Florida's Partnerships for Success – Project Narrative Re-Submission (2016 – 2021)

ABSTRACT

Florida's Partnerships for Success Project is designed to reduce prescription drug misuse among Floridians ages 12-25 and the nonmedical use of opioids among Floridians ages 26 and older by strengthening prevention capacity and infrastructure at the state and community levels. The subrecipient communities are five urban counties (Broward, Duval, Hillsborough, Manatee, and Palm Beach) and three rural counties (Franklin, Walton, and Washington).

A statewide Opioid Overdose Prevention Awareness campaign will be implemented to educate the public on opioid overdose recognition and response, how to use naloxone to reverse an overdose, and where to access naloxone in Florida. The campaign will develop a website, create targeted digital advertising, and conduct educational resource dissemination to increase awareness of and access to naloxone to save lives from opioid overdose. Each year, at least 100 individuals will be trained on naloxone through a minimum of 10 overdose prevention trainings throughout the subrecipient communities.

Care coordination pilot programs will utilize peer specialists to link overdose victims to drug treatment providers after they are discharged from the hospital. School- and family-based prevention programs that effectively reduce prescription drug misuse will be implemented in each PFS county. Local Drug Epidemiology Networks (DENs) will be developed and integrated into the State Epidemiological Outcomes Workgroup (SEOW). Members of the SEOW will develop county-level reports on naloxone reversals by paramedics and EMTs and prescription drug and heroin exposures from Florida Poison Control Centers. They will also collaborate on an analysis of patterns of service utilization prior to drug-related suicide attempts and completed suicides.

Enhancements to Florida's Prescription Drug Monitoring Program (PDMP) will be deployed to modify prescribing practices. These include customized alerts, prescriber report cards, a self-paced online training course, and a naloxone co-prescribing alert for high-risk patients. County-specific data reporting templates will also be developed to help inform community-based prevention activities and modify prescribing practices. All of these components are designed to increase the percentage of physicians that voluntarily consult the PDMP prior to writing prescriptions for controlled substances, reduce the number of patients obtaining controlled substance prescriptions from five or more prescribers and five or more dispensers, and reduce the number of patients receiving concurrent prescriptions of opioids and sedatives.

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Award Amount: $1.2 million per year (for a total of $6.1 million over the 5-year project period)
Funding Opportunity Announcement: www.samhsa.gov/grants/grant-announcements/sp-16-003

A-1. Identify the proposed catchment area and provide demographic information on the population(s) to engage in substance abuse prevention activities through the targeted systems or agencies in terms of race, ethnicity, federally recognized tribe, language, sex, gender identity, sexual orientation, age, and socioeconomic status.

The proposed catchment area is composed of five urban counties (Broward, Duval, Hillsborough, Manatee, and Palm Beach) and three rural counties (Franklin, Walton, and Washington) in the state of Florida. The target populations of this proposal are people ages 12-25 who misuse prescription drugs and people ages 26 and older engaged in nonmedical opioid use. Demographic data for these populations, presented in the tables below, are based on publicly-funded drug treatment admission records (for State Fiscal Years 12-13, 13-14, and 14-15), Florida Youth Substance Abuse Survey responses (from 2014), and mortality records from the Florida Medical Examiners Commission (from 2014).

Treatment Admission for Primary Abuse of Prescription Drugs Among Individuals Ages 12-25									
	Female	Male	White	Black	Multi-Racial	Other	Hispanic	Co-Occurring	Did Not Graduate HS
Broward	47%	53%	91%	6%	4%	<1%	15%	18%	30%
Duval	61%	39%	95%	3%	2%	<1%	3%	33%	42%
Hillsborough	47%	53%	73%	14%	12%	1%	18%	69%	48%
Manatee	69%	31%	97%	2%	1%	<1%	5%	55%	27%
Palm Beach	53%	47%	94%	4%	2%	<1%	8%	69%	35%
Franklin	93%	7%	96%	2%	0%	2%	0%	5%	42%
Walton	38%	62%	94%	6%	0%	0%	0%	48%	63%
Washington	NA	NA	NA	NA	NA	NA	NA	NA	NA

Treatment Admissions for Primary Abuse of Prescription Opioids and Heroin Among Individuals Ages 26+									
	Female	Male	White	Black	Multi-Racial	Other	Hispanic	Co-Occurring	Did Not Graduate HS
Broward	47%	53%	91%	6%	4%	<1%	15%	18%	30%
Duval	61%	39%	95%	3%	2%	<1%	3%	33%	42%
Hillsborough	52%	48%	85%	7&	7%	1%	14%	59%	33%
Manatee	56%	44%	96%	3%	1%	<1%	5%	46%	24%
Palm Beach	45%	55%	93%	5%	2%	<1%	7%	71%	27%
Franklin	72%	28%	97%	0%	2%	1%	0%	9%	28%
Walton	54%	46%	92%	4%	3%	1%	3%	38%	44%
Washington	NA	NA	NA	NA	NA	NA	NA	NA	NA

Middle and High School Students that Misused a Prescription Drug in the Past 30 Days							
	Female	Male	White	Black	Other or Multi-Racial	Hispanic	Speak English at Home
Broward	66%	34%	30%	17%	24%	30%	73%
Duval	53%	47%	50%	27%	16%	5%	97%
Hillsborough	48%	52%	41%	24%	31%	14%	93%
Manatee	61%	39%	74%	0%	4%	22%	89%
Palm Beach	53%	47%	45%	12%	24%	19%	82%
Franklin	75%	25%	10%	0%	0%	0%	100%
Walton	47%	53%	82%	5%	0%	4%	95%
Washington	45%	55%	92%	2%	0%	0%	99%

Individuals Ages 12-25 Whose Death Was Caused by at Least One Prescription Drug					
	Female	Male	White	Black	Hispanic
Broward	31%	69%	81%	13%	6%
Duval	67%	33%	100%	0%	0%
Hillsborough	14%	86%	100%	0%	0%
Manatee	43%	57%	100%	0%	0%
Palm Beach	16%	84%	96%	0%	4%
Franklin	NA	NA	NA	NA	NA
Walton	NA	NA	NA	NA	NA
Washington	NA	NA	NA	NA	NA

Individuals Ages 26+ Whose Death Was Caused by at Least One Prescription Opioid or Heroin					
	Female	Male	White	Black	Hispanic
Broward	44%	56%	91%	6%	3%
Duval	47%	53%	96%	4%	0%
Hillsborough	48%	52%	97%	3%	0%
Manatee	44%	56%	90%	5%	3%
Palm Beach	30%	70%	97%	3%	0%
Franklin	NA	NA	NA	NA	NA
Walton	NA	NA	NA	NA	NA
Washington	NA	NA	NA	NA	NA

There are several limitations with regard to the demographic data for these populations. Currently, there are no behavioral health surveillance systems in Florida that collect data on gender identity or sexual orientation. Furthermore, income is inconsistently reported in the Department's treatment records. However, since these records come from the publicly-funded system of care, it can reasonably be inferred that the vast majority of these individuals are indigent. Nonetheless, high school completion rates were reported as proxy for socioeconomic status. Finally, the Florida Youth Substance Abuse Survey does not contain an adequate measure of socioeconomic status. Students are asked about the highest level of schooling achieved by their father and the highest level of schooling achieved by their mother, but 10% to 24% (depending on which county one is looking at) of respondents who are prescription drug misusers indicate that they either do not know or that it does not apply. Therefore, in addition to being an imperfect proxy for socioeconomic status, these records are too incomplete to report. Additionally, the frequency of treatment admissions for Washington County is too small to contribute meaningful demographic information. The frequency of deaths is also too low in Franklin, Walton, and Washington counties to use for identifying meaningful variation in demographics. Finally, none of the available datasets specifically identify members of the two federally recognized tribes in Florida (the Miccosukee Tribe and the Seminole Tribe).

A-2. Discuss the relationship of your population of focus to the overall population in your geographic catchment area and identify sub-population disparities, if any, related to access/use/outcomes of your provided substance abuse prevention activities, citing relevant data. Demonstrate an understanding of these populations consistent with the purpose of the SPF-PFS grant program and intent of the FOA.

Comparing the demographics of the overall population in each high-need county, presented in the table below, to the demographics of target populations (as documented in treatment

admission records, self-reported survey data, and mortality reports) reveals consistent patterns. In general, it is clear that the demographics of middle and high school students who misuse prescription drugs more closely mirror the demographics of the overall population in each county. Disparities in access to, and use of, the prevention activities in this proposal are also clear. There are no providers implementing SAMHSA's Opioid Overdose Prevention Toolkit in the three high-need rural communities. Furthermore, none of these rural counties are served by a local Drug Epidemiology Network that would help assess and analyze local conditions that contribute to prescription drug misuse, nonmedical opioid use, and related consequences. Additionally, research shows that the drug overdose burden is 45% higher in rural areas than it is in urban areas and that rural communities are disproportionately affected by underutilization of the opioid overdose reversal agent naloxone.[1]

Overall County Population				
	White	Black	Other	Hispanic
Broward	66%	28%	6%	26%
Duval	62%	30%	8%	9%
Hillsborough	76%	18%	7%	26%
Manatee	87%	9%	4%	17%
Palm Beach	77%	18%	5%	17%
Franklin	84%	14%	2%	5%
Walton	89%	7%	4%	6%
Washington	82%	15%	4%	3%

A-3. Document the need for an enhanced infrastructure to increase the capacity to implement, sustain, and improve effective substance abuse prevention activities in the proposed catchment area that is consistent with the purpose of the grant program and intent of the FOA. Include the service gaps and other problems related to the need for infrastructure development. Identify the source of the data. Documentation of need may come from a variety of qualitative and quantitative sources. Examples of data sources for the quantitative data that could be used are local epidemiologic data, state data (e.g., from state needs assessments, NSDUH), and/or national data (e.g., from NSDUH). This list is not exhaustive; applicants may submit other valid data, as appropriate for your program.

