Statewide Drug Policy Advisory Council
2019 Annual Report

To the Governor,

the President of the Senate,

and the Speaker of the
House of Representatives

December 1, 2019

Table of Contents

Statewide Drug Policy Advisory Council
Members and Designees

Department of Health
- Scott A. Rivkees, MD
  State Surgeon General

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- The Honorable Ashley Moody
- Andrew Benard
  Assistant Deputy Attorney General
  and Special Counsel

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  Commissioner
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  Secretary
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  Office of Substance Abuse and Mental Health

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  Secretary
- Patrick Mahoney
  Director
  Development, Improvement and Readiness

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  Commissioner
- Penny Taylor
  Director *Healthy Schools*

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  Secretary
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- COL Michael A. Ladd
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  Florida National Guard

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  Judiciary Member
- Aaron Gerson

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  Executive Advisor
  Florida Behavioral Health Association
- Dotti Groover-Skipper
  Florida Anti-Trafficking Director
  The Salvation Army
- Doug Leonardo, LCSW
  Sr. VP Operations and Development
  Central and North
  Chrysalis Health
- Peggy Sapp
  President, CEO
  Informed Families/The Florida Family Partnership
- Kimberly K. Spence
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- Roaya Tyson
  COO Gracepoint
- John VanDelinder, PhD
  Executive Director
  Sunshine State Association of Christian Schools

Staff Liaison
- Nathan Dunn, MSA

Acronyms Used in this Report

ACGME:	Accreditation Council for Graduate Medical Education
AHCA	Agency for Health Care Administration
API	Application Programming Interface
CAPT	Center for Application of Prevention Technologies
CDC	Centers for Disease Control and Prevention
CDP	Consumer Driven Product
CHD	County Health Department
CNPPA	Child Nicotine Poisoning Prevention Act
DCF	Department of Children and Families
DEA	Drug Enforcement Agency
DEN	Drug Epidemiology Network
DOE	Department of Educations
DOH	Department of Health
DTO	Drug Trafficking Organization
ED	Emergency Department
EMS	Emergency Medical Services
EMSTARS	EMS Tracking and Reporting System
FADAA	Florida Alcohol and Drug Abuse Association
FDA	Food and Drug Administration
FDC	Florida Department of Corrections
FDLE	Florida Department of Law Enforcement
FLHealthCHARTS	Florida Health Community Health Assessment Resource Tool Set
FPQC	Florida Perinatal Quality Collaborative
FQHC	Federally Qualified Health Center
FSAM	Florida Society of Addiction Medicine
FYSAS	Florida Youth Substance Abuse Survey
HEROS	Helping Emergency Responders Obtain Support
HIDTA	High Intensity Drug Trafficking Areas
HMO	Health Maintenance Organization

IDEA	Infectious Disease Elimination Act
MAT	Medication Assisted Therapy
MH	Mental Health
MHPAEA	Mental Health Parity and Addiction Equity Act
NAS	Neonatal Abstinence Syndrome
NIDA	National Institute on Drug Abuse
NSDUH	National Survey on Drug Use and Health
OD	Opioid Overdose
OD2A	Overdose Data to Action
ODMAP	Overdose Detection Mapping Application Program
ONDCP	Office of National Drug Control Policy
OUD	Opioid Use Disorder
PDMP	Prescription Drug Monitoring Program
PPO	Preferred Provider Organization
RCO	Recovery Community Organization
ROSC	Recovery Oriented System of Care
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SBIRT	Screening, Brief Intervention and Referral to Treatment
SEOW	State Epidemiological Outcomes Workgroup
SEP	Syringe Exchange Program
SMMC	Statewide Medicaid Managed Care
SOR	State Opioid Response
STR	State Targeted Response
SUD	Substance Use Disorder

Message from the State Surgeon General Scott A. Rivkees, MD

The 2019 Annual Report of the Statewide Drug Policy Advisory Council (Council) has been made available for policymakers and statewide leadership as we continue our efforts to address the opioid epidemic and other substance abuse issues in Florida. Section 397.333, Florida Statutes, directs the Florida Department of Health (DOH) to serve as the coordinating entity for the Council and the content of this report reflects the updates and information from its members.

In response to the opioid epidemic in 2019, Governor Ron DeSantis issued Executive Order 19-97 which created the Office of Drug Control and established a Statewide Task Force on Opioid Abuse. The executive order directs the Office of Drug Control to coordinate and centralize efforts to treat and prevent substance abuse in Florida. The office will gather information to develop a statewide prevention strategy and identify funding to limit substance abuse. The Statewide Task Force on Opioid Abuse will research and assess the nature of opioid drug abuse in Florida while identifying best practices to address the opioid epidemic through education, treatment, prevention, recovery and law enforcement.

DOH continues to work diligently in collaboration with other state agencies and organizations to address this important issue. We maintain Florida's Enhanced State Opioid Overdose Surveillance, which is a three-year grant from the Centers for Disease Control and Prevention (CDC). This grant is accelerating the delivery of fatal and nonfatal opioid surveillance and findings to key stakeholders working to prevent or respond to opioid overdoses. The Prescription Drug Monitoring Program (PDMP) is also administered through DOH and provides quarterly opioid dispensing data in support of surveillance efforts with key partners. A quarterly Prescriber Report Summary is disseminated from the PDMP to prescribers for self-evaluation while integration into Electronic Health Records and interstate data sharing is ongoing. The Department developed an online, county-level data resource (FLHealthCHARTS) that provides opioid-related data for county health departments and key partners. This profile will be updated quarterly and annually and includes important information such as pre-hospital response, hospital admission and death data. The ability to document and act, based on local data sources, is essential to overcoming the opioid epidemic.

I would also like to highlight the important work being accomplished through the Helping Emergency Responders Obtain Support (HEROS) Program. The Florida Legislature provided $5,000,000 from the General Revenue Fund for emergency opioid antagonists to be made available to emergency responders. Eligible emergency responders include law enforcement officers, firefighters, emergency medical technicians, paramedics, correctional officers and correctional probation officers. During fiscal year 2018-2019, DOH provided 154,905 doses of naloxone to approximately 217 agencies that employ licensed emergency responders. We provided naloxone to agencies that employ licensed emergency responders located in 53 of Florida's 67 counties. Our goal is to expand distribution to all 67 counties by the end of 2021.

Finally, it is important to note that Florida received a new source of federal funding in 2019 in the form of the Overdose Data to Action (OD2A) grant. This grant provides DOH and our local partners with better access to complete, timely data on prescribing and nonfatal and fatal drug overdoses to help understand the full scope and course of this epidemic. This important grant serves as an opportunity for Florida and local public health systems to further mobilize surveillance and prevention efforts to address the opioid overdose crisis.

Looking forward, the Council is proposing several important next steps. The report includes recommendations intended to expand the use of naloxone in our communities and address the emerging concerns surrounding teenage vaping. The Council recommended expanded marketing to young people regarding the dangers of drug abuse and increased efforts to help

children who are born with Neonatal Abstinence Syndrome. There continues to be a focus on increasing the number of physicians with a specialty in addiction medicine as well as an effort to reduce the abuse of methamphetamines in our state.

Together, we will continue working to successfully address the opioid epidemic in our state. The Florida Department of Health remains committed to working with the other agencies and organizations that belong to the Statewide Drug Policy Advisory Council as well as our local, state and national partners to enhance our collaborative efforts and improve our collective efficacy.

Scott A. Rivkees, MD
State Surgeon General

Summary of 2019 Meetings
Statewide Drug Policy Advisory Council

As required by section 397.333(4)(b), Florida Statutes, Florida's Statewide Drug Policy Advisory Council's 2019 Annual Report analyzes the problem of substance abuse in the state and provides updates on recommendations to the Governor and Legislature for consideration.

The Statewide Drug Policy Advisory Council (Council) held four meetings during 2019 in Tallahassee: January 29, April 23, July 23 and October 29. The Council received presentations from a broad spectrum of public and private sector experts in the fields of addiction, prevention, treatment, surveillance and law enforcement.

This report provides background regarding the issue of drug abuse in Florida and specifically the current opioid epidemic. The remainder of the report is structured around the areas of focus contained in the 2019 National Drug Control Strategy: 1) Prevention, 2) Treatment and Recovery, and 3) Reducing the Availability of Illicit Drugs. The report will also include recommendations regarding 4) Data Collection and Surveillance.

During the January 29, 2019, meeting, the Council heard from Dr. Maya Balakrishnan, with the Florida Perinatal Quality Collaborative (FPQC), who explained that most facilities lack standardized processes in screening substance using pregnant women, determining safe discharge and facilitating outpatient pharmacologic management after discharge. Length of hospital stay is used as an indicator of efficiency. FPQC's goal is that by June 2020, participating hospitals will have a 20 percent decrease in average length of stay. Karen Weaver with the Florida Department of Law Enforcement (FDLE) shared that there are four High Intensity Drug Trafficking Areas (HIDTA) task forces in Florida that encompass 29 counties. Efforts of the HIDTAs include coordination among law enforcement agencies in each area of responsibility and include identification and effective disruption and dismantlement of local, multi-state and international Drug Trafficking Organizations (DTO). Vicki Koenig, FDLE's Bureau Chief of Policy & Special Programs, shared updates from the Florida Medical Examiners 2017 Annual Report. Eveline van Beek from KPMG shared the importance of having different priorities for each agency/department that need to be balanced in a statewide approach that allows for local implementation regarding the opioid epidemic. Javier Betancourt, Grant Resources Manager with DOH, shared that epidemiologists are analyzing and disseminating data to internal and external stakeholders to ensure coordinated intervention and prevention efforts between federal, state, and local officials and partners.

The Council met on April 23, 2019, and received updates from Melissa Jordan, Director, Public Health Research with DOH. She shared that the short-term goals of the opioid surveillance workgroup are to develop an Opioid Surveillance Plan and improve the data dissemination through a county profile report. Identifying end user needs, improving data visualization tools and timeliness, and supporting data linkages are the long-term goals of the workgroup. Tom Wallace, Assistant Secretary for Medicaid Finance and Analytics, Agency for Health Care Administration (AHCA), explained how AHCA was one of six agencies selected through an application process nationwide to participate in the fall 2018 Substance Use Disorders Data Dashboards Flash Track program. Lorraine Austin, Opioid Response Grant Project Director, Office of Substance Abuse and Mental Health, with the Department of Children and Families (DCF), explained the different ways their agency works to reduce opioid related deaths, prevent prescription opioid misuse among young people, increase access to medication assisted treatment (MAT), and increase the number of people trained in MAT and recovery support services. Mary Booker, State Opioid Coordinator, Office of Substance Abuse and Mental Health, with DCF, said that to effectively respond to the opioid crisis, it is critical to identify the streams

of federal and private sector funding coming into the state and the services being provided by these diverse resources. Ms. Booker briefly explained that recovery peer specialists use their own unique, life-altering experience, to guide and support others recovering from addiction, mental health disorders, and/or abuse. Zack Gibson, Chief Child Advocate and Director, Office of Adoption and Child Protection, Executive Office of the Governor, and Brenna Kawar, from DOH's Division of Children's Medical Services, Bureau of Child Protective Services, shared about the *Handle with Care* program, which is an intervention for any student who has experienced a recent traumatic event. Patrick Mahoney, Acting Director of Development, Improvement and Readiness, with the Florida Department of Corrections (FDC) shared that there are 4,165 inmates with opioid related charges and that 349 (8 percent) have successfully completed treatment for a substance use disorder and 439 (11 percent) are currently enrolled in treatment for a substance use disorder.

During the July 23, 2019, meeting, the Council heard from Jennifer Johnson, MPH, Interim Assistant Deputy Secretary for Health, who provided an overview of the Florida State Health Improvement Plan. She emphasized the goals to reduce the number of newborns experiencing neonatal abstinence syndrome (NAS) and the number of opioid overdose deaths. Wes Evans, Statewide Coordinator of Integration and Recovery Services with DCF, provided an overview of Peer Specialists which included their role, benefits, barriers, preparation, billing and supervision. Mara Michniewicz, Prevention Program Manager, HIV/AIDS Section with DOH, provided a presentation on the expansion of the Infection Disease Elimination Act (IDEA), which will allows county commissions to authorize syringe exchange programs by way of a county ordinance and is applicable to all counties. Jason Fields, MD, former President of Florida Society of Addiction Medicine (FSAM), communicated that states are using federal and state funds to deliver high-quality, competency-based addiction medicine education. Council members discussed updates for the 2019 Annual Report and provided agency and member updates.

The fourth quarterly meeting of the year was held on October 29, 2019. The Council heard a presentation from Courtney Coppola, DOH Chief of Staff and Medical Marijuana Coordinator. She noted that there are now more than 2,500 physicians certified to prescribe medical marijuana in Florida and more than 277,000 Florida citizens who are active qualified patients. The Council then heard a presentation from Erica Floyd Thomas, AHCA's Chief of Medicaid Policy, and Susan Williams, a Senior Pharmacist at AHCA. Their presentation informed the Council that all medication-assisted treatments are covered by Florida Medicaid which includes naltrexone tablets, vivitrol injections, buprenorphine; and suboxone tablets and film. The next presentation was done by Paula Williams, an Epidemiologist with DCF, who spoke on the "Patterns and Trends of the Opioid Epidemic in Florida." She noted that white males ages 25-35 were among the highest group of opioid-caused deaths. The final presentation was done by Melissa Jordan, Director of Public Health Research with DOH. She spoke about the Overdose to Action Opioid grant, which is a 3-year grant from the Center for Disease Control and Prevention (CDC), worth $58.8 million. The grant work will seek to decrease the rate of opioid misuse and opioid use disorder (OUD), increase provision of evidence-based treatment for OUD, decrease the rate of emergency department (ED) visits due to misuse or OUD and decrease drug overdose death rate, including prescription and illicit opioid overdose death rates. The Council used the remainder of the meeting to discuss updates to the 2019 Annual Report draft and to provide agency updates.

Summary of Findings

Introduction

Florida continues to face ongoing threats like the opioid epidemic while developing new strategies to meet emerging issues like the growing abuse of methamphetamines and the danger that vaping is bringing to our youth. The Drugs Identified in Deceased Persons by Florida Medical Examiners 2018 Annual Report indicated that during 2018, there were 5,576 opioid-related deaths reported in Florida. This is 602 less than the previous year, which represents a 10 percent decrease. The report also indicated that occurrences of methamphetamine increased by 23 percent (198 more) and deaths caused by methamphetamine increased by 33 percent (155 more).[1] Regarding teenage vaping, there has been a 583% increase in the use of e-cigarettes/e-liquids by Florida's youth (ages 11-17) since 2012.[2] These continuing risks provide the need for ongoing collaboration at the local, state and national level.

