

## **FLORIDA'S OPIOID STATE TARGETED RESPONSE PROJECT**

### **ABSTRACT**

Florida's Opioid State Targeted Response Project is designed to address the opioid crisis by providing evidence-based prevention, medication-assisted treatment, and recovery support services. The four goals of this proposal include reducing opioid-related deaths, preventing prescription opioid misuse among young people, increasing the number of individuals trained to provide medication-assisted treatment and recovery support services, and increasing access to medication-assisted treatment among individuals with opioid use disorders.

Middle and high school students in high-need rural counties will receive school-based life skills training proven to prevent prescription opioid misuse. Funds will also be used to purchase and distribute naloxone, an opioid overdose antidote proven to reduce opioid overdose deaths.

Uninsured and underinsured individuals with opioid use disorders will be targeted to receive medication-assisted treatment, recovery support, and overdose prevention services. The majority of the funding will be used for methadone maintenance and buprenorphine maintenance because controlled trials demonstrate that these services are most effective at retaining individuals in care, reducing illicit opioid use, and reducing opioid-related mortality. Funds will also be used for an extended release formulation of naltrexone that blocks the effects of opioids and is approved for the prevention of relapse to opioid dependence. Hospital-based pilot programs will seek to initiate buprenorphine assisted treatment with individuals who have overdosed on opioids and coordinate ongoing care with community-based providers. Preliminary and conservative estimates indicate that funds can be used to serve at least 2,789 individuals during the first year and a total of 5,578 individuals over the two-year project period. Funds will also be used provide training and technical assistance on medication-assisted treatment and recovery support services to a variety of stakeholders, including potential prescribers, peers in recovery, child welfare staff, and court staff, among others. The American Society of Addiction Medicine's computerized structured interview and clinical decision support tool will also be piloted by providers.

A competitive hiring process will be used to select a full-time Project Director who will be responsible for overall project oversight and management to ensure that goals and objectives are met, strategic planning, tracking measurable objectives, implementing quality improvement initiatives, and ensuring compliance with all aspects of the terms and conditions of the award. An epidemiologist will assist with data analysis, develop reports to inform strategic planning and evaluation activities, critically review grant funded reports and analyses, and advise key project staff and subrecipients regarding surveillance data. Qualified peer specialists will be employed in six regions to assist with regional needs assessments, conduct quality assurance visits with providers, and manage activities related to the development of recovery-oriented systems of care. Behavioral Health Consultants will train and assist child protective investigators.

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**A-1. Identify your communities of focus at highest risk for OUD. Provide a comprehensive demographic profile of this population in your local area in terms of race, ethnicity, federally recognized tribe (if applicable), language, sex, gender identity, sexual orientation, age, rural/urban population, and socioeconomic (including insurance) status.**

There are two populations of focus for this proposal. The first is middle and high school students in rural counties with the highest prevalence of nonmedical opioid use for that age group, to be targeted for primary prevention programs. The second is individuals with opioid use disorders to be targeted for treatment and overdose prevention resources. In order to direct limited resources for the second group and obtain greatest impact, the following individuals who misuse opioids should be prioritized for services. This is not meant to imply that other individuals are ineligible for services.

- Pregnant women who are injecting opioids;
- Pregnant women;
- Caretakers involved with child welfare;
- Caretakers of children ages 0-5;
- Individuals re-entering the community from incarceration.

The Florida Department of Children and Families (DCF) contracts with seven Managing Entities (MEs) for the administration and management of regional behavioral health systems of care. MEs are private, non-profit organizations responsible for overseeing contracts with local service providers for the provision of prevention, treatment, and recovery support services. The table below identifies each ME, along with the distribution of the 67 counties they serve.

| <b>Number of Florida Counties by Managing Entity Region and DCF Region</b> |                               |                       |                           |                       |
|--|-------------------------------|-----------------------|---------------------------|-----------------------|
| <b>Managing Entity</b>   | <b>DCF Region(s)</b>          | <b>Rural Counties</b> | <b>Non-Rural Counties</b> | <b>Total Counties</b> |
| Broward Behavioral Health Coalition (BBHC)                                 | Southeast Region              | 0                     | 1                         | 1                     |
| Central Florida Cares Health System (CFCHS)                                | Central Region                | 0                     | 4                         | 4                     |
| Central Florida Behavioral Health Network (CFBHN)                          | Suncoast & Central Regions    | 5                     | 9                         | 14                    |
| Lutheran Services Florida Health Systems (LSFHS)                           | Northwest & Central Regions   | 10                    | 13                        | 23                    |
| Big Bend Community Based Care (BBCBC)                                      | Northeast & Northwest Regions | 13                    | 5                         | 18                    |
| South Florida Behavioral Health Network (SFBHN)                            | Southern Region               | 1                     | 1                         | 2                     |
| Southeast Florida Behavioral Health Network (SEFBHN)                       | Southeast Region              | 1                     | 4                         | 5                     |
| <b>Entire State of Florida</b>   |                               | <b>30</b>             | <b>37</b>                 | <b>67</b>             |

The table below shows the demographic profile of individuals admitted to treatment for opioids during State Fiscal Year 15-16, by ME region. The vast majority of individuals treated for opioids are ages 26 and older and white. About half are male and half are female. It should be noted that Florida’s treatment records do not 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, these records do not specifically identify members of the two federally recognized tribes in Florida (the Miccosukee Tribe and the Seminole Tribe).

| <b>Demographic Profile of Individuals Admitted to Treatment for Opioids in State Fiscal Year 15-16 by Managing Entity</b> |        |      |            |            |          |       |       |              |            |          |                        |
|---|--------|------|------------|------------|----------|-------|-------|--------------|------------|----------|------------------------|
|   | Female | Male | Ages 12-17 | Ages 18-25 | Ages 26+ | Black | White | Multi-Racial | Other Race | Hispanic | No High School Diploma |
| <b>BBCBC</b>  | 58%    | 42%  | <1%        | 18%        | 82%      | 6%    | 91%   | 3%           | <1%        | 3%       | 44%                    |
| <b>LSFHS</b>  | 56%    | 44%  | <1%        | 18%        | 81%      | 4%    | 91%   | 2%           | 2%         | 4%       | 39%                    |
| <b>CFBHN</b>  | 51%    | 49%  | 2%         | 17%        | 81%      | 2%    | 92%   | 5%           | 1%         | 13%      | 39%                    |
| <b>CFCHS</b>  | 45%    | 55%  | 1%         | 17%        | 83%      | 2%    | 85%   | 6%           | 6%         | 21%      | 26%                    |
| <b>SEFBHN</b>   | 55%    | 45%  | <1%        | 19%        | 81%      | 2%    | 92%   | 4%           | 2%         | 6%       | 31%                    |
| <b>BBHC</b>   | 47%    | 53%  | 1%         | 16%        | 83%      | 7%    | 87%   | 3%           | 3%         | 10%      | 29%                    |
| <b>SFBHN</b>  | 38%    | 62%  | 1%         | 17%        | 83%      | 8%    | 87%   | 4%           | 1%         | 24%      | 28%                    |
| <b>State Average</b>  | 50%    | 50%  | 1%         | 17%        | 82%      | 4%    | 89%   | 4%           | 3%         | 12%      | 34%                    |

Nonmedical prescription pain reliever users (or misusers) are a population at risk of experiencing an opioid use disorder. The National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), collects data from a representative sample of the non-institutionalized household population through face-to-face interviews, but age is the only demographic variable with publicly-available subgroup estimates. The table below shows the most currently available estimates of past-year prevalence of nonmedical pain reliever use, by ME region, for all age groupings, based on combined NSDUH data from 2012-2014.<sup>1</sup>

| <b>Estimated Past-Year Prevalence of Nonmedical Prescription Pain Reliever Use, by Age Group (2012-2014)</b> |             |             |             |             |             |
|--|-------------|-------------|-------------|-------------|-------------|
| Managing Entity  | Ages 12+    | Ages 12-17  | Ages 18+    | Ages 18-25  | Ages 26+    |
| BBHC   | 3.4%        | 4.4%        | 3.3%        | 7.6%        | 2.7%        |
| CFCHS  | 3.6%        | 4.5%        | 3.5%        | 7.6%        | 2.7%        |
| CFBHN  | 3.4%        | 4.4%        | 3.3%        | 7.8%        | 2.7%        |
| LSFHS  | 3.6%        | 4.4%        | 3.5%        | 8.2%        | 2.8%        |
| BBCBC  | 4.1%        | 4.7%        | 4.0%        | 8.5%        | 3.1%        |
| SFBHN  | 2.9%        | 4.1%        | 2.8%        | 5.6%        | 2.4%        |
| SEFBHN   | 3.4%        | 4.3%        | 3.3%        | 8.3%        | 2.6%        |
| <b>Entire State of Florida</b>   | <b>3.4%</b> | <b>4.4%</b> | <b>3.3%</b> | <b>7.6%</b> | <b>2.7%</b> |

Across all age groups, the BBCBC region has the highest prevalence of nonmedical pain reliever use. The BBCBC region is comprised of 18 counties in the northwest panhandle area of Florida. The BBCBC region has more rural counties than any other region. In contrast, the SFBHN

region has the lowest prevalence of nonmedical pain reliever use out of all the regions and across all age groups. The SFBHN region is comprised of the two counties at the most southern part of the state (Miami-Dade and Monroe). Miami-Dade is home to the most populous metropolitan area in Florida. This is the only area of the state with rates of nonmedical pain reliever use that are lower than the state average for every age group.