The Department of Children and Families disseminated a series of questions designed to assess Florida's capacity and infrastructure for addressing prescription drug misuse and nonmedical opioid use to prevention providers throughout the state. The Department received responses from 42 prevention providers, indicating that the most commonly implemented activities are designed to reduce the supply of prescription drugs available for theft, diversion, and misuse. These activities include safe storage and disposal campaigns, participation in drug "Take-Back" events, the establishment of prescription drug drop boxes, and the provision of lock boxes and drug deactivation systems. The respondents identified information dissemination and community education as the second most prevalent set of activities. Safe use, safe storage, and safe disposal messages are typical components of these awareness campaigns. Coalitions in the targeted

[1] Faul, M., Dailey, M. W., Sugerman, D. E., Sasser, S. M., Levy, B., & Paulozzi, L. J. (2015). Disparity in Naloxone Administration by Emergency Service Providers and the Burden of Drug Overdose in US Rural Communities. *American Journal of Public Health, 105*(S3), 26-32.

counties are committed to leveraging non-PFS resources to help implement these promising activities.

Florida's Emergency Treatment and Recovery Act, enacted on June 10, 2015, allows health care practitioners to prescribe and dispense naloxone to individuals at risk of experiencing an opioid overdose and bystanders/caregivers who might witness an overdose. Only three prevention providers reported that they are engaged in training and promotional activities related to naloxone. When surveyed about the kind of infrastructure/capacity improvements needed to more effectively respond to prescription drug misuse and heroin use, the most commonly cited need was training regarding the use of naloxone by paramedics, law enforcement officers, and other first responders, including caregivers. Florida's proposal is designed to enhance the infrastructure and strengthen the capacity of the state's prevention and treatment system to disseminate information regarding overdose recognition and response, conduct naloxone trainings, and implement other life-saving components of SAMHSA's Opioid Overdose Prevention Toolkit.

With regard to gaps in the data infrastructure, prevention providers most frequently cited a need for data from Emergency Medical Services on overdose calls and naloxone reversals. The next most cited needs were for data on overdoses treated in hospital emergency departments and data on physician utilization of the Prescription Drug Monitoring Program. Furthermore, only two out of the eight high-need communities identified have a functioning local Drug Epidemiology Network (DEN). Local DENs operate within anti-drug coalitions to help community stakeholders gain a comprehensive understanding of local consumption patterns, consequences, risk and protective factors, and contributing conditions. They can serve as sentinels for detecting emerging drug threats. DENs are also supposed to help analyze and disseminate surveillance data for use in the development of local polices, practices, strategies, and programs. Florida's proposal is designed to address all of these gaps in the state and local level data infrastructure.

A-4. Document how the state will work with their SEOWs to carry out such tasks as developing a systematic, ongoing monitoring system to track progress in reducing prescription drug misuse in their communities of high need, detect trends, and use such information to redirect resources toward the goals of the SPF-PFS grant program.

Key project staff, including the Project Director, Lead Evaluator, Lead Epidemiologist, and Lead Analyst, will work in coordination with the Department's State Epidemiological Outcomes Workgroup (SEOW) on improvements to Florida's surveillance system. The Lead Epidemiologist and Lead Analyst will co-chair the SEOW and help develop and mentor local Drug Epidemiology Networks (DENs) in the subrecipient communities. Members of the SEOW, the Lead Evaluator, Project Director, and Grant Coordinator will review and analyze performance data on a quarterly basis. Members of the SEOW will also prepare briefings with the Project Director for the Drug Policy Advisory Council and will make recommendations on ways to enhance surveillance systems. In order to document needs, track trends, inform resource allocation decisions, and strengthen surveillance capacity, the DENs will prepare county-level reports on naloxone reversals by paramedics and EMTs and prescription drug and heroin exposures from Florida Poison Control Centers before incorporating these reports into a larger statewide surveillance analysis produced by the SEOW. In order to assist with planning and

evaluation of care coordination activities for individuals hospitalized for opioid overdoses (including individuals who attempted suicide), the SEOW will obtain and analyze hospital admission, discharge, and referral source data from drug treatment providers.

B-1. Describe the purpose of the proposed project, including its goals and measureable objectives. These must relate to the intent of the FOA, SAMHSA's Strategic Initiative: Prevention of Substance Abuse and Mental Illness, and the performance measures identified in Section D: Data Collection and Performance Measurement.

The purpose of this project and the proposed goals mirror the intent of the FOA and the goals from SAMHSA's Strategic Initiative. Florida's first goal calls for reducing prescription drug misuse among Floridians ages 12-25. This aligns with SAMHSA's Goal 1.1 (promote emotional health and wellness, prevent or delay the onset of and complications from substance abuse, and identify and respond to emerging behavioral health issues) and Goal 1.4 (prevent and reduce prescription drug and illicit opioid misuse and abuse). Florida's second goal calls for increased awareness of overdose prevention activities and overdose recognition and response. This aligns with SAMHSA's Goal 1.1 (specifically to "prevent or delay the onset and complications from substance abuse") and Goal 1.4 (prevent and reduce prescription drug and illicit opioid misuse and abuse). Florida's third goal calls for strengthening prevention capacity and infrastructure at the state and community levels. This goal echoes the intent of the FOA which, in addition to preventing the onset and reducing the progression of misuse and related problems, also calls for strengthening prevention capacity and infrastructure.

1. Reduce prescription drug misuse among Floridians ages 12-25 years old.

- Objective 1.1: Implement an evidence-based school- and family-based prevention program for youth in each PFS county.
- Objective 1.2: Increase the percentage of physicians that voluntarily consult the Prescription Drug Monitoring Program prior to writing a prescription for a controlled substance by 10% between 2017 and 2021;
- Objective 1.3: Reduce the number of patients obtaining controlled substance prescriptions from five or more prescribers and five or more dispensers by 10% between 2017 and 2021;
- Objective 1.4: Support the development or adoption of safe prescribing guidelines with the Board of Medicine;
- Objective 1.5: Reduce the number of patients receiving concurrent prescriptions of an opioid, alprazolam, and carisoprodol by 10% between 2017 and 2021;
- Objective 1.6: Implement a pilot program with at least one emergency department that links individuals who have experienced a drug overdose to an addiction treatment provider;

2. Increase awareness of opioid overdose recognition and response.

- Objective 2.1: Increase the number of pharmacies dispensing naloxone under non-patient specific standing orders;
- Objective 2.2: Remove the prior authorization insurance requirement for naloxone under Florida Medicaid;
- Objective 2.3: Implement a statewide Opioid Overdose Prevention Campaign to increase awareness about naloxone and Florida's 911 Good Samaritan law.

3. Strengthen prevention capacity and infrastructure at the state and community levels.

- Objective 3.1: Conduct at least 10 naloxone training events per year;
- Objective 3.2: Train at least 100 individuals in overdose prevention per year;
- Objective 3.3: Obtain and analyze data on the use of naloxone and the provision of referrals to treatment by paramedics and emergency medical technicians;
- Objective 3.4: Develop and activate eight Drug Epidemiology Networks (DENs) that serve high-need communities.

B-2. Describe the proposed project activities, how they meet your infrastructure needs, and how achievement of goals will increase system capacity to support effective substance abuse prevention activities.

The State of Florida has enacted policies to address the opioid overdose crisis through the adoption of a statewide 911 Good Samaritan Act (2012) and the Emergency Treatment and Recovery Act (2015). The 911 Good Samaritan Act aims to increase emergency medical care for victims of overdose by providing legal protections to witnesses who call for help and to individuals experiencing an overdose. This is important because when someone in America overdoses, a call for help occurs less than 50% of the time.[2] Even if a call for help is made, it may be too late to save a life by the time the ambulance arrives. Increased awareness of this law will work to encourage witnesses of an overdose to dispatch first responders to the scene without fear of criminal prosecution for possession of controlled substances. Florida's Emergency Treatment and Recovery Act is a law which allows health care practitioners to prescribe and dispense naloxone to individuals at risk witnessing or experiencing an opioid overdose. Pharmacies are also authorized to dispense naloxone to individuals without a prescription under non-patient specific standing orders. The legislation is an attempt to get naloxone into the hands of patients and caregivers who may experience or witness an overdose. When someone is not breathing, every moment counts, and the administration of naloxone can mean the difference between life and death (or severe brain damage). Together, these laws work to decrease the number of lives lost to accidental overdose across the state. Education and awareness of these laws are critical to ensuring that they are used when a life could be saved from opioid overdose.

In an effort to expand awareness of the 911 Good Samaritan Act and the Emergency Treatment and Recovery Act to save lives from overdose overdose, the Project Director and Grant

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[2] Tobin, K. E., Davey, M. A., & Latkin, C. A. (2005). Calling Emergency Medical Services During Drug Overdose: An Examination of Individual, Social, and Setting Correlates. *Addiction, 100*(3), 397-404; Baca, C. T., & Grant, K. J. (2007). What Heroin Users Tell Us About Overdose. *Journal of Addictive Diseases, 26*(4), 63-68; Sherman, S. G., Gann, D. S., Scott, G., et al. (2008). A Qualitative Study of Overdose Responses Among Chicago IDUs. *Harm Reduction Journal, 5*(1), 2; Smart, A. T. & Porucznik, C. (n. d.). *Drug Overdose Prevention and Education Study*; Tracy, Piper, T. M., Ompad, D., et al. (2005). Circumstances of Witnessed Drug Overdose in New York City: Implications for Intervention. *Drug and Alcohol Dependence, 79*, 181-190.

[2] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General (2016). Facing Addicition in America: The Surgeon General's Report on M., Piper, T. M., Ompad, D., et al. (2005). Circumstances of Witnessed Drug Overdose in New York City: Implications for Intervention. *Drug and Alcohol Dependence, 79*, 181-190.

Coordinator will collaborate with a contracted vendor to design a statewide Opioid Overdose Prevention Awareness Campaign. The comprehensive statewide strategy of the campaign will be to increase awareness of opioid overdose recognition and response, how to use naloxone to reverse an overdose, and where to access naloxone in Florida. The campaign will provide information regarding Florida laws, provide education on overdose recognition and response, and increase awareness of resources for individuals with opioid use disorder. The intended audience of the campaign is the general public, but will also include targeted information to people who use drugs and their loved ones, treatment providers, prescribers, pharmacists, law enforcement, and other first responders. As a component of the campaign, a website will be developed to house educational materials and provide information on where to access naloxone in Florida.

