO Start-up; Board Governance; Peer Leadership Development; Sustainability; Strategic Planning; Ethical Issues; Risk Management; Effective Advocacy; Organizational Wellness; and Compassion Fatigue. The RCO Toolkit was revised and updated to include content to reflect current challenges faced by emerging Florida recovery initiatives. For implementation of RCO Bootcamps and Recovery Launchpads, both curriculums were updated and revised to meet the needs in Florida. Subject matter experts were identified to facilitate all learning events. In addition, a comprehensive organizational manual has been developed with examples of best practices (in alignment with CAPRSS standards) in all areas of organizational systems and processes.

FAVOR conducted statewide assessments of RCOs and recovery support service providers in each region. An assessment tool was created to assist with both gathering resources available in each region as well as begin asset mapping. A mentoring program for RCO's was also developed to support agencies that are working towards or ready to apply for ARCO membership. FAVOR facilitated asset mapping in cooperation with MEs and has made information on regional recovery support services available on the agency's website.

Two Recovery Community Organizations, Rebel Recovery and South Florida Wellness Network are actively engaged in preparations for the Council on Accreditation of Peer Recovery Support Services (CAPRSS) accreditation. South Florida Wellness Network is scheduled to participate in RCO bootcamp, which provides leadership development, training to increase organizational capacity on governance, sustainability, ethics, strategic planning, and staff development. Rebel Recovery is farther along and has begun the accreditation process.

During Year 1, FAVOR updated its website to include the work being done under Florida's SOR and provide Florida-specific recovery information and resources. For more information, visit [Florida Recovery Project \(https://facesandvoicesofrecovery.org/about/news-events/florida-recovery-project.html\)](https://facesandvoicesofrecovery.org/about/news-events/florida-recovery-project.html). Other training and technical assistance provided by FAVOR during this reporting period include:

- Virtual Learning Community: 5 sessions
- Recovery Ambassador Training: 6 have been held across the state.
- RCO Bootcamps: 3 have been held across the state.
- CAPRSS Learning Community: Accreditation Academy-in person training.
- CAPRSS Accreditation Webinars: Accreditation 101 and Accreditation 201
- In regions where no RCO exists and stakeholders express an interest in starting an RCO, Faces and Voices is providing support through mentoring in the following counties: Palm Beach, Hillsborough, Pinellas, Pasco, Duval, Putnam, Osceola, Miami-Dade, St. Lucie and Volusia.
- The Florida Mentor Manual was introduced at the August 20th stakeholders meeting to support emerging organizations.
- Conducted a "Trainer of Trainers" session for the Recovery Launchpad trainings, creating a cadre of five trainers to facilitate future trainings across the state.
- Two Recovery Community Organizations, Rebel Recovery and South Florida Wellness Network are actively engaged in preparations for the Council on Accreditation of Peer Recovery Support Services (CAPRSS) accreditation.

- Peer Support Coalition of Florida and Faces and Voices are actively engaged in ongoing organizational readiness assessments for organizations to determine training and technical assistance needs to be formally established as an RCO to build capacity across the state.

Oxford House

Oxford House is a democratically run, self-supporting and drug-free home for people in recovery from drug and alcohol addiction. As safe and affordable housing remains one of the most critical needs of people in recovery, through SOR’s partnership with Oxford House, recovery residences have increased throughout the state. The number of residents in each house may range from six to fifteen. There are houses for men, houses for women, and houses for women with children. Established in 1975, Oxford House is an effective and low-cost resource to help prevent relapse. There are over 2,000 houses in the United States. Prior to receiving SOR funding, there was only one Oxford House in Florida. SOR has funded Oxford House to open 60 houses in Florida; 30 houses in Year 1 and 30 in Year 2 of the grant. The contract was executed in February 2019, and since that time, a total of fourteen additional Oxford Houses have been opened in eight Florida cities; Altamonte Springs, Cape Coral, Jacksonville, Lantana, Riviera Beach, Tallahassee, and West Palm Beach.

| Oxford House – Florida | | | |
|-------------------------|-------------------|----------------|------------|
| September 2019 | | | |
| HOUSE NAME | CITY | M/W/WC | BEDS |
| Ashton | Pensacola | WC | 8 |
| Cain | Pensacola | M | 6 |
| Clusia | West Palm Beach | W | 6 |
| Danny | Pensacola | M | 8 |
| Dolphin | Riviera Beach | M | 8 |
| Firefly | Tallahassee | W | 9 |
| Flamingo | Cape Coral | W | 7 |
| Glo | Pensacola | W | 8 |
| Gwendolyn | Pensacola | WC | 10 |
| Key Lime | Altamonte Springs | M | 8 |
| Leon | Tallahassee | W | 10 |
| Mango | Lantana | W | 6 |
| Mill Cove | Jacksonville | M | 8 |
| Pineapple | West Palm Beach | M | 8 |
| Tallahassee | Tallahassee | M | 7 |
| Total Houses: 15 | | | |
| Total Beds: | | | 117 |
| | | WC = | |
| M = Men | W = Women | Women/Children | |

As of September 2019, there were a total of 15 Oxford Houses and 117 beds; 7 houses for men (53 beds); 6 houses for women (46 beds); and 2 houses for women with children (18 beds). There are 8 houses in the Northwest Region; 1 house in the Northeast; 1 in Central; 1 house in Suncoast; and 4 in Southeast. By the

end of this project period, the occupancy rate was at 81.2%, up from the mid-year report of 50%, and only 8.5% of departures were reportedly due to relapse. Based on self-report, Oxford House reports an abstinence rate of 91.9%.

The Oxford House staff continue to travel throughout the state to learn more about the recovery support needs in Florida and assess areas of greatest need. Consideration is also made for communities that are open and supportive of having recovery housing located in their area. The organization has met with and engaged dozens of treatment centers and attended conferences to inform providers of the services and share process for referrals and the establishment of new Oxford Houses. Although Oxford House achieved less than 50% (14/30) of the Year 1 target, it is worth noting that as of this writing, there are now 27 houses in Florida. Additional information will be provided in future reports. For more information about Oxford House, including the state directory, visit <https://www.oxfordhouse.org/userfiles/file/house-directory.php>. The following pictures are of two of the six houses (Gwendolyn and Chiquita) chartered in September 2019.



Gwendolyn - Pensacola



Chiquita – Cape Coral

Veteran's Support Line

Crisis Center of Tampa Bay manages the Veteran's Support Line which provides services to veterans and their family members across the state. Services provided include information and referral, crisis intervention, and peer-to-peer care coordination services to connect Florida Veterans to behavioral health services. Additionally, services include the maintenance of a database of veteran specific resources. The line provides information and referral services using the 844-MYFLVET line, 24 hours a day, 7 days a week, and 365 days a year. During this reporting period, MyFLVet has reported the following services:

- 6,199 Calls from veterans and their families
- 4,921 Callers received at least one referral
- 15,469 Referrals provided to veterans and their family members
- 1,048 Veterans were linked to Care Coordination Services
- 987 Veterans in Care Coordination were linked to services

The Crisis Center received calls from 55 of Florida's 67 counties. The center is also responsible for managing resources to ensure staff have the most up to date information for referrals. There are over 2,700 resources in the database, and during Year 1, 210 veteran-specific resources were added to the listing.

TRAINING/CAPACITY BUILDING

Overdose Recognition and Response Training

The Department conducts overdose prevention and harm reduction trainings for providers interested in enrolling in the program to receive and distribute naloxone. Training content includes information on appropriate opioid overdose recognition and response, how to use naloxone, research on the effectiveness of community-based naloxone distribution to people who use drugs, misconceptions about naloxone access, and how to enroll in the Overdose Prevention Program. The training was updated during Year 1 to also include information on Florida’s new syringe exchange law, expanded 911 Good Samaritan law, myths and facts about fentanyl, and research on the effectiveness of syringe exchange programs at engaging people who use drugs to distribute naloxone. Due to overlap with the STR grant, all trainings conducted prior to 4/30/19 were included as activities associated with STR. As a result, SOR naloxone trainings did not occur until May 2019. Additionally, due to statewide travel restrictions in place at the time, the majority of trainings were conducted via webinar.