The table below shows the demographic profile of the Department’s other population of focus, middle and high school students in rural counties with the highest prevalence rates of past 30 day nonmedical opioid use. While the past 30 day prevalence of nonmedical opioid use was used to rank the rural counties according to need, the demographic profile below pertains to middle and high school students that reported using an opioid nonmedically at least once in their lifetime.

| <b>Demographic Profile of Middle and High School Students that Used Opioids Nonmedically at Least Once from the Top Six Non-PFS Funded High-Need Rural Counties</b> |               |             |              |              |               |                              |                 |                              |
|---|---------------|-------------|--------------|--------------|---------------|------------------------------|-----------------|------------------------------|
| <b>County</b>   | <b>Female</b> | <b>Male</b> | <b>White</b> | <b>Black</b> | <b>Latino</b> | <b>Other or Multi-Racial</b> | <b>Hispanic</b> | <b>Speak English at Home</b> |
| <b>Jackson</b>  | 67%           | 33%         | 59%          | 14%          | 2.7%          | 25%                          | 13%             | 97%                          |
| <b>Jefferson</b>  | 54%           | 46%         | 17%          | 65%          | 0%            | 18%                          | 0%              | 100%                         |
| <b>Taylor</b>   | 26%           | 74%         | 90%          | 0%           | 10%           | 0%                           | 5%              | 100%                         |
| <b>Hardee</b>   | 55%           | 45%         | 41%          | 3%           | 43%           | 13%                          | 56%             | 85%                          |
| <b>Okeechobee</b>   | 59%           | 41%         | 56%          | 5%           | 19%           | 20%                          | 30%             | 88%                          |
| <b>Gilchrist</b>  | 62%           | 38%         | 90%          | 4%           | 1%            | 5%                           | 14%             | 100%                         |

In the absence of any other state- or substate-level demographic subgroup estimates, findings at the national-level can still be informative. The following information is from the 2015 NSDUH. It should be noted that any NSDUH data presented in this proposal collected prior to 2015 defined nonmedical use of pain relievers as use without a prescription or use that occurs simply for the experience or feeling the drug causes. The 2015 prescription drug questions were revised to ask survey respondents about the use of prescription drugs “in any way that a doctor did not direct you to use them,” including (1) use without a prescription of the respondent’s own; (2) use in greater amounts, more often, or longer than the respondent was told to take them; or (3) use in any way a doctor did not direct the respondent to use them. Along with these changes, NSDUH reports no longer use the term “nonmedical use” and instead use the term “misuse.” For the purposes of this proposal, nonmedical pain reliever use and pain reliever “misuse” are used synonymously. The use of the broader term “opioid misuse” is intended to encompass nonmedical pain reliever use/misuse, illicit heroin use, and the use of synthetic opioids such as fentanyl.

Nationwide, males aged 12 or older are more likely than their female counterparts to have misused prescription pain relievers in the past year (5.3% vs. 4.0%). Rates of past year pain reliever misuse are similar among individuals in large metropolitan areas (with a population of 1 million or more), small metropolitan areas (with a population of fewer than 1 million) and nonmetropolitan areas (4.7%, 4.6%, and 4.6%, respectively). The past year prevalence of pain reliever misuse ranges from a low of 1.8% among non-Hispanic Asian people to a high of 8.4% among non-Hispanic people who report two or more races. Percentages of non-Hispanics and Hispanics were similar for prescription pain reliever misuse (4.6% vs. 5.0%).<sup>2</sup> The table below depicts estimates by Hispanic origin and race.

| <b>Misuse of Pain Relievers in the Past Year Among Individuals Aged 12 and Older, by Hispanic Origin and Race (2015)</b> |   |
|--|---|
| <b>Hispanic Origin and Race</b>  | <b>Prevalence of Pain Reliever Misuse</b> |
| Hispanic or Latino   | 5.0%                                      |
| Not Hispanic or Latino   | 4.6%                                      |
| ▪ White  | 4.8%                                      |
| ▪ Black or African American  | 4.4%                                      |
| ▪ American Indian or Alaska Native   | 5.6%                                      |
| ▪ Native Hawaiian or Other Pacific Islander  | 5.4%                                      |
| ▪ Asian  | 1.8%                                      |
| ▪ Two or More Races  | 8.4%                                      |

There are statistically significant differences between sexual minority adults (lesbian, gay, or bisexual) and sexual majority adults (heterosexual or straight) with regard to the prevalence of past year nonmedical pain reliever use and disorders. The prevalence of nonmedical pain reliever use is 10.4% among sexual minority adults, compared to 4.5% among sexual majority adults. With regard to pain reliever use disorders, the prevalence is 2.0% among sexual minority adults and 0.7% among sexual majority adults.<sup>3</sup>

Individuals who use heroin are also at risk of experiencing an opioid use disorder. State- and substate-level estimates of the prevalence of heroin use are generally not included in published NSDUH reports. This means that rates of heroin use by demographic subpopulation are also not available at the state- or substate-level without access to the NSDUH Restricted-Use Data Analysis System. According to representatives from SAMHSA’s Substance Abuse and Mental Health Data Archive, the NSDUH Restricted-Use Data Analysis System should be available in March of 2017. However, a special analysis was recently provided by SAMHSA in response to a request for information needed for strategic planning activities related to Florida’s Partnerships for Success grant. This analysis only analyzed Floridians ages 26 and older and had to pool multiple years of data (2005-2012) to produce substate estimates of the prevalence of lifetime heroin use.<sup>4</sup> Depicted in the table below are prevalence rates, along with the estimated number of heroin users, for each Managing Entity region.

| <b>Lifetime Prevalence of Heroin Use and Number of Heroin Users, Ages 26 and Older (2005-2012)</b> |                                 |                               |
|--|---------------------------------|-------------------------------|
| <b>Managing Entity</b>   | <b>Prevalence of Heroin Use</b> | <b>Number of Heroin Users</b> |
| BBHC   | 1.5%                            | 20,000                        |
| CFCHS  | 2.6%                            | 40,000                        |
| CFBHN  | 2.5%                            | 90,000                        |
| LSFHS  | 1.4%                            | 30,000                        |
| BBCBC  | 1.5%                            | 10,000                        |
| SFBHN  | 0.4%                            | 10,000                        |
| SEFBHN   | 2.2%                            | 30,000                        |
| <b>Entire State of Florida</b>   | <b>1.9%</b>                     | <b>230,000</b>                |

This table shows that the CFCHS, CFBHN, and SEFBHN regions have the top three highest prevalence rates, all of which are slightly above the statewide average. Consistent with

previously discussed findings regarding the prevalence of nonmedical pain reliever use, the SFBHN region has the lowest prevalence of heroin use out of all the regions in the state.

In the absence of any state- or substate-level estimates of heroin use among demographic subpopulations, variations in risk for some demographic subpopulations can still be described using national estimates. According to an analysis of 2011-2013 NSDUH data, past-year rates of heroin use are higher among individuals ages 18-25 than they are among individuals ages 12-17 and 26 or older (7.3%, 1.6%, and 1.9%, respectively). The prevalence of heroin use is higher among males (3.6%) than among their female counterparts (1.6%). Rates in large metropolitan areas (3.0%) are higher than rates in all other areas (2.1%). Rates among non-Hispanic whites (3.0%) are higher than all other races/ethnicities (1.7%). With regard to annual household income, rates of heroin are highest among those with less than \$20,000 per year (5.5%), compared to those with between \$20,000-\$49,000 per year (2.3%) and those with more than or equal to \$50,000 per year (1.6%). Furthermore, the prevalence of past-year heroin use is 6.7% among individuals with no health insurance, 4.7% among those with Medicaid, and 1.3% among those with private insurance. Looking specifically at heroin abuse or dependence, a multivariable logistic regression model, adjusted for demographic variables, indicates that the following characteristics are associated with higher odds of experiencing a past-year heroin abuse or dependence: male sex; aged 18-25 years; non-Hispanic white race/ethnicity; residence in large urban areas; less than \$20,000 annual household income; and having no health insurance or Medicaid.<sup>5</sup>

Finally, there are statistically significant differences between sexual minority adults (lesbian, gay, or bisexual) and sexual majority adults (heterosexual or straight) with regard to the prevalence of past year heroin use and dependence. The prevalence of heroin use is 0.9% among sexual minority adults and 0.3% among sexual majority adults. With regard to heroin abuse or dependence, the prevalence is 0.6% among sexual minority adults and 0.2% among sexual majority adults. Although sexual minority adults are more likely than their sexual majority counterparts to engage in nonmedical opioid use and experience related disorders, they are also more likely to receive treatment.<sup>6</sup>

**A-2. Discuss the differences in access, service use, and outcomes for your population of focus in comparison with the general population in the local service area, citing relevant data. Describe how the proposed project will improve these disparities in access, service use, and outcomes.**

NSDUH is the only available data source that can identify individuals with opioid use disorders among the general household (non-institutionalized) population and estimate how many sought and received treatment services. Analyzing the most complete Florida-specific NSDUH file requires access to the NSDUH Restricted-Use Data Analysis System (R-DAS). According to representatives from SAMHSA's Substance Abuse and Mental Health Data Archive, the NSDUH Restricted-Use Data Analysis System should be available in March of 2017. DCF will attempt to analyze substate disparities in access and utilization using the restricted Florida dataset at that time.

During the first year of this grant, the Project Director will collaborate with the MEs on an in-depth analysis of disparities in access to care (by treatment modality, with an emphasis on MAT vs. other types of services), dropout rates, discharge reasons, program completion rates, and outcomes (including reductions in illicit opioid use and improvements in social functioning across multiple domains). The Project Director will work with DCF's Director of Substance Abuse and Mental Health Quality Assurance and Data Liaisons at the MEs on the development of a standardized approach to analyzing service records. A demographic analysis of waitlist records and individuals with an unmet need for treatment from the NSDUH Restricted-Use Data Analysis System (if available) will be conducted. Working in collaboration with the MEs, the Project Director will explore disparities among individuals with opioid use disorders by reviewing relevant findings from complaints, consumer satisfaction surveys, "secret shopper" calls, incident reports, Cultural and Linguistic Competency Plans, Behavioral Health Disparity Impact Statements, on-site monitoring reports, and interviews with persons served and staff. Any disparities identified will be addressed through training and quality improvement initiatives.

**A-3. Describe the nature of the opioid use disorder problem. Document the extent of the need (i.e., current prevalence rates or incidence data) for the population(s) of focus identified in your response to question A.1. Describe currently available resources and service gaps.**

Drug overdose is now the leading cause of injury-related death in the United States. In 2015, over 52,000 deaths in the U.S. were attributed to drug poisoning, and over 33,000 (63%) of these involved some type of opioid (prescription or illicit). Since 2000, drug overdose death rates 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 2015, Florida ranked 4<sup>th</sup> in the nation with 3,228 deaths.<sup>7</sup> More specifically, 2,566 deaths were caused by at least one opioid in 2015. This means that at least 7 lives per day are lost to opioid overdose in Florida.<sup>8</sup>

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 14<sup>th</sup> 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 21<sup>st</sup> 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.<sup>9</sup>

Fentanyl is a synthetic opioid 50-100 times more potent than morphine and approved for the management of surgical/post-operative pain, severe chronic pain, and breakthrough cancer pain. The Drug Enforcement Administration's National Forensic Laboratory Information System collects drug identification results from drug cases analyzed by federal, state, and local forensic laboratories throughout the United States. During 2013-2014, fentanyl submissions increased 494% in Florida, concurrent with a 115% increase in fentanyl deaths throughout the state. Florida's fentanyl death rates increased approximately 250% among persons aged 14-24 from

2010-2012 to 2013-2014. The highest fentanyl death rates in Florida during 2013-2014 occurred among persons aged 25-34 years (3.2 per 100,000) and 35-50 years (2.9 per 100,000), males (2.5 per 100,000), and whites (2.1 per 100,000). Additionally, fentanyl analogs were involved in 29 fatal drug overdoses in Florida during January-June 2015, including acetyl fentanyl (26), butyryl fentanyl (5), and beta-hydroxythiofentanyl (18). The rapid increase in fentanyl deaths in Florida illustrate the high potency of fentanyl, with the possibility of rapid death, highlighting the importance of quickly recognizing an overdose, calling 911, facilitating rapid administration of one or more doses of naloxone, and the need to expand naloxone availability.<sup>10</sup>