Intervention during an opioid-related overdose through the use of naloxone can be lifesaving. Since the first opioid overdose prevention program began in 1996, over 152,000 people have received training and naloxone kits and over 26,400 overdose reversals have been reported.[3] Through the statewide Opioid Overdose Prevention Awareness Campaign, information will be disseminated on recognizing the signs of an opioid overdose and how to properly respond using naloxone. Included in these communications will be the nature and scope of the opioid overdose epidemic in Florida, the laws regarding responding to an overdose (the 911 Good Samaritan Act and the Emergency Treatment and Recovery Act), and information on how to access naloxone. In addition to building statewide awareness on overdose recognition and response through the campaign's comprehensive media strategy, the Project Director and Grant Coordinator will develop overdose prevention training to be delivered to targeted audiences. The in-person and webinar trainings teach participants how to respond to an overdose and utilize naloxone. Trainings will be available to organizations interested in enrolling in the Department's Naloxone Program to increase access to the medication in their communities. Trainings will also be available to the state's Managing Entities, substance use treatment providers, prescribers, pharmacists, first responders (including law enforcement), general community members, and other interested stakeholders.

As recommended in SAMHSA's Opioid Overdose Prevention Toolkit, educational materials distributed at the opioid overdose prevention training sessions will include content on how to access treatment services and content on Florida's 911 Good Samaritan Act, which protects people who seek or obtain medical assistance from prosecution for drug possession in the event of an overdose. Individuals with opioid use disorders are at particularly high risk for experiencing a fatal opioid overdose. Treatment providers need to be aware that the period immediately following discharge from detoxification or abstinence-based treatment is one of elevated overdose risk.[4] Opioid tolerance is low and one instance of use can potentially be fatal.

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[3] Centers for Disease Control and Prevention. (2015). Opioid Overdose Prevention Programs Providing Naloxone to Laypersons - United States, 2014. *Morbidity and Mortality Weekly Report, 64*, 631-635.

[4] Davoli, M., Bargagli, A. M., Perucci, C. A., Schifano, P., Belleudi, V., et al. (2007). Risk of Fatal Overdose During and After Specialist Drug Treatment: The VEde TTE Study, A National Multi-site Prospective Cohort Study. *Addiction, 102*(12), 1954-1959; Strang, J., McCambridge, J., Best, D., Beswick, T., Bearn, J., Rees, S., & Gossop, M., (2003). Loss of Tolerance and Overdose Mortality after Inpatient Opiate Detoxification: Follow-up Study. *BMJ, 326*(7396), 959-960; Maxwell, S., Bigg, D., Stanczykiewicz, K., & Carlberg-Racich, S. (2006). Prescribing

This makes overdose prevention and response training an extremely important part of preparing individuals for discharge. Through the campaign, targeted information will be provided to treatment providers regarding the need to prepare patients for discharge by engaging in overdose prevention conversations and providing information on how to access naloxone. On the campaign website, the educational materials and resources will be available to the public.

The Project Director will collaborate with the Florida Department of Health, Bureau of Pharmacy, Board of Medicine, and the Agency for Health Care Administration to identify and reduce barriers to physicians' ability to issue prescriptions for naloxone to patients and caregivers. Currently, all Medicaid and Medicaid Managed Care programs in Florida require a physician to complete a prior authorization for a naloxone prescription. The managed care plan then decides whether or not to authorize covering the costs of the medication. The Project Director will identify private insurance plans that require a prior authorization for naloxone and how such prior authorizations apply to the various naloxone products. Using a collaborative approach, the Project Director will facilitate efforts to remove prior authorization requirements among public and private insurance plans.

Research shows that only 40% of patients that experience an opioid-related hospitalization receive any follow-up services within 30 days. Only 10.7% of patients receive the recommended combination of both medication and a therapeutic service.[5] These findings only apply to individuals with private insurance. It is reasonable to assume that post-discharge care coordination is more challenging for individuals without insurance. Providing care coordination that links people who experience an overdose to supportive, evidence-based post-discharge care is critical to stopping the cycle of relapses and overdoses. Preliminary research shows that continuity of care, operationally defined as experiencing an outpatient treatment encounter for a substance use disorder within 14 days after discharge from a residential facility, is associated with significantly lower odds of deaths within a two-year post-discharge period.[6] Additionally, a randomized controlled trial of brief, in-home psychotherapy intervention provided to individuals who were hospitalized for deliberate self-poisoning found that it reduced suicide ideation and subsequent attempts at self harm.[7] During Year 1 of this proposal, the Project Director and SEOW will conduct a detailed assessment of the need for care coordination services and community-level readiness and infrastructure to adopt them in the five high-need, urban communities. The objective is to implement at least one care coordination pilot program beginning in Year 2 that involves at least one hospital and providers of Medication Assisted Treatment, counseling, recovery peer support, and therapeutic services. PFS funds will be used to support peer recovery specialists who assess, motivate, and link individuals to treatment.

Naloxone to Actively Injecting Heroin Users: A Program to Reduce Heroin Overdose Deaths. *Journal of Addictive Diseases, 25*(3), 89-96.

[5] Ali, M. M., & Mutter, R. (2016). *The CBHSQ Report: Patients Who Are Privately Insured Receive Limited Follow-up Services After Opioid-Related Hospitalization*.

[6] Harris, A. H. S., Gupta, S., Bowe, T., Ellerbe, L. S., Phelps, T. E., et al. (2015). Predictive Validity of Two Process-of-Care Quality Measures for Residential Substance Use Disorder Treatment. *Addiction Science and Clinical Practice, 10*(22), 1-8.

[7] Guthrie, E., Kapur, N., Mackway-Jones, K., Chew-Graham, C., Moorey, J., et al. (2001). Randomised Controlled Trial of Brief Psychological Intervention After Deliberate Self-Poisoning. *British Medical Journal, 323*, 1-5.

Replicable procedures for assessing overdose victims and linking them to treatment and recovery services will be developed, tested, and disseminated if found to be effective.

The Department will use PFS funds to expand school- and family-based prevention programs that show evidence of effectiveness at reducing prescription drug misuse. Researchers conducted randomized controlled trials of the Strengthening Families Program, and Life Skills Training combined with the Strengthening Families Program, in rural communities and small towns. Despite the fact that these school- and family-based interventions did not have any specific content related to the prevention of prescription drug misuse, they demonstrated significant reductions in prescription drug misuse (with relative reduction rates ranging from 20% to 65%).[8] Additional research has found that Life Skills Training alone, and the Strengthening Families Program combined with either All Stars or Life Skills Training, significantly reduce nonmedical opioid use. The combined delivery of Life Skills Training and the Strengthening Families Program appears to be the most cost-effective way to reduce nonmedical opioid use.[9] PFS funds will be utilized to develop and expand school-based prevention programs in each subrecipient community.

The prescription drug misuse epidemic is fueled in part by a minority of prescribers who over-prescribe or otherwise deviate from standards of practice. Prescribers who deviate from accepted standards of practice or whose prescribing is unusual or uncharacteristic for their specialty are considered at-risk prescribers.[10] In Florida, the top 10% of prescribers account for approximately 64% of all prescribing.[11] In response to the heroin epidemic, the CDC directs states to reduce prescription opioid painkiller misuse by improving prescribing practices and identifying high-risk individuals early, particularly through the use of prescribing guidelines and Prescription Drug Monitoring Programs (PDMPs). Research shows that implementing opioid dosing guidelines is a promising way to reduce the prescription of high dosages of opioids and rates of prescription opioid poisoning.[12] Florida's proposal commits the Project Director to supporting the development of safe prescribing and dosing guidelines with the Florida Board of Medicine. This proposal also commits PFS funds to the design, development, and delivery of a self-paced online training program through the Department of Health's PDMP. The CDC also recommends that PDMPs have the capacity to proactively notify users of high-risk behaviors.[13] Report cards

[8] Spoth, R., Trudeau, L., Shin, Chungyeol, S., Ralston, E., Redmond, C., Greenberg, M., & Feinberg, M. (2013). Longitudinal Effects of Universal Preventive Intervention on Prescription Drug Misuse: Three Randomized Controlled Trials with Late Adolescents and Young Adults. *American Journal of Public Health, 103*(4), 665672.
[9] Crowley, D. M., Jones, D. E., Coffman, D. L., & Greenberg, M. T. (2014). Can We Build an Efficient Response to the Prescription Drug Abuse Epidemic? Assessing the Cost Effectiveness of Universal Prevention in the PROSPER Trial. *Prevention Medicine, 62*, 71-77.
[10] Prescription Drug Monitoring Program Center of Excellence at Brandeis. (2014). *Using PDMP Data to Guide Interventions with Possible At-Risk Prescribers*.
[11] Florida Department of Health. (2015). *2014-2015 Prescription Drug Monitoring Program Annual Report*.
[12] Garg, R. K., Fulton-Kehoe, D., Turner, J. A., Bauer, A. M., Wickizer, T., Sullivan, M. D., & Franklin, G. M. (2013). Changes in Opioid Prescribing for Washington Workers' Compensation Claimants After Implementation of an Opioid Dosing Guideline for Chronic Noncancer Pain: 2004 to 2010. *The Journal of Pain, 14*(12), 1620-1628; Fulton-Kehoe, D., Sullivan, M. D., Turner, J. A., Garg, R. K., Bauer, A. M., Wickizer, T. M., & Franklin, G. M. (2015). Opioid Poisonings in Washington State Medicaid: Trends, Dosing, and Guidelines. *Medical Care, 53*(8), 679-685.
[13] Centers for Disease Control and Prevention. (2016). *Prevention Status Report (PSR) – Florida*.

and alerts can increase awareness and help prescribers re-examine their prescribing practices and policies. This proposal commits PFS funding to the development of alerts driven by the system users that enable them to establish alerts based on customized thresholds. Additionally, PFS funds will be used to pay for a system enhancement that prompts physicians to co-prescribe naloxone to individuals at high-risk for an overdose. According to SAMHSA's Opioid Overdose Prevention Toolkit, patients who are good candidates for naloxone kits include those who are taking high doses of opioids for long-term management of chronic malignant or non-malignant pain, receiving rotating opioid medication regimes, taking extended release/long-acting opioid preparations, discharged from emergency medical care following opioid intoxication or poisoning, or completing mandatory detoxification or abstinence programs.

The CDC also recommends that PDMP data is accessible to public health agencies for tracking trends. Briefing community stakeholders using PDMP data can help highlight unique factors that contribute to local problems, motivate prescribers to utilize the PDMP and improve prescribing practices, and increase community readiness to change.[14] Increasing the dissemination and utilization of PDMP data can help improve Florida's data infrastructure and increase community readiness. PFS funds will be used to support the development of county-specific data reporting templates that can be used to inform community-based prevention efforts that seek to modify prescribing practices. Once fully implemented, these activities are expected to help Florida achieve several of the measureable objectives in this proposal. The PDMP system enhancements and data sharing with community stakeholders should increase the percentage of physicians that voluntarily consult the PDMP prior to writing a prescription for a controlled substance. Safer prescribing practices and proactive utilization should also reduce the number of Floridians obtaining controlled substance prescriptions from five or more prescribers and five or more dispensers, and reduce the number of patients receiving concurrent prescriptions of an opioid, alprazolam, and carisoprodol, a particularly dangerous combination that is commonly desired by individuals who misuse medications and engage in doctor shopping.