Need for Services and Receipt of Services among the General Population

The National Survey on Drug Use and Health (NSDUH) provides important estimates of substance use, substance use disorders, and other mental illnesses at the national, state and sub-state levels. The NSDUH is an annual survey of the civilian, noninstitutionalized population ages 12 and older, using face-to-face, computer-assisted interviews. The NSDUH collects information from residents of households, persons in non-institutional group quarters (e.g., shelters, rooming/boarding houses, college dormitories, migratory worker camps and halfway houses), and civilians living on military bases. Persons *excluded* from the survey include persons with no fixed household address (e.g., homeless and/or transient persons not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term hospitals. State- and sub-state level estimates are usually based on 2-year or 3-year averages to enhance precision. There is usually at least a 2-year lag between the date when the data are collected and the state-level estimates are published.

According to the most recently published, Florida-specific estimates from the 2016-2017 NSDUH, approximately 4.5% of children ages 12-17 and 7. 1% of adults ages 18 and older experienced a substance use disorder in the past year.[3] The majority of individuals with substance use disorders do not receive treatment, including approximately 92% of individuals with alcohol use disorders and 87% of individuals with an illicit drug use disorder.[4] Importantly, the vast majority (95%) of individuals classified by the NSDUH as needing, but not receiving, drug treatment also report that they did not feel they needed it. Only about 2% felt they needed treatment and made an effort to get it.[5]

The State Epidemiological Outcomes Workgroup (SEOW)

Florida's State Epidemiological Outcomes Workgroup (SEOW) plays several roles in state, regional, and community drug-related morbidity and mortality surveillance. Membership (n = 18) consists of epidemiologists and individuals who are knowledgeable about substance use issues including prevention, intervention, and treatment. Participating entities include DCF, FDLE–Medical Examiners Commission, DOH, AHCA, and the Department of Education. In addition, the SEOW's composition includes a representative from each of the Drug Epidemiology Networks (DENs) that operate across the state of Florida. Through the Partnerships for Success grant, eight counties were selected for DEN development and implementation including Broward, Duval, Franklin, Hillsborough, Manatee, Palm Beach, Walton and Washington. Both

the SEOW and individual DENs produce annual reports that are reviewed by DOH and incorporated into strategic initiatives as appropriate. Additionally, fentanyl and fentanyl-analogs continue to drive overdoses, including deaths involving cocaine. Polydrug toxicity is still the most common pattern observed among deaths caused by drugs. Rural counties report an increase in heroin use and the emergence of fentanyl. A copy of the 2018 SEOW Report is available at the following location: https://www.myflfamilies.com/serviceprograms/samh/publications/docs/Florida%20SEOW%20Annual%20Report%202018.pdf.

Primary Prevention of Substance Use: Trends from the Florida Youth Substance Abuse Survey (FYSAS)

Substance use among youth in Florida continues to trend downward. Among middle and high school students in Florida, between 2008 and 2019, the prevalence of lifetime alcohol use decreased from 53 percent to 37 percent and the past-30-day prevalence of alcohol use decreased from 30 percent to 15 percent. Regarding binge drinking by students (in the past two weeks), the prevalence decreased from 15 percent to 7 percent. High schoolers are asked if they ever woke up after a night of drinking and did not remember the things they did or the places they went. The lifetime prevalence of "blacking out" among high schoolers decreased from 19 percent to 13 percent.

Regarding marijuana use, the prevalence of lifetime and past 30-day marijuana use among middle and high school students is essentially flat between 2008 and 2019. Lifetime prevalence decreased from 21 percent to 20 percent, and past 30-day prevalence decreased from 11 percent to 10 percent. Looking more specifically at *vaping* marijuana, approximately 15 percent of middle and high school students reported vaping marijuana at least once in their lifetimes in 2019, and approximately 8 percent did so in the past 30-days. Regarding the use of any illicit drug other than marijuana, the lifetime prevalence decreased from 21 percent to 15 percent between 2008 and 2019. The prevalence of the current (past 30-day) use of any illicit drugs other than marijuana decreased from 9 percent to 6 percent.[6]

Opioid Epidemic

Nationally, the opioid epidemic continues to be a challenge for public health officials, law enforcement and policy makers. According to the National Institute on Drug Abuse (NIDA), more than 130 people nationwide died every day during 2017 due to an opioid overdose. There are a number of factors that have contributed to this toll. For example, 21 to 29 percent of patients who are prescribed opioids for chronic pain have misused the substance. In addition, approximately 80 percent of people using heroin originally abused prescription opioids. The nationwide impact of opioid overdoses causes $78.5 billion a year in medical costs, criminal justice actions and lost productivity.[7] In July 2019, the CDC announced that new drug overdoses had decreased by 4.2 percent in 2018. However, this encouraging news was also balanced with the fact that 18 states saw an increase in drug overdose deaths.[8]

The Drugs Identified in Deceased Persons by Florida Medical Examiners 2018 Annual Report indicated that there were 5,576 opioid-related deaths reported (which averages more than 15 deaths per day). This is 602 less than the previous year, which represents a 10 percent decrease. Overall, 6,701 individuals died with one or more prescription drugs in their system, which is a 3 percent decrease. The drugs were identified as either the cause of death or merely present in the decedent. These drugs may have also been mixed with illicit drugs and/or alcohol. The drugs that caused the most deaths were fentanyl (2,348), cocaine (1,644), benzodiazepines (1,136, including 664 alprazolam deaths), morphine (1,102), fentanyl analogs (874), ethyl alcohol (866) and heroin (806).[9]

Evidence-Based Responses to the State of Emergency Due to the Epidemic of Opioid-Related Deaths

DCF has taken the lead regarding the deployment of evidence-based resources to prevent opioid-related deaths. State and federal funds, including the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Targeted Response (STR) Grant, State Opioid Response (SOR), and Substance Abuse Prevention and Treatment (SAPT) Block Grant, are directed at the most effective interventions. According to a model published in the *American Journal of Public Health* in 2018, the interventions that will reduce the greatest number of opioid overdose deaths over 5 to 10 years in the U.S. are identified in the table below.[10] All of these interventions were recommended by Florida's Drug Policy Advisory Council in previous Annual Reports. An update on each of them follows.

Figure A. Evidence-Based Interventions to Reduce Opioid Deaths Nationwide Over 5 to 10 Years[11]

Intervention	Estimated Number of Opioid Deaths Prevented Over 5 Years	Estimated Number of Opioid Deaths Prevented Over 10 Years
Expansion of Naloxone Availability	10,200	21,200
Expanded Access to Medication-Assisted Treatment	4,900	12,500
Expansion of Needle Exchange Programs	2,700	5,900
Reduced Prescribing for Acute Pain	1,900	8,000
Expansion of Prescription Drug Disposal Programs	300	2,400

Expansion of Naloxone Availability

Research indicates that naloxone distribution can reduce opioid overdose rates by as much as 11% to 46%.[12] It is conservatively estimated that one heroin overdose death is prevented for every 164 naloxone kits distributed.[13] Additionally, studies suggest that increasing health awareness through training programs that accompany naloxone distribution may reduce the use of opioids and increases users' desire to seek addiction treatment.[14] DOH initiated an Overdose Prevention Program in August 2016. The program has been funded through a variety of sources, including General Revenue, the SAPT Block Grant, the STR grant, and the SOR grant. Organizations enrolled in the program distribute free, take-home naloxone kits directly to people who use drugs or are otherwise at risk of experiencing an overdose and to their loved ones who may witness an overdose. There are currently 110 organizations participating in the program, including substance use and mental health treatment facilities, hospital EDs, harm reduction programs, peer recovery organizations, homeless service providers, FQHCs and other community-based organizations. Since the start of the program, over 76,000 naloxone kits have been distributed among participating providers and 3,010 overdose reversals have been reported. In order to take the fight against opioid deaths to the next level, DCF will endeavor to increase the number of hospital ED sites participating in the naloxone distribution program (currently there are only 10) and the number of emergency medical services (EMS)/Fire naloxone leave-behind programs in operation (currently there are only 5).

In response to the nationwide opioid epidemic, funding has been made available through DOH for emergency opioid antagonists. DOH has been appropriated $5,000,000 from the General Revenue Fund for the purchase of emergency opioid antagonists to be made available to emergency responders. DOH has established the Helping Emergency Responders Obtain Support (HEROS) Program for the purpose of acquiring emergency opioid antagonists for

agencies that employ emergency responders. This year, HEROS has provided 154,905 doses of naloxone to approximately 217 agencies that employ licensed emergency responders. This has allowed DOH to provided naloxone to agencies that employ licensed emergency responders located in 53 of Florida's 67 counties. The HEROS Program recently shipped naloxone to emergency responder agencies that applied for naloxone between July 1, 2019, and August 31, 2019, that met award requirements. The HEROS program began accepting applications for FY 2019/2020 Round 2 applications in November 2019.

Expanded Access to Medication-Assisted Treatment (MAT)

Methadone and buprenorphine maintenance are effective ways to decrease the illicit use of opioids and reduce the risk of overdose. Research shows that the risk of fatal overdoses is at least cut in half when individuals are enrolled in agonist (methadone or buprenorphine) maintenance treatment for opioid dependence.[15] Nearly 13,000 individuals received medication-assisted treatment services under DOH's STR Grant, which concluded in April 2019. Approximately 55 percent were served with buprenorphine, 34 percent were served with methadone, and 11 percent were served with long-acting naltrexone (Vivitrol).

Additionally, before STR there were only 65 authorized buprenorphine prescribers in DOH's network of publicly-funded treatment providers. Now there are 163 prescribers, representing a 150 percent increase in capacity. For clients who have already completed opioid detoxification, long-acting injectable naltrexone (Vivitrol) is another U.S. Food and Drug Administration (FDA)-approved medication that helps prevent relapse. The number of Vivitrol prescribers in DOH's network quadrupled over the course of STR, increasing from only 11 prescribers up to 46. Regarding outcomes, the percent of negative drug test results increased from 70.5 percent in the first month of treatment to 90.2 percent at the sixth month of treatment. After the initial 31 days in services, the rate of non-fatal overdoses decreased by 70 percent and continues to drop. There is considerable room for improvement with regard to retention. Approximately two-thirds of all STR discharges from care were due to individuals disengaging and leaving voluntarily, or because they were administratively discharged (including those who were non-compliant with program rules).

Expansion of Syringe Exchange Programs (SEPs)

Syringe exchange programs are front line public health interventions that effectively reduce the spread of HIV and hepatitis C by reducing the sharing, reuse, and circulation of syringes and injecting equipment.[16] Research shows that every dollar spent on syringe exchange programs saves at least three dollars in treatment costs averted.[17] Syringe exchange programs provide a range of comprehensive healthcare services including testing and counseling for various infectious diseases, overdose prevention, and vaccinations. Syringe exchange programs also facilitate recovery by linking people with substance use disorders to treatment services.[18] Florida's first legal syringe exchange program – called the IDEA Exchange – opened in Miami-Dade County on December 1, 2016. The program provides compassionate and nonjudgmental services and empowers people who use drugs to make healthier and safer choices regardless of whether they are ready to stop using drugs. Since the start of the IDEA Exchange in Miami, 1,147 have enrolled in the program.

A total of 1,059 HIV rapid tests have been performed among participants, with an HIV positivity rate of 12.5% (self-reported or newly diagnosed). A total of 877 hepatitis C rapid tests have been performed, with a 46.7% positivity rate. Additionally, 340 participants have been referred to substance use treatment services. Compared to the fixed exchange site in Miami, the mobile van is more likely to attract people who inject drugs from higher risk and harder to reach groups (i.e., more women, more African Americans, higher self-reported hepatitis C virus seropositivity, lower socioeconomic status, more homelessness).[19] Miami's program also reduced the number of syringes improperly disposed of in public places by nearly 50%.[20]

The recently released 2018 Annual Report on *Drugs Identified in Deceased Persons by Florida Medical Examiners* reflects a 13% reduction in opioid-caused deaths compared to 2017.[21] Naloxone distribution to people who use drugs through the Miami IDEA syringe exchange may have contributed to steeper reductions in opioid-caused deaths in South Florida. Miami-Dade had a 39% reduction and Broward had a 29% reduction in opioid-caused deaths.[22] It should be noted that about 10% of the IDEA Exchange participants using the mobile van unit and 20% of those using fixed site in Miami are residents of Broward County.[23] In partnership with DOH, the IDEA Exchange has distributed 2,432 boxes of naloxone and documented 1,347 reported reversals.

Effective on July 1, 2019, new legislation in Florida (Senate Bill 366) permits county commissions to authorize the establishment of additional syringe exchange programs through county ordinances.[24] The law requires county commissioners to take several steps including enlisting the help of county health departments to provide ongoing advice and recommendations regarding program operation. DCF will ensure that new programs are equipped with overdose reversal kits and establishing the processes and relationships needed to effectively link individuals to addiction treatment services.

Reduce Prescribing for Acute Pain

DCF, DOH, and a variety of community-based partners, including anti-drug coalitions throughout the state, have worked for many years on educational campaigns and initiatives designed to encourage safe prescribing practices and reduce the volume of unused opioids available for theft, diversion, and abuse. These efforts recently culminated with the enactment of new legislation (House Bill 21), which went into effect in Florida on July 1, 2018, that limits prescriptions for acute pain to a 3-day supply (with the potential for an extension up to a maximum of 7 days with additional documentation).[25] Preliminary research shows that the law substantially reduced opioid prescriptions. Six months after implementation of the law, the proportion of patients receiving opioid prescriptions for common outpatient surgical procedures decreased by 21%, and the average total opioid dose prescribed decreased by 64 Morphine Milligram Equivalents.[26] The proportion of patients receiving opioid prescriptions for longer than a 3-day supply decreased by 68%. The authors of this study concluded that, "The legislation should significantly decrease the amount of unused opioid pills potentially available for diversion and abuse."[27] Updates from the Department of Health also reflect decreases in the number of days' supply of controlled substances dispensed to patients and the Morphine Milligram Equivalents per prescription.[28]

Expansion of Prescription Drug Disposal Programs

Historically, the most commonly implemented opioid misuse prevention activities in Florida have been 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. Community education and awareness campaigns incorporating safe use, safe storage, and safe disposal messages have been supported by the Substance Abuse Block Grant's primary prevention set-aside and the Drug Free Communities grant for at least a decade. SAMHSA's Center for Application of Prevention Technologies (CAPT) recently summarized evaluation findings from a selection of media campaigns designed to prevent prescription drug misuse.[29] According to SAMHSA's summary, during the implementation of the *Use Only as Directed: Utah Prescription Pain Medication Program*, the number of unintentional prescription drug-related overdose deaths decreased, along with willingness to share prescriptions and to use someone else's prescription drugs.[30] In addition to Block Grant primary prevention set-aside funds,

DCF also authorizes the use of State Opioid Response grant prevention funds for media campaigns based on the *Use Only as Directed* initiative. To date, thousands of Floridians are estimated to have been reached by campaign messages.