Prescription opioid abuse places a substantial economic burden on society. Societal costs of prescription opioid abuse in the United States totaled \$55.7 billion in 2007 (with workplace costs accounting for 46%, health care costs accounting for 45%, and criminal justice costs accounting for 9%).<sup>11</sup> Prescription opioid overdoses result in 830,652 years of potential life lost before age 65.<sup>12</sup> Over the past decade, the annual prevalence of diagnosed opioid abuse more than doubled among both privately insured and Florida Medicaid populations. Researchers compared individuals with opioid abuse and demographically matched controls using privately insured and Florida Medicaid administrative claims data from 2003 to 2007. Individuals with opioid abuse and caregivers had greater resource use in both privately insured and Florida Medicaid populations compared with controls. Mean excess annual cost per privately insured individual was \$20,546 and mean excess cost per caregiver was \$1,010. Mean excess cost per individual with Florida Medicaid was \$15,183.<sup>13</sup>

A recent analysis of 85 million diagnostic and billing records from 302 Florida hospitals from all 67 counties found that costs linked to heroin-related overdoses, hepatitis C, bacterial infections, and neonatal abstinence syndrome now exceed \$1.1 billion per year (or \$4.1 million per day). Florida's Medicaid program was billed \$2.1 billion as the primary insurer for the hospitalizations over a six-year period. By late 2015, the amount billed averaged roughly \$1 million a day more than in 2010. Charges for individuals with hepatitis C who used opiates were \$731,000 a day higher in 2015 than in 2010.<sup>14</sup>

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, Florida enacted pain clinic regulations, conducted law enforcement raids, and banned dispensing of schedule II or III drugs from physician offices. 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.<sup>15</sup> Overdose death rates for opioid analgesics and benzodiazepines also declined as a result.<sup>16</sup> 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.<sup>17</sup> Interviews with heroin users who sought treatment between 2010 and 2013 support this conclusion because the vast majority initiated use with prescription opioids and then switched to heroin because prescription opioids were far more expensive and harder to obtain.<sup>18</sup> Nationwide, over 77% of people using both opioid pain

relievers and heroin in the past year report using opioid pain relievers *prior* to heroin initiation.<sup>19</sup> 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.<sup>20</sup>

SAMHSA recently provided Florida-specific estimates from NSDUH of the prevalence of past year opioid use (which includes heroin and the nonmedical use of prescription pain relievers), opioid abuse or dependence, and unmet treatment need among individuals ages 12 or older for three time periods: 2003-2006, 2007-2010, and 2011-2014.<sup>21</sup> Multiple years of data were pooled to increase the precision of the estimates.

The table below depicts a statistically significant decrease in the prevalence of opioid use from 5.2% in 2003-2006 to 3.6% in 2011-2014. With regard to the past year prevalence of opioid abuse or dependence, the increase from 6.7% to 7.7% from 2003-2006 to 2011-2014 is not statistically significant. Finally, the estimated number of individuals with an opioid use disorder that did not receive treatment at a specialty facility was 92,000 for the 2003-2006 period and 101,000 for the 2011-2014 period.

| <b>Past Year Prevalence of Nonmedical Opioid Use, Abuse or Dependence, and Unmet Treatment Need among Floridians Ages 12 and Older (2003-2014)</b> |                  |                  |                  |
|--|------------------|------------------|------------------|
|  | <b>2003-2006</b> | <b>2007-2010</b> | <b>2011-2014</b> |
| Nonmedical Opioid Use  | 5.2%             | 4.3%             | 3.6%             |
| Opioid Abuse or Dependence   | 6.7%             | 7.7%             | 7.8%             |
| Unmet Need for Treatment   | 92,000           | 105,000          | 101,000          |

In contrast to the broader opioid measures depicted above, there are substate estimates and estimates by age group available for nonmedical pain reliever use. The table below shows the prevalence of nonmedical pain reliever use by age group, which has been decreasing since peaks in the 2005-2007 period.

| <b>Prevalence of Past Year Nonmedical Pain Reliever among Floridians, by Age Group, 2002-2014</b> |              |              |              |              |              |              |              |              |              |              |              |              |
|---|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
|   | <b>02-03</b> | <b>03-04</b> | <b>04-05</b> | <b>05-06</b> | <b>06-07</b> | <b>07-08</b> | <b>08-09</b> | <b>09-10</b> | <b>10-11</b> | <b>11-12</b> | <b>12-13</b> | <b>13-14</b> |
| <b>Ages 12-17</b>   | 7.0%         | 7.1%         | 7.1%         | 7.1%         | 7.2%         | 6.5%         | 5.9%         | 6.0%         | 5.5%         | 4.9%         | 4.4%         | 4.4%         |
| <b>Ages 18-25</b>   | 12.8%        | 12.6%        | 12.8%        | 13.0%        | 12.1%        | 10.9%        | 10.4%        | 9.8%         | 8.6%         | 8.3%         | 7.8%         | 7.3%         |
| <b>Ages 26+</b>   | 3.5%         | 3.4%         | 3.7%         | 3.8%         | 3.3%         | 2.8%         | 3.0%         | 3.4%         | 3.2%         | 3.1%         | 2.9%         | 2.7%         |

The most recent and relevant substate estimates available are for past-year nonmedical pain reliever use. Three years of NSDUH data (2012, 2013, and 2014) are combined to increase the precision of the estimates. Presented in the table below are estimates for four age groups (12-17, 18+, 18-25, 26+) for each Managing Entity region.<sup>22</sup>

| <b>Prevalence of Past Year Nonmedical Pain Reliever Use among Floridians, by Managing Entity and Age Group, 2012-2014</b> |                   |                 |                   |                 |
|---|-------------------|-----------------|-------------------|-----------------|
| <b>Managing Entity</b>  | <b>Ages 12-17</b> | <b>Ages 18+</b> | <b>Ages 18-25</b> | <b>Ages 26+</b> |
| Broward Behavioral Health Coalition (BBHC)  | 4.4%              | 3.3%            | 7.6%              | 2.7%            |
| Central Florida Cares Health System (CFCHS)   | 4.5%              | 3.5%            | 7.6%              | 2.7%            |
| Central Florida Behavioral Health Network (CFBHN)   | 4.4%              | 3.3%            | 7.8%              | 2.7%            |

|  |             |             |             |             |
|--|-------------|-------------|-------------|-------------|
| Lutheran Services Florida Health Systems (LSFHS)     | 4.4%        | 3.5%        | 8.2%        | 2.8%        |
| Big Bend Community Based Care (BBCBC)                | 4.7%        | 4.0%        | 8.5%        | 3.1%        |
| South Florida Behavioral Health Network (SFBHN)      | 4.1%        | 2.8%        | 5.6%        | 2.4%        |
| Southeast Florida Behavioral Health Network (SEFBHN) | 4.3%        | 3.3%        | 8.3%        | 2.6%        |
| <b>Entire State of Florida</b>                       | <b>4.4%</b> | <b>3.3%</b> | <b>7.6%</b> | <b>2.7%</b> |

With regard to changes in substate estimates, looking at Floridians ages 12 and older, comparisons can be made between two estimates for two time periods: 2002-2004 and 2012-2014. These estimates are only available for a subset of substate areas that were consistently defined across the two time periods.<sup>23</sup>

| <b>Prevalence of Past Year Nonmedical Pain Reliever Use, by Substate Area, 2002-2004 vs. 2012-2014</b>                      |                           |                           |
|---|---------------------------|---------------------------|
| <b>Counties (Managing Entity)</b>   | <b>2002-2004 Estimate</b> | <b>2012-2014 Estimate</b> |
| Broward (BBHC)  | 4.4%                      | 3.4%*                     |
| Hardee, Highland, and Polk (CFBHN)  | 4.5%                      | 3.5%**                    |
| Charlotte, Collier, Glades, Hendry, and Lee (CFBHN)   | 4.3%                      | 3.5%                      |
| Citrus, Hernando, Lake, Marion, and Sumter (LSFHS)  | 4.3%                      | 3.1%*                     |
| Escambia, Okaloosa, Santa Rosa, and Walton (BBCBC)  | 6.7%                      | 4.0%*                     |
| Miami-Dade and Monroe (SFBHN)   | 3.4%                      | 2.9%                      |
| Palm Beach (SEFBHN)   | 4.5%                      | 3.4%*                     |
| Indian River, Martin, Okeechobee, and St. Lucie (SEFBHN)  | 4.0%                      | 3.3%                      |
| <b>Entire State of Florida</b>  | <b>4.8%</b>               | <b>3.4%*</b>              |
| * The difference between the 2002-2004 estimate and the 2012-2014 estimate is statistically significant at the 0.05 level.  |                           |                           |
| ** The difference between the 2002-2004 estimate and the 2012-2014 estimate is statistically significant at the 0.10 level. |                           |                           |

Unfortunately, state-level trends in heroin use are not included in published NSDUH reports and SAMHSA officials advise against attempting a special trend analysis of state-level rates of heroin use because the estimates are too unreliable. The most recent special analysis provided by SAMHSA had to pool multiple years of data (2005-2012) to produce a single estimate of the lifetime prevalence of heroin use in Florida. This analysis, which looked exclusively at Floridians ages 26 and older, found that 1.9% reported using heroin at least once. The table below depicts specific estimates for each Managing Entity, along with the estimated number of heroin users.

| <b>Estimated Lifetime Prevalence of Heroin Use and Number of Heroin Users among Floridians Ages 26 and Older (2005-2012)</b> |                                 |                            |
|--|---------------------------------|----------------------------|
| <b>Managing Entity</b>   | <b>Prevalence of Heroin Use</b> | <b>Number Heroin Users</b> |
| Broward Behavioral Health Coalition (BBHC)   | 1.5%                            | 20,000                     |
| Central Florida Cares Health System (CFCHS)  | 2.6%                            | 40,000                     |
| Central Florida Behavioral Health Network (CFBHN)  | 2.5%                            | 90,000                     |
| Lutheran Services Florida Health Systems (LSFHS)   | 1.4%                            | 30,000                     |
| Big Bend Community Based Care (BBCBC)  | 1.5%                            | 10,000                     |
| South Florida Behavioral Health Network (SFBHN)  | 0.4%                            | 10,000                     |
| Southeast Florida Behavioral Health Network (SEFBHN)   | 2.2%                            | 30,000                     |
| <b>Entire State of Florida</b>   | <b>1.9%</b>                     | <b>230,000</b>             |

These figures probably underestimate the true prevalence because, as noted by researchers from the RAND Drug Policy Research Center, individuals who are dependent on heroin are “unsurprisingly invisible” in household surveys. NSDUH might correctly identify only about 6% of the total number of daily and near-daily heroin users in the United States.<sup>24</sup>

The opioid epidemic has had a major impact on Florida’s child welfare system, which has seen an increase in infants in out of home care from about 1,880 in October 2014 to 2,100 in September 2016. A recent case review of 30 cases of infants with parents with a substance use disorder showed that child welfare staff have a difficult time establishing in-home safety plans as so many of the household/family members who might provide safety management services are also using drugs and alcohol. It is also difficult to engage many of the parents into treatment, especially those using opioids, and many are resistant to higher levels of care such as residential services even when it is available. The benefits of medication-assisted treatment are not widely acknowledged in the child welfare system. Medications are not widely used with this population.