During Year 1, 9 overdose recognition and response trainings were conducted, educating 151 individuals. Trainings were conducted via webinar for Okaloosa County Jail, three methadone clinics, three behavioral health providers, and one hospital emergency department. An in-person training was also conducted at Florida’s Annual Behavioral Health Conference in Orlando, to educate participants on naloxone, overdose prevention and harm reduction initiatives in the state, and the new syringe exchange and expanded 911 Good Samaritan laws. The Department co-presented with a staff member of Miami’s syringe exchange program at the conference to provide data and discuss success of the program at engaging people who use drugs, saving lives through naloxone distribution, and linking participants to other healthcare services including HIV/HCV testing and treatment, housing, and behavioral health treatment.

| Overdose Prevention Program - Training, Technical Assistance and Education | | | |
|--|-----------------------------------|-------------------------------|--------------|
| Professions | Quarter 3 April - June 2019 | Quarter 4 July - Sept 2019 | Year 1 Total |
| Physicians | 7 | 4 | 11 |
| Physician Assistants | 0 | 0 | 0 |
| Nurse Practitioners | 0 | 5 | 5 |
| Nurse (RN, LPN) | 8 | 6 | 14 |
| Social Workers | 10 | 30 | 40 |
| Addiction Counselors | 33 | 29 | 62 |
| Peer Recovery Support Positions | 0 | 8 | 8 |
| Prevention | 0 | 6 | 6 |
| Others (describe): Jail staff (4), pharmacist (1) | 4 | 1 | 5 |
| TOTAL | 62 | 89 | 151 |

Peer Prescriber Mentors

The Prescriber Peer Mentor Program began in July 2017. Initially funded by STR, FADAA received funding from the Department to support the engagement and services of physicians with the background, education, and experience to serve as peers for other physicians and medical professionals who want to provide or support Medication-Assisted Treatment (MAT). The major goal of this project is to provide expert consultation and technical assistance to potential prescribers of buprenorphine, methadone, and naltrexone and to help them develop medication assisted treatment (MAT) programs and protocols. Beginning in July 2019, the program has been funded by SOR and hosts a cadre of nine peer prescriber mentors (PPM's) who support MAT around the state. Under this initiative, FADAA recruits, engages, trains, and maintains a cohort of physicians with the appropriate credentials and experience to provide prescriber mentoring and training to medical and behavioral health providers and other stakeholders providing treatment and recovery related services to individuals with opioid use disorders. The mentoring and training opportunities are also be made available to other professionals working with individuals with opioid use disorders such as hospital emergency department medical staff and community-based clinics.

| Florida Peer Prescriber Mentors | | | |
|-----------------------------------|--|-----------------------------|--|
| Mentor | Specialty and Affiliation | Mentor | Specialty and Affiliation |
| Jason Baker Fields, MD | BayCare Health Systems Associate Medical Director Specialty: Addiction Medicine | Eduardo B. Camps-Romero, MD | FIU College of Medicine Director of Behavioral Health Specialty: Psychiatry |
| Jason Hunt, MD, AADC | UF College of Medicine Assistant Professor/Attending Physician Specialty: Obstetrics and Gynecology, Addiction Medicine | Raymond M. Pomm, MD | Gateway Community Services Chief Medical Officer Specialty: Addiction Psychiatry |
| Suresh P. Rajpara, MD, FAPA | Jerome Golden Center for Behavioral Health Chief Medical Officer/Medical Director Specialty: Psychiatry, Addiction Psychiatry | Courtney E. Rowling, MD | Health Care District of Palm Beach Director of Behavioral Health Specialty: Psychiatry, Addiction medicine |
| Mark Schlosser, MD | Access Recovery Solutions Addiction Physician Specialty: Addiction Medicine | Aaron Wohl, MD, FACEP | Lee Health Systems Emergency Physician Specialty: Emergency Medicine |
| Mark G. Stavros, MD, FACEP, FASAM | FSU College of Medicine Emergency Medicine Education Director West Florida Regional Hospital Emergency Department Medical Director Specialty: Emergency Medicine, Addiction Medicine | | |

FADAA identifies the training needs of special populations and develops and provides MAT training; and mentors facilitate the *Medication Assisted Treatment Training Series*. During Year 1, the target population

for the training efforts include the Department of Corrections staff and staff at jails throughout Florida. The major goal of this project is to increase the knowledge of MAT with staff working in corrections and jail settings throughout Florida, with an emphasis on probation and re-entry program staff, including their leadership and their community-based provider partners.

During Year 1, FADAA developed a webpage for the project. The page provides a list of resources and contact information to request training and consultation services and a list of resources. The webpage is available at <https://www.fadaa.org/page/MATPrescriberMentoring>. The current list of PPM's follows. See **Attachment 2. Peer Prescriber Mentoring Program** for a detailed map of mentors and coverage areas. Please note that Dr. Rajpara joined FADAA as a PPM in September 2019 and is not yet listed on the map.

SOR-funded MAT training began July 2019, and peer mentoring support was provided in a variety of ways. During this reporting period, mentors have trained 402 people in MAT, including 139 physicians and licensed clinicians. Trainings have been provided in various settings using a number of modalities, including teleconferences and lunch and learns.

| Peer Prescriber Mentor Trainings | Year 1 Total |
|--|----------------|
| Roles/Professions | Number Trained |
| Physicians | 117 |
| Licensed Clinicians | 22 |
| Nurse (RN, LPN) | 8 |
| Social Workers | 2 |
| Addiction Counselors | 3 |
| Peer Recovery Support Positions | 4 |
| Prevention | 3 |
| Others: | 243 |
| TOTAL | 402 |
| SOR-funded training began in Quarter 4 | |
| Quarter 4 = 6 trainings conducted | |

PPM's presented at conferences, community forums and professional meetings, including the annual symposium of the Florida College of Emergency Physicians, where 88 were in attendance. PPM's also facilitated sessions at the Florida Behavioral Health Conference where 136 attended sessions on MAT and 39 attendees were present for a session on hospital intervention strategies. Please note that given the number of attendees at the Behavioral Health Conference, the number for each role/profession was not captured. PPM's also provided support to the work being done to increase MAT knowledge and training capacity in the court system. Three PPM's assisted the Department with its review of proposals received for medical schools for curriculum development.

Opioid Summit

In collaboration with FADAA, the Department hosted a Statewide Provider Opioid Summit, *"Effectively Treating Individuals with Opioid Use Disorders: A Summit on Strategies to Maximize the Use of Evidence-Based Practices"*. The purpose of the summit was to bring together service providers, MEs, and regional

staff to provide updates on the SOR project and provide training on MAT and best practices. The summit was held in April 2019 and over 200 were in attendance. The agenda included a discussion on current MAT practices across the state. Agencies were also asked to share their organizations' definition of treatment success, and a group of practitioners were empaneled to share their success and challenges in engaging and retaining patients in services. A panel of peers led a session on the utilization of peers in treatment and recovery. The Department presented an update on SOR and program guidance. **See Attachment. SOR Guidance** A follow-up summit will be held in April 2020.

Integrative Harm Reduction Psychotherapy Trainings

Center for Optimal Living conducted three 3-day Integrative Harm Reduction Psychotherapy (IHRP) trainings during this report period. The chart illustrates the total number trained. Additional training is scheduled in Year 2.

| Integrative Harm Reduction Psychotherapy Training | |
|--|---------------|
| Participant Professions | Total Trained |
| Social Workers | 11 |
| Addiction Counselors | 9 |
| Peer Recovery Support | 12 |
| Prevention | 4 |
| Program Director/Administrator | 7 |
| Mental Health Counselor (LMHC) | 22 |
| Others (describe): Care Coordinator, Substance Abuse Licensing, Baker Act Specialist, Case Manager, Educator | 11 |
| TOTAL | 76 |

Court System

A significant number of people who are involved in the court system have problems with substance misuse and often lack support and resources for treatment and recovery. The court system judges and staff are important partners in helping to facilitate access to treatment and support services for people who have an opioid use disorder or opioid misuse. In Year 1, the Department entered into an Interagency Agreement with the Office of State Court Administrators (OSCA) to provide MAT technical assistance and training to judges and court staff from a variety of courts (including drug courts and dependency courts) throughout the state. Under the agreement, OSCA's opioid response project is responsible for performing the following project tasks:

- Conduct a court-related literature review of the opioid crisis;
- Conduct a needs assessment with Florida's courts; and conduct two webinars based on the needs assessment results;
- Develop training/technical assistance materials, including fact sheets, and e-Learning modules;

- Develop bench guides and data reports;
- Make recommendations for quality improvement initiatives in the court system to better address substance use disorders;
- Perform data enhancements to the Office of Court Improvement's two data systems to better capture substance use data; and
- Work with subject matter experts to plan regional and statewide training events.

During Year 1, OSCA conducted court assessments and engaged judges and staff to support the SOR project. Two judges, Judge Hope Bristol from the 17th circuit and Judge Steve Leifman from the 11th circuit, were selected to serve as statewide champions for the OSCA project. The OSCA Coordinator conducted a literature review to help guide self-study for judges and court staff. Using the literature review as a guide, the goal is that each participating judge and court staff will read and research information about the opioid epidemic in Florida. Additionally, participants were expected to learn more about substance use disorders and recovery support options, becoming subject matter experts for the court system. Chief judges have recruited 67 judges and court staff, representing all 20 circuits, to serve as local circuit opioid response champions to provide education and increased support for the project. All county court judges appointed or elected to the circuit court bench are required to attend judicial college for continuing judicial education. During the 2019 Advanced Judicial College, Miami-Dade Circuit Judge Cohen worked with the OSCA Opioid Response Coordinator, two MAT physicians, and two people with lived experience to facilitate a six-hour opioid course to support the efforts of SOR. During Year 1, OSCA , developed and published a [Dependency Court Benchguide](#), *Service and Treatment Considerations*, to address opioid use disorder and provide guidance for judges and court staff when working with individuals with opioid use disorder.

Workforce Development

To increase the capacity of Florida's healthcare workforce to prevent and treat opioid misuse and opioid use disorders, the Department has contracted with the Florida Certification Board (FCB) to develop a Behavioral Health Workforce Development Survey to assist in identifying knowledge gaps, workforce development needs, including a focus on assessing training needs to address opioid use disorder and opioid misuse. FCB conducted research and developed the survey questions and methodology for administering the survey. The agency also conducted cognitive interviews, piloting the instrument for validation.