PFS funds will also be used to support the development of local Drug Epidemiology Networks (DENs) and their integration into the State Epidemiological Outcomes Workgroup (SEOW). Currently, only two out of the eight high-need communities have a functioning local DEN. Local DENs operate within anti-drug coalitions to help community stakeholders gain a comprehensive understanding of local consumption patterns, consequences, risk and protective factors, and contributing conditions. DENs are comprised of local community members, including local representatives from relevant state and federal agencies, who are able to obtain and assess information on county-level drug trends. They serve as sentinels for detecting emerging drug threats and they help analyze and disseminate surveillance data for use in the development of local polices, practices, strategies, and programs. The DEN development activities proposed as part of this project were generated by longstanding members of Florida's SEOW. PFS funds will be used to support the development of comprehensive assessments of local conditions and needs through DENs linked with anti-drug coalitions or treatment providers in all eight subrecipient communities. Key project staff and the SEOW will help establish local DENs to serve each of the eight PFS counties identified as subrecipients. PFS funds will support DEN trainings,

[14] Prescription Drug Monitoring Program Center of Excellence at Brandeis. (2012). Project *Lazarus: Using PDMP Data to Mobilize and Measure Community Drug Abuse Prevention*.

workshops, and face-to-face meetings. DEN reports will mirror the outline and layout used by the National Institute on Drug Abuse's National Drug Early Warning System annual Sentinel Site Reports.

Capacity building entails increasing the resources, abilities, and skills of individuals, groups, and organizations to plan, implement, and sustain initiatives.[15] The proposed activities address key components of capacity building and infrastructure development.[16] Active promotion by multiple champions across organizations and systems helps increase stakeholder awareness and ensure success. Florida will promote opioid overdose recognition and response, the use of naloxone, and knowledge of Florida's relevant laws that address opioid overdose by engaging community members, first responders, prescribers, law enforcement, and local drug coalitions. SAMHSA's Opioid Overdose Prevention Toolkit, which contains recommended activities for community members, first responders, prescribers, patients, and family members, will also be promoted by project staff and subrecipients. Strengthening collaboration and coordination is important for capacity building. Florida's proposal entails the collaboration of coalitions, treatment providers, prescribers, pharmacists, hospitals, first responders, government agencies, and local DENs through training, education and awareness, drug surveillance, and other prevention activities. Improving the knowledge, skills, and abilities of the workforce also supports capacity building and sustainability. This proposal supports the prevention workforce through awareness, training and technical assistance on opioid overdose prevention, coordinating care for overdose victims, and implementing the recommendations in SAMHSA's Opioid Overdose Prevention Toolkit. Developing policies and procedures ensures that innovations remain part of the routine practice of organizations and sends a clear message about the expectation that efforts will be sustained. Florida's proposal supports collaborative efforts to remove the prior authorization requirement for naloxone, expand the scope of Emergency Medical Technician (EMT) practice to include the ability to carry and administer naloxone, and develop safe prescribing guidelines.

B-3. Describe the stakeholders and resources in the catchment area that can help implement the needed infrastructure development.

Anti-drug coalitions that serve the five urban subrecipient counties, united under the banner of the Florida Coalition Alliance, are experienced with the Strategic Prevention Framework and committed to bringing their partnerships, networks, media platforms, and other resources together in support of this proposal. Licensed treatment providers and members of Florida Alcohol and Drug Abuse Association will assist with the care coordination and training components by recruiting qualified providers and promoting naloxone training events. The Department contracts with Managing Entities to oversee regional networks of subcontracted prevention and treatment providers. Each of the five Managing Entities that have a high-need community under their catchment area employs Prevention Coordinators to manage their prevention service contracts. These Managing Entity Prevention Coordinators will ensure that

[15] Community Anti-Drug Coalitions of America. (2012). *Handbook for Community Anti-Drug Coalitions*; Center for the Application of Prevention Technologies. (2015). *Step 2: Build Capacity*.

[16] Johnson, K., Hays, C., Center, H., & Daley, C. (2004). Building Capacity and Sustainable Prevention Innovations: A Sustainability Planning Model. *Evaluation and Program Planning, 27*, 135-149; Center for the Application of Prevention Technologies. (2015). *Step 2: Build Capacity*; Center for the Application of Prevention Technologies. (2015). *Factors That Contribute to Capacity Building and Sustainability*.

broader networks of contracted prevention providers are connected with training events, new epidemiological findings, process improvement initiatives, and evaluation findings. Additionally, the Department will utilize the DCF Regional Offices to support information dissemination and training within the appropriate areas. Utilizing the Regional Offices will facilitate a broader reach for the statewide campaign to ensure all licensed drug treatment providers receive relevant information, educational materials, and training.

B-4. Identify the proposed prevention priorities to be targeted using SPF-PFS funds, specifying whether the state proposes to target one or both of the selected substance abuse prevention priorities. Explain why you chose this priority, including how prevalence data and other information support your choice.

Florida proposes to target prescription drug misuse among persons aged 12 to 25 and not underage drinking. Despite the fact that alcohol is frequently ranked among the most harmful substances to both users (particularly young users) and society,[17] Florida did not choose underage drinking as a priority for several reasons. First, the Department, prevention providers, and anti-drug coalitions have prioritized reductions in underage drinking in Florida for more than a decade. Activities and strategies intended to reduce underage drinking are the most widely implemented throughout Florida. Underage drinking was also the target priority for the last round of Partnerships for Success grant funding that Florida received. However, it is important to bear in mind that one of the primary purposes of the current funding opportunity is to strengthen capacity and infrastructure in areas where Florida's communities are lacking. With regard to preventing underage drinking, the existing prevention infrastructure and capacity is strong and sustainable relative to the prevention of prescription drug misuse. The prevalence of prescription drug misuse among young people in Florida is alarming. Among high school seniors in Florida, the lifetime prevalence rates for prescription depressant use (7.4%), prescription pain reliever misuse (7.4%), and prescription stimulant misuse (7.5%) are higher than the rates for all illicit drugs except marijuana and synthetic marijuana.[18] According to 2013-2014 Florida-specific estimates from the National Survey on Drug Use and Health, the prevalence of past-year nonmedical pain reliever use is 4.4% among 12-17 year olds and 7.2% among 18-25 year olds.[19] The misuse of prescription pain relievers is particularly dangerous because of the potential for a fatal overdose. In 2014, there were 130 deaths caused by prescription opioids among 12-25 year

[17] Nutt, D., King, L. A., Saulsbury, W., & Blakemore, C. (2007). Development of a Rational Scale to Assess the Harm of Drugs of Potential Misuse. *The Lancet, 369*, 1047-1053; van Amsterdam, J., Opperhuizen, A., Koeter, M., & van den Brink, W. (2010). Ranking the Harm of Alcohol, Tobacco, and Illicit Drugs for the Individuals and the Population. *European Addiction Research*, 16, 202-207. Begg, S., Vos, T., Barker, B., Stanley, L. & Lopez, A.D. (2007). *The Burden of Disease and Injury in Australia 2003*. Canberra: Australian Institute of Health and Welfare; Thomas, G. & Davis, C. (2009). Cannabis, Tobacco, and Alcohol Use in Canada: Comparing Risks of Harm and Costs to Society. *Visions Journal, 5* (4), 11-13; Nutt, D. J., King, L. A., & Phillips, L. D. (2010). Drug Harms in the UK: A Multicriteria Decision Analysis. *The Lancet, 376* (9752), 1558-1565; Lachenmeier, D. W. & Rehm, J. (2015). Comparative Risk Assessment of Alcohol, Tobacco, Cannabis, and Other Illicit Drugs Using the Margin of Exposure Approach. *Scientific Reports, 5*(8126), 1-7.

[18] Florida Department of Children and Families. (2015). 2015 Florida Youth Substance Abuse Survey.

[19] Substance Abuse and Mental Health Services Administration. (2016). *Selected Drug Use Measures in Florida, by Age Group: Percentages, Annual Averages Based on 2013-2014 National Surveys on Drug Use and Health*.

olds in Florida.[20] Prescription opioid misuse is also a serious concern because research indicates that it is an important risk factor for heroin use.[21] Over 77% of people using both opioid pain relievers and heroin in the past year report using opioid pain relievers prior to heroin initiation.[22]

B-5. If you are proposing to use SPF-PFS funds to target an additional, data-driven prevention priority (marijuana, heroin, etc.) in your state: a) Identify the prevention priority and provide prevalence data and other information that support your choice of this priority. b) Explain why you chose this priority over other prevention priorities in your state.