Currently, Florida’s child welfare data system does not identify parents using opioids compared to other drugs or alcohol. Although anecdotally, the field staff report that many of the families are struggling with opioid addiction. An analysis of the child welfare data system completed in December 2016 showed that 21,086 children in the child welfare system in 2015-16 had at least one parent with a substance use disorder. Of these children, 53.8% were age five and under showing a potentially devastating impact on not only the parent’s health but the child’s development as well. The data analysis identified approximately 21,192 parents with substance use disorders, many who likely have an opioid use disorder.

In the Southwest portion of the state where opioid use has been a very serious problem, a behavioral health program partnered with the child welfare system and staffed behavioral health consultants within the child welfare units. The behavioral health consultants are licensed therapists and provide consultation, assistance in identification of substance use disorders including those with opioid disorders, outreach and engagement services, and linkages to treatment. Although these positions have only been in place for less than a year and adequate data has not been collected on their impact, the child protective investigative staff report that their assistance is extremely beneficial.

According to an analysis of survey responses recently received from 42 prevention providers, the most commonly implemented opioid misuse prevention 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 second most prevalent set of prevention activities are information dissemination and community education. Safe use, safe storage, and safe disposal messages are typical components of these awareness campaigns.

Florida’s Emergency Treatment and Recovery Act (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. Effective July 1, 2016, Florida pharmacies are authorized to dispense naloxone under non-patient specific standing orders to

individuals without a prescription. In light of these statutory changes, coupled with the fact that Florida did not have an active network for naloxone training or distribution, the Department began implementing an Overdose Prevention Program in January of last year. Overdose recognition and response training has been conducted among an estimated 510 individuals, including drug treatment provider staff, community members, law enforcement officers, DCF regional and Managing Entity staff, the recovery community, physicians, nurses, pharmacists, and other health care professionals. Approximately \$294,000 in Substance Abuse Prevention and Treatment Block Grant funds were utilized to purchase 2,448 NARCAN® Nasal Spray kits. The NARCAN® kits were distributed to 13 publicly-funded drug treatment providers who expressed willingness and capacity to distribute the medication to persons served at risk of witnessing or experiencing an opioid overdose. Distribution of NARCAN® to drug treatment providers began in August 2016 and stopped in December 2016 due to the depletion of supply and a lack of funds to purchase additional kits. In order to stretch limited resources, drug treatment providers submitted reduced NARCAN® orders. However, many providers still did not receive kits due to the lack of supply.

At adequate doses, methadone prevents or reverses withdrawal symptoms and blocks the euphoric effects of heroin. A meta-analysis of 11 randomized clinical trials involving 1,969 heroin dependent participants found that methadone is the most effective way to retain individuals in treatment and reduce heroin use (as measured by self-reports and urine/hair analysis).<sup>25</sup> There are 51 methadone clinic sites throughout Florida, including both full clinics and satellite clinics. Not for profit corporations operate 21 of these sites as depicted in the table below:

| <b>Managing Entity Catchment Area</b> | <b>County</b> | <b>Program Name</b>                                 | <b>Annual Census Average</b> |
|---------------------------------------|---------------|---|------------------------------|
| BBCBC                                 | Escambia      | Lakeview Center (Century Clinic)                    | 78                           |
| BBCBC                                 | Escambia      | Lakeview Center (Shalimar)                          | 246                          |
| BBCBC                                 | Escambia      | Lakeview Center (Pensacola)                         | 299                          |
| CFBHN                                 | Hillsborough  | DACCO (Tampa)                                       | 729                          |
| CFBHN                                 | Polk          | DACCO (Lakeland)                                    | 26                           |
| CFBHN                                 | Manatee       | Operation PAR (Bradenton)                           | 621                          |
| CFBHN                                 | Pinellas      | Operation PAR (Clearwater)                          | 819                          |
| CFBHN                                 | Lee           | Operation PAR (Fort Myers)                          | 1,080                        |
| CFBHN                                 | Pasco         | Operation PAR (Port Richey)                         | 716                          |
| CFBHN                                 | Sarasota      | Operation PAR (Sarasota)                            | 415                          |
| CFBHN                                 | Charlotte     | Operation PAR (Port Charlotte Satellite Clinic)     | Not available                |
| CFBHN                                 | Pinellas      | Operation PAR (St. Petersburg Satellite Clinic)     | Not available                |
| CFCBS                                 | Orange        | Aspire Health Partners                              | 147                          |
| LSFHS                                 | Columbia      | Meridian Behavioral Healthcare (Lake City)          | 152                          |
| LSFHS                                 | Alachua       | Meridian Behavioral Healthcare (Gainesville)        | 352                          |
| LSFHS                                 | Hernando      | Operation PAR (Hernando)                            | 404                          |
| LSFHS                                 | Duval         | River Region Human Services (Jacksonville)          | 777                          |
| LSFHS                                 | Clay          | River Region Human Services (Orange Park Satellite) | Not available                |
| SFBHN                                 | Miami-Dade    | Comprehensive Psychiatric Center (Central)          | 58                           |
| SFBHN                                 | Miami-Dade    | Comprehensive Psychiatric Center (North)            | 107                          |
| SFBHN                                 | Miami-Dade    | Comprehensive Psychiatric Center (South)            | 104                          |

According to an analysis of survey responses from 359 individuals receiving methadone from publicly-funded clinics throughout Florida, the cost of self-pay was the most frequently cited problem that interfered with treatment compliance.<sup>26</sup> Additionally, according to an analysis of 10 years of discharge records there were 3,892 methadone recipients discharged due to inability to pay or loss of insurance coverage (or nearly 390 per year on average).

Researchers from the Florida Mental Health Institute analyzed survey responses from 45 professionals who make clinical or administrative decisions regarding service delivery in publicly-funded Opioid Treatment Programs across 12 counties in Florida.<sup>27</sup> About half of the individuals served in these programs were self-pay and about half were covered by Medicaid. Most respondents (88%) reported that their clinic prescribed buprenorphine, but the vast majority (95%) reported that buprenorphine was “rarely/never” prescribed at their site. About 68% reported that when it was prescribed, it was on a case-by-case basis. Approximately 86% of respondents indicated that clients do not choose buprenorphine due to the additional personal expense. Qualitative responses reflected the perception that the cost of the medication was the primary barrier to wider adoption by individuals served:

Qualitative responses generated by program staff communicated concern that “clients can barely pay \$12 a day to dose with self-pay, \$2 with Medicaid, and \$8 with Medicare. Why would they be able to pay \$16+ for alternative medications?” They added that “\$28 more per week” adds up to “\$1,400 more per year” and that this additional expense would “hinder their ability to provide food and shelter” and interfere with their ability to cover “transportation, childcare, and additional medical expenses.” Their overwhelming position is that the cost passed on to the client makes it a prohibitive option based on current reimbursement strategies.<sup>28</sup>

According to a study of 359 individuals receiving methadone at publicly funded clinics in Florida, 26% reported taking buprenorphine at some time in the past, and the majority of these reported they ceased taking it (namely Suboxone) due to the price or limitations of their insurance (particularly Medicaid).<sup>29</sup> Only 5.3% of buprenorphine prescriptions in Florida are funded by Medicaid, giving Florida the third lowest share of buprenorphine prescriptions funded by Medicaid out of all 50 states and the District of Columbia. Nationwide, on average, Medicaid covers about 24% of buprenorphine prescriptions.<sup>30</sup>

A recent study compared the rate of past-year opioid abuse or dependence (using combined 2009 to 2012 restricted-use NSDUH data) among Floridians ages 12 and older (7.7 per 1,000) to the maximum number of individuals who could be treated with buprenorphine in Florida (4.2 per 1,000) and found buprenorphine is potentially available to only about half of the people who might need it.<sup>31</sup>

SAMHSA publishes a list of doctors in Florida who are waived per the Drug Addiction Treatment Act of 2000 (DATA 2000) to treat opioid use disorders with buprenorphine and who have opted to be publicly listed.<sup>32</sup> Of those doctors listed, only about half are accepting new patients. Therefore, this list has limited utility for individuals seeking services and analysts attempting to gauge system-wide capacity. Notwithstanding these limitations, the table below

depicts an increasing trend in the number of DATA 2000 waived and publicly listed physicians from 2002 to 2016.

| Year | Certified Physicians with 30 Patients | Certified Physicians with 100 Patients |
|------|---------------------------------------|--|
| 2002 | 43                                    | 0                                      |
| 2003 | 44                                    | 0                                      |
| 2004 | 84                                    | 0                                      |
| 2005 | 101                                   | 0                                      |
| 2006 | 157                                   | 0                                      |
| 2007 | 187                                   | 122                                    |
| 2008 | 200                                   | 48                                     |
| 2009 | 157                                   | 76                                     |
| 2010 | 146                                   | 61                                     |
| 2011 | 122                                   | 44                                     |
| 2012 | 162                                   | 48                                     |
| 2013 | 146                                   | 64                                     |
| 2014 | 138                                   | 70                                     |
| 2015 | 193                                   | 124                                    |
| 2016 | 213                                   | 101                                    |

The total number of waived Florida physicians listed publicly on SAMHSA’s site is half the number of physicians listed on the [www.suboxone.com](http://www.suboxone.com) site maintained by Indivior, Inc. (314 vs. 626). Unfortunately, neither of these resources provides information on the number and location of individuals who are currently being prescribed buprenorphine for opioid use disorders. However, according to a recent analysis of Florida pharmacy claims for buprenorphine formulations (without an FDA indication for treatment of pain) from 2010-2013, the median monthly patient census among Florida prescribers is 11 patients. The interquartile range, which describes the range of patients treated by the middle 50% of the distribution of prescribers, is between 4 and 30 patients.<sup>33</sup> During this period, waived physicians were restricted to treating up to 30 patients concurrently, or, after a year, up to 100 patients upon request (the cap was recently increased to 275). This analysis reveals that Florida prescribers, similar to their counterparts in the rest of the country, tend to treat below regulatory limits. A survey of professionals in Florida Opioid Treatment Programs found that only 57% reported that their agency had provided focused training regarding the adoption and use of buprenorphine to clinical staff. However, 88% reported a desire for additional training on the use of buprenorphine for opioid dependence.<sup>34</sup>

Initiating buprenorphine treatment for opioid use disorders in emergency department with primary care office-based follow-up is an effective way to expand access to treatment. Research shows that only 40% of individuals that experience an opioid-related hospitalization receive any follow-up services within 30 days. Only 10.7% of individuals receive the recommended combination of both medication and a therapeutic service.<sup>35</sup> 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.