FCB launched the survey in May 2019. Surveys were conducted with a wide range of disciplines, including, but not limited to, behavioral health professionals, primary care physicians, dentists, nurse practitioners, and physician assistants. The survey examined workforce issues for behavioral health providers and identified specific training needs. The survey was also completed to gain insight into work competencies, supervision, job retention and satisfaction, and knowledge, attitudes, and practices related to opioid use disorder and medication-assisted treatment. Non-medical behavioral health providers, including inpatient and outpatient treatment and prevention providers, were surveyed. The survey was open from April – May 2019, and analysis was completed in August. Following are a few highlights from the survey:

- 2,555 participants responded to the survey. There were 2,082 valid participant responses.
- Participants were asked which of the following they do in Florida (more than one choice could be selected) and responded:
 - Provide direct behavioral health services to clients/patients (74%; n = 1,884)

- Supervise others who provide behavioral health services to clients/patients (34%; n = 865)
- Provide support or administrative behavioral health services (28%; n = 723)
- 36% indicated that “cost of training events has been too high” and 21% reported that “lack of organization resources was a barrier” were barriers to obtaining professional development.
- 74% were “very knowledgeable” or “moderately knowledgeable” about the medications used to treat opioid use disorder.
- 50% “strongly agreed” or “agreed” that using methadone or buprenorphine improves patient outcomes.
- Those who work in a private practice, therapeutic communities, recovery residences or corrections facilities had less favorable attitudes about MAT compared to the rest of the sample.
- Overall, 81% were “very satisfied” or “satisfied” with their current job. The lowest level of reported satisfaction related to salary and benefits.
- Work settings should be encouraged to provide greater support to enhance the skills of direct care staff.
- It would be beneficial if they provided additional opportunities for training their staff using a variety of methods, such as in-service training, online training, direct supervision, and in-house mentoring. Work settings can also assist their staff by covering the costs associated with training. Enhancing staff skills and practice through training is important as access to and participation in training is associated with improved job satisfaction and retention intentions.
- Organizations should also be encouraged to provide greater opportunities for their staff to receive case conference clinical supervision, as this is also related to higher job satisfaction.
- Future investigations should explore why being: (1) African American was associated with lower job satisfaction and retention intention; and, (2) Hispanic/Latino or male was related to decreased job retention intention.
- Service providers who had the following certifications should also be targeted for training due to less favorable attitudes regarding MAT: Certified Addiction Professionals, Certified Addiction Counselors, Certified Mental Health Professionals and Certified Recovery Support Specialists.

The survey and findings are comprehensive. Next steps are to develop training plans to address the outcomes and training needs.

Medical School Curriculum

Historically, substance use disorder treatment has focused on acute episodes of care. For a more comprehensive and expanded approach, it is critically important that healthcare providers are equipped early in medical education matriculation to assess and treat patients from the perspective that substance use disorders are a chronic diseases like other chronic diseases such as type II diabetes, cancer, and

cardiovascular disease, and should be treated as such. SOR has allocated \$2.5M in funding to support development of medical education curriculum ensuring integration of best practices in assessing and treating substance use disorders, with emphasis on opioid use disorder and misuse. Each medical school was invited to submit a proposal for funding to include the following:

- Assess current medical education curricula and student training practices related to screening, diagnosis, and treatment for substance use disorders, including opioid use disorders and opioid misuse in Florida medical colleges;
- Develop, expand and enhance medical education curricula to ensure integration of substance use disorders, to include focus on opioid use disorders and opioid misuse; prescribing practices; overdose prevention; and pharmacotherapy (medication-assisted treatment); and
- Implement curricula in each participating medical college.

The following schools submitted proposals to implement and enhance their respective curricula:

- Florida Atlantic University Charles E. Schmidt College of Medicine
- Nova Southeastern University Dr. Kiran C. Patel College of Allopathic Medicine
- University of Central Florida College of Medicine
- University of South Florida Morsani College of Medicine
- Florida State University College of Medicine
- University of Florida College of Medicine
- Lake Erie College of Osteopathic Medicine (Bradenton, FL Campus)
- Florida International University Herbert Wertheim College of Medicine
- Nova Southeastern University College of Osteopathic Medicine
- University of Miami Leonard M. Miller School of Medicine

The Department reviewed and approved each proposal with support from medical experts and medical educators who also serve as Peer Prescriber Mentors. Curriculum projects will begin in Year 2.

FLORIDA OPIOID FUNDING INVENTORY

To ensure that federal funds are being effectively utilized to help those most impacted by the opioid epidemic, SAMHSA requires that grantees promote coordination among agencies receiving federal opioid resources. As designated by the SOR grant, the role of the State Opioid Coordinator is to identify opioid related federal funding directed to Florida agencies and to facilitate interagency cooperation and coordination of the resulting services. The Coordinator is engaged in identifying federal, state, local and private sector funding allocated to combat the opioid epidemic in Florida and is compiling an inventory of these resources. This inventory will help to inform Florida's key behavioral health stakeholders and policy makers of the range and scope of available services and funding.

In addition to an overview of local, state, federal and private sector funding, the inventory includes additional spreadsheets listing subgrantees/contracted funds for federal opioid-related funds that pass through the Florida Department and Children and Families, the Department of Health and the Florida

Department of Law Enforcement. The total funding for each of these original federal grants is listed under the information for each of these three state agencies.

The approach for this initiative is a systematic review and compilation of opioid-related prevention, treatment, recovery and interdiction monies directed to organizations and providers in Florida. Appropriations and grants from federal, state, local and private sector sources are included in this review. As these funders are identified, telephonic or face-to-face interviews are conducted with the grantees and/or funding sources to identify various factors including, the scope of services to be provided, the service recipients and geographical service area, the funding cycles and amounts and the key contacts for each organization. At the time of each contact, the State Opioid Coordinator shares appropriate information with other organizations to ensure optimum coordination of activities for system advancement. The inventory will be forwarded to each organizational contact to ensure systemwide awareness of the scope of service being provided within Florida and the contact person for each of these programmatic activities.

As new sources of funding are emerging frequently, the inventory is a living document. Since these activities began in January 2019, 198 organizations have been contacted including Florida school districts. As each state, federal and private sector entity has a different grant/contractual funding cycle ranging from one to ten years, the total funds presented in this report cover the fiscal years 2018-19 through 2021-22. If the information was available, the comment section for the inventory includes the total project funding amount and funding cycle. The State Opioid Coordinator was able to identify a total of **\$424,362,907** in opioid related funding disseminated to organizations in Florida from federal, state, local and private sector funding sources covering FY 2018-19 to 2021-22. Of these funds, \$347,681,985 were federal monies; \$56,606,479 were state funds; \$15,247,000 were local funds; \$3,050,000 were private sector funds and \$1,777,443 were from a combination of these funding sources. Given the size of the document, the inventory will be submitted to the SAMHSA Project Officer under separate cover.

DATA AND REPORTING

In keeping with the SAMHSA requirement to collect and report data on MAT and associated treatment services, the Department contracted with FEI Systems to collect all SOR related client data from community providers through WITS (Web Infrastructure for Treatment Services). WITS is a web-based application designed to capture client services data, including outcomes and costs, in one place. WITS satisfies mandatory government reporting requirements for the planning, administration, and monitoring of behavioral treatment programs. Through use of WITS, FEI Systems uploads data to SPARS (SAMHSA's Performance Accountability and Reporting System), as required by SAMHSA. Several in-person trainings and webinars were conducted for Department staff, Managing Entities, and service providers.

To ensure accurate and timely prevention activity data, a one-time modification to the Department's Performance Based Prevention System (PBPS) was implemented using SOR funds. This modification has helped to ensure that the Department can capture and report prevention service data and develop standardized reports for the state. The system is also capable of customizing ad-hoc reports as needed by users.

Additionally, SOR funding was utilized to purchase ASAM CONTINUUM Licenses for the American Society of Addiction Medicine's (ASAM) CONTINUUM software from FEI Systems. CONTINUUM is a computerized

structured interview and clinical decision support system for use by intake clinicians. It provides the entire treatment team with a computer-guided interview for assessing individuals with substance use disorders and co-occurring conditions. It facilitates a full biopsychosocial assessment that addresses all six dimensions of the ASAM Criteria. The decision engine uses questions and tools (such as the DSM-5, Addiction Severity Index, Clinical Institute Withdrawal Assessment, and Clinical Institute Narcotic Assessment instruments) to generate a comprehensive report which includes a quantitatively-derived, ASAM-endorsed, recommended level of care determination. FEI has integrated the CONTINUUM into the Florida WITS platform. Licenses have been distributed and providers have been trained.

PLANNING AND IMPLEMENTATION

The initial months of the Year 1 grant period was focused on developing and distributing clear expectations for contracted providers, allocating funds to the managing entities in a data-driven methodology, hiring grant staff, and executing contracts. Highlights of staffing and administrative progress during Year 1.

- Created and distributed a SOR Grant Guidance which outlines priorities, permissible uses, and prohibited uses for grant funds.
- Developed an allocation methodology for prevention, treatment, and recovery services and amended funds into Managing Entity contracts.
- Met with over 30 network service providers to discuss expectations around service array, emphasis on medication assisted treatment and recovery supports, and data collection.
- Hired the following staff: Project Director, State Opioid Coordinator, OSCA Opioid Response Coordinator, 2 Epidemiologist Assistants, 1 Pharmacy Technician, 12 Behavioral Health Consultants, 6 Recovery Quality Improvement Specialists.
- Developed and released Request for Proposals for medical school curriculum projects.
- Entered into an Interagency Agreement with the Office of State Courts Administrators for training targeting the judiciary, and
- Executed contracts with the following:
 - Managing Entities for prevention, treatment, and support services, who have allocated funds to 122 network service providers.
 - Faces & Voices of Recovery for training and Recovery Community Organization development.
 - Peer Support Coalition of Florida for training and Recovery Community Organization development.
 - Center for Optimal Living for Integrated Harm Reduction Psychotherapy Training.
 - Collaborative Planning Group Systems to enhance the Department's prevention data system to include SOR funded programs.