As an additional priority, Florida proposes to target the consequences (overdose) associated with the nonmedical use of opioids, including both prescription opioids and heroin, among individuals ages 26 and older. The nonmedical use of opioids is prioritized over other concerns primarily because of how many people die prematurely from opioid overdoses and to a lesser extent because of the negative impacts on workplace costs, healthcare costs, and criminal justice costs. Drug overdose is now the leading cause of injury-related death in the United States. In 2014, a total of 47,055 deaths in the U.S. were attributed to drug poisoning, and 61% of these involved some type of opioid, including heroin. Since 2000, the rate of deaths from drug overdoses has increased 137%, including a 200% increase in the rate of overdose deaths involving opioids (opioid pain relievers and heroin). In terms of the total number of overdose deaths in 2014, Florida ranked 4th in the nation with 2,634 deaths.[23] More specifically, 1,937 deaths were caused by at least one opioid in 2014. This means that at least five lives per day are lost to opioid overdose in Florida.[24] Approximately 90% of these deaths occurred among our proposed target population of individuals ages 26 and older. Florida-specific increases in relevant mortality rates and comparisons of these rates with national averages and rates from other states also establish a compelling rationale for selecting this priority. From 1999-2014, the national age-adjusted mortality rate for prescription opioid overdoses was 4 per 100,000. Florida's rate of 5.8 deaths per 100,000 individuals exceeds the national average. Florida ranks 14th out of all 50 states and District of Columbia on this measure. Florida's rate more than tripled over this time span, increasing from 1.5 per 100,000 in 1999 to 5.8 per 100,000 in 2014. From 1999-2014, the national age-adjusted mortality rate for opioid drug overdoses (which includes heroin and pharmaceutical opioids) was 5.8 per 100,000. Florida's rate of 6.8 per 100,000 exceeds the national average. Florida ranks 21st out of all 50 states and the District of Columbia on this measure. Florida's rate more than doubled over this time span, increasing from 2.6 per 100,000 in 1999 to 7.2 per 100,000 in 2014.[25]

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[20] Florida Department of Law Enforcement. (2014). *Medical Examiners Commission Report on Drugs Identified in Deceased Persons*.
[21] Centers for Disease Control and Prevention. (2015). *Today's Heroin Epidemic: More People At Risk, Multiple Drugs Abuse*.
[22] Jones, C. M. (2013). Heroin Use and Heroin Use Risk Behaviors among Nonmedical Users of Prescription Opioid Pain Relievers – United States, 2002-2004 and 2008-2010. *Drug and Alcohol Dependence, 132*, 95-100.
[23] Rudd, R. A., Aleshire, N., Zibbell, J. E., & Gladden, M. R. (2016). Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. *MMWR, 64*, 1378-1382.
[24] Florida Department of Law Enforcement. (2013). *Medical Examiners Commission Report on Drugs Identified in Deceased Persons*.
[25] Centers for Disease Control and Prevention. (2015). *1999-2014 Average Death Rates for Opioid Drug Overdose by State*.

Prescription opioid misuse places a substantial economic burden on society. Total societal costs of prescription opioid misuse in the United States were estimated at $55.7 billion in 2007 (with workplace costs accounting for 46%, health care costs accounting for 45%, and criminal justice costs accounting for 9%).[26] Prescription opioid overdoses result in 830,652 years of potential life lost before age 65.[27] Over the past decade, the annual prevalence of diagnosed opioid use disorder more than doubled among both privately insured and Florida Medicaid populations. Researchers compared patients with opioid use disorder and demographically matched controls using privately insured and Florida Medicaid administrative claims data from 2003 to 2007. Patients with OUD and caregivers had greater resource use in both privately insured and Florida Medicaid populations compared with controls. Mean excess annual cost per privately insured patient was $20,546 and mean excess cost per caregiver was $1,010. Mean excess cost per Florida Medicaid patient was $15,183.[28]

From 2003-2009, pain clinics in Florida were prescribing large quantities of drugs for pain with little medical justification, primarily opioid analgesics, benzodiazepines, and muscle relaxants. In 2010, 98 out of the 100 U.S. physicians who dispensed the highest quantities of oxycodone were located in Florida. In response, pain clinical regulations were enacted, law enforcement raids were conducted, and physician dispensing of schedule II or III drugs from their offices was banned. Dispenser reporting to a newly created Prescription Drug Monitoring Program was mandated and additional regulations on wholesale distributors were enacted. Research shows that the implementation of Florida's Prescription Drug Monitoring Program and "pill mill" regulations resulted in a modest decrease in opioid prescriptions, opioid volume, and mean morphine milligram equivalent per transaction.[29] Overdose death rates for opioid analgesics and benzodiazepines also declined as a result.[30] These decreases continued through 2014; however, heroin death rates increased by 462%, suggesting that users responded to the reduced availability of prescription opioids by substituting heroin.[31] As previously noted, the strongest risk factor for heroin addiction is addiction to prescription opioid painkillers. People who are addicted to prescription opioid painkillers are 40 times more likely to be addicted to heroin.[32] Florida's proposal to target prescription drug misuse among individuals ages 12 to 25, with a particular emphasis on the misuse of opioid painkillers, is therefore critical to efforts to reduce heroin use

[26] Birnbaum, H. G., White, A. G., Schiller, M., Waldman, T., Cleveland, J. M., & Roland, C. L. (2011). Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States. *Pain Medicine, 12*, 657-667.
[27] Meyer, R., Patel, A. M., Rattana, S. K., Quock, T. P., & Mody, S. H. (2014). Prescription Opioid Abuse: A Literature Review of the Clinical and Economic Burden in the United States. *Population Health Management, 17*(6), 372-387.
[28] White, A. G., Birnbaum, H. G., Schiller, M., Waldman, T., Cleveland, J. M., & Roland, C. L. (2011). Economic Impact of Opioid Abuse, Dependence, and Misuse. *American Journal of Pharmacy Benefits, 3*(4), e59-e70.
[29] Rutkow, L, Chang, H., Daubresse, M., Webster, D. W., Stuart, E. A., & Alexander, C. (2015). Effect of Florida's Prescription Drug Monitoring Program and Pill Mill Laws on Opioid Prescribing and Use. *JAMA Internal Medicine, 175*(10), 1642-1649.
[30] Johnson, H., Paulozzi, L., Porucznik, C., Mack, K., & Herter, B. (2014). Decline in Drug Overdose Deaths After State Policy Changes – Florida, 2010-2012. *MMWR, 63*(26), 569-574; Kennedy-Hendricks, A., Richey, M., McGinty, E. E., Stuart, E. A., Barry, C. L., & Webster, D. W. (2016). Opioid Overdose Deaths and Florida's Crackdown on Pill Mills. *American Journal of Public Health, 106*(2), 291-297.
[31] Johnson, H. (2015). *An Update on the Decline in Drug Overdose Deaths After State Policy Changes – Florida, 2013*. Presented at the Council of State and Territorial Epidemiologists Annual Meeting in Boston, MA.
[32] Centers for Disease Control and Prevention. (2015). Today's Heroin Epidemic: More People At Risk, Multiple Drugs Abuse.

among individuals ages 26 and older. It is imperative that Florida implement the evidence-based activities in this proposal as soon as possible because research shows that preventive interventions are more effective when implemented during the early stages of an epidemic.[33]

B-6. Provide a brief summary of the state's proposed approach and level of effort to carry out the proposed project that addresses the following components: a) A description of how the state proposes to address the priorities through the work of its subrecipient communities, including its approach for building community infrastructure/capacity to implement effective community-level prevention activities according to the SPF process and your project goals. b) A description of your state's approach and methodology to identify and select communities, including: 1) a list of your selected subrecipient communities; 2) documentation of high need in each proposed community; 3) why these communities were selected over other high-need communities in the state; and 4) your state's approach for considering the needs of tribes and tribal entities as potential communities to receive SPF-PFS funds.

Florida's proposed approach is data-driven, evidence-based, comprehensive, and multifaceted. All of the proposed activities align with recommendations contained in SAMHSA's Opioid Overdose Prevention Toolkit. It is designed to strengthen capacity and infrastructure and yield sustainable results. The Department is fully committed to carrying out this project in partnership with Managing Entities, anti-drug coalitions, treatment providers, and other stakeholders and sustaining the components that are found to be effective. In order to prepare this application, the Department engaged in a rapid, abbreviated, state-level version of the Strategic Prevention Framework. A variety of relevant data sets were compiled and shared with the State Epidemiological Outcomes Workgroup (SEOW) to assess the scope and nature of the problem. A survey was developed and disseminated to prevention providers throughout the state to assess needs, resources, and gaps/weaknesses in current infrastructure and capacity. The scientific literature was reviewed to identify evidence-based strategies that will most likely produce the desired outcomes. Implementation and evaluation details and plans were developed to the greatest extent possible given the short timeframe. Upon receipt of the award, Florida will build community infrastructure and capacity by providing training to enhance the knowledge, skills, and abilities of the workforce; facilitating collaboration from a diverse range of stakeholders; promoting and championing initiatives through leadership; and implementing policies and procedures that remove structural barriers to implementation and support sustainability. Improving Florida's data infrastructure is essential to helping subrecipient communities properly assess the nature and scope of their prescription drug misuse and nonmedical opioid use problems. In order to identify and select several urban communities of high-need, four county-level data sets were obtained and analyzed by the SEOW.

Prevalence rates of past 30-day misuse of any prescription drug among Florida's middle and high school students were obtained from the 2014 Florida Youth Substance Abuse Survey (FYSAS). This tells us a big part of the picture for our target priority of individuals ages 12-25 because it includes students whose ages mostly range from 12-18. There are a few FYSAS respondents that

[33] Winkler, D., Caulkins, J. P., Behrens, D. A., & Tragler, G. (2004). Estimating the Relative Efficiency of Various Forms of Prevention at Different Stages of a Drug Epidemic. *Socio-Economic Planning Sciences, 38,* 43-56.

are younger than age 12 (less than 2% of the individuals from this dataset) and a few respondents that are age 19 or older (also less than 2% of the individuals from this dataset). Prevalence of past-year nonmedical use of prescription pain relievers among individuals ages 18 and older was obtained from the 2010 Behavioral Risk Factor Surveillance System (BRFSS). It should be noted that these prevalence rates technically straddle both of our target populations. These figures reflect prescription opioid misuse among individuals ages 18-25 and prescription opioid misuse use among individuals ages 26 and older. No attempt was made to separate these two age-specific priority populations because doing so would have reduced the precision of the estimates at the county level. Despite the fact that these estimates are 6 years old, they were included in this assessment because they are the only self-reported estimates available for individuals ages 18 and older (aside from the state-level estimates from NSDUH, which are only available at the substate-level and not the county-level). Admissions to treatment for the primary drug of choice of a prescription drug among individuals ages 12 to 25 and admissions to treatment for the primary drug of choice of an opioid (including both prescription opioids and heroin) among individuals ages 26 and older were obtained from the Department's treatment admission records for FY 12-13, FY 13-14, and FY 14-15 combined. The number of individuals ages 12-25 whose death was caused by at least one prescription opioid and the number of individuals ages 26 and older whose death was caused by at least one opioid (including both prescription opioids and heroin) were derived from the 2014 master dataset used by the Florida Medical Examiners Commission to populate the "Drugs Identified in Deceased Persons by Florida Medical Examiners" report.