VIVITROL® is an extended release formulation of naltrexone that is FDA-approved for the prevention of relapse to opioid dependence. VIVITROL blocks the effects of opioids, including

heroin and opioid pain medications. The Florida Alcohol and Drug Abuse Association (FADAA) administers state funding allocated to the Department of Children and Families and the Office of State Courts Administrator for VIVITROL. Since FADAA’s VIVITROL program began, over 4,000 VIVITROL injections have been administered to 1,431 individuals, and 42 providers have become enrolled participants. The table below shows the programs that have enrolled with FADAA to receive DCF funds for MAT using VIVITROL:

| <b>Providers Enrolled with FADAA for DCF VIVITROL Services, by Managing Entity (December 2016)</b> |   |
|--|---|
| <b>Managing Entity</b>   | <b>Provider Name</b>  |
| Broward Behavioral Health Coalition (BBHC)   | None  |
| Central Florida Cares Health System (CFCHS)  | Aspire Health Partners (Orange)<br>Transition House (Orange)<br>STEPS (Orange)<br>House of Freedom (Osceola)  |
| Central Florida Behavioral Health Network (CFBHN)  | Agency for Community Treatment Services (Hillsborough)<br>DACCO (Hillsborough)<br>BayCare Behavioral Health (Pasco)<br>Centerstone (Manatee)<br>Charlotte Behavioral Health Care (Charlotte)<br>David Lawrence Center (Collier)<br>Operation PAR (Pinellas)<br>Tri-County Human Services (Polk)     |
| Lutheran Services Florida Health Systems (LSFHS)   | EPIC Behavioral Healthcare (St. Johns)<br>Gateway Community Services (Duval)<br>LifeStream Behavioral Healthcare (Lake)<br>Meridian Behavioral Center (Alachua)<br>River Region Human Services (Duval)<br>SMA Behavioral Health Services (Volusia)<br>Starting Point Behavioral Healthcare (Nassau) |
| Big Bend Community Based Care (BBCBC)  | Chemical Addictions Recovery Effort (Bay)<br>DISC Village (Leon)<br>Lakeview Center (Escambia)  |
| South Florida Behavioral Health Network (SFBHN)  | Banyan Community Health Center (Miami-Dade)<br>Guidance/Care Center (Monroe)  |
| Southeast Florida Behavioral Health Network (SEFBHN)   | Drug Abuse Foundation of Palm Beach County (Palm Beach)   |

**B-1. Describe the purpose of the proposed project, including its goals and measurable objectives. These must relate to the intent of the FOA and performance measures you identify in Section E: Data Collection and Performance Measurement.**

The purpose this proposed project is to reduce opioid-related deaths and the unmet need for treatment by implementing evidence-based prevention, medication-assisted treatment (MAT), and recovery support services for opioid use disorders. This mirrors the intent of the FOA, as do the goals and objectives described below.

Goal 1: Reduce numbers and rates of opioid-related deaths.

- Objective: Distribute at least 10,000 naloxone kits to treatment providers per year.
- Objective: Train at least 300 individuals on overdose prevention and naloxone per year.

Goal 2: Prevent prescription opioid misuse among young people.

- Objective: Increase the number of evidence-based life skills training programs implemented in schools within rural counties.

Goal 3: Increase access to MAT among individuals with opioid use disorders.

- Objective : Increase the number of providers implementing MAT
- Objective: Increase the number of DATA 2000 waived physicians in Florida
- Objective: Increase the number of individuals with opioid use disorders treated with buprenorphine.
- Objective: Increase the number of people who receive recovery support services.

Goal 4: Increase the number of individuals that are trained to provide MAT and recovery support services for opioid use disorders.

- Objective: The Florida Alcohol and Drug Abuse Association will conduct at least 4 training events per year.
- Objective: The Florida Certification Board will conduct at least one training event per year.
- Objective: The Peer Support Coalition of Florida will conduct at least one training event per year.
- Objective: Behavioral Health Consultants will conduct at least 5 training events per year.

These goals and objectives are preliminary. They will be modified and enhanced in response to findings from the needs assessment and in light of content developed for the comprehensive state strategic plan.

**B-2. If applicable, describe other state and Federal resources, such as CDC resources, that address the objectives of the proposed projects and how Opioid STR funds will work synergistically with these activities to enhance and not duplicate existing efforts.**

DCF was awarded the Strategic Prevention Framework – Partnerships for Success (SPF-PFS) grant in July 2016 to reduce prescription drug misuse among Floridians ages 12-25 and the nonmedical use of opioids among Floridians ages 26 and older and strengthen prevention capacity and infrastructure at the state and community levels. Florida’s PFS subrecipient communities include five urban counties (Broward, Duval, Hillsborough, Manatee, and Palm Beach) and three rural counties (Franklin, Walton, and Washington).

The PFS project involves the implementation of two care coordination pilot programs in hospital emergency departments. These pilot programs will use peer specialists to link overdose victims discharged from the hospital to drug treatment providers. School- and family-based prevention programs that effectively reduce prescription drug misuse will be implemented in rural counties to prevent the initiation of prescription drug and opioid use. Local Drug Epidemiology Networks will be developed and integrated into the State Epidemiological Outcomes Workgroup (SEOW), and members of the SEOW will develop county-level reports on naloxone reversals by paramedics and EMTs, prescription drug and heroin exposures from Florida Poison Control Centers, and non-fatal opioid poisonings in hospital emergency departments.

Florida’s PFS project also includes enhancements to the state Prescription Drug Monitoring Program (PDMP) to modify prescribing practices and increase voluntary prescriber utilization. Enhancements 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.

**B-3. Provide a chart or graph depicting a realistic time line for the two (2) 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 4 Months | Year 1 | Year 2 |
|---|---|----------------|--------|--------|
| Develop a Needs Assessment  | Project Director                              | X              |        |        |
| Develop a Comprehensive State Strategic Plan                                      | Project Director                              | X              |        |        |
| Develop a Needs-Based Allocation Methodology                                      | Project Director                              | X              |        |        |
| Conduct an Analysis of Disparities  | Project Director and Managing Entities        | X              |        |        |
| Review of EBPs and Best Practices for MAT   | Project Director                              | X              |        |        |
| Implement Prevention Activities   | Managing Entities                             |                | X      | X      |
| Evaluate Prevention Activities  | Evaluator                                     |                | X      | X      |
| Expand Access to Medication-Assisted Treatment                                    | Managing Entities                             | X              | X      | X      |
| Provide Treatment to Patients Criminal Justice Re-entry Programs                  | Managing Entities                             |                | X      | X      |
| Enhance Peer Recovery Support Services  | Project Director                              |                | X      | X      |
| Implement Training Activities   | FADAA, FCB, Peer Support Coalition of Florida |                | X      | X      |
| Implement ASAM CONTINUUM Project  | FEi Systems                                   |                | X      | X      |
| Deploy Behavioral Health Consultants  | Managing Entities                             |                | X      | X      |
| Implement the MAT Prescriber Peer Mentoring Project                               | FADAA   |                | X      | X      |
| Deploy Peers for Recovery Oriented System of Care Quality Improvement Initiatives | DCF Regional SAMH Directors                   |                | X      | X      |

**B-4. Describe clearly your administrative and infrastructure costs (up to 5 percent of the award) and how these will lead to your program’s success.**

The administrative and infrastructure costs of this project include personnel costs to manage and administer the grant, an evaluation of the prevention activities, and data enhancements to the state’s prevention data system, as described below:

A competitive hiring process will be used to select a qualified Project Director with a Certified Addiction Professional designation, a master’s degree in human services or a related field, and at least two years of relevant experience. The Project Director’s role entails overall project oversight and management to ensure that goals and objectives are met, strategic planning,

tracking measurable objectives, implementing quality improvement initiatives, and ensuring compliance with all aspects of the terms and conditions of the award. An epidemiologist will manage the contract with FEi Systems and assist with data analysis; develop reports to inform strategic planning and evaluation activities; critically review grant funded reports and analyses; and consult with and advise key project staff and subrecipients regarding surveillance data.

Grantees are also required to enhance or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery. A competitive hiring process will be used to select qualified peer specialists. These individuals will be based in the six DCF regional Substance Abuse and Mental Health offices and serve as the liaison with the managing entities on grant related activities; assist the Project Director with regional needs assessments; complete quality assurance visits with service providers; and manage ROSC-related activities.

Grantees are required to evaluate prevention services implemented as part of this proposal. The evidence-based prevention strategies selected by Florida are naloxone training and distribution and school-based life skills training. These strategies are proven to prevent prescription opioid misuse and opioid-related deaths. These activities are described in more detail in other sections of the application. An evaluation of these services will be procured using grant funds. In order to capture service data from the school-based prevention programs, some administrative/infrastructure funds will be used to create new fields and codes in Florida’s Performance Based Prevention System, the database used for prevention services.

**B-5. Describe the prevention activities that will be implemented as part of your comprehensive approach to address the opioid crisis. Please clearly identify strategies to accomplish the required activities and any other activities you plan to undertake.**

Compared with adolescents who reside in large metropolitan areas, those in rural areas are significantly more likely to have ever used prescription pain relievers nonmedically, even after controlling for sociodemographics, health, and other lifetime drug use.<sup>36</sup> Randomized controlled trials of school-based life skills training in rural communities demonstrate significant reductions in prescription opioid misuse.<sup>37</sup> Florida will use a portion of these funds to implement life skills training in the following 6 rural counties with the highest rates of past 30 day opioid use that are not already receiving prevention funds through the Partnerships for Success grant:

| <b>Top 6 Non-PFS Funded Rural Counties According to Past 30 Day Prevalence of Nonmedical Opioid Use, Grades 6-12 (2016)</b> |                        |
|---|------------------------|
| <b>County (Managing Entity)</b>   | <b>Prevalence Rate</b> |
| Jackson (BBCBC)   | 3.6%                   |
| Jefferson (BBCBC)   | 3.4%                   |
| Taylor (BBCBC)  | 3.1%                   |
| Hardee (CFBHN)  | 3.0%                   |
| Okeechobee (SEFBHN)   | 2.9%                   |
| Gilchrist (LSFHS)   | 2.7%                   |

It should be noted that the Department may modify this list of counties and redirect funding based on new findings that emerge from the comprehensive needs assessment, particularly with regard to the existing infrastructure and capacity to implement life skills training in these counties.