- Florida Certification Board to provide training and assess behavioral health workforce training needs.
- FEI Systems for development of Florida WITS data management platform, and integration of ASAM CONTIUUM.
- Oxford House, Inc. to establish 30 Oxford Houses in Florida in Year 1 of the grant and 30 additional Oxford Houses in Year 2.
- Florida Alcohol and Drug Abuse Association for Vivitrol; training and management of Peer Prescriber Mentors.
- Crisis Center of Tampa Bay for expansion MYFLVET veterans support line.
- Florida Alliance for Healthy Communities/AHEC for training health professionals.

Barriers – Year 1

The following provides an overview of barriers encountered during Year 1 of the project. As requested by SAMHSA, the program has provided information on how each challenge has been addressed and the current status.

- A major challenge has been capturing and reporting of project data from the Departments Managing Entitles (MEs). The Department transitioned to a new data reporting system in December 2018. There has been a steep learning curve in both learning the new system and the transition from STR to SOR data collection. These data reporting errors impact timely reporting, as agencies are tasked with re-entering data correctly and fixing errors. In addition to ongoing technical assistance from the Epidemiology team, the Department is working to develop and implement business rules and data validations for quality assurance.
- As the SOR Tool is a required component of the project, having not received the revised tool has delayed provider training and implementation, thus client-specific data on service outcomes and outputs is not yet available. Staff met with ME's and providers to provide expectations for the administration and reporting, however; due to the delay in receipt, any new information and data collection requirements are not being collected. After receipt of the revised tool, guidance and training will be developed and shared with providers. To ensure collection of related data, in December 2018, the Department provided ME's with the draft SOR Baseline Tool and SOR Follow-up and Discharge Tool, provided by SAMHSA. They were informed that the tool had not been approved by the Office of Management and Budget and may change. ME's were instructed to start using the SOR Baseline Tool with individuals served with SOR funds and keep the paper version until final forms become available. The Department also developed and distributed Supplemental Questions for the SOR grant to be completed in conjunction with the SAMHSA Tools which include questions on:
 - What medication-assisted treatment the individual is receiving at time of interview,

- The number of lifetime non-fatal overdoses,
- The number of non-fatal overdoses in the past 30 days,
- Whether or not the individual carries naloxone, and
- Whether or not the individual has been offered naloxone by their treatment provider.

Update: After receiving the revised GPRA in June 2019, the Department has conducted training and ongoing technical assistance to Managing Entities and network providers.

- Oxford House administration has shared that although treatment providers are very pleased that more housing options are being made available through Oxford House, many of the treatment facilities that have been contacted had been informed that the houses must have the Florida Association of Recovery Residences (FARR) certification before they could refer any clients to Oxford House. This created a significant impact on receipt of referrals and the overall success of the project. The Department held a call and disseminated information to the MEs ensuring them that referrals are allowable based on a statutory exemption for providers under contract with the MEs. During the 2019 legislative session, the Florida House and Senate passed HB 369. **See Attachment 3.** Effective, July 1, 2019, a new exception is created to allow licensed service providers to be able to make referrals to or accept referrals from a non-certified recovery residence that is democratically operated by its residents pursuant to a charter from a congressionally recognized or sanctioned entity provided the residence or any resident of the residence does not receive a benefit, directly or indirectly, for the referral; this would apply to recovery residences such as the Oxford House. Additional guidance will be provided to support successful establishment of and participation in the Oxford House model.
- Florida experienced significant challenges when Hurricane Michael made landfall on October 10, 2018 near Mexico Beach, Florida as a category 4 hurricane with peak winds of 155 mph. Implementing disaster behavioral health response became an immediate priority for the impacted counties. This natural disaster delayed grant roll-out to some degree, however, the Department adjusted functions and duties to prioritize implementation of the grant.
- In the aftermath of Hurricane Michael, the state issued a travel ban which significantly reduced opportunities for Department staff to go out into the community to conduct in-person trainings. In effort to ensure ongoing training, staff has conducted an increased number of webinars to ensure responsiveness to requests for training.
- Hiring staff with the appropriate credentials and experience for a two-year project is challenging. To expand our reach, instead of relying solely on the usual advertisement through human resources, we have utilized intentional outreach to individuals who are in master's level programs and can use these positions to gain experience, as well as persons who have retired, but are passionate and knowledgeable about behavioral health and ending the opioid epidemic. As of February 2019, all key staff positions have been filled.
- Another significant barrier is that during implementation, the Department's budget authority was only for state fiscal year 2018-19. This has made it difficult to execute multi-year contracts. The Department has worked one-on-one with potential vendors to contract through this state fiscal

year with the intent to amend the remaining funds into contracts once State Fiscal Year 2019-20 budget authority for the grant funds is obtained.

- Some providers were still utilizing their STR allocations and will continue to do so through April 2019. Additionally, some components of the STR project will continue into a no-cost extension period, which might impact the timing of the arrival of SOR funds for some providers. Service implementation in Big Bend Community Based Care’s catchment area (the northwest region) was significantly disrupted by Hurricane Michael. Behavioral health provider capacity was significantly impacted. The provision of STR-funded school-based prevention services and medication-assisted treatment services, including buprenorphine induction and peer support services through a planned hospital pilot, was disrupted as a result. The implementation of school-based prevention services in Okeechobee County was delayed when a school unexpectedly opted not to participate as planned for a second semester. Another school will participate during the proposed STR no-cost extension. Additionally, implementation of Southeast Florida Behavioral Health Network’s hospital pilot program was delayed because the Palm Beach Health Care District’s plans to open a Centralized Addiction Emergency Room fell through. This impacted SEFBHN’s plans to provide STR-funded peer-based recovery support for MAT engagement through this site. The no-cost extension period will allow time for the completion of the originally planned services through other entities. The use of these STR funds may impact the timing of the arrival of SOR funds for some providers and services.

Program-Related Updates

The following select updates are related to the work being carried out under Florida SOR and impacts the program directly or indirectly.

- On April 1, 2019, Governor Ron DeSantis signed Executive Order 19-97, establishing the Office of Drug Control and the Statewide Task Force on Opioid Abuse. As a part of the Governor’s plan to combat Florida’s opioid epidemic, the order sites that *“a coordinated and comprehensive statewide drug control and substance abuse prevention strategy is imperative for education, prevention, treatment, recovery and law enforcement efforts...”* The Office is charged with coordinating and centralizing efforts in the state, and the task force will research and assess the nature of opioid drug abuse and develop a statewide strategy to identify best practices to combat the opioid epidemic. Since implementation, the Department has supported the efforts of the task force through provision of reports on the current opioid-related trends and the work undertaken with STR and SOR grant funding. The SAMH Director, who serves as Principal Investigator for SOR, has made presentations to the task which could inform their current work, including potential policy and funding recommendations.
- On March 20, 2019, the National Academies of Sciences, Engineering, and Medicine issued a landmark Consensus Study Report titled, *Medications for Opioid Use Disorder Save Lives* (available at <https://doi.org/10.17226/25310>). Several findings and conclusions have important implications for the Department’s efforts to improve retention. At the outset, the committee chose to use the term “medication-based treatment for OUD” instead of “medication-assisted treatment” because

this emphasizes the committee’s “conceptual framework of OUD as a chronic disorder for which medications are first-line treatments that are often an integral part of a person’s long-term treatment plan, rather than complementary or temporary aids on the path to recovery.” Furthermore, while acknowledging that “evidence-based behavioral interventions can be useful in engaging people with opioid use disorder in treatment, retaining them in treatment, improving outcomes, and helping them resume a healthy functioning life,” they also concluded that, “Behavioral interventions, in addition to medical management, do not appear to be necessary as treatment in all cases.” Simply put, “Some people may do well with medication and medical management alone.”