The SEOW recommended that the Department sort all urban counties from highest value to lowest value and then assign a positional rank to each county. The county with the highest value on any given indicator would receive a score of 1, the second highest county would receive a score of 2, the third highest county would receive a score of 3, and so on. Counties with identical values received the same positional rank score. At the end of this process, scores for each county, across all the relevant measures, were tabulated. Counties with low summary scores were considered to be in high-need. The top five urban counties are 1) Broward, 2) Duval, 3) Palm Beach, 4) Hillsborough, and 5) Manatee. Florida's 30 rural counties were analyzed and ranked separately from the 37 urban counties. Only the FYSAS estimates of the past 30 day prevalence of prescription drug misuse were used to rank order these rural counties because the FYSAS estimates are more precise than the BRFSS estimates for these sparsely populated areas and because the frequency of deaths and treatment admissions are too low to help reveal meaningful variation from county to county. The top three rural counties are 1) Franklin, 2) Washington, and 3) Walton. These high-need communities were also selected because of their limited resources, infrastructure, and capacity to address the identified priorities. SAMHSA's Opioid Overdose Prevention Toolkit is only being utilized by two high-need communities (Duval and Broward). Furthermore, only two out of the eight high-need communities identified have a functioning local Drug Epidemiology Network, which are needed to help community stakeholders gain a comprehensive understanding of local consumption patterns, consequences, risk and protective factors, and contributing conditions.

B-7. Briefly summarize the state's ability to provide adequate support and guidance to your subrecipient communities to implement the proposed project, with respect to each of

the following SPF-based components: assessment, capacity building, planning, implementation, and evaluation.

Florida is capable of supporting and guiding subrecipient communities through the assessment and evaluation phases using the expertise and resources of the Drug Policy Advisory Council and the State Epidemiological Outcomes Workgroup. The Office of Substance Abuse and Mental (SAMH), as the Single State Authority in these domains, also contributes in-kind support services. Members of the Data Team and Quality Improvement Team will provide assistance that enhances assessment and evaluation activities. Support for planning, implementation, and capacity building, including components involving training, revisions to policies and procedures, and leveraging other funding streams for sustainability, will also come from the key project staff, the Council and Workgroup previously mentioned, and additional, ancillary project support at the Office SAMH headquarters in Tallahassee, Florida and within the five Managing Entities that oversee regional networks of prevention and treatment service providers on behalf of the Department. For example, SAMH staff currently manages contracts with the Florida Alcohol and Drug Abuse Association and Florida Certification Board for training and technical assistance and also frequently utilize free technical assistance provided by the Center for the Application of Prevention Technologies. This makes them well-positioned to help align workforce development plans and leverage other funding sources. The Department's Substance Abuse and Mental Health Block Grant Coordinators, Policy Team, Quality Improvement Team, and the Managing Entities' Prevention Coordinators all have strategic planning experience and resources that will be used to guide implementation and ensure the sustainability of efforts.

B-8. Provide a chart or graph depicting a realistic time line for the entire 5 years of the project period showing dates, key activities, and responsible staff. These key activities should include the requirements outlined in Section I-2: Expectations.

Key Activities	Responsible Staff	First 60 Days	Year 1	Year 2	Year 3	Year 4	Year 5
Opioid Overdose Prevention Awareness Campaign	Project Director, Grant Coordinator		x	x	x	x	x
School-Based Prevention Programs	Project Director, Grant Coordinator		x	x	x	x	x
Care Coordination Pilot Program	Project Director, Grant Coordinator, Epidemiologist, Lead Analyst			x	x	x	x
PDMP System Enhancements	Project Director, Grant Coordinator		x				
Local Drug Epidemiology Network Development	Lead Epidemiologist, Lead Analyst, Grant Coordinator		x	x	x	x	x

DENs and SEOW Analyses	Lead Epidemiologist, Lead Analyst	x	x	x	x	x	x
Behavioral Health Disparities Impact Statement	Project Director, Grant Coordinator, Lead Epidemiologist	x					

B-9. Describe how the proposed activities will adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (go to http://ThinkCulturalHealth.hhs.gov). Select one element of each of the CLAS Standards: 1) Governance, Leadership and Workforce; 2) Communication and Language Assistance; and 3) Engagement, Continuous Improvement, and Accountability, and specifically describe how these activities will address each element you selected.

CLAS standard #4 calls for education and training for the workforce in culturally and linguistically appropriate policies and practices. In order to adhere to this standard, all training and educational content produced in support of this proposal will be subject to the review and approval of Florida's Cultural and Linguistic Competency Committee. The Committee will be charged with ensuring that all proposed content is culturally and linguistically appropriate. Furthermore, the Director of Florida's System of Care grant and all 40 members of the Cultural and Linguistic Competency Committee have the capacity to provide training to PFS staff and subrecipients. The Project Director will work with the Director and the Committee to develop CLAS training content that is tailored to the goals, objectives, and target priorities of this project. CLAS standard #8 requires the provision of easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in our service areas. The Department will obtain the services of certified translators to ensure that all print and multimedia materials are offered in the languages used by the target populations in the subrecipient communities. CLAS standard #10 calls for the ongoing assessment of CLAS-related activities and the integration of CLAS-related measures into measurement and continuous quality improvement activities. The Project Director will work with the Cultural and Linguistic Competency Committee on the development of questions that will be included in consumer satisfaction surveys. These questions will help the Project Director and Lead Evaluator identify any strengths and weaknesses in the services provided from the perspective of cultural and linguistic competence. These consumer satisfaction surveys will be used to inform the Continuous Quality Improvement process that will be implemented under this proposal.

B-10. Describe your project's Advisory Council, its membership, roles, functions, and frequency of meetings. Briefly describe how the state's existing or proposed Advisory Council, SEOW (or other data-driven epidemiological workgroup), and Evidence-based Programs (EBP) Workgroup will work together to assist funded communities to achieve the goals of the proposed project, including how your EBP Workgroup will work with your subrecipient communities to help them select and monitor their EBPs.

The Advisory Council for this project will be the Statewide Drug Policy Advisory Council (DPAC), located within the Florida Department of Health. The Surgeon General is the chairperson, though he has designated this role to Dr. Jennifer Bencie, the Administrator for the

Department of Health in Manatee County, one of the five urban counties identified as having a high need for the activities in this proposal. DPAC is statutorily required to meet at least four times a year. Among other things, DPAC is also statutorily required to conduct a comprehensive analysis of the problem of substance use disorder and make recommendations to the Governor and Legislature for developing and implementing a state drug control strategy. DPAC also makes recommendations to the Governor and Legislature on funding substance use services and on changes in law which would remove barriers to the implementation of a comprehensive state drug control strategy. DPAC is also tasked with ensuring there is a coordinated, integrated, and multidisciplinary response to the substance use problem in Florida, with special attention given to creating partnerships within and between the public and private sectors, and to the coordinated, supported, and integrated delivery of multiple-system services for people with substance use disorder, including a multiagency team approach to service delivery. DPAC is required to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, each year, which contains a summary of the Council's work and the Council's recommendations. The 19 officials appointed to serve on DPAC represent relevant executive level agencies, all three branches of government, and multiple sectors of the community. Members are also required to have expertise in law enforcement, prevention, treatment, and faith-based services. As the attached letter of commitment from the Chair of DPAC indicates, a standing agenda item at each of DPAC's quarterly meetings will be devoted to a briefing from the key project staff (including leaders of the State Epidemiological Outcomes Workgroup and the Evidence-Based Practice Workgroup), a question and answer session, and the consideration of recommendations from the Council members. The Department of Health and Department of Children and Families staff members that provide administrative support to DPAC are also tasked with facilitating this collaboration. The Department of Children and Families also commits 6 staff members to serve on an Evidence-Based Practice (EBP) Workgroup. These members are drawn from the Clinical Team, Discretionary Grant Team, and Office of Suicide Prevention within the Department's Office of Substance Abuse and Mental Health. The EBP Workgroup meets monthly and is tasked with reviewing and expanding the EBP matrix developed by the Substance Abuse and Mental Health Program Office. The EBP matrix will be updated with current research related to the priority populations and strategies associated with the PFS project. Members of the EBP Workgroup will also draft and disseminate guidance documents that are tailored to help subrecipient communities select, implement, and evaluate culturally-competent policies, programs, and practices.

B-11. Identify any SAMHSA grantees from Cooperative Agreements for Tribal Behavioral Health and/or State-Sponsored Youth Suicide Prevention and Early Intervention in your state or tribal entity. Describe their roles and responsibilities and demonstrate their commitment to the project. Describe how you will consider the effects of substance misuse and its potential linkages to suicide in the assessment, planning, and implementation tasks you propose in your project. Explain how your approach will help ensure that substance abuse prevention efforts and suicide prevention efforts are more closely aligned and better coordinated. Describe how you plan to collaborate and coordinate with these grantees and their local level prevention and clinical service providers (including those working in health, mental health, and substance abuse) trained to assess, manage, and treat youth at risk for suicide. Include letters of commitment from these organizations in Attachment 1 of

your application. If there are no such grantees in your state, include a statement to that effect.

The Department solicited input from the Director of the Statewide Office for Suicide Prevention and the Florida Suicide Coordinating Council on ways to ensure that substance use prevention and suicide prevention efforts are more closely aligned and better coordinated. Client-specific utilization data will be obtained from community mental health centers, drug treatment providers, State Mental Health Treatment Facilities, hospitals, prisons, and jails. The analysis will be used to identify training needs and service gaps and to plan and build support for Zero Suicide initiatives in Florida. Other states have demonstrated the value of analyzing patterns of service utilization prior to attempted and completed suicides.[34] The epidemiologist that completes this analysis will also serve on the SEOW and be tasked with developing data sharing agreements as needed.

B-12. Describe how you intend to leverage prevention funds and other resources (including, for states, the prevention set-aside of the Substance Abuse Prevention and Treatment Block Grant) at the state, tribal, and community levels to support SPF-PFS project goals.

Lessons learned from this project and evidence of the effectiveness of these initiatives will help justify the utilization of other sustainable funding streams. For example, Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds can be used to support overdose prevention initiatives. Primary prevention set-aside funds may be utilized to support overdose prevention education and training. Block Grant funds (other than primary prevention set-aside funds) will be utilized to purchase and distribute naloxone to individuals at risk of witnessing or experiencing an overdose. Block Grant funds can also be used to sustain outreach and care coordination efforts for victims of overdoses who are hospitalized. The Department is prepared to commit Block Grant funds for these purposes in the future if this PFS project establishes the infrastructure and demonstrates positive outcomes. The Project Director will be responsible for spearheading plans for sustainable funding through the Block Grant, Florida's Indigent Drug Program, Medicaid, charitable foundations, and other discretionary grant opportunities.