The FOA also calls for grantees to implement primary and secondary prevention methods proven to reduce deaths associated with opioid use disorders. Florida's proposed project will reduce the number of fatal opioid overdoses through naloxone distribution and training. Naloxone is an opioid antagonist that can reverse opioid respiratory depression. For more than 40 years, naloxone has been FDA approved and used by emergency medical services personnel to reverse opioid overdoses and revive individuals who otherwise might have died without it. Naloxone is remarkably safe and has no potential for abuse. When given to individuals who are not under the influence of opioids, it produces no harmful effects, even at high doses, and while rapid opioid withdrawal may be unpleasant, it is not life-threatening. Opioid users and their loved ones are easy to train and can respond effectively to an overdose.<sup>38</sup> There is no evidence indicating that naloxone distribution encourages or increases the use of heroin or other opioids. Rather, studies suggest that increasing health awareness through training programs that accompany naloxone distribution actually reduces the use of opioids and increases users' desire to seek addiction treatment.<sup>39</sup>

Research indicates that naloxone distribution can reduce community-level overdose mortality by as much as 37% to 90%.<sup>40</sup> One analysis that focused exclusively on heroin overdoses estimated that naloxone distribution prevents 6.5% of all overdose deaths for each 20% of heroin users reached by the program. Stated another way, it is conservatively estimated that one heroin overdose death will be prevented for every 164 naloxone kits distributed.<sup>41</sup> 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.<sup>42</sup> Opioid tolerance is low and one instance of use can potentially be fatal. This makes overdose prevention and response training an extremely important part of preparing individuals for discharge.

Opioid STR grant funds will purchase NARCAN® Nasal Spray, an FDA-approved needle-free device that requires no assembly prior to use, at a cost of \$75 per 2-dose kit. Kits will be provided to individuals entering treatment due to opioid use upon admission or discharge, as well as to the friends and family members of these persons served. As recommended in SAMHSA's Opioid Overdose Prevention Toolkit, training materials 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.

**B-6. Describe the treatment/recovery support services (not less than 80 percent of award after administrative costs) that will be implemented as part of your comprehensive plan to address the opioid crisis. Please clearly identify strategies to accomplish the required activities and any other activities you plan to undertake.**

Florida will utilize approximately 87% of grant funds in the treatment/recovery support services component of the grant. This includes direct treatment and support services for individuals with opioid use disorders, implementation of standardized assessment and service need recommendations, training and technical assistance for health care professionals, child welfare personnel, and the judiciary, and two pilot projects for hospital-based buprenorphine induction.

### **Medication-Assisted Treatment**

Florida will use the majority of grant funds to expand MAT services throughout the state as part of a comprehensive plan to address the opioid crisis. According to SAMHSA, medication-assisted treatment (MAT) is an effective response to opioid use disorders. MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-person approach for the treatment of substance use disorders. The ultimate goal of MAT is full recovery. MAT for opioid use disorders involves the use of three FDA-approved medications in combination with psychosocial interventions. These medications are methadone, buprenorphine (including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations), and naltrexone (including extended-release and oral formulations or implantable buprenorphine). Florida Administrative Code currently mandates individuals who participate in medication and methadone maintenance receive counseling and that a comprehensive range of services be available based on individual need.

Grant funds will be used to pay for methadone or buprenorphine maintenance treatment for indigent, uninsured, and underinsured individuals in need, which may include screening and assessment, lab work, cost of the medication, medication administration, therapy, peer support, and other services or supports to assist the individual's recovery. DCF will develop a need-based allocation methodology for distributing funds to each of the MEs, who will in turn contract with methadone or buprenorphine maintenance treatment providers. DCF will work with each managing entity to develop an implementation plan outlining the greatest area of need in their region, current MAT capacity and how to increase it, and service targets.

DCF will also expand an existing contract with the Florida Alcohol and Drug Abuse Association (FADAA) to pay for MAT using VIVITROL for indigent, uninsured, and underinsured individuals with opioid use disorders. VIVITROL® is an extended release formulation of naltrexone that is FDA-approved for the prevention of relapse to opioid dependence. VIVITROL blocks the effects of opioids, including heroin and opioid pain medications. The recommended dose of VIVITROL is 380mg delivered intramuscularly once a month. To prevent precipitated withdrawal, patients should be opioid-free for a minimum of seven days before starting VIVITROL treatment. VIVITROL should be part of a comprehensive treatment program that includes psychosocial support.<sup>43</sup> Ideal candidates include individuals who are experiencing increased stress or other relapse risks (e.g., visiting places of previous drug use, loss of a spouse, or loss of a job), individuals with a short or less severe addiction history, and individuals who must demonstrate to professional boards or criminal justice officials that their risk of opioid use is low. VIVITROL has no potential for abuse or diversion.<sup>44</sup> FADAA estimates that these funds will help serve an additional 403 individuals per year. FADAA will reimburse providers for

screening, assessment, and medication administration. FADAA will also monitor system capacity, track expenditures, collect data, and conduct random site visits with enrolled providers.

### **Hospital-Based Buprenorphine Induction**

Florida intends to implement two hospital-based pilot programs that aim to initiate buprenorphine treatment with individuals with opioid use disorders that have overdosed. The goal is to utilize the time spent in the emergency room following an overdose to engage the individual in treatment and immediately begin buprenorphine induction. The individual is provided a prescription for buprenorphine upon discharge and linked to a maintenance provider in the community. This will keep the individual from experiencing withdrawal symptoms upon release. The pilot programs will use peer specialists to assist with engagement of the individual, provide linkage to the maintenance provider and other community support resources, and provide peer support until the individual is linked with community-based care.

### **Standardized Assessment and Service Need Recommendations**

DCF will contract with FEi Systems to implement a pilot program using the American Society of Addiction Medicine's (ASAM) CONTINUUM software. CONTINUUM is a computerized structured interview and clinical decision support system for use by intake clinicians. It provides the entire treatment team with a computer-guided, structured interview for assessing and caring for individuals with substance use disorders and co-occurring conditions. It facilitates a full biopsychosocial assessment that addresses all six dimensions of the ASAM Criteria. The decision engine uses questions and tools (such as the DSM-5, Addiction Severity Index, Clinical Institute Withdraw Assessment, and Clinical Institute Narcotic Assessment instruments) to generate a comprehensive report which includes a quantitatively-derived, ASAM-endorsed, recommended level of care determination. The CONTINUUM Triage Screener is a 21 question, computer guided, structured interview based on ASAM Criteria and the Addiction Severity Index which helps clinicians refer patients to the correct level of care. Triage enhances efficiency and increases the likelihood that a patient goes to the correct level of care fitting their needs. Triage can be administered either in person or over the phone in 15-20 minutes and generates an output report which recommends an ASAM provisional level of care placement. The patient is then referred to a provider who can provide that level of care and performs the CONTINUUM assessment to fully assess the patient's needs and identify the recommended level of care determination.

In year one, FEi Systems will integrate CONTINUUM with 7 service providers' electronic health records and the CONTINUUM Triage with central receiving entities. In year two, integration will occur with an additional 15 service providers. In total, DCF estimates that this will add 500 licensed CONTINUUM users to the system of care. FEi Systems will also provide in-person and web based training sessions and data collection and analytic functions.

### **Training and Technical Assistance**

There continue to be barriers to providing and accessing MAT because of biases within the substance abuse treatment, medical, judiciary, and child welfare systems. Although the research indicates that MAT is an effective treatment modality for individuals with opioid use disorders, it is often not presented as an option for those seeking treatment. DCF will utilize grant funds to provide training and technical assistance in MAT and other best practices to entities that come in contact with the target populations and have the opportunity to engage and link to services, including:

- Substance abuse treatment providers;
- Child welfare staff;
- The judiciary; and
- Medical personnel.

DCF will expand an existing contract with the Florida Certification Board and execute a new contract with the Peer Support Coalition of Florida to provide training for peer specialists and provider agencies. DCF will work with these two entities to develop a two-year training plan on topics such as Recovery-Oriented Systems of Care and Wellness Recovery Action Plans for Addictions. A Wellness Recovery Action Plan (WRAP®) is self-designed prevention and wellness process that helps individuals monitor their feelings, track triggering events and early warning signs of relapse, decrease the severity and frequency of undesirable feelings and behaviors, and improve their functioning and their quality of life. The development of crisis plans and post-crisis plans is also addressed in this training. The six peer specialists who will be employed in the regional DCF offices will also be trained to review assessments, treatment plans, and progress notes for evidence of recovery-oriented principles and practices and to participate in quality improvement initiatives for individuals receiving MAT services. Components of the training will include a peer review process, curriculum, and tools/templates for reviewers. Additional topics to be addressed in the second year of the project will be based on needs identified during the first year.

DCF will also expand an existing training contract with FADAA to add training specific to MAT. FADAA will provide webinars and on-site workshops that present the protocols for each type of MAT and other topics, many of which will be archived for ongoing use. FADAA will also assess the training needs of child welfare staff and family court judicial staff and develop and deliver training materials to address those needs. Face-to-face trainings and online learning modules and toolkits will be developed.

FADAA will also expand their existing MAT Prescriber Peer Mentoring Project, which currently uses four expert mentors to advise and guide VIVITROL prescribers through both formal instructional sessions and real-time, on-the-fly consultations. This project was the driving force behind rapid increases in the number of programs using VIVITROL and the number of patients receiving it. New expert peer mentors will be brought on to provide guidance to potential prescribers of buprenorphine, methadone, naltrexone, and naloxone and help them develop MAT programs and protocols. The peer mentors will participate in on-site trainings, quarterly technical assistance teleconferences, annual face to face meetings, and a statewide MAT stakeholder session. After all the peer mentors are trained, FADAA will disseminate their contact information and begin linking them up with mentees. The peer mentors will provide expert

consultation and technical assistance by phone and through web-based teleconferencing. They will identify strategies for integrating basic addiction and MAT content in the curricula in Florida's medical schools. Mentee recruitment efforts will focus on potential prescribers within Federally Qualified Health Centers, urgent care clinics, emergency departments, and primary care clinics. FADAA staff will review mentor-to-mentee calls and summarize questions asked and the answers given. These summaries will inform training plans and quality improvement initiatives. They will also provide statistics regarding the number of unique contacts, duration of contacts, mentor self-perceived effectiveness ratings, and mentee satisfaction ratings.