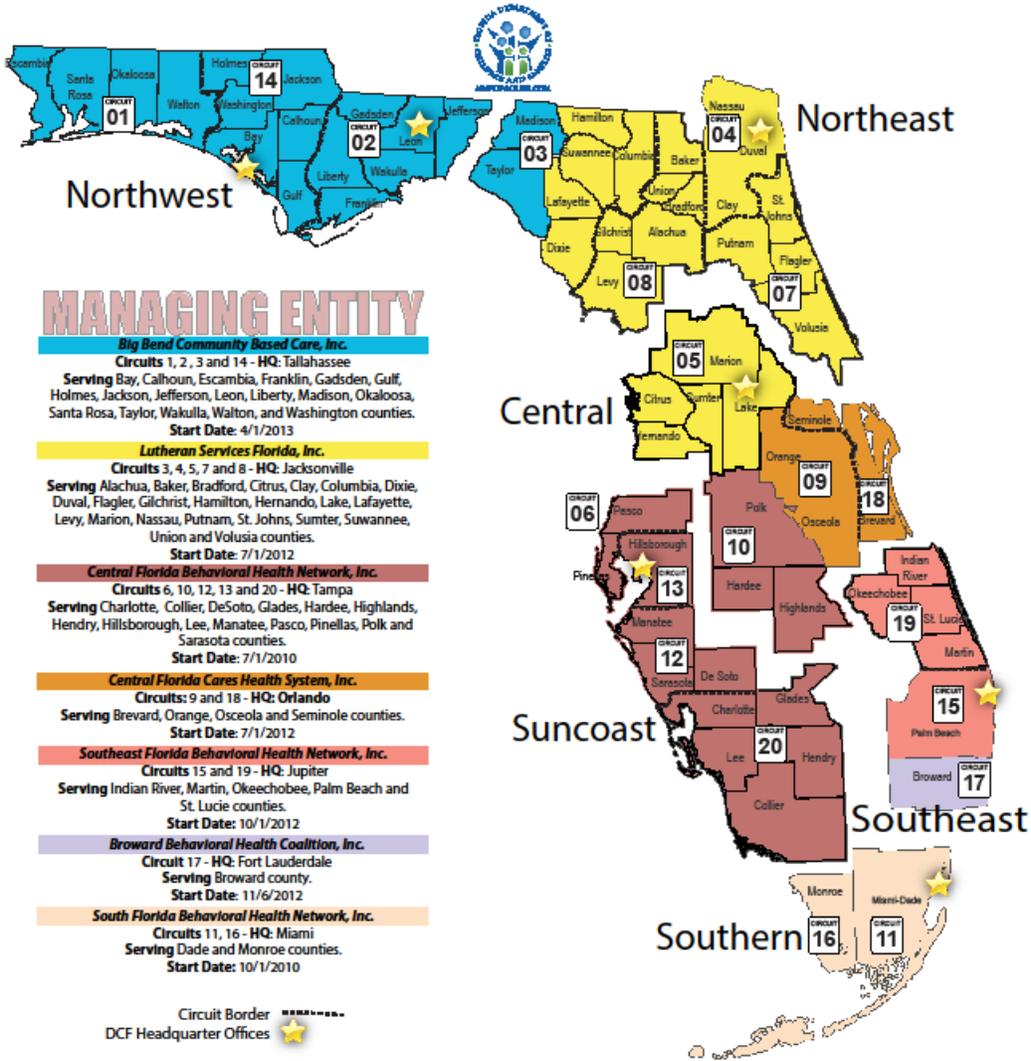
The committee concluded that, “A lack of availability or utilization of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder.” In other words, an individual’s refusal to participate in counseling does not justify involuntarily discharging them out of medication-based treatment. The Department is aware that some treatment providers in the SOR-funded network discharge individuals for failing to attend counseling sessions. It is also possible that failed admissions are related to counseling requirements that are perceived as onerous. To the extent that counseling requirements constitute a barrier to admission and retention in medication-based treatment, these policies and practices will need to be systematically identified and addressed through guidance documents, contract provisions, and training.

Update:

The Department included this latest guidance on the agenda for the Provider Summit held in April 2019. The SOR guidance will be updated to reflect recommendations as appropriate.

Overall, given the various barriers and challenges, SOR is now fully staffed, all major contracts have been executed, and the project has been successfully implemented across the state during this reporting period.

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| 6. State-wide Provider Inventory (submitted under separate cover) | |



Allocation Methodology for Funds from the State Opioid Response (SOR) Grant

This document describes the Department’s proposed methodology for allocating \$27,059,406 per year in State Opioid Response (SOR) Grant funds among the seven Managing Entities (MEs) for comprehensive medication-assisted treatment services (including hospital induction/bridge projects) for opioid use disorders, prevention activities, and operational functions.

SAMHSA allocated SOR funding to the states using a formula based on two elements that were equally weighted. These elements are the state’s proportion of people with an opioid use disorder (including both heroin and prescription pain relievers) who have not received treatment, using estimates from the 2015-2016 National Survey on Drug Use and Health, and the state’s proportion of drug poisoning deaths, using 2016 estimates from the CDC’s surveillance system.ⁱ Since the formula is evenly weighted, 50% of the funding was driven by the portion of individuals with an unmet need for opioid use disorder treatment and 50% was driven by the portion of poisoning deaths.

The Department proposes a similar approach for allocating the following amounts between the MEs:

- \$25,059,506 for medication-assisted treatment services; and
- \$2,000,000 for evidence-based prevention activities;

The most relevant and currently available variables at the substate/ME-level are as follows:

- The number of adults ages 18 and older that used heroin in the past year, using substate estimates from the 2014-2016 National Survey on Drug Use and Health.ⁱⁱ
- The number of adults ages 18 and older that used heroin in the past year, using substate estimates from the 2012-2014 National Survey on Drug Use and Health.ⁱⁱⁱ
- The number of deaths caused by at least one opioid in Fiscal Year 16-17, from the Florida Medical Examiners Commission.^{iv}

The tables below depict each component of the allocation.

| Number and Percentage of Adult Heroin and Nonmedical Pain Reliever Users by Managing Entity Region and the Corresponding Portions of the Allocation (50%) | | | | |
|---|---------------------|--|-------------------------|-----------------------|
| ME | Number of Users | Percentage of Statewide Total of Users | MAT/Hospital Allocation | Prevention Allocation |
| CFBHN | 170428.1882 | 27.97209056 | \$3,504,819.87 | \$279,720.91 |
| LSFHS | 119350.8560 | 19.58885433 | \$2,454,425.27 | \$195,888.54 |
| CFCHS | 81985.9422 | 13.45621416 | \$1,686,023.67 | \$134,562.14 |
| SEFBHN | 61175.1195 | 10.040569 | \$1,258,053.47 | \$100,405.69 |
| BBHC | 52952.2945 | 8.690970624 | \$1,088,952.81 | \$86,909.71 |
| SFBHN | 70307.6971 | 11.53948353 | \$1,445,863.01 | \$115,394.84 |
| BBCBC | 53079.3120 | 8.711817792 | \$1,091,564.90 | \$87,118.18 |
| TOTAL: | 609,279.4095 | 100% | \$12,529,703 | \$1,000,000 |

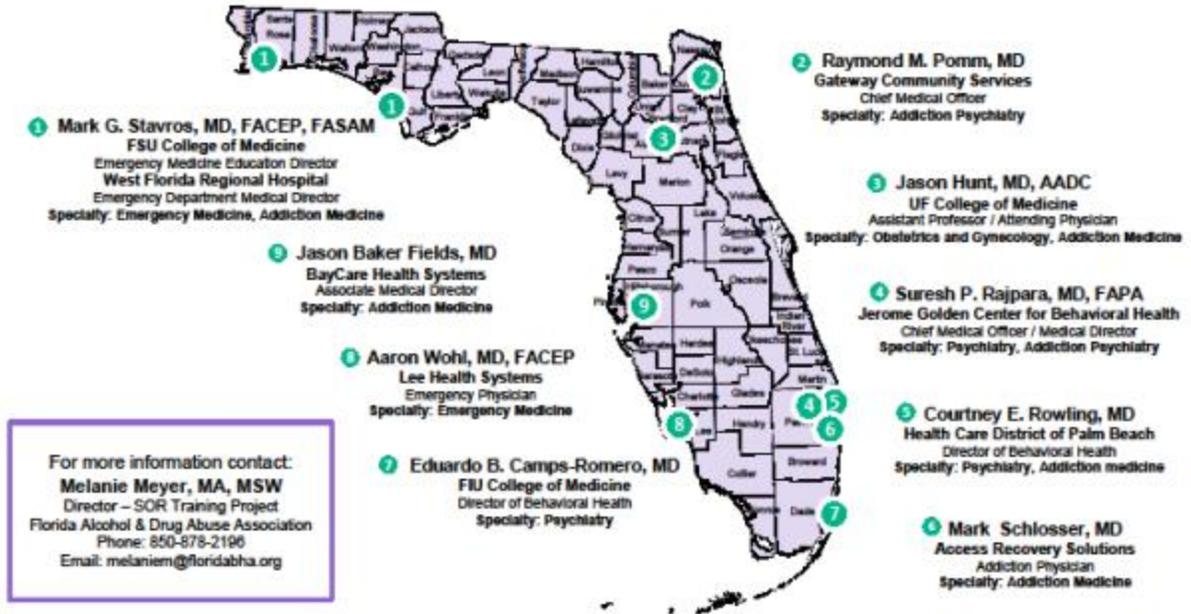
| Number and Percentage of Opioid-Caused Deaths by Managing Entity Region and the Corresponding Portions of the Allocation (50%) | | | | |
|--|--------------------------------|---|-------------------------|-----------------------|
| | Number of Opioid-Caused Deaths | Percentage of Statewide Total of Opioid-Caused Deaths | MAT/Hospital Allocation | Prevention Allocation |
| CFBHN | 1090 | 24.95992672 | \$3,127,404.69 | \$249,599.27 |
| LSFHS | 940 | 21.52507442 | \$2,697,027.90 | \$215,250.74 |
| CFCHS | 497 | 11.38081063 | \$1,425,981.77 | \$113,808.11 |
| SEFBHN | 799 | 18.29631326 | \$2,292,473.71 | \$182,963.13 |
| BBHC | 525 | 12.02198305 | \$1,506,318.77 | \$120,219.83 |
| SFBHN | 367 | 8.403938631 | \$1,052,988.55 | \$84,039.39 |
| BBCBC | 149 | 3.411953286 | \$427,507.61 | \$34,119.53 |
| TOTAL: | 4,367 | 100% | \$12,529,703 | \$1,000,000 |

From their total allocation (MAT, hospital bridge programs, and prevention), MEs are provided a little over 5.17% for operational costs to support at least one full-time employee to manage grant activities and other operational activities directly associated with the implementation and oversight of this grant.

| Summary of Managing Entity Allocations | | | | |
|--|------------------------|-----------------------|-----------------------|------------------------|
| | MAT/Hospital | Prevention | Operational | Total |
| CFBHN | \$6,261,700.43 | \$529,320.17 | \$370,524.12 | \$7,161,544.73 |
| LSFHS | \$4,863,655.66 | \$411,139.29 | \$287,797.52 | \$5,562,592.45 |
| CFCHS | \$2,938,146.27 | \$248,370.25 | \$173,859.18 | \$3,360,375.69 |
| SEFBHN | \$3,352,169.00 | \$283,368.82 | \$198,358.18 | \$3,833,896.01 |
| BBHC | \$2,450,280.92 | \$207,129.54 | \$144,990.65 | \$2,802,401.12 |
| SFBHN | \$2,359,247.61 | \$199,434.22 | \$139,603.95 | \$2,698,285.79 |
| BBCBC | \$1,434,206.11 | \$121,237.71 | \$84,866.40 | \$1,640,310.22 |
| TOTAL: | \$23,659,406.00 | \$2,000,000.00 | \$1,400,000.00 | \$27,059,406.00 |

Florida Peer Prescriber Mentoring (PPM) Program

The PPM program provides physicians specially trained in Opioid Use Disorder and Medication Assisted Treatment (MAT) to serve as peers for other physicians and professionals. This team of nine (9) prescriber mentors are available to train, educate and mentor professionals on MAT throughout Florida.