Florida Prescription Drug Monitoring Program

The Florida Prescription Drug Monitoring Program (PDMP) provides data related to controlled substance prescriptions in the state. From July 1, 2018, to June 30, 2019, there were 29,935,352 controlled substance prescriptions dispensed to Florida patients, a 9.8 percent decline from the previous year. In addition, 4.95 million people in Florida were prescribed one or more controlled substances, a decrease of 10.3 percent. Alprazolam, oxycodone SA and hydrocodone SA were ranked the top three most commonly dispensed controlled substances for the fourth year in a row, together representing 37.4 percent of the total controlled substances dispensed from July 1, 2018, to June 30, 2019. Drugs with the largest year-to-year decreases in dispensing were hydrocodone SA (-19.7 percent), tramadol SA (-13.1 percent) and phentermine (-13.1 percent).[31]

Behavioral Health Workforce

Florida is experiencing a shortage of health care professionals to meet the growing needs of our state. For behavioral health professionals, the shortage is reaching near critical levels. Supply and demand for behavioral health practitioners are affected by factors including: population growth, aging of Florida's population, expansion of insurance coverage, changes in health care reimbursement, retirement, attrition, reduction in stigma to seek care, the opioid epidemic, low reimbursement rates, and geographic location of the health care workforce. While need grows, the workforce remains static at best. Meanwhile, Florida's aging population (65 and older) is expected to exceed any other age group by 2030 causing a dynamic shift in future behavioral health care needs. A recent addition to the behavioral health workforce has been the utilization of peers with lived experience, however, many of these individuals are unable to work due to background screening requirements and the bureaucratic burden of seeking an exemption. In addition, the medical workforce with a specialty in addiction medicine is inadequate to meet the growing need.[32]

Law Enforcement Perspective

Florida law enforcement remains engaged in the current effort to reduce the availability of heroin, fentanyl and fentanyl analogs and other substances contributing to opioid-involved overdose and overdose deaths. Efforts to reduce deaths involving specific opioids (heroin and fentanyl analogs) appear to be trending slowly in a positive direction, based on indicators used to gauge illicit drug activities and the drug abuse environment. According to the Drugs Identified in Deceased Persons by Florida Medical Examiners 2018 Annual Report, deaths involving heroin and deaths involving fentanyl analogs decreased. However, deaths involving fentanyl increased substantially (29.5 percent); and deaths caused by fentanyl increased (35 percent).

A comparison of FDLE laboratory submissions between the first half of 2018 and the first half of 2019 revealed increases in heroin, fentanyl, morphine and buprenorphine. Prescription opioids, hydrocodone, hydromorphone and oxycodone decreased. Of particular interest though were increased submissions seen in methamphetamine, certain synthetic cathinone drugs and synthetic cannabinoids, all of which increased, in both occurrences in the deceased and in the cause of death according to the annual report of the Florida Medical Examiners.[33]

In the continued effort to mitigate opioid overdose (OD) deaths in Florida, a project was launched to expand the use of naloxone by law enforcement and emergency responders on the scenes of suspected opioid overdose and capture those data for response, treatment and prevention follow up activities. The project is a collaborative project of the Seminole County Sheriff's Office, FDLE, DOH, South Florida HIDTA, Central Florida HIDTA, North Florida HIDTA, the Gulf Coast HIDTA, the

Washington/Baltimore HIDTA, and the Florida National Guard Counterdrug Program.[34] This initiative builds on the current practice, by EMS within the state, of inputting case information into the Florida Prehospital EMS Tracking and Reporting System (EMSTARS).

As part of the grant-funded project, DOH is developing an application programming interface (API) to streamline EMSTARS overdose data into an easy to use solution that interfaces with the Overdose Detection Mapping Application Program (ODMAP). ODMAP is a tool to identify near real-time suspected overdose surveillance data across jurisdictions to support public safety and public health efforts to mobilize an immediate response to a sudden increase, or spike in overdose events. A parallel effort to engage law enforcement agencies statewide in ODMAP expansion efforts is being mounted, in particular, to capture fatal overdose data to be used for improvements in overdose-related public safety outcomes. As the lead agency, the Seminole County Sheriff's Office will create an ODMAP and OD Data Center of Excellence which will include public safety and health care (response, treatment and prevention) related best practices utilizing OD data.

While the opioid crisis continues, it is important to note increases in the availability of and illicit activities with respect to methamphetamine and cocaine. The geographical size and diverse population of Florida has resulted in diverse drug problems across the state. Regions within the state are experiencing variations on what is perceived as the primary drug concern for that region. For instance, cocaine was seen as the most prevalent illegal drug being distributed throughout the South Florida region. Coca cultivation and cocaine production over the past three years has increased the flow of cocaine into Florida. In the Central Florida region, heroin is reported as the most prevalent illegal drug, especially in the Orlando and Tampa areas. The North Florida region has reported that methamphetamine is the prevalent illegal drug being distributed. In recent years, the production of methamphetamine has shifted from being small localized operations to large Mexican cartel-operations. The change in the source of supply, its purity and relative low cost has also fueled the expansion of methamphetamine throughout the state, creating new markets where few existed.

Progress continues in combatting illegal drug activities throughout Florida. The opioid issue continues to be the priority problem. However, impacts of widespread use of many other dangerous drugs will require vigilance from the law enforcement community, in partnership with other stakeholder communities.

Statewide Drug Policy Advisory Council
Previous Recommendations from Annual Reports
Accomplished

1. Require prescribers to complete a continuing education course on prescribing controlled substances, particularly opiates, alternative treatment and risks of opioid addiction following all stages of treatment in management of acute pain.

The Controlled Substances Bill, or HB 21, was signed into law July 2018. The new law mandates continuing education for controlled substance prescribers.[35]

2. Establish standards of practice for prescribing of controlled substances for the treatment of acute pain, as well as limiting the days' supply of an opioid prescription to reduce the probability of dependence or addiction.

Significant progress on this recommendation was made in 2018. HB 21 placed a three-day limit on prescribed opioids for acute pain, unless strict conditions are met for a seven-day supply. In addition, the bill established standards regarding prescribing requirements for non-acute pain and created new requirements for pain management clinics, mandating they register with the Florida Department of Health by January 1, 2019.[36]

3. Review a patient's controlled substance dispensing history in the Prescription Drug Monitoring Program (PDMP) prior to prescribing or dispensing a controlled substance.

A major provision of HB 21 from July 2018 was a requirement that health care prescribers or dispensers of opioids consult the PDMP. To increase utilization of the PDMP, direct access was expanded with passage of HB 21 authorizing health care practitioners employed by the federal Department of Veteran Affairs, Department of Defense and the Indian Health Service who are not licensed in Florida to request information from the PDMP.[37]

4. Increase access to substance use disorder treatment, at all levels of the continuum of care, and funding for additional treatment capacity.

In 2018, the Florida Legislature appropriated $14,626,911 in recurring General Revenue funds to expand treatment capacity, including recovery support services and medication assisted treatment (MAT). SAMHSA is also awarding DCF over $127 million in SOR grant funds between 10/1/18 and 9/29/20 for a variety of initiatives and an array of services including, but not limited to, MAT and recovery support services. It is important to note that these services are provided by non-recurring federal grant funds. In order to sustain these initiatives, the Council will need to revisit this recommendation in future reports.

5. Expand syringe services programs to operate in multiple sites throughout Florida to reduce the spread of infectious disease, reduce overdose deaths and link to substance use disorder treatment.

On July 1, 2019, Senate Bill 366 went into effect which permits county commissions to authorize the establishment of additional syringe exchange programs through county ordinances.[38]

6. Expand access to PDMP information to Florida medical examiners to facilitate the medico-legal death investigation process and certification of the cause and manner of death.

House Bill 21 from 2018 enabled Florida's medical examiners to have access to the PDMP information.[39]

7. Establish the Office of Drug Control and Policy.

On April 1, 2019, Governor Ron DeSantis signed Executive Order 19-97, which establishes the Office of Drug Control within the Executive Office of the Governor. Appointments of staff to this office are forthcoming.

8. Integration and interoperability of PDMP data to encourage safer prescribing of controlled substances and reduce drug abuse and diversion within Florida.

DOH is currently engaged in reciprocal interstate data sharing with 16 states and has integrated PDMP information into 455 electronic health recordkeeping systems across the state.

2019 Recommendations

Prevention

1. Develop and implement a public awareness campaign designed to (1) prevent substance use among youth, (2) increase awareness of substance use treatment options, and (3) reduce the stigma associated with the treatment of substance use disorder and mental illness. Messaging should include anti-drug prevention messages designed for youth (ages 12-17), increase awareness of medically assisted treatment and psychological service opportunities, and reduce the stigma associated with addiction.

In many ways, Florida has made significant gains in preventing substance use among youth. According to the 2018 Florida Youth Substance Abuse Survey (FYSAS) high school students reported a 27% reduction in their past 30-Day alcohol use, 11% reduction in tobacco use and 0.9% reduction in marijuana use as compared to 2002.[40] Despite these gains, new trends demonstrate the need for concern. For example, vaping among teens has increased across the United States. According to a study conducted by the University of Michigan and the National Institute on Drug Abuse (NIDA), 37.3% of 12th graders reported using some form of e-cigarette (nicotine and/or marijuana) in 2018.[41] This was an increase of 9.5% as compared to the same period in 2017. The 2018 FYSAS showed a similar increase of 9.1% among Florida's 12th graders.[42]

Recognizing vaping as a significant problem, the Food and Drug Administration (FDA) launched a vaping/e-cigarette prevention campaign in the U.S. The campaign, entitled "The Real Cost," targets youth ages 12-17 and uses a science-based approach to educate young people on the dangers of e-cigarettes.[43] To reach their target audience, the FDA employs television ads, online videos, websites, social media, and printed materials.

With the use of a multifaceted drug prevention campaign, Florida can reduce and/or delay the use of alcohol, vaping, tobacco, and/or other recreational drugs by youth ages 12-17. To maximize impact, community partners such as DCF, DOH, DOE, Florida National Guard Counterdrug Program, and other anti-drug organizations should be engaged in the process.

Once a physician or mental health counselor has assessed and diagnosed an individual with a substance use disorder, they can properly assist the client in identifying treatment options. Treatment plans are built upon the individuals' need to include short and long-term goals for maintaining sobriety. Primary treatment goals often include evidence-based therapeutic modalities, medically assisted treatment, or a combination of the two.

Through a public awareness campaign, Florida can (1) educate citizens on the benefits of these recovery options and (2) guide them in obtaining treatment. Parallel to this effort, Florida should continue to bring awareness to DCF's Overdose Prevention Awareness Campaign. DCF's campaign has educated Florida's citizens on the benefit of naloxone, the medication that reverses opioid overdose. They also provide information on where individuals can access medication in Florida. The targeted audience for the campaign should include high-risk populations, their friends and family. Campaign materials include radio ads, interviews with key stakeholders, printed materials and a website that allows individuals to search for the nearest naloxone distribution site in their area: https://isavefl.com/.

Individuals with a substance use or mental health disorder often experience three forms of stigma. These types include structural, public, and self-stigma. Societal norms and attitudes drive the first two types; while the third occurs when individuals internalize these negative opinions.[44, 45] Self-stigma causes lowered self-esteem, decreased self-efficacy, and amplified feelings of embarrassment and shame. As a result, stigma can impede an individual's willingness to pursue treatment, thus placing them at a higher risk for crisis and/or fatal overdose.

A two-pronged approach can be utilized to (1) reduce the negative perceptions of addiction within the community and (2) increase the likelihood of an individual to seek out/pursue and engage in appropriate treatment.

2. Increase substance use prevention efforts by (1) securing/sustaining front-end prevention funding and (2) expanding state partnerships with anti-drug coalitions, education institutions, faith-based organizations, and law enforcement. These partnerships will improve the greater understanding of addiction, reduce the impact of stigma, and allow for the unified employment of limited resources towards a common goal.

Preventing drug use before it starts is a fundamental tenet of a comprehensive approach to drug control.[46] It has been proven that early intervention can be accomplished through anti-drug awareness campaigns, expanding drug take-back events, and strengthening anti-drug coalitions. To accomplish this, Florida should continue to support its anti-drug coalitions by maintaining or expanding grant opportunities similar to DCF's Prevention Partnership grants, Substance Abuse and Mental Health Services Administration (SAMHSA) grants, and the Office of National Drug Control Policy (ONDCP) grants.[47, 48,49]. Funds obtained through these sources are used to implement evidence-based prevention programs, local prevention messaging campaigns, and expanding prescription drug take-back events.

These intervention initiatives conducted in conjunction with a large-scale prevention campaign would potentially have a significant impact to the community. Partner organizations and community stakeholders could utilize their already existing social media platforms, websites and other media outlets to dispatch prevention, stigma and treatment-related messages. As a result, these messages would be more widely available throughout the state and at minimal cost to the taxpayer. Moreover, these early investments pay large dividends in substantially reduced treatment and criminal justice costs, saving taxpayer dollars while reducing the number of young people whose lives are tragically affected by early substance abuse[50].

3. Implement a substance-use prevention strategy designed to reduce drug use among youth ages 12-17. The program will focus on evidence-based and/or evidence informed prevention strategies proven to reduce substance use, while also increasing youth resiliency, coping strategies, positive mental health, and responsible decision-making. DCF should lead, in collaboration with DOH and DOE, a statewide initiative to increase and coordinate prevention efforts across Florida through a partnership with coalitions, community SUD providers, school districts, faith-based groups, and business interests. The end goal would be to better link existing prevention efforts and to increase the availability and funding for prevention efforts.