B-13. Describe how the proposed project will address the following issues in your catchment area:

- **Demographics – race, ethnicity, tribe, religion, sexual orientation, gender identity, age, geography, and socioeconomic status;**
- **Language and literacy;**
- **Disability; and**
- **The needs of veterans and military families, if applicable, in selected subrecipient communities. If veterans and/or military families are not part of your population of focus, indicate so in your response.**

Veterans and military families are not part of Florida's population of focus. Florida's behavioral health surveillance systems do not provide information on sexual orientation or gender identify,

[34] Suicide Prevention Resource Center. (2015). *Surveillance Success Stories: Kentucky*; Suicide Prevention Resource Center. (2015). *Surveillance Success Stories: Vermont*.

impeding the ability to identify disparities in access and other potential issues. Nonetheless, every effort will be made to ensure that all project activities and services align with Department's mission to protect the most vulnerable and the Department's values of tolerance and respect. Florida's project will address language and literacy concerns by ensuring that all communication is culturally competent and adheres to plain language guidelines. Training and educational content produced in support of this proposal will be reviewed and improved by Florida's Cultural and Linguistic Competency Committee. The Project Director will also work with the Cultural and Linguistic Competency Committee on the development of questions that will be included in consumer satisfaction surveys. These questions will help the Project Director and Lead Evaluator identify any strengths and weaknesses in the services provided from the perspective of cultural and linguistic competence.

Compared with adolescents who reside in urban/large metropolitan areas, those in rural/non-metropolitan areas are significantly more likely to have ever used prescription pain relievers or tranquilizers nonmedically, even after controlling for sociodemographics, health, and other lifetime drug use.[35] Florida's project will address the intersection of poverty and rurality by supporting evidence-based prevention in schools located in the high-need counties identified. These school-based prevention programs will address multiple risk and protective factors germane to youth in economically disadvantaged, rural settings. Research shows that the drug overdose burden is 45% higher in rural areas than it is in urban areas and that rural communities are disproportionately affected by underutilization of naloxone.[36] According to the CDC, overdose disparities can be reduced by ensuring that the scope of practice for EMTs is broad enough to allow them to administer intranasal or intramuscular naloxone.[37] In Florida, regional protocols may grant some EMTs in Florida access to naloxone, but some protocols currently do not mention naloxone, depriving these EMTs of access to this life-saving medication.

The Project Director will coordinate with the Florida Department of Health, the Florida College of Emergency Physicians, and the Florida Association of EMS Medical Directors to assess access to naloxone among emergency personnel throughout the state. The Project Director will collaborate with the Florida College of Emergency Physicians to conduct a needs assessment among all EMS medical directors in Florida in order to determine the EMS agencies that do not currently carry naloxone. The Project Director will collaborate with the Statewide EMS Medical Director to publish a statewide model protocol regarding naloxone for paramedics and EMTs. Once drafted, the Project Director will work with the appropriate EMS agencies to encourage each EMS medical director to adopt the model protocol for naloxone in order to facilitate access among paramedics and EMTs that do not currently carry it.

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[35] Havens, J. R., Young, A. M., Havens, C. E. (2011). Nonmedical Prescription Drug Use in a Nationally Representative Sample of Adolescents. Archives of Pediatrics and Adolescent Medicine, 165(3), 250-255.
[36] Faul, M., Dailey, M. W., Sugerman, D. E., Sasser, S. M., Levy, B., & Paulozzi, L. J. (2015). Disparity in Naloxone Administration by Emergency Service Providers and the Burden of Drug Overdose in US Rural Communities. *American Journal of Public Health, 105*(S3), 26-32.
[37] American Public Health Association, Public Health Newswire. (2015). *Q&A with CDC Researcher, Mark Faul: Disparities in Naloxone Administration*.

C-1. Discuss the capability and experience of the applicant organization with similar projects and populations, including experience in providing culturally appropriate/competent services.

The Department's Office of Substance Abuse and Mental Health, as the Single State Authority for behavioral health, has considerable experience gained by implementing previous Strategic Prevention Framework and Partnerships for Success grants from the Center for Substance Abuse Prevention. The Office of SAMH prevention staff and State Epidemiological Outcomes Workgroup members are trained and experienced in the use of the Strategic Prevention Framework, which is the principle paradigm applied to the primary prevention set-aside dollars from SAMHSA's Substance Abuse Prevention and Treatment Block Grant. The Office of SAMH also has a considerable amount of prior experience with prevention projects of this nature gained through the implementation of previous Strategic Prevention Framework State Incentive and Enhancement grants, the Enforcing Underage Drinking Laws grant, the Collegiate Success Initiative grant, and the Partnerships for Success grant. The Project Director will utilize the administrative support structure and shared service arrangements available to a team of discretionary grant staff. One of the discretionary grants supported by the Office of SAMH is the Children's Mental Health System of Care Expansion and Implementation grant. This grant helped facilitate Florida's Cultural and Linguistic Competency Committee and a statewide network of Cultural and Linguistic Competency coordinators that are capable of providing tailored guidance and technical assistance on cultural and linguistic competency.

C-2. Discuss the capability and experience of other partnering organizations with similar projects and populations, including experience in providing culturally appropriate/competent services. If you are not partnering with any other organizations, indicate so in your response.

The Department's Managing Entities have the capability and experience needed to incorporate contract language improvements for sustainability, leverage funding streams, support training and technical assistance initiatives, and incorporate findings into regional needs assessments, in addition to procuring some services on the behalf of the Department. The Department will also partner with the Florida Alcohol and Drug Abuse Association (FADAA) to promote the training activities and recruit treatment providers to participate in overdose prevention training, as well as the care coordination activities designed to link overdose victims to behavioral health services after they are discharged from emergency departments. FADAA is a non-profit association that represents over 100 substance use prevention and treatment providers throughout Florida. FADAA's staff members are well-trained, culturally competent professionals who represent and respect Florida's diversity. The capable and experienced staff they bring to the table include a Director of Prevention, Director of Marketing and Communications, Director of Training and Events, Director of Research and Practice Improvement, and a Director of Legislative Affairs. The Project Director will collaborate with FADAA on any changes that need to be made to rules, regulations, and statutes in order to facilitate implementation and ensure the sustainability of these efforts.

Training and educational content produced in support of this proposal will be reviewed and improved by Florida's Cultural and Linguistic Competency Committee, which is currently

supported by the System of Care grant that the Department administers. The Project Director will also work with the Cultural and Linguistic Competency Committee on the development of questions that will be included in consumer satisfaction surveys. These questions will help the Project Director and Lead Evaluator identify any strengths and weaknesses in the services provided from the perspective of cultural and linguistic competence. The Department's Office of Civil Rights and Contract Unit also help ensure that all contracted service providers participating in this project are culturally and linguistically competent through compliance reviews and monitoring.

C-3. Provide a complete list of staff positions for the project, including the Project Director, SEOW data analyst, and other key personnel, showing the role of each and their level of effort and qualifications. Demonstrate successful project implementation for the level of effort budgeted for the Project Director and key staff.

The proposed Project Director is Amanda Muller (level of effort: 20%; all in-kind). Her qualifications include a Bachelor of Science degree in psychology and six years of relevant experience. Her role entails overall project oversight and management to ensure that goals and objectives are met, strategic planning, leading policy change initiatives, leveraging other funding streams, providing training and technical assistance, implementing quality improvement initiatives, and ensuring compliance with all aspects of the terms and conditions of the award.

A competitive hiring process will be used to select a qualified Evaluator (level of effort: 100%). In order to qualify, the Lead Evaluator will be required to have a master's in epidemiology or a related field and at least 3 years of relevant experience. The role of the Lead Evaluator entails designing and implementing a comprehensive evaluation plan; overseeing data collection at the state level and community level; developing surveys and other instruments that inform quality improvement initiatives; drafting quarterly progress reports, annual reports, and ad-hoc reports; and assisting with the identification of TA and training needs.

A competitive hiring process will be used to select a qualified Lead Epidemiologist (level of effort: 50%). In order to qualify, the Lead Epidemiologist will be required to have a master's degree in epidemiology or a related field and at least three years of relevant experience. The role of the Lead Epidemiologist entails co-chairing the State Epidemiological Outcomes Workgroup, developing reports to inform strategic planning and evaluation activities, critical review of all PFS-funded research reports and analyses, management and development of local Drug Epidemiology Networks, and advising other key staff and subrecipients regarding surveillance data.

The Lead Analyst, Jim Hall (level of effort: 50%; all in-kind). His qualifications include a bachelor's degree and over 30 years of experience in surveillance epidemiology of substance use. The Lead Analyst's role entails co-chairing the State Epidemiological Outcomes Workgroup, conducting analyses that support PFS-related planning and evaluation activities, and assisting with the development of local Drug Epidemiology Networks.

A competitive hiring process will be used to select a qualified Grant Coordinator (level of effort: 100%). In order to qualify, the Grant Coordinator will be required to have a bachelor's degree in

a social science field or evidence of enrollment in such a program. The Grant Coordinator's role entails assisting the Project Director with planning and coordinating project services and activities, coordinating meetings for key project staff and the State Epidemiological Outcomes Workgroup, conducting preliminary reviews of contracted deliverables, preparing and processing draft reports for review and approval by leadership, and assisting with the compilation and submission of data.

C-4. Discuss how key staff has demonstrated experience and are qualified to develop the infrastructure for the population(s) to engage in activities and are familiar with their culture(s) and language(s).

In her previous role as Harm Reduction Coordinator for the North Carolina Harm Reduction Coalition, the Project Director, Amanda Muller, assisted with the development of infrastructure needed to implement community-based naloxone distribution. Ms. Muller provided naloxone training to law enforcement officers, drug treatment providers, and clients receiving methadone and counseling services. She conducted street outreach and provided overdose prevention education and naloxone training to people who use drugs, their friends and families, people engaged in sex work, people living with HIV and hepatitis C, and individuals in jails and prisons. She helped distribute over 1,000 naloxone kits in the community and documented hundreds of overdose reversals over the course of one year. She helped implement a peer education and naloxone distribution model that empowered current and former drug users to become volunteers and provide harm reduction services to marginalized and stigmatized users in the community. In her previous role as Project Coordinator for the CDC's Expanded HIV Testing Initiative at the Florida Department of Health, Ms. Muller provided comprehensive training and technical assistance to over 600 HIV provider staff members on the use of various HIV testing technologies and best practices for implementing and evaluating HIV counseling and testing programs.