Sponsored by the
 Florida Alcohol and Drug Abuse Association and the
 State of Florida, Department of Children and Families



*State Opioid Response (SOR) Grant Guidance
System Priorities, Permissible Uses, and Prohibited Uses*

System Priorities

- 1. ESTABLISH EMERGENCY DEPARTMENT BRIDGES TO COMMUNITY-BASED METHADONE OR BUPRENORPHINE PRESCRIBERS THROUGHOUT THE STATE.** Ensure that Emergency Departments (EDs) that induct patients on buprenorphine are linked to a community-based methadone or buprenorphine maintenance provider. Identify and engage community-based providers that can use State Opioid Response (SOR) grant funds to provide assessments and medication maintenance *7 days a week* for patients inducted in the ED. Managing Entities, community-based providers, and EDs must work together to overcome any obstacles to establishing or maintaining these programs. SOR funds can be used to hire prescribers and peers and establish telehealth programs. SOR funds can also be used to pay for incidentals for transporting patients from hospitals to community-based prescribers. Do not think of these as hospital “pilot” programs anymore. Think of them as standard components of your system of care going forward.
- 2. ENSURE ACCESS TO BUPRENORPHINE MAINTENANCE IN ALL COUNTIES.** If existing network providers are unwilling to provide buprenorphine maintenance, then Managing Entities must identify and engage other providers who are willing to prescribe buprenorphine. State Targeted Response (STR) grant funds have supported network capacity development for a year and a half. If at this point there are still providers in your network that have only added Vivitrol to their service array, then individuals are not getting access to all options. Managing Entities will need to work quickly to bring new buprenorphine providers into their networks. SOR expenditures will be reviewed 6 months into the project to see if changes are necessary.
- 3. ANALYZE AND PLAN FOR SUSTAINABILITY.** Managing Entities should monitor and analyze the “stock and flow” of individuals whose methadone and buprenorphine are paid for by STR and SOR funds. Individuals may be maintained on these medications indefinitely, but these funding streams are limited, so it is important to consider variables like the rates of admissions and discharges and the average length of care. Make sure that MAT providers are screening individuals for Medicaid eligibility. Also, go back and analyze what services for opioid use disorders were previously purchased using Block Grant dollars. The Block Grant-funded residential and detoxification services for OUDs may need to be re-allocated to support evidence-based methadone or buprenorphine maintenance. Finally, bear in mind that a portion of the \$14.6 million in recurring General Revenue funds are intended to help meet the need for methadone or buprenorphine maintenance.
- 4. MONITOR AND IMPROVE RETENTION IN CARE BY CHANGING DISCHARGE PRACTICES AND POLICIES.** Retention in care is an important measure of success and it should be systematically monitored and improved as a priority. Several findings and conclusions from a landmark Consensus Study

Report issued by the National Academies of Sciences, Engineering, and Medicine (*Medications for Opioid Use Disorder Save Lives* available at <https://doi.org/10.17226/25310>), have important implications for efforts to improve retention. The report observed that, “Behavioral interventions, in addition to medical management, do not appear to be necessary as treatment in all cases.” The committee concluded that, “A lack of availability or utilization of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder.” In other words, an individual’s refusal or unwillingness to participate in counseling does not justify involuntarily discharging them out of medication-assisted treatment or withholding OUD medications.

This mirrors the position of SAMHSA's experts within the Treatment Improvement Protocol 63, which states that, "Counseling and ancillary services should target patients' needs and shouldn't be arbitrarily required as a condition for receiving opioid use disorder medication." Buprenorphine providers are therefore discouraged from establishing arbitrary counseling requirements that can constitute a barrier to admission and retention in medication-based treatment services. Buprenorphine providers are also discouraged from involuntarily discharging individuals for not attending or participating in counseling services. **Individuals should not be denied life-saving medications just because they are not ready to engage in therapy, counseling, or AA/NA groups.**

Another barrier to systematically improving retention in medication-based treatment is the practice of involuntarily discharging individuals for positive drug tests. According to SAMHSA's Treatment Improvement Protocol 63, “If a patient does not discontinue all illicit drugs for extended periods, it doesn’t mean treatment has failed and should not result in automatic discharge. It means the treatment plan may require modification to meet the patient’s needs.” The expert panel issued the following directive: “Do not require discontinuation of pharmacotherapy because of incomplete treatment response. Doing so is not a rational therapeutic response to the predicted course of a chronic condition.” Remember that relapses and rule violations are common behaviors for individuals with substance use disorders, and these behaviors should not result in immediate discharges from medication-based treatment services.

5. **BUILD PEER CAPACITY.** If providers in your network have been slow to hire peers, then Managing Entities should consider getting more involved, perhaps by developing peer-run organizations in their network, which ideally should be on-call and available to engage overdose victims in hospitals 7 days a week. ED officials are looking to the Managing Entities and their networks to have peers involved in bridge programs when needed.
6. **ENSURE ACCESS TO NALOXONE.** Ensure that providers in your network are enrolled in the Department’s Overdose Prevention Program and are providing take-home naloxone kits to individuals at risk of experiencing an opioid overdose and to their loved ones that may witness an overdose. Managing Entities should also engage hospital emergency departments, homeless service organizations, harm reduction programs, recovery support organizations, Fire/EMS departments (for naloxone leave-behind programs), and other community-based organizations that provide direct services to people who use drugs to enroll in the program and distribute naloxone to at-risk individuals. Providers do not have to contract with Managing Entities or the Department to enroll in the program and distribute naloxone.

7. **PARTNER WITH LOCAL SYRINGE EXCHANGE PROGRAMS.** The Florida legislature passed SB 366 during the 2019 session, and effective July 1, 2019, the law allows county commissions to authorize syringe exchange programs (SEPs) through local ordinances. Entities eligible to operate an SEP include hospitals licensed under chapter 365, health care clinics licensed under part X of chapter 400, accredited medical schools, licensed addictions receiving facilities as defined in s. 397.311(26)(a)1, and 501(c)(3) HIV/AIDS service organizations. While there is currently only one authorized program in Florida (the IDEA Exchange in Miami-Dade), it is expected that there will be an increase in SEPs throughout the state. Managing Entities and their providers should work closely with local SEPs as they become established to ensure that SEP participants seeking substance use treatment services are immediately linked to services, and that buprenorphine or methadone maintenance are available to participants with opioid use disorders who are seeking treatment.

Permissible Uses of SOR Grant Funds

1. **ELIGIBILITY.** Funds must be used to serve indigent, uninsured, and underinsured individuals with opioid use disorders (or who are misusing opioids) who are receiving or will receive methadone, buprenorphine, or naltrexone maintenance treatment.
2. **FDA-APPROVED MEDICATIONS FOR OPIOID USE DISORDERS.** This includes methadone, buprenorphine products, including single-entity buprenorphine products, buprenorphine/naloxone tablets, films, buccal preparations, long-acting injectable buprenorphine products, and buprenorphine implants (Probuphine). Probuphine, which was approved by the FDA in 2016, is a six-month implant that may offer improved patient convenience from not needing to take medication daily, and it avoids the possibility of a pill or film being lost or stolen.

According to the National Academies of Sciences Report, “Naltrexone...can be administered by mouth daily or as depot injection once monthly, but the oral formulation has been shown to be ineffective for OUD.” The committee concluded that, “Only an extended-release formulation of naltrexone is approved by the FDA for the treatment of OUD.” Therefore, SOR funds cannot be used to purchase oral naltrexone to be used as a maintenance medication as it is not FDA-approved to treat OUD. However, SOR funds may be used to purchase oral naltrexone for the specific instances outlined below:

- For patients who opt to receive Vivitrol and are currently in an inpatient or residential treatment setting, where medication compliance can be monitored, and oral naltrexone may be a more cost-effective option. For this instance, it is expected that the patients will be transitioned to Vivitrol prior to or upon discharge from an inpatient or residential treatment setting.
 - As a placeholder for patients wanting to start Vivitrol treatment until the first injection is made available
 - To conduct a naltrexone challenge to ensure patients are opioid-free prior to receiving a Vivitrol injection to avoid precipitated withdrawal
 - To ensure patients do not have a naltrexone allergy prior to receiving a Vivitrol injection
3. **LONG-ACTING NALTREXONE (VIVITROL).** The Florida Alcohol and Drug Abuse Association (FADAA) will continue to fund Vivitrol injections and the associated screening, assessment, and medical costs. SOR funds can be used for the list of covered services below to support individuals receiving Vivitrol, except for Assessment, Medical Services and Medication-Assisted Treatment.