It is estimated that 17.5% of adults in Florida have experienced some form of mental illness in the past year and 7.1% have experienced a substance use disorder.[51]The initial onset of mental health and/or substance use disorders typically occurs during childhood or adolescence. This information provides state and local leadership the opportunity to address these issues prior to an individual reaching a crisis state. Communities can do this by implementing evidence-based practices designed to treat mental health issues early and prevent substance use among youth.

Florida's communities are geographically and culturally unique; therefore, all evidence-based practices utilized must be flexible and adaptable to the needs of a specific population. These practices must contain a core prevention foundation that remains uniform across the state and provides guidance to administrators on acceptable changes or adaptations in methods of delivery. This process would ensure fidelity and provide measurable, repeatable, and effective outcomes. Collaboration between evidence-based administrators, researchers, and developers would be mandatory. To facilitate this process, SAMHSA has established an evidence-based practice online resource center. The SAMHSA resource center contains a collection of science-based resources for a broad range of audiences.

These resources include substance use prevention plans, treatment improvement protocols, toolkits, resource guides, clinical practice guidelines, and other science-based resources.[52]

In Florida, quality mental and emotional health education and substance use and abuse health education were identified as high priorities by Governor DeSantis, First Lady DeSantis and the Florida Legislature. For decades, Comprehensive Health Education has included mental and emotional health and substance use and abuse as part of required instruction through section 1003.42 (2)(n), Florida Statutes, but did not include an instructional time requirement or the assurance mechanisms to support and verify instruction.

Florida Administrative Code rule 6A-1.094121, was approved by the State Board of Education on July 17, 2019. This rule establishes a minimum of five hours of required instruction related to mental and emotional health education for students in grades 6-12.

Florida Administrative Code rule 6A-1.094122, was approved by the State Board of Education on August 21, 2019. This rule requires school districts to annually provide instruction to students in grades K-12 related to youth substance use and abuse health education.

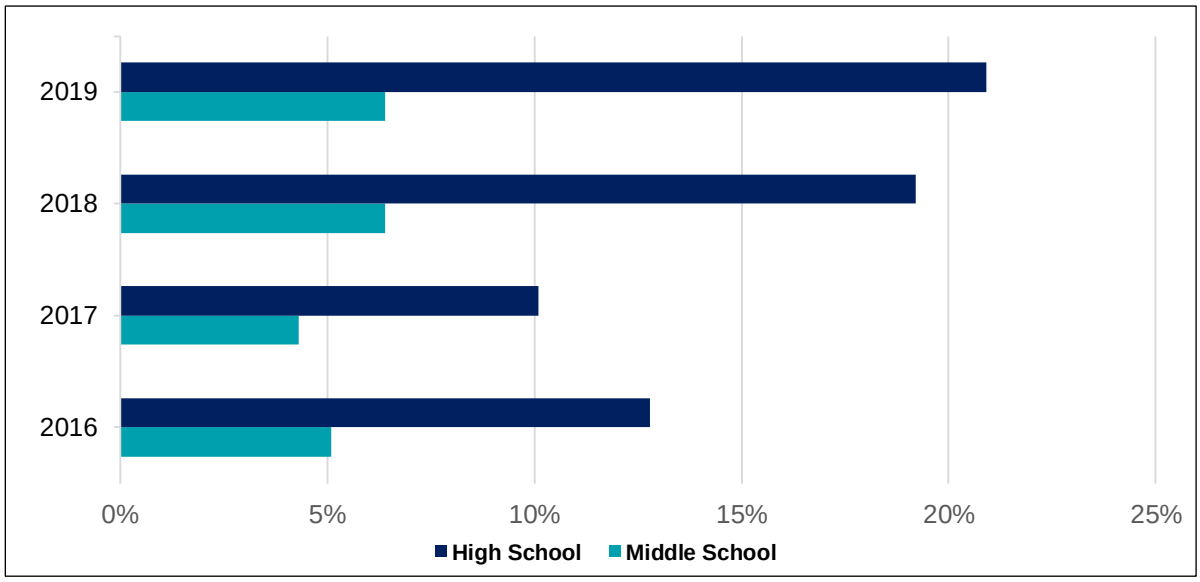
Content must advance each year through developmentally appropriate instruction and skill building. Decisions about which course(s) will be used to deliver this instruction and curricula used will be determined at the school district level. These rules are in effect for the 2019-2020 school year.

Prevention programs for elementary school children should target the following skills: self-control; emotional awareness; communication; social problem-solving; and academic support, especially reading. Prevention programs for middle and high school students should increase social and academic competence through the following skills: study habits and academic support; communication; peer relationships; self-efficacy and assertiveness; drug resistance skills; reinforcement of anti-drug attitudes; and strengthening of personal commitments against drug abuse.[53] These skills contribute to the healthy development of youth, promote mental wellness, and reduce risky behavior. An effective framework involves coordinated strategies across schools, classrooms, homes and community organizations.

4. Develop and implement a comprehensive e-cigarette/e-liquid prevention strategy designed to reduce vaping among youth (ages 11-17) and limit the negative health effects associated with e-cigarettes, e-liquids, and/or other vaping materials.

There has been a 583% increase in the use of e-cigarettes/e-liquids by Florida's youth (ages 11-17) since 2012.[54] According to the Centers for Disease Control and Prevention (CDC), this health emergency is a national epidemic. The CDC's research confirms that 1.5M youth are actively using vaping devises across the country.[55] This steep rise in e-cigarette use is likely due to uncontrolled advertising methods, a wide range of flavored vaping products, and an extremely high nicotine content. Many of these devices come in shapes designed to mimic the look of markers, highlighters, USB flash drives, etc., making them very easy to conceal.

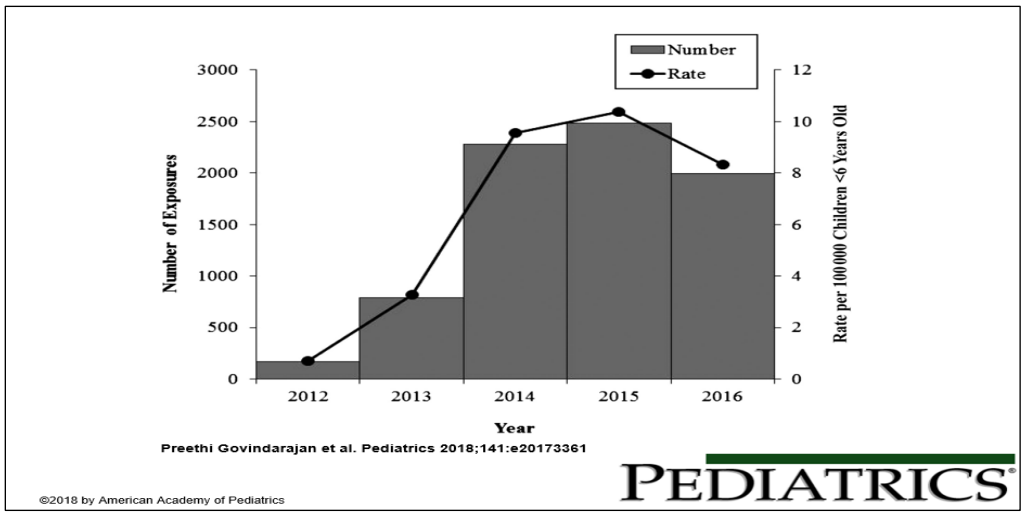
Figure B. Florida Youth Substance Abuse Survey Past 30 Day Vaping Trend



Source: https://www.myflfamilies.com/service-programs/samh/prevention/fysas/2019/docs/FYSAS%202019%20(Final).pdf

Additionally, 8,269 children (ages 6 or less) were accidentally poisoned by consuming e-liquids during the period of 2012-2017.[56] Most, 92.5% of these children were exposed by ingesting e-liquids.[57] The Food and Drug Administration (FDA) believes these children consumed liquid nicotine because of the child-friendly packaging, cartoon placement, and diverse flavoring options.[58] The Child Nicotine Poisoning Prevention Act (CNPPA) of 2015 requires all e-liquids sold, manufactured, and/or distributed to be packaged in child resistant containers.[59] The CNPPA has helped reduce e-liquid exposures; however, the poisoning rate remains high as compared to 2012. In fact, new trends suggest that some youth populations are now deliberately drinking e-liquids and/or eating/chewing e-liquid pods/cartridges to gain access to the nicotine.[60]

Figure C. Annual Number and Rate of Liquid Nicotine Exposures Among Children <6 Years Old, NPDS 2012-2016



Source: American Academy of Pediatrics, 2018.

In 2016, the FDA published a rule that extends its regulatory authority to all tobacco products. This regulation includes e-cigarettes, e-liquids, hookahs, cigars, and pipe tobacco. Prior to this

regulation, these products were sold without any review of their ingredients, manufacturing processes, or their potential dangers.[61] Additionally, the ruling ensures e-cigarettes/e-liquids are not sold to minors and not available for purchase in vending machines that are accessible by youth. Since 2016, the FDA has sent 594 warning letters and issued 125 fines to Florida businesses for violating FDA's 2016 e-cigarette/e-liquid regulation.[62] Given FDA's limited time and resources, it should be assumed that additional violations would have been identified if other agencies were given the authority to conduct compliancy inspections.

While section 877.112, Florida Statutes, clearly prohibits the sale of e-cigarettes/e-liquids to minors, it does not establish e-cigarette/e-liquid advertising laws that prohibit youth targeting or ban the sale of flavored vaping products popular among Florida's children. Tobacco companies, prior to the 1998 "Master Settlement Agreement," commonly used marketing practices designed to target youth, while encouraging them to experiment with cigarettes, chewing tobacco, and other items containing nicotine. These practices included the use of cartoon advertisements, brand name endorsements, outdoor signage, billboards, public transit ads, and free tobacco company merchandise/samples. Many of these same advertising methods have been retooled by vaping companies and are now being employed to target youth. The Florida Division of Alcoholic Beverages and Tobacco does not require a business in the state of Florida to obtain a Tobacco Retail License to sell or manufacture e-cigarettes and/or e-liquids.[63] This precludes Florida's ability to inspect and/or regulate e-cigarette/e-liquid manufacturing processes and retail establishments where these products are sold.

On September 11, 2019, the President of the United States announced his intent to ban the sale of flavored e-cigarettes/e-liquids within the United States. Since the President's announcement, New York, Michigan, Rhode Island, Massachusetts and Washington State have all implemented their own bans on flavored vaping products.[64, 65, 66, 67] These bans are expected to reduce the use of e-cigarettes/e-liquids by youth, limit accidental poisoning, and/or prevent its use entirely.

With the development and deployment of a comprehensive e-cigarette/e-liquid prevention strategy, Florida can better protect its youth and limit the negative health effects associated with vaping.

5. DOH should lead an initiative to review current practices utilized in primary care settings to solicit patient information on alcohol and drug use and to what extent Screening, Brief Intervention, and Referral to Treatment (SBIRT) or other evidence-based practices are being utilized to identify and intervene with patients showing symptoms of problematic alcohol or drug use. A report from AHCA on availability of Medicaid coverage for SBIRT should be a part of this initiative.

Early identification is the key to addressing the potential of an individual developing a substance use disorder. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and drugs. Typically, this practice is conducted in medical settings, including community health centers, and has proved successful in hospitals, specialty medical practices such as HIV/STD clinics, emergency department, and workforce wellness programs. SBIRT can be easily used in primary care settings and enables health care professionals to systematically screen and assist people who may not be seeking help for a substance abuse problem, but whose drinking and drug use may cause or complicate their ability to handle health, work, and family issues. SBIRT aims to prevent unhealthy consequences of alcohol and drug use among those whose use may not have reached the diagnostic level of a substance use disorder[68].

Research validates that the SBIRT model reduces health care costs[69], decreases severity of drug and alcohol use, and reduces the risk of physical trauma and the percentage of patients who go without specialized substance abuse treatment.[70]

SBIRT's use across health care settings is dependent on the state's coding and billing policies. Some states are working to "activate" Medicaid codes for SBIRT in their respective Medicaid plans.

Treatment and Recovery

6. Expanding naloxone availability among people who use drugs and their peers as the most effective way to reduce opioid overdose deaths.

Research shows that overdose mortality can be reduced by distributing naloxone to individuals at risk of experiencing an overdose and to their peers and family who may witness an overdose, through syringe access programs, drug treatment programs, community meetings, support groups for family members of people who use opioids, re-entry programs, mobile outreach programs, homeless service providers, and other community-based distribution programs that provide continuous, low-barrier access to naloxone.[71] It is conservatively estimated that one heroin overdose death is prevented for every 164 naloxone kits distributed.[72]

According to a recent statement from the FDA supporting the expansion of naloxone access, "Naloxone is a critical tool for individuals, families, first responders, and communities to help reduce opioid overdose deaths, but access to naloxone continues to be limited in some communities." The FDA reiterated that "all three forms of naloxone are FDA-approved and may be considered as options *for community distribution* and use by individuals *with or without medical training* to stop or reverse the effects of an opioid overdose." The FDA is also continuing the agency's efforts to make naloxone available over-the-counter.[73]

Bystanders are present in approximately 40% of opioid overdose deaths and approximately 65% of nonfatal overdoses.[74] Tragically though, when someone overdoses in America, a 911 call is made less than 50% of the time.[75] Fear of police involvement is the most commonly cited reason for delaying or deterring a call for help for an overdose victim.[76]

Fortunately, people who use opioids and their friends and family members can reverse opioid overdoses and revive individuals using naloxone. 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. It is relatively quick and easy to train people who use opioids and their loved ones on the use of naloxone. Research confirms that bystander/layperson naloxone administration is a safe and effective community-based method for preventing overdose deaths and that the associated education effectively improves overdose recognition and response.[77] It is critical that we get naloxone into the hands of people who use drugs and their peers, as they are commonly the first responders at the scene of an overdose and are able to immediately administer naloxone to someone who is not breathing and save their life.

DCF initiated an Overdose Prevention Program in August of 2016. The program has been funded through a variety of sources, including General Revenue, the SAPT Block Grant, the STR grant, and the SOR grant. Organizations enrolled in the program distribute free, take-home naloxone kits directly to people who use drugs, people with a history of drug use, and to their peers and loved ones who may witness an overdose. There are currently 110 organizations participating in the program, including substance use and mental health treatment facilities, hospital EDs, harm reduction programs, peer recovery organizations, homeless service providers, FQHCs, and other community-based organizations. Since the start of the program, over 79,000 naloxone kits have been distributed among participating providers and 3,184 overdose reversals have been reported. In Palm Beach County, Rebel Recovery distributed 5,481 naloxone kits and documented 478 reported reversals.[78] Unsurprisingly, and much like the experience in other states, the most effective naloxone distribution programs enrolled in DCF's program are operated by organizations that serve people who use drugs with a peer-oriented, harm-reduction framework.