The Managing Entities will hire six Behavioral Health Consultants (BHCs) to support child protective investigative staff. The BHCs will provide clinical expertise and assist with the identification of parents with opioid disorders in the child welfare system. The BHCs will consult and collaborate with Child Protective Investigators (CPIs) and dependency case managers to build expertise with front line staff in the identification of substance use disorders, with specific focus on those with possible opioid disorders, improve engagement with families, and improve access to treatment. They will be required to have a Florida license in the areas of psychology, social work, mental health counseling, or family and marriage therapy, and a minimum three years of experience treating substance use disorders. Knowledge of the child welfare system and motivational interviewing is preferred. The essential functions they will perform are as follows:

- Actively establish relationships with CPIs in co-located office space.
- Educate CPIs and dependency case managers on the identification of behavioral health disorders with an emphasis on opioid use.
- Support the investigative staff and dependency case managers in understanding the effects of the behavioral health issue on parent/caregiver behavior. Assist investigative staff and dependency case managers in understanding the signs and symptoms of opioid disorders and the best practices to engage and treat.
- Educate CPIs and dependency case managers on the use of MAT.
- Assist in the field and provide office consultation during pre- or post-commencement when there is an open investigation with a suspected or identified behavioral health need.
- Actively demonstrate engagement techniques with the family when in the field with investigative staff.
- Partner with the investigative staff to provide consultations to assist in identifying danger threats, adult functioning, parental protective capacities (diminished or present), and safety management services.
- Maintain a working knowledge of community mental health and substance use providers.
- Work collaboratively with community service providers and the ME to develop contacts, facilitate referrals, and assist investigative staff with engaging clients in recommended services and improving timely access to treatment.
- Track the referrals and entry into treatment for parents with opioid disorders.
- Support investigators in mitigating behavioral issues and crises.
- Participate in legal, multi-disciplinary, and any other meetings that will assist the investigative staff and families.

## **Other Required Activities**

Spending at least 80% of the award on treatment and recovery support services is only one of several requirements in the FOA. Florida's preliminary strategies for accomplishing the other required activities identified in the FOA are described below.

Grantees are required to develop a needs assessment that identifies areas of the state where opioid misuse and related harms are most prevalent, the location of opioid treatment providers, and gaps in prevention, treatment, and recovery support activities. Working with the MEs, the Project Director will develop a needs assessment that is inclusive and comprehensive. Needs and gaps will be solicited from a variety of stakeholders, including patients, providers, and other state agencies. An emphasis will be placed on identifying barriers to access and retention in MAT. The Project Director will also collaborate with representatives from prison- and jail-based reentry programs on the identification of unmet MAT needs among individuals reentering communities from these settings. Addressing the unmet needs among this reentry population through the provision of MAT is another required activity. The needs of the Seminole Tribe and the Miccosukee Tribe will also be assessed in collaboration with community-based treatment providers that have existing relationships and service arrangements with them.

Findings from the needs assessment will inform the development of a comprehensive strategic plan, which is another required activity in the FOA. The Department will solicit input for the plan from a variety of relevant stakeholders. Representatives from criminal justice reentry programs and tribal communities are key stakeholders that will be asked to help develop the plan as required. The feedback and input the Department receives will likely precipitate revisions to the preliminary goals and objectives identified in this proposal.

Grantees are required to expand access to MAT and eliminate or reduce treatment costs for under- and uninsured patients. Previous findings from studies of individuals receiving publicly-funded MAT indicate that out of pocket costs are a major obstacle and that inability to pay potentially impacts hundreds of patients each year. The Department will address these requirements by using funds to pay for MAT services and an MAT Prescriber Peer Mentoring Project designed to increase the number of physicians and programs that offer MAT.

Grantees are required to implement and evaluate prevention services proven to reduce the number of persons with opioid use disorders and associated deaths. Florida will address this requirement by purchasing and distributing naloxone and expanding school-based life skills training programs in rural counties. These activities are described in more detail in other sections of the application. An evaluation of these services will also be procured using grant funds.

Grantees are also required to enhance or support the provision of peer and other recovery support services designed to improve treatment access and retention and support long-term recovery. Florida's proposal addresses this requirement by providing training to Certified Recovery Peer Specialists, employing six of them throughout the state to assist with quality improvement initiatives, and incorporating them into one of the pilot sites that will promote buprenorphine initiation in emergency departments.

**B-7. Describe how you will identify, recruit, and retain the population(s) of focus, and how this approach will take into consideration the language, beliefs, norms, values, and socioeconomic factors of this/these population(s).**

Individuals with opioid use disorders will be identified and recruited through the following venues:

- Behavioral health treatment providers
- Hospital emergency departments
- Urgent care clinics
- Prison and jail re-entry programs throughout the state
- Child protective investigators
- Primary care settings
- Federally Qualified Health Centers
- County Health Departments

In terms of retention, Florida recently received a technical assistance grant through SAMHSA's Bringing Recovery Supports to Scale Technical Assistance Center Strategy to promote the widespread adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental health conditions. We have completed statewide and regional summits to engage the treatment community and other stakeholders in adopting these practices to better engage and retain individuals in services and supports. We will leverage this transformative initiative with the proposed activities described in this application.

Findings from the planned needs assessment will help identify training content and service delivery strategies needed to address the unique cultural and socioeconomic needs that individuals with opioid use disorders present. Since Florida is extremely diverse and cultural norms, values and languages vary significantly from county to county - and at times within counties – it is imperative that approaches are developed at the local level.

**B-8. State the unduplicated number of individuals to which you propose to provide treatment and recovery support services (annually and over the entire project period) with grant funds. Include the types and numbers of other services to be provided and anticipated outcomes. Explain how you arrived at this number and that it is reasonable given your budget request.**

Not for profit methadone clinics provided preliminary estimates of the number of new indigent or uninsured patients that could receive either methadone or buprenorphine maintenance services each year. These estimates were based on an initial review of waitlists, call-back lists, referrals, and discharges or incomplete admissions due to inability to pay. These preliminary estimates indicate that between 2,986 and 5,220 new patients could receive methadone or buprenorphine maintenance services each year (for a total of between 5,972 and 10,440 new patients over the two year period). If all of the funding budgeted for methadone or buprenorphine maintenance was used on methadone, it is estimated that 2,386 individuals could be served per year based on average annual per person rates provided by publicly-funded methadone providers. Methadone

services are used for this exercise because DCF has more accurate and complete cost estimates for methadone. Current estimates of the cost of buprenorphine do not adequately account for the out of pocket costs that indigent and uninsured clients will face when obtaining their prescriptions. These will be developed and incorporated at a later date.

The estimated number of new patients that could receive VIVITROL per year is based on FADAA's analysis of historical trends in utilization and current reimbursement rates. They estimate that 403 new patients could receive VIVITROL each year (for a total of 806 new patients over the two year period). If these VIVITROL figures are added to the estimates above, then approximately 2,789 individuals per year (or 5,578 total over the two-year period) will receive MAT services.

These estimates will need to be refined and revised once more information regarding average retention rates and length of care is obtained. These estimates will also be refined in light of findings from the planned needs assessment, which will aim to identify unmet needs for methadone or buprenorphine maintenance from a broader array of prescribers and treatment providers, including criminal justice reentry programs.

**C-1. Describe the system design and implementation models that you will use to increase availability of services to prevent and treat OUD.**

A few models seem particularly relevant in light of the goals of this proposal and the needs identified thus far. These models are highlighted below. However, it is important to remain flexible while needs are still being identified and strategic plans are still being developed. According to the Agency for Healthcare Research and Quality, no trials comparing the effectiveness of one MAT primary care model to another have been conducted yet.<sup>45</sup> Practical considerations, as opposed to empirical evidence regarding comparative effectiveness, will drive the selection of implementation models.

The Department is particularly interested in funding hospital-based pilot programs that attempt buprenorphine induction in emergency departments with transitions to continued care in the community through primary care providers or specialty addiction treatment programs. There are two models associated with these aims – the Emergency Department Initiation of OBOT Model and the Inpatient Initiation of Medication-Assisted Treatment Model. Both of these models appear to enhance rates of retention in care compared to simple referrals for outpatient initiation of MAT after discharge from the hospital.<sup>46</sup> In developing the parameters for the proposals that will be solicited, the Department will rely heavily on lessons learned from other states that have implemented these models and the empirical research regarding their effectiveness, including research on the components that appear to be necessary for success.

The Emergency Department Initiation of OBOT Model identifies individuals with opioid use disorders in the emergency department and initiates buprenorphine induction in the emergency department. Physicians perform brief “medical management” counseling. Patients are eventually transferred to ongoing, office-based maintenance treatment or detoxification. Depending on what is available in the community, this emergency department initiation model can be used to “feed” patients into various office-based models of care.<sup>47</sup>

The Inpatient Initiation of Medication-Assisted Treatment Model also involves the identification of individuals with opioid use disorders in the hospital, with initiation of MAT (methadone, buprenorphine, or naltrexone) during the hospitalization by a multidisciplinary addiction consult service. Patients are connected with primary care or specialty addictions care, where treatment continues following hospital discharge. In some programs, when relevant, there is a buprenorphine “bridge” clinic for stabilization prior to transitioning to primary care. Primary care sites provide ongoing psychosocial services. A variation of this model involves identification of individuals with opioid use disorders in the hospital and brief counseling, with facilitated referral to a community-based clinic for induction of MAT and ongoing care following hospital discharge. Another variation uses a program nurse to identify individuals with opioid use disorders, a bridge clinic for initiation of methadone following discharge with provision of psychosocial services, and transition to another Opioid Treatment Program for long-term management. This type of program could be adapted for office-based prescribing of buprenorphine.<sup>48</sup>

With regard to rural areas of the state where individuals with opioid use disorders may face limited access to primary care physicians and specialty addiction treatment programs, the Hub and Spoke Model and Project Extension for Community Healthcare Outcomes (ECHO) Model may offer certain advantages. The Hub and Spoke model uses regional specialty treatment centers that dispense methadone and support tapering off MAT as “hubs.” The “spokes” are clinics in the community that primarily provide buprenorphine. Coordination and integration activities are carried out by a registered nurse, clinician case manager, or other “care connector” (via peer-to-peer support or behavioral health workers). Project ECHO Model entails the use of primary care clinics in rural areas that link with a university health system for tele-education and tele-consulting. This model emphasizes practitioner- or physician assistant-based screening with referral to collaborating physicians prior to initiation of MAT and for ongoing treatment.<sup>49</sup>

**C-2. Describe the Opioid Use Prevention and Treatment EBP(s) that will be used. Document how each EBP chosen is appropriate for the outcomes you want to achieve. Justify the use of each EBP for your population of focus. Explain how the chosen EBP(s) meet SAMHSA’s goals for this program. If an EBP does not exist/apply for your program, fully describe the practice you plan to implement, explain why it is appropriate for the population of focus, and justify its use compared to an appropriate existing EBP.**

The Department identifies methadone or buprenorphine maintenance as the EBPs to address the goals of reducing the unmet need for treatment and reducing opioid overdose deaths. Compared to the use of psychosocial interventions alone, methadone or buprenorphine maintenance is more likely to retain individuals in treatment and reduce heroin use and the use of pharmaceutical opioids.