The Lead Analyst on this project, James Hall, has been actively involved in surveillance epidemiology of substance use disorder at the community, state, national, and international level for the past 31 years. He served as the Florida representative to the National Institute on Drug Abuse (NIDA) Community Epidemiology Work Group from 1985 until 2014 when he became a founding member of the NIDA National Drug Early Warning System (NDEWS). Hall is the one of 12 Sentinel Site Epidemiologist for the NDEWS and serves on its Scientific Support Group. Hall's lectures, conference presentations, workshops, and webinars are provided to many diverse audiences including community substance abuse prevention and treatment professionals, law enforcement officers, state administrators, paramedics, physicians, and the general public. As senior epidemiologist for the Center for Applied Research on Substance Use and Health Disparities at Nova Southeastern University, he has contact with fellow staff members engaged in ethnographic studies of active drug users. Hall created the model for a community Drug Epidemiology Network and has focused his work over the past three decades on converting research data to actionable information.

The Lead Epidemiologist for the Florida PFS project is Stephanie Moody-Geissler. Stephanie Moody-Geissler has her Bachelors in Microbiology and her Master's in Public Health /

Epidemiology with a focus on infectious disease and global health. She has been a member of response teams coordinated by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) related to Ebola outbreaks in Sierra Leone. She has also worked for the Bureau of Epidemiology at the Florida Department of Health as the Vector-Borne Disease Surveillance Coordinator and their Infectious Disease Regional Epidemiologist. She has a personal interest and focus in developing harm reduction services for people who use drugs.

The Department advertised for a PFS Grant Coordinator and hired Miranda Gottlieb in this position in December 2016. Ms. Gottlieb holds a B.A. in Political Science and Hispanic Studies. Her experience includes an internship in epidemiology with the New Mexico Department of Health, public policy work with the U.S. House of Representatives and Senate, and several years of experience working in drug policy and harm reduction. She has experience conducting naloxone training sessions for community members and has worked in health promotion on her college campus and within her community. Ms. Gottlieb is a fluent Spanish speaker and has experience working with Latin American communities.

D-1. Document your ability to collect and report on the required performance measures as specified in Section I-2.3 of this FOA.

The Department has the ability to collect and report all of the required data. The Department will ensure that the service contracts contain all necessary data collection and reporting requirements. The process measures at the state level will be incorporated into service contracts and compiled by the Project Director. The process measures at the subrecipient-level are already built into Florida's Performance Based Prevention System (PBPS) and with small enhancements, PFS staff will be able to monitor activities of the DENs and school-and family-based prevention program activities. Subrecipients will be contractually required to upload all subrecipient-level data into this system. Key project staff will have the ability to extract this data for reporting as needed. Florida can report on all of the measures in Table 1 of the FOA (Required State and Community Level Outcome Data). As a participant in the National Survey on Drug Use and Health, Florida-specific estimates are available for past 30-day alcohol use, binge drinking, and prescription drug misuse. Florida-specific NSDUH estimates are also available for measures of perceptions of parental and peer disapproval, perceived harm, and family communication around drug use.

Florida also submits data on alcohol- and drug-related traffic crashes, injuries, and fatalities to the National Highway Traffic Safety Administration through the Florida Department of Highway Safety and Motor Vehicles. District level alcohol- and drug-related suspensions and expulsions are currently captured in the Florida Department of Education's School Safety Incident Report and Discipline Data. Alcohol- and drug-related crime data are submitted by law enforcement agencies throughout Florida to the Florida Department of Law Enforcement (FDLE). FDLE in turn submits these data to the Federal Bureau of Investigation for inclusion in annual Uniform Crime Reports. Finally, alcohol- and prescription-drug-related emergency room visits throughout Florida are captured in the Department of Health's Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE). Florida's ESSENCE surveillance system collects emergency department data from participating hospitals and urgent care centers throughout Florida. This also includes call data from the Florida Poison Information Center Network.

Past 30-day prescription drug misuse is measured at the state and community levels using the Florida Youth Substance Abuse Survey (FYSAS). The FYSAS produces estimates for individuals ages 12 to 18, leaving a gap in data with regard to the portion of the target population that falls within the age range of 18 to 25. Past 30-day prescription drug misuse estimates for individuals ages 18 to 25 are available at the state and substate/regional level from the NSDUH. Perceived peer disapproval, perceived parental disapproval, and perceived harm of prescription drug misuse are also measured at the state and county levels for individuals ages 12 to 18 using the FYSAS.

Again, this leaves a gap in data with regard to the portion of the target population that falls within the age range of 18 to 25 at the county level. Perceived peer disapproval, perceived parental disapproval, and perceived harm of prescription drug misuse among individuals ages 18 to 25 at the state and substate/regional levels will need to be obtained from the NSDUH. If a NSDUH measures captures family communication specific to prescription drug misuse, this will need to be obtained from SAMHSA at the state and substate/regional levels. In order to obtain this information at the county level, the Department plans to add a new question to the FYSAS that mirrors the NSDUH measure on family communication, but with a specific focus on communication about prescription drug misuse.

Florida is targeting the consequences, mainly overdose, associated with nonmedical opioid use among individuals ages 26 and older as our additional prevention priority, which means that Florida must report one required annual community-level outcome measure for this priority. A question will need to be added to the BRFSS to capture past 30-day nonmedical opioid use among individuals ages 26 and older at the county level. County level BRFSS estimates are only produced every three years, which means that the next opportunity to document this measure will be in 2019.

The Project Director, Lead Evaluator, and State Epidemiological Outcomes Workgroup will explore different ways of obtaining this information on a more frequent basis. Although Florida is not selecting underage drinking as a priority, SAMHSA still requires each of the subrecipient communities to report three measures related to underage drinking among persons aged 12 to 20. Consumption will be measured and reported using the past 30-day prevalence of drinking question from the Florida Youth Substance Abuse Survey (FYSAS). The FYSAS will also be used to measure and report the percentage of students that perceive great risk of harm from having five or more drinks of alcohol as the intervening variable. With regard to a consequence measure, the prevalence of "blacking out" will also be measured and reported using an FYSAS question that asks, "On how many occasions (if any) in your lifetime have you woken up after a night of drinking alcoholic beverages and not been able to remember the thing that you did or place that you went?"

D-2. Describe your specific plan for data collection, management, analysis, and reporting of data for the population served by your infrastructure program. The data collection plan must specify the staff person(s) responsible for tracking the measureable objectives that are identified in your response to question B1.

State- and community-level process and outcome measures will be collected by the Lead Evaluator using specially designed survey instruments and reporting templates. The Grant Coordinator will be responsible for reporting data through SAMHSA's online reporting platform. The Grant Coordinator will report progress data quarterly, state- and community-level process data semi-annually (in May and November), and state- and community-level outcome data annually. The Project Director will be responsible for tracking the measurable objectives identified in response to question B1. The Project Director, Lead Evaluator, Lead Epidemiologist, and Lead Analyst will review and analyze the performance data on a quarterly basis. The Project Director will be responsible for addressing all recommendations from the Lead Evaluator, Lead Epidemiologist, Lead Analyst, and Drug Policy Advisory Council on ways to improve data collection and performance. The Project Director will also be responsible for responding to the feedback from the SAMHSA's Government Project Officer in response to the progress reports.

D-3. Describe your plan for conducting the local performance assessment as specified in Section I-2.4 of this FOA and document your ability to conduct the assessment.

The Department will contract with an independent Lead Evaluator who will answer the outcome and process questions outlined in the FOA and other questions that have been tailored to assess unique components of this proposal. The Project Director, Lead Evaluator, Lead Epidemiologist, and Lead Analyst will collectively review and analyze performance data on a quarterly basis. Quarterly reports will contain updates on progress achieved, barriers encountered, and efforts to overcome these barriers. The Project Director and Lead Evaluator will assess progress and share findings with the Drug Policy Advisory Council on a quarterly basis. Recommendations will be solicited from SAMHSA's Government Project Officer and Drug Policy Advisory Council on ways to improve the management of the grant, improve the quality of the services provided, and overcome any barriers encountered. The Project Director will be responsible for carrying out the recommendations. The Project Director and Lead Epidemiologist will comply with the requirements of the cross-site evaluation. The quarterly progress reports, which will undergo a team-based review to help drive quality improvement initiatives and strategic realignment, are one component of the cross-site evaluation. The Project Director will also participate in the three interviews that are required in February and June. The Project Director, Grant Coordinator, and Lead Evaluator will ensure that the reporting instruments being developed by SAMHSA are accurately completed and submitted by the dates specified in the cross site evaluation reporting schedule.

D-4. Describe the quality improvement process that will be used to track whether your performance measures and objectives are being met, and how any necessary adjustments to the implementation of the project will be made.

The Department will use the Network for Improving Addiction Treatment (NIATx) model of process improvement. This model uses principles and factors that have been found to consistently influence efforts to overcome barriers to process improvement. Understanding the needs of the individuals served and involving them in the improvement process is one of these principles. The Lead Evaluator and Project Director will develop satisfaction surveys to be completed by trainers, trainees, users of the Prescription Drug Monitoring Program, overdose

victims that receive care coordination services, youth engaged in school-based interventions, and other relevant stakeholders. The Lead Evaluator will analyze and summarize these surveys for the Project Director and SAMHSA's Government Project Officer who will collaborate on the identification of quality improvement initiatives that address any weaknesses. Program data documenting disparities in access, use, and outcomes will also be incorporated into the quality improvement process. Examining ideas and practices from other fields and organizations is another component of the NIATx model that will be incorporated into the quality improvement process. Findings from progress reports, evaluations, and consumer satisfaction surveys will be summarized and shared with the Drug Policy Advisory Council (DPAC). Finally, rapid-cycle testing of quality improvement ideas on a small scale will be used to help the Project Director develop effective changes prior to expanding them or making them permanent.

D-5. Specify the data sources you plan to use for meeting federal data requirements.

Florida will use the following data sources, previously described and discussed, for meeting federal data requirements: DCF's Florida Youth Substance Abuse Survey, SAMHSA's National Survey on Drug Use and Health, the CDC's Behavioral Risk Factor Surveillance System, the Florida Department of Highway Safety and Motor Vehicles' traffic crash reports, the Florida Department of Educations' School Safety Incident Report and Discipline Data report, the Florida Department of Law Enforcement's Uniform Crime Reports, and the Department of Health's Electronic Surveillance System for the Early Notification of Community-based Epidemics database.