Between 2006 and 2009, Massachusetts provided overdose education and naloxone kits to thousands of people who use opioids and their families, friends and social service providers. An interrupted time series analysis compared communities that did not implement the program to

low implementation communities (enrolling ≤ 100 participants per 100,000 population) and high implementation communities (enrolling > 100 participants per 100,000 population). Low implementation communities experienced a 27% decrease in opioid overdose death rates, and high implementation communities experienced a 46% decrease in opioid overdose death rates.[79]

In 2013, North Carolina began prioritizing naloxone distribution to populations at high risk for overdose, namely people who inject drugs, individuals receiving medication-assisted treatment, people with a history of opioid use who were formerly incarcerated, and individuals engaged in sex work. A recently published evaluation of this program found that high distribution counties experienced a 14% decrease in opioid overdose death rates, and low distribution counties experienced an 11% decrease in opioid overdose death rates, relative to counties with no naloxone distribution.[80] Several other studies conducted in the U.S. have also documented reductions in opioid overdose mortality associated with naloxone distribution programs, all of which were evaluations of naloxone distribution programs that *prioritized people who use drugs and those around them*, most commonly through Syringe Exchange Programs and drug treatment programs, but also through mobile vans, HIV education drop-in centers, pain management clinics, and single room occupancy hotels, for example.[81]

Researchers recently simulated the impact of 13 different naloxone distribution models on overdose deaths and found that expanding naloxone distribution through a single Syringe Exchange Program can reduce a community's overdose deaths by 65%. Results showed that, "Optimal [naloxone] distribution methods may include secondary distribution so that the person who picks up naloxone kits can enable others in the community to administer naloxone, as well as targeting naloxone distribution to sites where individuals at high-risk for opioid overdose death are likely to visit, such as syringe exchange programs." [82]

Additional research demonstrates that distributing naloxone to laypeople, particularly those likely to experience or witness an overdose, is the most cost-effective way to prevent overdose deaths. Researchers analyzed the cost-effectiveness of 8 different naloxone distribution strategies among three target groups (laypeople, police and fire personnel, and EMS personnel). The top 4 most cost-effective strategies all involve high naloxone distribution to laypersons. Strategies that did not distribute a significant amount of naloxone kits to laypeople always ranked last. Thus, when facing resource constraints, naloxone distribution to laypeople should be prioritized.[83] Other research shows that people who use drugs deploy take-home naloxone to save a life at a rate nearly 10 times that of laypeople who do not use drugs, emphasizing the need to prioritize naloxone distribution efforts and resources among people who are actively using drugs.[84]

There is no evidence indicating that access to naloxone encourages or increases the use of heroin or other opioids. Rather, studies suggest that increasing health awareness through naloxone training and distribution actually reduces the use of opioids.[85] DCF's Overdose Prevention Coordinator and Harm Reduction Coordinator is available to help with training and technical assistance to organizations interested in establishing targeted naloxone distribution programs.

7. Encourage county commissions to establish Syringe Exchange Programs to distribute naloxone to people who use drugs and prevent new cases of HIV and Hepatitis C.

In order to make a larger impact in reducing overdose deaths, Florida needs to do a better job of targeting naloxone distribution to people most likely to experience an opioid overdose. While SEPs are the most effective organizations at saving lives by distributing naloxone directly to people who use drugs, there is currently only one SEP operating in Florida: the IDEA Exchange in Miami-Dade County. The IDEA Exchange has distributed 2,432 naloxone kits and documented 1,347 reported reversals. During the 2019 session, the Florida Legislature voted to

expand SEPs statewide through the passage of SB 366, which allows county commissions to pass ordinances to authorize local SEPs. County commissions are encouraged to pass ordinances establishing new SEPs throughout the state.

8. Take steps to ensure opioid overdose survivors in emergency departments and floor units are provided low-barrier access to naloxone kits before being discharged. Low barrier access entails no cost for indigent or uninsured individuals, little to no paper work, and no separate trip to the pharmacy (i.e., bring the meds-to-beds).

People who have experienced an overdose are treated in Florida emergency departments every day, making these important settings for expanding naloxone distribution. Nonfatal opioid overdose remains the most significant risk factor for subsequent fatal overdose and provides an identifiable opportunity for overdose education and naloxone distribution. Research confirms that emergency departments are an effective way to provide take-home naloxone kits to high-risk individuals who have not previously received overdose education and naloxone.[86]

Hospital EDs and floor units should be offering take-home naloxone kits prior to/upon discharge to patients at risk of experiencing an opioid overdose. Hospitals should operate under non-patient specific naloxone standing orders in order to allow for broader distribution of naloxone, reduce the burden on prescribers and dispensers by removing the need to write individual prescriptions, reduce bureaucratic and system-wide barriers to receiving naloxone, and allow for ED and floor unit staff to hand naloxone directly to the patient (as opposed to sending the patient to a pharmacy where the medication may never be obtained due to cost, stigma, and other barriers). It is also important to allow for patients to receive more than one naloxone kit, as they may know people at risk of overdose, they can provide additional kits to directly and can provide kits to their friends and family that may witness an overdose.

Hospital EDs and floor units should offer naloxone kits upon discharge to:

- People who received treatment for an overdose.
- Patients being treated for other drug-related issues, such as endocarditis, cellulitis, abscesses, and vein/wound care related to injection-drug use.
- Patients identified as having an OUD.

The Florida Hospital Association issued the following guidelines to help increase access to naloxone in EDs:

> "Emergency department providers and hospital-based pharmacies should operate under non-patient specific naloxone standing orders to ensure that take-home naloxone kits are offered and provided to anyone in the emergency department at risk of opioid overdose, and to the friends and family of those patients at risk of opioid overdose. Any patient in the emergency department due to opioid overdose should be provided with a take-home naloxone kit upon discharge. Friends and family members of the patient should also be provided with take-home naloxone kits upon the patient's discharge. Hospitals are encouraged to coordinate a follow-up process for individuals who need additional naloxone kits."[87]

Florida hospitals can have a role in helping to save lives by making sure opioid overdose survivors and those around them are easily and readily equipped with the antidote before they are discharged from emergency departments.

9. Encourage the establishment of warm handoff programs from EDs to community OUD providers; convene a summit of hospital administrators, EDs, and community OUD providers to ascertain roadblocks and develop strategies to eliminate these roadblocks

The Centers for Disease Control and Prevention has cited Emergency Departments (ED) as important centers for treatment and referral, including medication assisted treatment (MAT),

which has been shown to be superior to motivational interviewing and referral alone.[88] [89] Direct linkage from the ED to community OUD providers, known as a warm handoff, is proving to be a better option to serve this population; however, these interventions are sparse. The Florida Hospital Association documents 209 EDs in Florida. Of these, only approximately 18 to date have been identified as having, or in the process of implementing, a warm handoff initiative.

As the opioid epidemic continues, EDs will play an integral part in mitigating the human toll on many levels through screening and identification of patients at risk for opioid use disorder, managing acute opioid withdrawal, initiating medication assisted therapy, and coordinating linkage to outpatient treatment. However, much work remains to be done to create, validate, disseminate, and implement effective evidence-based strategies to accomplish these challenging tasks within the unique care environment of the ED. [90]

DCF's Substance Abuse and Mental Health Program Office, when allocating federal State Opioid Response grant funds, has prioritized the development of ED warm handoff programs for individuals experiencing an opioid overdose. Utilizing the resources of the Aetna All in for Florida: An ER Intervention Project grant program managed by the Florida Alcohol and Drug Abuse Association (FADAA), multiple issues related to the establishment of ED warm handoff programs have been surfaced including providing health care with non-recurring funding, available funding for community providers to accept ED referrals, issues related to peers working in the ED, a waiver to prescribe buprenorphine under the Drug Addiction Treatment Act of 2000 (DATA 2000) training for physicians, training for peers and providers, hospital pharmacy rules, legal considerations and hospital administration support.

10. Increase the number of EMS/Fire Rescue naloxone leave-behind programs throughout the state.

In 2018, the Florida Legislature appropriated $5 million in recurring General Revenue Funds to the Department of Health "for the purchase of emergency opioid antagonists to be made available to emergency responders."[91] The naloxone distribution program established with these funds is called the Helping Emergency Responders Obtain Support (HEROS) Program. DOH can help expand these life-saving efforts by encouraging EMS/Fire Rescue to establish naloxone leave-behind programs. Some EMS/Fire Rescue programs leave naloxone kits behind at the scene of an overdose, with overdose survivors, friends, family members and bystanders who may be at high risk for witnessing or experiencing an overdose. The HEROS Program has the resources available to do evidence-based, targeted distribution through leave-behind programs.

It should also be noted that entities receiving naloxone through DOH's HEROS Program are required to enter data into EMSTARS or ODMAPS. Both of these surveillance and overdose hotspot mapping initiatives should be used to help guide the targeted deployment of evidence-based resources that prevent overdose deaths, like distributing naloxone directly to individuals who use drugs or who are likely to witness an overdose.

Consider the following directive, which comes directly from the *Overdose Spike Response Framework* guide for ODMAP stakeholders: "Developing a plan for messaging and engaging families and friends of individuals at risk is one key component to reducing injury and death from overdose. Family and friends of individuals at risk for an overdose will approach and manage their loved one's risk, based on their own stage of readiness for change, as well as the stage of readiness of their loved one. Therefore, family and friends require information on a variety of topics including: where to get naloxone, how to administer naloxone, and/or how to encourage their loved one(s) to seek treatment."[92] Rather than having emergency responders advise individuals at the scene of an overdose on where to obtain naloxone, they should just distribute naloxone at the scene. Currently, there are only six EMS/Fire Rescue naloxone leave behind programs in operation in Florida. DOH may need to review and revise (as needed) any track-

and-trace rules, and any other rules, that may constitute barriers to establishing naloxone leave-behind programs.

11. Increase the number of county health departments (CHDs) and FQHCs that are actively distributing naloxone to people who use drugs through outreach initiatives (like Hepatitis A vaccination teams).

CHDs and FQHCs can also help distribute naloxone kits to targeted at-risk populations. These entities can use EMSTARS to identify opioid overdose hotspots and develop outreach and distribution strategies to saturate at-risk individuals in those communities with naloxone. In response to public health emergencies, DOH is capable of mobilizing outreach teams through CHDs to engage individuals who use drugs in order to provide them with Hepatitis A vaccines, for example.

12. Expand additional fellowship and residency programs for physicians to obtain a specialty in addiction medicine with a goal of increasing physicians with an addiction medicine specialty.

There is an opportunity to expand the subspecialty of addiction medicine to help ensure patients with a substance use disorder are being properly treated by medical professionals. The Accreditation Council for Graduate Medical Education (ACGME) has accredited three institutions to sponsor Addiction Psychiatry Fellowships, which are one-year training programs. Jackson Memorial is approved for three positions and two are filled. The University of South Florida is approved for two positions and both are currently filled. And the University of Florida is approved for three positions, but none of the positions are currently filled.[93]

The opioid epidemic in Florida is changing the dynamic on the delivery of substance use disorder treatment and care. The standard for care for an opioid use disorder is MAT combined with behavioral counseling. SUD treatment programs across the state have had to add and/or increase medical professionals on the treatment team in order to evaluate, prescribe, and medically monitor MAT medications. In addition, to prescribe buprenorphine medical personnel must complete a training course and pursue a waiver to prescribe buprenorphine under the Drug Addiction Treatment Act of 2000 (DATA 2000). In addition, there is a growing need for physicians certified in addiction medicine.[94]

13. Pass model legislation that will ensure enforcement of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) by requiring all state health agencies, health plans and commercial insurance to report annually on the implementation of the parity act in Florida. The reports should be transparent and available to inform the public.

In 2008 the United States Congress unanimously approved the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, known as the federal parity law. Many state legislatures have passed similar laws to ensure parity enforcement. The federal law seeks to eliminate discriminatory access to mental health (MH) and SUD benefits in certain health insurance coverage. The federal parity law prohibits plans from applying financial requirements or treatment limitations to MH and SUD benefits that are more restrictive than those applied to medical/surgical benefits. Treatment limitations and financial requirements to be evaluated include co-pays, deductions, co-insurance, day or visit limits, pre-authorization policies, frequency of treatment limits, fail first policies, and non-qualitative treatment limitations.

Many states have passed model legislation to facilitate implementation and enforcement of the MHPAEA and to strengthen parity provisions within state law. Examples include: explicit oversight requirements for state regulators (RI); requirements for annual report on claim denials, complaints, appeals (VA); requirement for plans to submit parity compliance information to the state insurance regulator and/or Medicaid agency (CA, MA, CT); requirement for state agency to develop performance quality indicators to evaluate plan compliance (VT); state laws requiring

coverage for prescription drugs for SUD (IL); length of stay protections (MD); and requirements for peer-reviewed clinical review criteria related to medical necessity determinations (NY). [95]

The Parity Tracking Project study highlights significant barriers to front-line state enforcement of the MHPAEA. The report concluded that regulators cannot conduct a complete assessment of parity compliance through form review with even a comprehensive data-gathering template because the required information is often not available in these documents. To address the barriers in parity compliance and consumer information, the report offered recommendations for consideration:

- Regulatory agencies should require carriers to submit their internal analyses for ensuring that plans are parity compliant.
- Regulatory agencies should use a parity compliance template.
- Regulatory agencies should develop model contracts that fully describe MH and SUD benefits.
- Regulatory agencies should inform consumers of their rights under the law, including how to take action.
- Regulatory agencies should enhance the provider community's capacity to identify potential parity act violations. [96]

ParityTrack is a national collaborative forum that works to aggregate and elevate the parity implementation work taking place across the country. ParityTrack aims to be the central site for mental health and substance use disorder, parity information and to offer an exclusive look at parity issues. ParityTrack seeks to help consumers understand their rights under the Federal Parity Law and state parity laws and to empower consumers to exercise those rights. ParityTrack evaluated each state to determine compliance of state statutes and practice to the federal parity legislation. Florida received a grade of "F." [97]

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the Agency for Health Care Administration (Agency) under the Statewide Medicaid Managed Care (SMMC) program. The current SMMC contract contains a requirement that the health plan must comply with the Mental Health Parity and Addiction Equity Act:

The Mental Health Parity and Addictions Equity Act:

1. The Managed Care Plan shall comply with all applicable federal and State laws, rules and regulations including 42 CFR part 438, Subpart K, and the Act.
2. The Managed Care Plan shall conduct an annual review of its administrative, clinical, and utilization management practices to assess its compliance with the Act under this Contract.
3. The Managed Care Plan shall submit to the Agency an attestation of the Managed Care Plan's compliance with the MHPAEA no later than November 1 of each year, in a manner and format to be specified by the Agency.[98]

The health plan must develop distinct policies and procedures for monitoring and demonstrating compliance with the Act, including procedures to monitor for and assure parity in the application of quantitative treatment limits and non-quantitative treatment limits for medical and behavioral health services[99]. Each plan is required to submit an annual attestation to the agency detailing compliance with the Act.