At adequate doses, methadone prevents or reverses withdrawal symptoms and blocks the euphoric effects of heroin. A meta-analysis of eleven randomized clinical trials involving 1,969 heroin dependent participants found that methadone maintenance was more effective than non-pharmacological approaches (placebo medication, drug-free treatment, detoxification, or wait-list control) at retaining individuals in treatment and reducing heroin use (as measured by self-

reports and urine/hair analysis).<sup>50</sup> However, at fixed medium or high doses, buprenorphine appears to be just as effective as methadone in retaining people in treatment and suppressing illicit opioid use.<sup>51</sup>

With regard to interventions for individuals who are dependent on pharmaceutical opioids (as opposed to heroin), a meta-analysis of six randomized controlled trials involving 607 participants found that maintenance treatment with buprenorphine is more effective than detoxification or psychological treatment (e.g., counseling). This analysis also found that methadone maintenance and buprenorphine maintenance are equally effective at keeping individuals in treatment and reducing opioid use.<sup>52</sup> Methadone maintenance and buprenorphine maintenance produce consistently superior results to short-term withdrawal protocols and dose tapering regimens.<sup>53</sup>

Research also shows that the risk of fatal overdoses is at least cut in half when individuals are enrolled in medication-assisted treatment for opioid dependence.<sup>54</sup> According to the largest cohort study published to date, individuals who receive only psychological support experience twice the risk of fatal opioid overdose compared to individuals who receive methadone or buprenorphine.<sup>55</sup> Furthermore, community-level analysis shows that there is a strong and statistically significant association between increases in the number individuals on buprenorphine maintenance and decreases in heroin-related overdose deaths.<sup>56</sup> Methadone or buprenorphine treatment for opioid-dependent injecting drug users also reduces injecting use and the sharing of injecting equipment. It is also associated with reductions in the proportion of injecting drug users reporting exchanges of sex for drugs or money. The reductions in these risk behaviors translate into reductions in cases of HIV infection.<sup>57</sup> A risk-adjusted retrospective analysis of insurance data found that MAT (including the use extended-release naltrexone, oral naltrexone, buprenorphine, and methadone) is associated with significantly fewer admissions for detoxification and/or rehabilitation and inpatient medical care, compared to treatment that does not include medication.<sup>58</sup>

The proposed prevention components of this project – school-based life skills training and naloxone training and distribution – are also evidence-based. Randomized controlled trials of school-based life skills training in rural communities demonstrate significant reductions in prescription opioid misuse.<sup>59</sup> Research indicates that naloxone distribution can reduce community-level overdose mortality by as much as 37% to 90%.<sup>60</sup> One analysis that focused exclusively on heroin overdoses estimated that naloxone distribution prevents 6.5% of all overdose deaths for each 20% of heroin users reached by the program. Stated another way, it is conservatively estimated that one heroin overdose death will be prevented for every 164 naloxone kits distributed.<sup>61</sup> It should also be noted that there is no evidence indicating that naloxone distribution encourages or increases the use of heroin or other opioids. Rather, studies suggest that increasing health awareness through training programs that accompany naloxone distribution actually reduces the use of opioids and increases users' desire to seek addiction treatment.<sup>62</sup>

**C-3. Explain how your choice of an EBP or practice will help you address disparities in service access, use, and outcomes for your population(s) of focus.**

Individuals seeking treatment in publicly funded programs face disparities in access to high-quality MAT. Compared to privately funded programs, publicly funded programs are significantly less likely to have a physician on staff and they prescribe significantly fewer medications for substance use disorders.<sup>63</sup> Florida intends to emphasize expanding access to maintenance medications among publicly funded provider networks to reduce these disparities.

The prevention components of this proposal are designed to reduce disparities in rural communities. 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.<sup>64</sup> Increasing access to naloxone will help address these disparities. Furthermore, compared with adolescents who reside in large metropolitan areas, those in rural areas are significantly more likely to have ever used prescription pain relievers nonmedically, even after controlling for sociodemographics, health, and other lifetime drug use.<sup>65</sup> Implementation of school-based life skills training programs in high-need rural counties will address disparities. These programs have been tested among rural populations and found to be effective at reducing in prescription opioid misuse.<sup>66</sup>

**C-4. Describe any modifications that will be made to the EBP or practice and the reasons the modifications are necessary. If you are not proposing any modifications, indicate so in your response.**

MAT is the principal evidence-based practice that will be deployed. Best practice guidelines for MAT will be reviewed, compiled, and shared with MAT providers funded under this grant. Existing guidelines published by SAMHSA addressing opioid use disorders and MAT will be promoted.<sup>67</sup> Providers will be asked to adhere to best practice guidelines to the greatest extent possible. At this point, no modifications have been identified, though this might change in response to findings from the needs assessment and quality improvement initiatives.

**C-5. Explain how you will monitor the delivery of the EBPs to ensure that they are implemented according to the EBP guidelines.**

The Project Director will work with the Managing Entities and the Florida Alcohol and Drug Abuse Association (FADAA) on the development of an EBP monitoring plan. This plan will identify current EBP monitoring activities conducted by the MEs and FADAA and propose ways that these activities can be expanded or enhanced to focus on EBPs related to MAT and opioid use disorders.

**D-1. Discuss the capability and experience of the applicant organization with similar projects and populations. Demonstrate that the applicant organization has linkages to the population(s) of focus and ties to grassroots/community-based organizations that are rooted in the culture(s) and language(s) of the population(s) of focus.**

The Department's Office of Substance Abuse and Mental Health, as the Single State Agency for behavioral health, has considerable experience gained by administering the Substance Abuse Prevention and Treatment Block Grant and by implementing a variety of discretionary grants from SAMHSA. For example, the Children's Mental Health System of Care Expansion and

Implementation grant developed 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.

The Department also has relevant experience gained by implementing the Strategic Prevention Framework – Partnerships for Success (SPF-PFS) grant. This project aims to reduce prescription drug misuse among Floridians ages 12-25 and the nonmedical use of opioids among Floridians ages 26 and older and strengthen prevention capacity and infrastructure at the state and community levels. Florida's Overdose Prevention Coordinator is the Project Director on the SPF-PFS grant and she will support the overdose prevention initiatives proposed in this application.

**D-2. Discuss the capability and experience of other partnering organizations with similar projects and populations. Demonstrate that other partnering organizations have linkages to the population(s) of focus and ties to grassroots/community-based organizations that are rooted in the culture(s) and language(s) of the population(s) of focus**

The MEs 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.

FADAA is a non-profit association that represents over 100 substance abuse 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. From 2006 to 2008, FADAA participated in the Advancing Recovery initiative, funded by the Robert Wood Johnson Foundation, to increase the use of VIVITROL. In conjunction with DCF, FADAA recruited providers to participate in the pilot, organized and facilitated training, and addressed barriers to service and developed the infrastructure needed to expand VIVITROL utilization. FADAA also successfully implemented the 2014-2015 funding allocation for VIVITROL expansion to individuals ordered into treatment by the courts. FADAA established a program to reimburse providers for screening and assessments and for administration of the medication. FADAA also identified and addressed MAT training and technical assistance needs using nationally recognized subject matter experts. FADAA's Prescriber Peer Mentor Program used expert medical consultants to provide training and technical assistance to new VIVITROL providers. FADAA implemented an additional 2015-2016 allocation for VIVITROL expansion. Since FADAA's VIVITROL program began, over 4,000 VIVITROL injections have been administered to 1,431 patients, and 42 providers have become enrolled participants. Furthermore, FADAA is currently partnering with NIATx to identify and engage Florida providers in a research study designed to improve statewide buprenorphine prescribing capacity.

**D-3. Provide a complete list of staff positions for the project, including the Project Director 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 only key staff position is the Project Director. Their level of effort will be 100%. A competitive hiring process will be used to select a qualified Project Director with a Certified Addiction Professional designation, a master's degree in human services or a related field, and at least two years of relevant experience. The Project Director's role entails overall project oversight and management to ensure that goals and objectives are met, strategic planning, tracking measurable objectives, implementing quality improvement initiatives, and ensuring compliance with all aspects of the terms and conditions of the award.

**D-4. Discuss how key staff members have demonstrated experience and are qualified to serve the population(s) of focus and are familiar with their culture(s) and language(s). If key staff members are to be hired, discuss the credentials and experience the new staff must possess to work effectively with the population of focus.**

The Department will use a competitive hiring process to select a qualified Project Director (level of effort: 100%). In order to qualify, the Project Director will be required to hold a Certified Addiction Professional designation, have a master's degree in human services or a related field, and have at least two years of relevant experience.

**D-5. Describe how your staff will ensure the input gathered from consumers, clients, and families in assessing, planning and implementing your project.**

The Project Director will compile and review all input previously gathered from consumers and their families by the Managing Entities as part of their regional needs assessments.

**E-1. Document your ability to collect and report on the required performance measures as specified in Section I-2.2 of this FOA.**

The Department has the ability to collect and report all of the required data. The Managing Entities will ensure that the service contracts contain all necessary data collection and reporting requirements. Each of the performance measures specified in Section I-2.2 will be collected and reported on as follows:

- Number of people who receive opioid use disorder treatment. Funded providers will submit these records to the Department's Substance Abuse and Mental Health Information System.
- Number of people who receive opioid use disorder recovery services. These records will be submitted by funded providers and collected in the Department's Substance Abuse and Mental Health Information System.
- Number of providers implementing MAT. These figures will be collected and reported by the Managing Entities and sent to the Project Director.
- Number of opioid use disorder prevention and treatment providers trained, to include NPs, PAs, as well as physicians, nurses, counselors, social workers, case managers, etc. These figures will be reported by FADAA and the Behavioral Health Consultants.

- Numbers and rates of opioid use. These figures will come from the National Survey on Drug Use and Health and may need to be reported by SAMHSA’s Center for Behavioral Health Statistic and Quality.
- Numbers and rates of opioid overdose-related deaths. These figures are collected and reported by the Florida Medical Examiners Commission.

**E-2. Describe your specific plan for data collection, management, analysis, and reporting. 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.**

The Project Director will be responsible for tracking the measurable objectives identified in response to question B1. The Project Director will review and analyze the performance data on a quarterly basis. The Project Director will also compile and submit mid-year progress reports and final annual reports.

**E-3. Describe the quality improvement process that will be used to track whether your performance measures and objectives are being met, and how these data will inform the ongoing implementation of the project.**

The Project Director 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 Project Director will analyze and summarize all available feedback from patients and identify 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 incorporated through program modifications. The Project Director will also collaborate with the regional peers who will be reviewing treatment plans to identify recovery-oriented principles and practices. 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.

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