4. **DEDUCTIBLE AND CO-PAYS.** Funds may be used to offset deductibles and co-pays for individuals with opioid use disorders who are receiving medication-assisted treatment.

5. **SERVICE ARRAY.** Indigent, uninsured, and underinsured individuals with opioid use disorders (or who are misusing opioids) who are or will be receiving methadone, buprenorphine, or naltrexone maintenance treatment can also have the following services paid for using SOR grant funds (highlighted services require additional data collection outlined in #10):
 - **Aftercare**
 - Assessment
 - **Case Management**
 - Crisis Support/Emergency
 - Day Care
 - **Day Treatment**
 - Incidental Expenses (excluding direct payments to individuals to enter into, or continue to participate in, prevention or treatment services)
 - Outreach (to identify and link individuals with opioid use disorders to medication-assisted treatment providers)
 - **Medical Services**
 - **Medication Assisted Treatment**
 - **Outpatient**
 - **In-Home and On-Site**
 - **Recovery Support**
 - **Supported Employment**
 - **Supportive Housing/Living**
 - **Residential Levels I and II only for individuals who are inducted on methadone, buprenorphine, or naltrexone, and the level of care must be reevaluated every 15 days (note this is different from the Opioid STR Grant).**
 - **Inpatient Detoxification and Outpatient Detoxification.** Per the grant FOA, medical withdrawal (detoxification) is not the standard of care for opioid use disorders, is associated with a very high relapse rate, and significantly increases an individual's risk for opioid overdose and death if opioid use is resumed. Therefore, medical withdrawal (detoxification) when done in isolation is not an evidence-based practice for OUD. If medical withdrawal (detoxification) is performed, it **must be** accompanied by injectable extended-release naltrexone (Vivitrol) to protect such individuals from opioid overdose when they relapse (note this is different from the Opioid STR Grant).

6. **RECOVERY SUPPORT.** SOR funds can be used to implement community recovery support services such as peer supports, recovery coaches, and recovery housing. Providers and Managing Entities must ensure that recovery housing supported under this grant is through houses that are certified by the Florida Association of Recovery Residences, unless the house is operated by an entity under contract with an ME or by Oxford House, Inc.

7. **CRIMINAL JUSTICE.** SOR funds can be used to provide treatment transition and coverage for individuals reentering communities from criminal justice settings or other rehabilitative settings. Services can start in the jail, with a smooth transition to community services upon release.

8. **TELEHEALTH.** SOR funds can be used to support innovative telehealth strategies for rural and underserved areas.
9. **PREVENTION.** SOR funds can be used to support evidence-based primary prevention programs. Allowable programs and strategies include media campaigns based on *Use Only as Directed: Utah Prescription Pain Medication Program*, Botvin LifeSkills Training, Caring School Community, Guiding Good Choices, InShape Prevention Plus Wellness, PAX Good Behavior Game, Positive Action, Project SUCCESS, Project Towards No Drug Abuse, SPORT Prevention Plus Wellness, Teen Intervene, and the Strengthening Families Program (for Parents and Youth 10-14) if done in combination with Botvin LifeSkills Training. Managing Entities may also request to implement evidence-based programs not listed, to be reviewed and approved by the Department. All prevention services must be entered into the Department's Performance Based Prevention System.

10. **DATA COLLECTION.**

FASAMS DATA: Providers must indicate what medications individuals are currently using in FASAMS with the MAT modifiers for methadone, buprenorphine mono, buprenorphine combo, and injection or oral naltrexone for all services. All individuals receiving SOR funds must have the MAT modifier attached to service events listed in FASAMS, even if the medication itself is not being provided by the same provider of the service being entered.

GPRA: The Government Performance and Results Modernization Act of 2010 (GPRA) is a federal mandate which requires all SAMHSA grantees to collect and report performance data using approved measurement tools. Providers of treatment and recovery support services (which are in orange on the above list) will be required to collect data at **five** data collection points (**baseline, 6 months post-intake, discharge, 3-months post-discharge, and 6-months post-discharge**) using the CSAT GPRA. The target completion rate is 100%; meaning programs must attempt to follow-up with all individuals. However, SAMHSA's expects the state to achieve a minimum 6-months post-intake follow-up rate of completion of 80%. The Department is currently working with FEI Systems to provide the GPRA online; however, providers will have to utilize paper forms until the system is set up. Guidance for data collection is provided below.

- **GPRA and a GPRA Supplemental form** must be administered by program/clinic staff and questions must be asked as written with no deviation. The GPRA cannot be self-administered by the funded individual.
- **All** individuals who receive SOR-funded covered services marked in orange font above, must have completed **GPRA and a GPRA Supplemental forms** for each of the 5 collection points.
 - 6 months post-intake data should be collected on all clients, regardless of whether an individual drops out of the program prior to the 6 months. When a program cannot follow-up with an individual, the program must use the GPRA tool to report that the individual was not located.
 - A Discharge GPRA must be completed each time an individual is discharged/transferred from SOR funding.

- If an individual is discharged from a treatment episode and the individual then returns to re-enroll in a new SOR-funded treatment episode, a new data collection timeline must be started.
 - EX: An individual is discharged “Left on own against staff advice with satisfactory progress” at 4 months post intake with a baseline having been completed. Individual re-enrolls 2 months later. A new baseline **MUST** be completed and continued on a new data collection timeline (for 6 months post-intake, discharge, 3-months post-discharge, and 6-months post-discharge). With the previous GPRA timeline discontinued.
- If an individual leaves SOR funding and is transferred within the same episode of care to another funding source, they **MUST** complete a discharge at that time and GPRAs at subsequent data collection points. If the same individual returns (transferred back) within a certain time point to SOR funding they **do not** have to complete a new Baseline. Follow the guidance below for these situations:
 - If an individual is transferred to another funding source and is transferred back to SOR funding between 0-6 months post-intake they must continue the timeline and at 6 months post-baseline complete the 6 months post-baseline GPRA.
 - If an individual is transferred to another funding source between 0-6 months post-intake and is transferred back to SOR funding after 6 months post-intake they must start a new timeline with a Baseline tool.
 - EX: Client completes baseline, transferred to other funding source at 2 months post intake, completes discharge, transferred back at 7 months post intake, client must complete new baseline and start new timeline.

WINDOWS FOR GPRA ADMINISTRATION:

- Intake/Baseline:
 - For residential facilities - GPRA intake/baseline interviews must be completed **within 3 days** after the individual enters the program.
 - For nonresidential programs - GPRA intake/baseline interviews must be completed **within 4 days** after the client enters the program.
- Follow-up (post-intake and post-discharge):
 - The window period allowed for GPRA follow-up interviews is one month before the (3 or 6 month) anniversary date and up to two months after the (3 or 6 month) anniversary date.
- Discharge:
 - Discharge interviews must be completed on the day of discharge, regardless of length of stay in the program (i.e. 1-day length of treatment still needs a discharge GPRA completed)
 - If an individual has not finished treatment, drops out, or is not present the day of discharge, the project will have 14 days after discharge to find the an individual and conduct the in-person discharge interview. If the interview has not been conducted by day 15, conduct an administrative discharge. For an administrative discharge when the interview is not conducted, interviewers must complete the first four items in Section A (Client ID, Client Type, Contract/Grant ID, Interview Type), Section J (Discharge), and Section K (Services Received) and mark that the interview was not completed.

REFUSALS: If individuals refuse to answer the GPRA questions, they cannot be denied treatment, but a GPRA still must be completed at each data collection point.

- A “REFUSED” answer option is available for all client-based questions, please use these to complete the GPRA if a client refuses to answer any questions.
- Interviewers must complete the first five items in Section A (Client ID, Client Type, Contract/Grant ID, Interview Type, Interview date), Section A: Behavioral Health Diagnosis, Section A Questions #1-3, Section A Planned Services, Section I (Follow-Up only), Section J (Discharge Only), and Section K: Services Received (Discharge only).

UNABLE TO LOCATE/LOST TO FOLLOW-UP: If an individual cannot be located after multiple attempts, including but not limited to their collateral contact, they still need a GPRA completed.

- Interviewer must complete the first four items in Section A (Client ID, Client Type, Contract/Grant ID, Interview Type), follow prompts by marking “NO” in Interview Type and continue to Section I (follow-up) or J (discharge)

HOSPITAL DATA: Separate data collection will be required for Emergency Department Bridge programs. The following data elements must be sent to the SOR lead epidemiologist on the 30th of each month:

- # of individuals screened
- # of individuals induced with buprenorphine in the ED/hospital prior to discharge
- # of individuals referred to treatment providers
- # of individuals linked to treatment providers

11. **OCA**s. Correct documentation and reporting of services and associated costs is critical for timely and accurate reporting to federal funders, leadership, and other stakeholders. The following provides an overview of SOR OCA's which must be used for allowable costs for each respective service. Please refer to Chart 8's for details.