The Agency has several other avenues for monitoring health plan compliance with parity. These include but are not limited to: review of health plan policies and procedures (including utilization management); monitoring of provider and recipient complaints; and monthly submission of complaint, grievance, and appeals reporting. Reports required by the Agency

include quantitative treatment limits and non-quantitative treatment limits, in addition to the following:

Denial, Reduction, Termination, or Suspension of Service Report

- Medical necessity
- Service authorization
- Service amounts and frequency

Enrollee Complaints, Grievances, and Appeals Report

- Access to care
- Medical necessity
- Service authorization
- Enrollment/disenrollment
- Pharmacy benefits
- Excluded benefits

Additionally, the Agency conducted its own analysis of how the state plan benefits for mental health meet the Parity rule requirements. The state plan benefit categories of services reviewed for both Mental Health/ Substance Abuse Benefits and Medical/Surgical benefits included:

- Inpatient
- Outpatient
- Emergency care
- Prescription drugs

The Agency determined from the analysis that Florida Medicaid makes available a periodicity of services under the behavioral health benefits, which is not more restrictive than what it offers under medical/surgical benefits. Additionally, the Agency determined that the behavioral health service limits were more expansive for adults than what is provided through the medical/surgical benefit.

14. State health agencies, health plans and commercial insurers should remove prior authorization requirements for evidence-based Medication Assisted Treatment to allow for use of medications such as buprenorphine and naltrexone especially where such an action would assist pregnant, post-partum and neo-natal populations.

Currently, Florida Medicaid covers behavioral health medication management services as part of a continuum of care for individuals diagnosed with a substance use disorder. Medication assisted treatment (MAT) is covered in conjunction with psychiatric evaluations, counseling, and behavioral therapies to ensure comprehensive treatment. For example, covered treatment may include monitoring current medication dosage and side-effects, as well as ensuring concerns or changes in health status are addressed properly. Behavioral health-related medical services such as screenings, verbal interactions and specimen collection are also covered to assist in drug management and treatment of substance use disorders. MAT services can also include methadone-based treatment. Florida Medicaid covers medication management services in addition to a bundled weekly reimbursement for MAT.

Additionally, several health plans provide expanded benefits for substance abuse such as additional behavioral health medical services, substance abuse treatment, and outpatient detoxification services. Expanded benefits are extra benefits above and beyond the minimum required benefits detailed in the State Plan. Health plans offer these benefits to their enrollees without a capitation payment from the Agency. A comprehensive listing of expanded benefits by health plan can be located on the Agency's website: http://ahca.myflorida.com/medicaid/statewide_mc/outreach_presentations.shtml.

Florida Medicaid enforces prior authorization standards for medication management services with all health plans. Additionally, Florida Medicaid requires continuity of care when a recipient is receiving MAT and changes plans. The new plan is required to cover the existing course of authorized treatment.

Specific to MAT, the Agency covers buprenorphine, naltrexone, and methadone patients with substance use disorder. The Agency allows Medicaid patients to receive up to a 7-day supply of buprenorphine, Suboxone film, or Zubsolv tablets for initiation of therapy for opioid use disorder without the prior authorization through the pharmacy benefit. This allows the prescriber to immediately start the patient on medication assisted treatment. If needed the patient can receive an additional 7-day supply of the buprenorphine for initiation of therapy within a 60-day period. The prescriber can then submit a prior authorization to Medicaid to continue treatment. Prior authorization requests are reviewed within 24 hours of receipt.

Medicaid patients can also receive the following medications to treat. These medications are available with no co-pay.

- Naltrexone tablets which are covered without prior authorization through the pharmacy benefit.
- Vivitrol (naltrexone) injectable can be received at the pharmacy through an automated prior authorization. The pharmacy computer system verifies that the recipient is 18 years of age or older and has a diagnosis of alcohol and/or opioid use disorder on file. If both are confirmed, the claim will pay. This automation eliminates the need for prior authorization paperwork submission through the pharmacy benefit. Vivitrol is also available through the medical benefit under J2315 if administered in a medical office setting.
- Sublocade (buprenorphine) injectable can be received at the pharmacy through an automated prior authorization. When the claim information is entered, the pharmacy computer system verifies that the recipient has received a minimum of 7 days of treatment with a buprenorphine-containing oral product. If confirmed, the claim will pay for Sublocade through the pharmacy. Sublocade is also available through the medical benefit under Q9992 if administered in the medical office setting.
- Methadone tablets are available through methadone clinics.
- Narcan (naloxone) nasal spray and naloxone vials are covered to treat overdose through the pharmacy benefit and under the medical setting under J2310.

The Medicaid preferred drug list is located at http://www.ahca.myflorida.com/medicaid/Prescribed_Drug/preferred_drug.shtml. MAT not listed on the preferred drug list require prior authorizations, which are reviewed within 24 hours of receipt. Medications on the preferred drug list are reviewed at least annually by the Pharmaceutical and Therapeutics Committee which is composed of physicians and pharmacists.

Medicaid has a single preferred drug list that the Medicaid health plans follow. The Medicaid health plans cannot be more restrictive than fee-for-service Medicaid. Under the medical benefit, plans can use step therapy or prior authorized medications.

When prior authorizations are required for treatment services, this may take up to several days to process with insurance providers. This processing time creates an immediate barrier to a patient's initiation onto medication assisted therapy (MAT) for substance abuse disorders. This delay forces patients to leave their provider's office without receiving potentially life-saving medication and requires them to return to receive it days later. During that time, treatment can

be derailed. A patient may lose interest, lose access to their doctor, lose transportation, suffer an injury, or even die from an overdose. Self-treatment with diverted (i.e. misused) opioid medications is common among individuals with opioid use disorder who have recently experienced barriers to or delays in starting buprenorphine-based MAT.[100, 101, 102]

Prior authorization limitations to Medication Assisted Therapy for substance abuse disorder disproportionately affects pregnant and post-partum women and their children due to their vulnerability especially for low-income populations who have severely limited alternative resources. In 2014, prior authorization for prescription buprenorphine was still required for 35% of Health Maintenance Organizations (HMOs), 36% of Preferred Provider Organizations (PPOs), and more than half of Consumer Driven Products (CDPs).[103]

During pregnancy, universal screening efforts and enhanced substance abuse services—including accessible Medication Assisted Therapy (MAT) for all women who need it—are important goals. At birth, the systematic approach to screening infants, monitoring for withdrawal signs using a scoring tool, and managing care for the mother and infant offer numerous opportunities for improving outcomes including the measured use of MAT.[104]

MAT is considered the standard of care for opioid-dependent pregnant women. Service delivery and treatment capacity should be streamlined to ensure women have access to needed services in a timely manner, staying in their community or medical home whenever possible. Compared to medication-assisted withdrawal, MAT is associated with better relapse prevention, decreased exposure to illicit drugs and other high-risk behaviors, improved adherence to prenatal care, and improved neonatal outcomes. The goal of MAT is to prevent withdrawal during pregnancy and minimize fetal exposure to illicit substances.[105, 106]

MAT is not the only solution, it is also important to consider the implications of identifying prenatal substance abuse in efforts to increase access to care and improve clinical outcomes, but it is a centerpiece of managing opioid dependency in pregnancy, best applied as part of a comprehensive treatment program that includes obstetric care, counseling, and wrap-around services.[107] However, there is a treatment gap in pregnant women's receipt of substance abuse services overall. Barriers to care included lack of transportation, lack of child care services, intensive time requirements, additional costs and co-pays, stigma and regulatory roadblocks such as prior authorization.[108, 109]

The removal of prior authorization requirements allows a patient to be initiated onto treatment the same day they see their doctor. This immediate initiation reduces the patient's risk of overdose in the subsequent days and increases the likelihood that they will successfully engage in and remain connected to treatment. Due to regulations governing the provision of methadone, buprenorphine and naltrexone are the only FDA-approved medications for opioid use disorder potentially subject to prior authorization requirements. There is a lower risk of overdose with buprenorphine because there is a ceiling effect on respiratory suppression.[110]

If prior authorization requirements were removed, health insurance providers would then cover the full cost of MAT as a standard benefit and all requirements that a physician contact the insurance provider for approval prior to writing the prescription (a process called "prior authorization") are removed. Without these prior authorization requirements, prescriptions for MAT medications to treat opioid use disorder can be written and filled as soon as a physician deems this treatment necessary, free from artificial delays. Policy makers and healthcare providers should work collaboratively with health insurance companies and state Medicaid programs to design and implement these policy changes.[111]

15. Promote legislation that adds the Secretary of AHCA and the Commissioner of the Office of Insurance Regulation as members to the Statewide Drug Policy Advisory Council.

AHCA is a health policy and planning entity for the state of Florida. AHCA serves as the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act. The Florida Medicaid program serves approximately 3.9 million Medicaid recipients at a cost of over $28 billion annually and has over 100,000 actively enrolled service providers. During state fiscal year 2017-2018, AHCA spent over $3 billion dollars on prescribed drugs through the Florida Medicaid program. AHCA shares similar goals with the Council and would be a valuable addition its membership.

The Office of Insurance Regulation (Office) is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the insurance code or Chapter 636, Florida Statutes, per https://www.floir.com/Office/AgencyOrganizationOperation.aspx. The Commissioner of Insurance Regulation who heads the Office would be a valuable member of the Council since the health insurance companies decide upon coverage and formularies affecting all of the residents of Florida.

16. Continue the statewide Recovery Oriented System of Care (ROSC) initiative designed to promote and enhance recovery efforts in Florida and support the continued development of recovery community organizations (RCOs) and a statewide RCO that helps link community initiatives.

Over the past several years, the Florida Department of Children and Families has led an initiative to transform Florida's substance use and mental health system into a Recovery Oriented System of Care (ROSC) which serves as a framework for coordinating multiple systems, services, and supports that are person-centered, self-directed and designed to readily adjust to meet the needs of persons served and their chosen pathway to recovery.

A ROSC is a network of clinical and nonclinical services and supports that sustain long-term, community-based recovery. As local organic entities, ROSCs reflect variations in each community's vision, institutions, resources, and priorities. Behavioral health systems and communities form ROSCs to:

- Promote good quality of life, community health, and wellness for all.
- Prevent the development of behavioral health conditions.
- Intervene earlier in the progression of illnesses.
- Reduce the harm caused by SUDs and MH conditions on individuals, families and communities.
- Provide the resources to assist people with behavioral health conditions to achieve and sustain their wellness and build meaningful lives for themselves in their communities.

Across the country, independent, non-profit organizations that are peer-led and governed by persons in recovery, family members, and recovery allies mobilize resources within the community to make it possible for the over 23 million Americans still struggling with SUD to find long-term recovery. Each organization has a mission that reflects the issues and concerns from within their community. These community groups, known as Recovery Community Organizations (RCOs), share three core principles – recovery vision; authenticity of voice; and accountability to the recovery community.

RCOs use three primary strategies to achieve their mission:

- Public education and awareness - putting a face and a voice on recovery to reduce stigma and educate the public, policy makers, service providers and the media that recovery is possible from SUD.
- Policy advocacy - to build recovery-oriented supportive communities, RCOs address public policy that eliminates discrimination against people in or seeking recovery and reduce barriers that keep persons seeking recovery from sustaining long-term recovery
- Peer-based and other recovery support services and activities - RCOs are innovating and delivering a variety of peer recovery support services and places to deliver those services, building a lasting physical presence in communities[112]

As a result of an Aetna Foundation grant to the FADAA, RCO development activities are taking place across Florida. Over the past year, the Volusia Recovery Alliance has formed an RCO and additional RCO development is taking place in eight (8) additional communities throughout Florida. In addition, RCO development is taking place through Floridians for Recovery (statewide RCO) in four (4) additional communities in Florida.[113]

17. Evaluate the impact of recent legislation and agency background screening requirements on the eligibility of individuals with lived experience/peers attempting to enter the workforce; continue efforts to reduce the administrative burden of the background screening and exemption process; and promote legislation that fully implements the legislative intent of SB 900 (2019) related to background screening and selected non-disqualifying offenses.

The use of peers, individuals with lived experience, has grown significantly in Florida over the past five years. Research has shown that recovery from a substance use disorder or mental illness is facilitated by the use of social support provided by peers.[114] These individuals serve multiple roles which include recovery support navigator by assisting in transition from institutional setting (jail/prison) to the community; crisis support; peer wellness coach; employment support coach; housing support specialist; and recovery coach.[115] Peers are essential team members of Community Action Teams, Family Intensive Treatment Teams, and FACT teams. In addressing the opioid epidemic, peers serve a key role in emergency warm handoff programs encouraging, and at times transporting, individuals who have overdosed to pursue a treatment intervention. The 2019 Florida Legislature recognized the role of peers by codifying the definition of peer specialist in section 397.311, Florida Statutes.

Currently there is a shortage of peers working in behavioral health services. One barrier to the use of peer services is the fact that peer specialists often cannot pass background screening requirements in sections 435.04 and 408.809, Florida Statutes. Persons who have recovered from a substance use disorder or mental illness often have a criminal history. Common offenses would include using and selling illegal substances, prostitution and financial fraud. Section 435.04, Florida Statutes, allows persons with certain disqualifying offenses identified through background screening to apply to the respective state agency head (DCF and AHCA Secretary) for an exemption if it has been three or more years since their conviction. The applicant must provide all court records regarding their convictions, letters of recommendation, evidence of their rehabilitation, education documents, evidence of employment, and fill out a questionnaire. The requirements of this exemption often deter persons from becoming peer specialists.[116]

The Council recommends eliminating disqualifying offenses that commonly disqualify peer specialists under the current background screening requirements. Offenses to be eliminated are listed in SB 528 from the 2019 legislative session.[117] As a result, more individuals with convictions in their past may be able to obtain certification as peer specialists. Also, private insurers and Medicaid managed care plans may see additional use of peer specialists.

18. Increase awareness and develop clinical and community interventions to address the trend toward increased stimulant use (cocaine and methamphetamine) across Florida, especially in rural communities.

One of the by-products of the attention on the opioid epidemic has been a shift of drug of choice to stimulants, especially methamphetamine and cocaine. FDLE reports a marked trend in methamphetamine trafficking from Mexico.[118] There also has been an increase in stimulants being laced with fentanyl, resulting in an increase of deaths connected to this combination.

In a cross-sectional study of 1 million urine drug test results from January 2013 through September 2018, positivity rates for nonprescribed fentanyl in the cocaine-positive group increased significantly. Positivity rates for nonprescribed fentanyl in the methamphetamine-positive group also increased significantly, from 0.9% to 7.9%, a 798% increase. The concomitant use of fentanyl with a stimulant poses a significant risk to public health because of heightened risk of overdose. [119]

Fentanyl contamination of other drugs is increasing overdose risk. In a 10-state study, almost 57% of people who died from an overdose tested positive for fentanyl and fentanyl analogs also tested positive for cocaine, methamphetamine, or heroin.[120]

Federal drug enforcement agents are alarmed that the opioid epidemic is fueling a spike in methamphetamine use, creating the “fourth wave” of the opioid crisis.[121]

19. The challenges facing the behavioral health workforce need to be addressed to ensure that a workforce is available in the future to serve individuals with a substance use disorder. An initiative across all relevant state agencies should be convened to analyze workforce challenges and develop recommendations for action.

Reducing the Availability of Illicit Drugs

20. When filling prescriptions for controlled substances, require pharmacies to educate consumers on safe medication storage and disposal procedures. Establish a media campaign to educate consumers on reason for safe use, safe storage and safe disposal and the location of safe disposal boxes in each community.

Several resources are available to help people in Florida understand the proper steps to dispose of unused medication:

- The Florida Department of Environment Protection (DEP) offers information online regarding pharmaceutical waste management for homeowners. In addition to addressing frequently asked questions, DEP's web page includes information about drug drop off locations and steps to take at home to properly dispose of old unused medication. DEP's web page is located here: https://floridadep.gov/waste/permitting-compliance-assistance/content/pharmaceutical-waste-management.
- The CVS Health locations with drop boxes may be found here: https://www.cvs.com/content/safer-communities-locate.
- The Walgreens locations with drop boxes may be found here: https://www.walgreens.com/topic/pharmacy/safe-medication-disposal.jsp.
- The Drug Enforcement Administration (DEA) Diversion Control Unit hosts National Take Back Days (https://takebackday.dea.gov/). There were 35,775 pounds collected in Florida during the April 27, 2019 Take Back Day. There were 138 law enforcement agencies participating and there were 204 collection sites across the state. The Florida National Guard also collaborated with partner agencies in North Florida to support Take Back events where more than 3,182 pounds of drugs were collected.
- Publix Pharmacy continues to partner with Informed Families/The Florida Family Partnership to feature the Lock Your Meds campaign. In-store signage was distributed to and displayed in 694 Publix stores at the pharmacy counter. Additionally, Publix "Carepoints" documents, featuring the Lock Your Meds message and an appeal to take the pledge to prevent prescription drug abuse, were printed and distributed with all prescription purchases. The month-long campaign reaches more than 1 million Floridians, or about 50 customers per store, per day. Those who took the pledge also received a home medicine inventory card download. They also had the opportunity to opt in to receive additional prevention education information throughout the year. Through their partnership with Publix, Informed Families also developed a web page focusing on safe disposal locations in Florida, which is consistently updated: https://www.informedfamilies.org/lym/safedisposal.
- Through the SOR grant, DCF is funding a safe use, safe storage, and safe disposal campaign based on the Use Only as Directed initiative from Utah. Over 1 million people have seen or heard a campaign message to date.

Data Collection and Surveillance

21. Modernize medical examiner data systems to reduce the wait time to obtain and produce invaluable drug-related death information.

DOH, Bureau of Vital Statistics, is seeking to improve the timeliness and quality of drug poisoning information on Florida death records and the transfer of this information between systems. Florida is exploring innovative strategies for the collection and transfer of relevant drug information in the Medical Examiners Case Management System to state Electronic Death Registration System and on to the CDC's National Center for Health Statistics. The Bureau of Vital Statistics will continue to investigate and analyze current medical examiner district and lab practices to identify opportunities to shorten the turnaround time.

22. Create a statewide dashboard of substance abuse data that are readily available to policy makers and the public and can be used to forecast trends and threats.

A statewide dashboard of substance abuse data should be created in Florida Health CHARTS similar to the Opioid Use Dashboard: http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.OpioidUseDashboard. Agencies should continue efforts to develop a more systematic and sustainable approach to linking data and developing indicators from existing datasets.

23. Provide ODMAP access to all law enforcement and non-EMSTARS fire departments statewide for the reporting of drug overdose incidents.

References

[1] https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2018-Annual-Drug-Report.aspx

[2] http://www.floridahealth.gov/statistics-and-data/survey-data/behavioral-risk-factor-surveillance-system/FYTSStateTables2012-20183-2019-FINAL.pdf

[3] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2016 and 2017). *Table 30 – Selected Drug Use, Perceptions of Great Risk, Past Year Substance Use Disorder and Treatment, and Past Year Mental Health Measures in Florida, by Age Group: Percentages, Annual Averages Based on 2016-2017 NSDUHs*. Retrieved from www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeSpecificStates2017B/NSDUHsaeFlorida2017.pdf

[4] Substance Abuse and Mental Health Services Administration. (2015). *Behavioral Health Barometer: Florida, 2015*. Retrieved from www.samhsa.gov/data/sites/default/files/2015_Florida_BHBarometer.pdf

[5] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2018). *Results from the 2017 National Survey on Drug Use and Health: Detailed Tables*. Table 5.52B Perceived Need for Substance Use Treatment and Whether Made an Effort to Get Treatment in Past Year among Persons Aged 12 or Older Classified as Needing But Not Receiving Substance Use Treatment, by Demographic Characteristics: Percentages, 2016 and 2017. Retrieved from www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.pdf

[6] Department of Children and Families. (2019). 2019 Florida Youth Substance Abuse Survey. Retrieved from www.myflfamilies.com/service-programs/samh/prevention/fysas/2019/

[7] National Institute on Drug Abuse. (2019). Opioid Overdose Crisis. Retrieved from https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis

[8] Simmons-Duffin, S. (2019). U.S. Overdose Deaths Dipped In 2018, But Some States Saw 'Devastating' Increases. National Public Radio, Retrieved from https://www.npr.org/sections/health-shots/2019/07/18/743161724/u-s-overdose-deaths-dipped-in-2018-but-some-states-saw-devastating increases?sc=tw&utm_campaign=Rx%20Summit&utm_source=hs_email&utm_medium=email&utm_content=75024743&_hsenc=p2ANqtz-_-sJz-pK6RGAuA3Dt1DVMzhew0-l27akccpGXJmYlDs1RNjp_HWjjtjeUDhAVphZo_2SqgXtYv3WF37U03ih-SUMcfPQ&_hsmi=75024743

[9] Drugs Identified in Deceased Persons by Florida Medical Examiners 2018 Annual Report, https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2018-Annual-Drug-Report.aspx

[10] Pitt, A. L., Humphreys, K., & Brandeau, M. L. (2018). Modeling Health Benefits and Harms of Public Policy Responses to the US Opioid Epidemic. *American Journal of Public Health, 108*(10), 1394-1400.

[11] Pitt, A. L., Humphreys, K., & Brandeau, M. L. (2018). Modeling Health Benefits and Harms of Public Policy Responses to the US Opioid Epidemic. *American Journal of Public Health, 108*(10), 1394-1400.

[12] Walley, A. Y., Xuan, Z., Hackman, H. H., Quinn, E., Doe-Simkins, M., Sorensen-Alawad, A., et al. (2013). Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis. *BMJ, 346*, f174; Doe-Simkins, M., Walley, A. Y., Epstein, A., & Moyer, P. (2009). Saved by the Nose: Bystander-administered Intransal Naloxone Hydrochloride for Opioid Overdose. *American Journal of Public Health, 99*, 788-791; Enteen, L., Bauer, J., McLean, R., Wheeler, E., Huriaux, E., Kral, A. H., et al. (2010). Overdose Prevention and Naloxone Prescription for Opioid Users in San Francisco. *Journal of Urban Health, 87*, 931-941; Maxwell, S., Bigg, D., Stanczykiewicz, K., & Carlberg-Racich, S. (2006). Prescribing Naloxone to Actively Injecting Heroin Users: A Program to Reduce Heroin Overdose Deaths. *Journal of Addictive Diseases, 25*, 89-96; Paone, D. Heller, D. Olson, C. & Kerker, B. (2010). Illicit Drug Use in New York City. NYC Vital Signs. New York City Department of Mental Health and Hygeine; Albert, S., Brason, F. W., Sanford, C. K., Dasgupta, N., Graham, J., & Lovette B. (2011). Project Lazarus: Community-based Overdose Prevention in Rural North Carolina. *Pain Medicine, 12* Supplement 2, S77-85; McAuley, A., Best, D., Taylor, A. Hunter C., & Robertson R. (2012). From Evidence to Policy: The Scottish National Naloxone Programme. *Drugs, 19*, 309-319.

[13] Coffin, P. O. & Sullivan, S. D. (2013). Cost-effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal. *Annals of Internal Medicine, 158*, 1-9.

[14] Maxwell, S., Bigg, D., Stanczykiewicz, K., & Carlberg-Racich, S. (2006). Prescribing Naloxone to Actively Injecting Heroin Users: A Program to Reduce Heroin Overdose Deaths. *Journal of Addictive Diseases, 25*(3), 89-96; Seal, K. H., Thawley, R., Gee, L., Bamberger, J., Kral, A. H., Ciccarone, D., Downing, M., & Edlin, B. R. (2005). Naloxone Distribution and Cardiopulmonary Resuscitation Training for injection Drug Users to Prevent Heroin Overdose Death: A Pilot Intervention Study. *Journal of Urban Health, 82*(2), 303-311; Wagner, K. D., Valente, T. W., Casanova, M., Partovi, S. M., Mendenhall, B. M., Hundley, J. H., Gonzalez, M., & Unger, J. B. (2010). Evaluation of an Overdose Prevention and Response Programme for Injection Drug Users in the Skid Row Area of Los Angeles, CA. *International Journal of Drug Policy, 21*, 186-193; Doe-Simkins, M., Quinn, E., Xuan, Z., Sorensen-Alawad, A., Hackman, H., Ozonoff, A., & Walley, A. Y. (2014). Overdose Rescues by Trained and Untrained Participants and Change in Opioid Use Among Substance-Using Participants in Overdose Education and Naloxone Distribution Programs: A Retrospective Cohort Study. *BMC Public Health, 14*(297).

[15] Degenhardt, L., Bucello, C., Mathers, B., Briegleb, C., Ali, H., Hickman, M., & McLaren, J. (2011). Mortality among Regular or Dependent Users of Heroin and Other Opioids: A Systematic Review and Meta-Analysis of Cohort Studies. *Addiction, 106*, 32-51; White, M., Burton, R., Darke, S., Eastwood, B., Knight, J., Millar, T., Musto, V., & Marsden, J. (2015). Fatal Opioid Poisoning: A Counterfactual Model to Estimate the Preventive Effect of Treatment for Opioid Use Disorder in England. *Addiction, 110*(8), 1321-1329; Pierce, M., Bird, S. M., Hickman, M., Marsden, J., Dunn, G., Jones, A., & Millar, T. (2016). Impact of Treatment for Opioid Dependence on Fatal Drug-Related Poisoning: A National Cohort Study in England. *Addiction, 111*(2), 298-308; Sordo, L., Barrio, G., Bravo, M. J., Indave, B. I., Degenhardt, L., Wiessing, L., Ferri, M., & Pastor-Barriuso, R. (2017). Mortality Risk During and After Opioid Substitution Treatment: Systematic Review and Meta-Analysis of Cohort Studies. *BMJ, 357*, j1550.

[16] Platt, L. et al. (2017). Needle and Syringe Programmes and Opioid Substitution Therapy for Preventing HCV Transmission Among People Who Inject Drugs: Findings from a Cochrane Review and Meta-Analysis. *Addiction, 113*, 545-563; Ksobiech, K. (2003). A Meta-Analysis of Needle Sharing, Lending, and Borrowing Behaviors of Needle Exchange Program Attenders. *AIDS Education and Prevention, 15*(3), 257-268; Wodak, A. & Cooney, A. (2006). Do Needle Syringe Programs Reduce HIV Infection Among Injecting Drug Users: A Comprehensive Review of the International Evidence. *Substance Use & Misuse, 41*, 777-813; Hagan, H., Jarlais, D. C., Friedman, S. R., Purchase, D., & Alter, M. J. (1995). Reduced Risk of Hepatitis B and Hepatitis C Among Injecting Drug Users Participating in the Tacoma Syringe-Exchange Program. *American Journal of Public Health, 85*, 1531–1537; Hagan, H., Pouget, E. R., Des Jarlais, D. C., & Lelutiu-Weinberger, C. (2008). Meta Regression of Hepatitis C Virus Infection in Relation to Time Since Onset of Illicit Drug Injection: The Influence of Time and Place. *American Journal of Epidemiology, 168*, 1099–1109; Turner, K. M., Hutchinson, S., Vickerman, P. Hope, V., Craine, N., Palmateer, N., May, M. Taylor, A., De Angelis, D., Cameron S., Parry, J., Lyons, M., Goldberg, D., Allen, E., & Hickman, M. (2011). The Impact of Needle and Syringe Provision and Opiate Substitution Therapy on the Incidence of Hepatitis C Virus in Injecting Drug Users: Pooling of UK Evidence. *Addiction, 106*(11), 1978–1988; MacDonald, M. et al. (2003). Effectiveness of Needle and Syringe Programmes for Preventing HIV Transmission. *International Journal of Drug Policy, 14*(5-6), 353-357.

[17] Nguyen, T. Q., Weir, B. W., Pinkerton, S. D., Des Jarlais, D. C., Holtgrave, D. (2012). Increasing Investment in Syringe Exchange is Cost Saving HIV Prevention: Modeling Hypothetical Syringe Coverage Levels in the United States. 19th International AIDS Conference, Washington D.C; Gold, M., Gafni, A., Nelligan, P., & Millson, P. (1997). Needle Exchange Programs: An Economic Evaluation of a Local Experience. *Canadian Medical Association Journal, 157*, 255-262.