| State Opioid Response Grant OCA's | | |
|-----------------------------------|-------------------|---|
| OCA | Short Description | Purpose |
| SOR17 | Admin/Regions | Allowable administrative and general program costs incurred by Regions. |
| SORFV | Vivitrol/FADAA | Allowable cost of funds provided to the Florida Alcohol and Drug Abuse Association for naltrexone extended-release injectable medication (Vivitrol) and associated services, such as assessment and medical services, to treat opioid use disorders. |
| MSSRCO | RCOs/MEs | Allowable costs of implementing Recovery Community Organizations (RCOs) to be accredited by the Council on Accreditation of Peer Recovery Support Services within Rebel Recovery (SEFBHN) and South Florida Wellness Network (BBHC). This includes start-up costs, staffing, training, and accreditation costs. Funds may also be utilized by Rebel Recovery and South Florida Wellness Network to provide Outreach; Information and Referral; Drop-in Center; and Recovery Support. |
| MSSOA | Admin/MEs | Allowable administrative and general program costs incurred by the Managing Entities. |
| MSSOP | Prevention/MEs | Allowable costs incurred by MEs for Primary Prevention programs included in the pre-approved list, and other evidence-based programs which have been reviewed and approved by the Department. |
| MSSOR | MAT/MEs | Allowable costs of Medication-Assisted Treatment (MAT) services for the treatment of opioid use disorder incurred by MEs. |

| | | |
|-------------------------------------|---------------|--|
| MSSOH Effective 7/1/19 | Hospitals/MEs | Allowable costs to support hospital bridge programs that initiate buprenorphine treatment, either in the ED or at a provider, for individuals with opioid use disorders who have overdosed or experienced other medical problems due to opioid misuse. Funds may be used to outreach and engage the individual in treatment, provide access to medication assisted treatment, and pay for maintenance treatment and recovery support services. |
|-------------------------------------|---------------|--|

12. **INCIDENTALS.** Providers using incidental funds must report what they are purchasing using the following procedure codes associated with covered service 28:

- IEC00 - Housing
- IED00 - Utilities
- IEE00 - Transportation
- IEF00 - Primary Care (includes coverage of behavioral health co-pays or fees)
- IEH00 - Employment Support
- IEP00 - Fees (for legal documents such as birth certificates, IDs, driver’s license, etc.)

Prohibited Uses of SOR Grant Funds:

1. **DENIAL OF CARE.** Funds may not be used by any provider that denies any eligible individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders, namely methadone and buprenorphine. In all cases, MAT must be permitted to be continued for as long as the prescriber determines that the medication is clinically beneficial. **Providers must assure that individuals will not be compelled to no longer use MAT as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber’s recommendation or valid prescription.**
2. **DIRECT PAYMENTS TO PERSONS SERVED.** Funds may not be used to make direct payments to individuals to induce them to enter prevention or treatment services. However, SAMHSA grant funds may be used for nonclinical support services (e.g., bus tokens, child care) designed to improve access to and retention in prevention and treatment programs.
3. **LIMITS ON DETOXIFICATION SERVICES.** Funds may not be used to provide detoxification services unless it is part of the transition to extended release naltrexone (Vivitrol). As previously noted, SAMHSA has declared that, “Medical withdrawal (detoxification) is not the standard of care for opioid use disorders, is associated with a very high relapse rate, and significantly increases an individual’s risk for opioid overdose and death if opioid use is resumed. Therefore, medical withdrawal (detoxification) when done in isolation is not an evidence-based practice for OUD. If medical withdrawal (detoxification) is performed, it must be accompanied by injectable extended-release naltrexone to protect such individuals from opioid overdose in relapse and improve treatment outcomes.”
4. **CONSTRUCTION:** Funds may not be used to pay for the purchase or construction of any building or structure to house any part of the program.
5. **EXECUTIVE SALARY LIMITS.** Funds may not be used to pay the salary of an individual at a rate in excess of \$189,600.

¹ Substance Abuse and Mental Health Services Administration. (2018). *State Opioid Response Grants Funding Opportunity Announcement No. TI-18-015*. Retrieved from www.samhsa.gov/sites/default/files/grants/pdf/sorfoafinal.6.14.18.pdf.

² Substance Abuse and Mental Health Services Administration. (2018). *2014-2016 National Survey on Drug Use and Health Substate Age Group Tables*. Retrieved from www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsubstateAgeGroupTabs2016/NSDUHsubstateAgeGroupTabs2016.pdf.

³ Substance Abuse and Mental Health Services Administration (2016). *2012-2014 National Survey on Drug Use and Health Substate Age Group Tables*. Retrieved from www.samhsa.gov/data/sites/default/files/NSDUHsubstateAgeGroupTabs2014/NSDUHsubstateAgeGroupTabs2014.pdf.

⁴ Data regarding deaths caused by at least one opioid were obtained from the Florida Medical Examiners Commission's raw spreadsheet for Calendar Year 2016 and the 2017 Interim Report of Drugs Identified in Deceased Persons. Deaths caused by any opioid (including pharmaceutical opioids, illicit heroin, fentanyl and synthetics like U47700) between July 1, 2016 and June 30, 2017 were counted. It should be noted that deaths caused by opioids are not exclusively overdoses. These figures also include deaths by motor vehicle crashes, drowning, etc., where the Medical Examiner determined that an opioid played a causal role after considering the totality of the circumstances. One homicide was excluded because homicides are not relevant for allocating treatment resources for opioid use disorders.

STATE OF FLORIDA

OFFICE OF THE GOVERNOR EXECUTIVE ORDER NUMBER 19-97

(Establishing the Office of Drug Control and the Statewide Task Force on Opioid Abuse to Combat Florida's Substance Abuse Crisis)

WHEREAS, limiting substance abuse and combating the opioid epidemic in Florida is a critical public health issue that requires immediate attention;

WHEREAS, pursuant to Article IV, Section 1 of the Constitution, the Governor is the chief administrative officer of the state responsible for the planning and budgeting for the state;

WHEREAS, I, as the Governor of Florida, recognize the urgency and importance of continuing to lead our statewide efforts against substance abuse in Florida;

WHEREAS, the number of opioid-caused deaths in Florida continues to increase;

WHEREAS, I, the Governor of Florida, signed Executive Order 19-36 extending Florida's state of emergency for the opioid epidemic;

WHEREAS, I, as the Governor of Florida, and my executive branch agencies are leading the statewide substance abuse prevention programs and services, including the Statewide Drug Policy Advisory Council under the Florida Department of Health and the Office of Substance Abuse and Mental Health under the Florida Department of Children and Families;

WHEREAS, a coordinated and comprehensive statewide drug control and substance abuse prevention strategy is imperative for education, prevention, treatment, recovery and law enforcement efforts; and

WHEREAS, establishing an Office of Drug Control within the Executive Office of the Governor provides the best opportunity to coordinate efforts among federal, state and local partners in the prevention of substance abuse statewide.

NOW, THEREFORE, I, RON DESANTIS, as Governor of Florida, by virtue of the authority vested in me by Article IV, Section (1)(a) of the Florida Constitution, and all other applicable laws, do hereby issue the following Executive Order, to take immediate effect:

Section 1: I hereby create the Office of Drug Control within the Executive Office of the Governor for the purpose of coordinating and centralizing efforts to treat and prevent substance abuse in the State of Florida by gathering information, developing a statewide prevention strategy and identifying funding to limit substance abuse, including grants and recoveries received through or on behalf of executive branch agencies.

Section 2: I hereby create the Statewide Task Force on Opioid Abuse (henceforth “Task Force”) to research and assess the nature of opioid drug abuse in Florida and develop a statewide strategy to identify best practices to combat the opioid epidemic through education, treatment, prevention, recovery and law enforcement. This strategy should include recommendations for how the state can best use resources and funding to combat the opioid epidemic. The Task Force shall gather information as required and present recommendations to the Governor, the President of the Senate and the Speaker of the Florida House of Representatives. The Director of the Office of Drug Control within the Executive Office of the Governor shall serve as the Executive Director of the Task Force. The Task Force shall be composed of the following twenty-one members:

-
- A. The Governor shall designate the Attorney General of Florida as Chairman of the Task Force. A Vice Chairman shall be designated from the membership of the Task Force.
- B. The Governor shall appoint fifteen members of the Task Force:
- a. The Commissioner of the Florida Department Education, or his or her designee;
 - b. The Secretary of the Florida Department of Children and Families, or his or her designee;
 - c. The Surgeon General of the Florida Department of Health, or his or her designee;
 - d. The Secretary of the Florida Department of Corrections, or his or her designee;
 - e. The Secretary of the Florida Department of Juvenile Justice, or his or her designee;
 - f. The Commissioner of the Florida Department of Law Enforcement, or his or her designee;
 - g. One current or former Sheriff;
 - h. One current or former Police Chief;
 - i. One current or former State Attorney;
 - j. One current or former Public Defender;
 - k. Three Mental Health, Substance Abuse or Addiction Recovery Experts;
 - l. Two At-Large Members.

C. The Legislature shall have the appointment of two members to the Task Force as provided below:

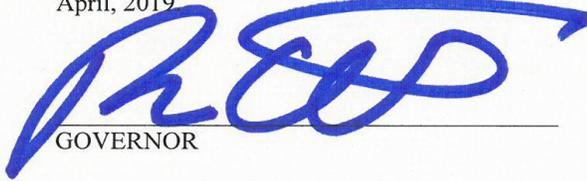
- a. The President of the Senate, or his or her designee;
- b. The Speaker of the House of Representatives, or his or her designee;

D. The Attorney General of Florida shall appoint three at-large members to the Task Force.

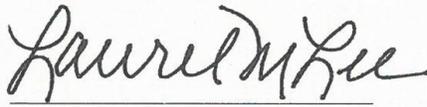
These actions will ensure that Florida is equipped to continue fighting the opioid epidemic and move Florida forward in the development of a coordinated statewide substance abuse prevention strategy.



IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed, at Tallahassee, this 1st day of April, 2019.


GOVERNOR

ATTEST:


SECRETARY OF STATE

FILED
2019 APR - 1 PM 4:46
DEPARTMENT OF STATE
TALLAHASSEE, FLORIDA