[18] Hagan, H., McGough, J. P., Thiede, H., Hopkins, S., Duchin, J., & Alexander, E. R. (2000). Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated with Needle-Exchange Participation in Seattle Drug Injectors. *Journal of Substance Abuse Treatment, 19*, 247-252; Kuo, I., Brady, J., Butler, C., Schwartz, R., Brooner, R., Vlahov, D. & Strathdee, S. A. (2003). Feasibility of Referring Drug Users from a Needle Exchange Program into an Addiction Treatment Program: Experience with a Mobile Treatment Van and LAAM Maintenance. *Journal of Substance Abuse Treatment, 24*, 67-74; Kidorf, M., King, V. L., Neufeld, K., Peirce, J., Kolodner, K., & Brooner, R. K. (2009). Improving Substance Abuse Treatment Enrollment in Community Syringe Exchangers. *Addiction, 104*, 786-795; Brooner, R., Kidorf, M., King, V., Beilenson, P., Svikis, D., & Vlahov, D. (1998). Drug Abuse

Treatment Success Among Needle Exchange Participants. *Public Health Reports, 113*(Supplement 1), 129-139; Heimer, R. (1998). Can Syringe Exchange Serve as a Conduit to Substance Abuse Treatment? *Journal of Substance Abuse Treatment, 15*, 183-191; Strathdee, S. A., Ricketts, E. P., Huettner, S., Cornelius, L., Bishai, D. Havens, J. R., Beilenson, P., Rapp, C., Lloyd, J. J., Latkin, C. A. (2006). Facilitating Entry into Drug Treatment Among Injection Drug Users Referred from a Needle Exchange Program: Results from a Community-Based Behavioral Intervention Trial. *Drug and Alcohol Dependence, 83*, 225-232; Shah, N. G., Celentano, D. D., Vlahov, D., Stambolis, V., Johnson, L., Nelson, K. E., Strathdee, S. A. (2000). Correlates of Enrollment in Methadone Maintenance Treatment Programs Differ by HIV-Serostatus. *AIDS, 14*, 2035-2043; Strathdee, S. A., Celentano, D. D., Shah, N., Lyles, C., Stambolis, V. A., Macalino, G., Nelson, K., & Vlahov, D. (1999). Needle-Exchange Attendance and Health Care Utilization Promote Entry into Detoxification. *Journal of Urban Health, 76*, 448-460.

[19] Lyengar, S., Kravietz, A., Bartholomew, T. S., Forrest, D., & Tookes, H. (2019). Baseline Differences in Characteristics and Risk Behaviors Among People Who Inject Drugs by Syringe Exchange Program Modality: An Analysis of the Miami IDEA Syringe Exchange. *Harm Reduction Journal, 16*(1), 7.

[20] Levin, H., Bartholomew, T. S., Rea-Wilson, V., Onugha, J., Arriola, D. J., Cardenas, G., Forrest, D. W., Kral, A. H., Metsch, L. R., Spencer, E., & Tookes, H. (2019). Syringe Disposal Among People Who Inject Drugs Before and After the Implementation of a Syringe Services Program. *Drug and Alcohol Dependence, 202*, 13-17.

[21] Florida Department of Law Enforcement, Medical Examiners Commission. (2019). *Drugs Identified in Deceased Persons by Florida Medical Examiners – 2018 Annual Report*. Retrieved from http://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2018-Annual-Drug-Report.aspx.

[22] University of Miami, Miller School of Medicine. (2019). IDEA Exchange DOH Quarterly Report (July 12, 2019).

[23] Lyengar, S., Kravietz, A., Bartholomew, T. S., Forrest, D., & Tookes, H. (2019). Baseline Differences in Characteristics and Risk Behaviors Among People Who Inject Drugs by Syringe Exchange Program Modality: An Analysis of the Miami IDEA Syringe Exchange. *Harm Reduction Journal, 16*(1), 7.

[24] Laws of Florida. (2019). *2019-143* (Committee Substitute for Committee Substitute for Senate Bill No. 366). Retrieved from http://laws.flrules.org/2019/143.

[25] Laws of Florida. (2018). *Chapter 2018-13* (Committee Substitute for Committee Substitute for House Bill No. 21). Retrieved from http://laws.flrules.org/files/Ch_2018_013.pdf

[26] Potnuru, P., Dudaryk, R., Gebhard, R. E., Diez, C., Velazquez, O. C., Candiotti, K. A., & Epstein, R. H. (2019). Opioid Prescriptions for Acute Pain after Outpatient Surgery at a Large Public University-affiliated Hospital: Impact of State Legislation in Florida. *Surgery* (article in press).

[27] Potnuru, P., Dudaryk, R., Gebhard, R. E., Diez, C., Velazquez, O. C., Candiotti, K. A., & Epstein, R. H. (2019). Opioid Prescriptions for Acute Pain after Outpatient Surgery at a Large Public University-affiliated Hospital: Impact of State Legislation in Florida. *Surgery* (article in press).

[28] Statewide Drug Policy Advisory Council. (2018). *DPAC Meeting Minutes: October 23, 2018*. Retrieved from www.floridahealth.gov/provider-and-partner-resources/dpac/DPAC_Meeting_Minutes_10_23_18.pdf

[29] Center for the Application of Prevention Technologies. (2017). *Media Campaigns to Prevent Prescription Drug Misuse, Youth Marijuana Misuse, and Underage Drinking: Evidence of Effectiveness*.

[30] Center for the Application of Prevention Technologies. (2017). *Media Campaigns to Prevent Prescription Drug Misuse, Youth Marijuana Misuse, and Underage Drinking: Evidence of Effectiveness*.

[31] Electronic-Florida Online Reporting of Controlled Substances Evaluation (E-FORCSE), 2018-2019. Prescription Drug Monitoring Program Annual Report. December 1, 2019.

[32] Mark Fontaine, Executive Advisor, Florida Behavioral Health Association

[33] https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2018-Interim-Drug-Report-FINAL.aspx

[34] HIDTA – High Intensity Drug Trafficking Area.

[35] Take Control of Controlled Substances website. http://www.flhealthsource.gov/FloridaTakeControl/

[36] Kemp, Claudia. House Bill 21 Presentation for Statewide Drug Policy Advisory Council. July 2018.

[37] Florida Department of Health, 2017-2018 Prescription Drug Monitoring Program Annual Report (2018), http://www.floridahealth.gov/statistics-and-data/e-forcse/news-reports/index.html

[38] Laws of Florida. (2019). *2019-143* (Committee Substitute for Committee Substitute for Senate Bill No. 366). Retrieved from http://laws.flrules.org/2019/143.

[39] Kemp, Claudia. House Bill 21 Presentation for Statewide Drug Policy Advisory Council. July 2018.

[40] https://www.myflfamilies.com/service-programs/samh/prevention/fysas/2018/docs/FYSAS%202018-survey.pdf

[41] https://www.nih.gov/news-events/news-releases/teens-using-vaping-devices-record-numbers

[42] https://www.myflfamilies.com/service-programs/samh/prevention/fysas/2018/docs/FYSAS%202018-survey.pdf

[43] https://www.fda.gov/tobacco-products/public-health-education-campaigns/real-cost-campaign

[44] https://www.ncbi.nlm.nih.gov/books/NBK384923

[45] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3610943/

[46] https://www.whitehouse.gov/wp-content/uploads/2019/01/NDCS-Final.pdf

[47] https://www.samhsa.gov/grants

[48] https://www.myflfamilies.com/service-programs/samh/prevention/prevention-partnership-grants-ppg.shtml

[49] https://www.whitehouse.gov/ondcp/grants-programs/

[50] https://www.whitehouse.gov/wp-content/uploads/2019/01/NDCS-Final.pdf

[51] Substance Abuse and Mental Health Services Administration. Selected Drug Use, Perceptions of Great Risk, Past Year Substance Use Disorder and Treatment, and Past Year Mental Health Measures in Florida, by Age Group: Percentages, Annual Averages Based on 2016-2017 NSDUHs. Retrieved from www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaeSpecificStates2017B/NSDUHsaeFlorida2017.pdf.

[52] https://www.samhsa.gov/ebp-resource-center

[53] https://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents-in-brief/prevention-principles

[54] http://www.floridahealth.gov/statistics-and-data/survey-data/behavioral-risk-factor-surveillance-system/FYTSStateTables2012-20183-2019-FINAL.pdf

[55] https://www.cdc.gov/vitalsigns/youth-tobacco-use/

[56] https://www.usatoday.com/story/news/politics/2018/05/01/feds-warn-e-cigarette-makers-packaging-after-thousands-kids-drink-toxic-liquid/567949002/

[57] https://pediatrics.aappublications.org/content/141/5/e20173361

[58] https://www.fda.gov/news-events/press-announcements/fda-warns-more-companies-stop-misleading-kids-e-liquids-resemble-kid-friendly-foods-part-youth

[59] https://www.congress.gov/bill/114th-congress/senate-bill/142

[60] https://www.foxnews.com/health/kids-kansas-eating-vape-cartridges

[61] https://www.fda.gov/consumers/consumer-updates/facts-fdas-new-tobacco-rule

[62] https://www.accessdata.fda.gov/scripts/oce/inspections/oce_insp_searching.cfm

[63] http://myfloridalicense.custhelp.com/app/answers/detail/a_id/2187/kw/what%20kind%20of%20license%20do%20i%20need%20to%20sell%20e-cigarettes.

[64] https://www.cnn.com/2019/09/17/health/new-york-ban-on-flavored-e-cigarettes/index.html

[65] https://www.washingtonpost.com/health/michigan-becomes-first-state-to-ban-flavored-e-cigarettes/2019/09/03/34f234c6-ce4c-11e9-8c1c-7c8ee785b855_story.html

[66] https://www.cnn.com/2019/09/27/health/flavored-e-cigarette-ban-washington-state-bn/index.html

[67] https://www.ri.gov/press/view/36788

[68] SBIRT: Screening, Brief Intervention, and Referral to Treatment Factsheet, SAMHSA-HRSA Center for Integrated Health Solutions, The National Council for Community Behavioral Healthcare

[69] Quanbeck A, Lang K, Enami K, & Brown RL. (2010). A cost-benefit analysis of Wisconsin's screening, brief intervention, and referral to treatment program; adding the employer's perspective. State Medicaid Society of Wisconsin, Feb.; 109 (1): 9-14

[70] Gentilello, L.M., Ebel, B.E.,Wickizer, T.M.,Salkever, D.S., & Rivara, E.P. (2005). Alcohol intervention for trauma patients treated in emergency department and hospitals: a cost benefit analysis. Annals of Surgery, 241 (4), 541-550

[71] Walley, A. Y., Xuan, Z., Hackman, H. H., Quinn, E., Doe-Simkins, M., Sorensen-Alawad, A., et al. (2013). Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis. *BMJ, 346*, f174; Doe-Simkins, M., Walley, A. Y., Epstein, A., & Moyer, P. (2009). Saved by the Nose: Bystander-administered Intransal Naloxone Hydrochloride for Opioid Overdose. *American Journal of Public Health, 99*, 788-791; Enteen, L., Bauer, J., McLean, R., Wheeler, E., Huriaux, E., Kral, A. H., et al. (2010). Overdose Prevention and Naloxone Prescription for Opioid Users in San Francisco. *Journal of Urban Health, 87*, 931-941; Maxwell, S., Bigg, D., Stanczykiewicz, K., & Carlberg-Racich, S. (2006). Prescribing Naloxone to Actively Injecting Heroin Users: A Program to Reduce Heroin Overdose Deaths. *Journal of Addictive Diseases, 25*, 89-96; Naumann, R.B., Durrance, C.P., Ranapurwala, S.I., Austin, A.E., Proescholdbell, S., Childs, R., Marshall, S.W., Kansagra, S., & Shanahan, M.E. (2019). Impact of a Community-Based Naloxone Distribution Program on Opioid Overdose Death Rates. *Drug and Alcohol Dependence, 204.*

[72] Coffin, P. O. & Sullivan, S. D. (2013). Cost-effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal. *Annals of Internal Medicine, 158*, 1-9.

[73] U.S. Food and Drug Administration. "Statement on continued efforts to increase availability of all forms of naloxone to help reduce opioid overdose deaths." FDA Press Release, 20 Sept. 2019. https://www.fda.gov/news-events/press-announcements/statement-continued-efforts-increase-availability-all-forms-naloxone-help-reduce-opioid-overdose

[74] Mattson, C. L., O'Donnell, J., Kariisas, M., Seth, P., Scholl, L., & Gladden, R. M. (2018). Opportunities to Prevent Overdose Deaths Involving Prescription and Illicit Opioids, 11, States, July 2016-June 2017. *MMWR, 67*(34), 945-957; Bohnert, A. S. B., Tracy, M., & Galea, S. (2012). Characteristics of Drug Users Who Witness Many Overdoses: Implications for Overdose Prevention. *Drug and Alcohol Dependence, 120*(1-3), 168-173.

[75] McLean, K. (2018). Good Samaritans vs. Predatory Peddlers: Problematizing the War on Overdose in the United States. *Journal of Crime and Justice, 41*(1), 1-13; Doe-Simkins, M., Quinn, E., Xuan, Z., Sorensen-Alawad, A., Hackman, H., Ozonoff, A., & Walley, A. Y. (2014). Overdose Rescues by Trained and Untrained Participants and Change in Opioid Use Among Substance-Using Participants in Overdose Education and Naloxone Distribution Programs: A Retrospective Cohort Study. *BMC Public Health, 14*(1); Sherman, S. G., Gann, D. S., Scott, G., et al. (2008). A Qualitative Study of Overdose Responses Among Chicago IDUs. *Harm Reduction Journal, 5*(1), 2; Baca, C. T., & Grant, K. J. (2007). What Heroin Users Tell Us About Overdose. *Journal of Addictive Diseases, 26*(4), 63-68; Tracy, M., Piper, T. M., Ompad, D., et al. (2005). Circumstances of Witnessed Drug Overdose in New York City: Implications for Intervention. *Drug and Alcohol Dependence, 79*, 181-190; Tobin, K. E., Davey, M. A., & Latkin, C. A. (2005). Calling Emergency Medical Services During Drug Overdose: An Examination of Individual, Social, and Setting Correlates. *Addiction, 100*(3), 397-404.

[76] Koester, S., Mueller, S. R., Raville, L., Langeggar, S., & Binswanger, I. A. (2017). Why Are Some People Who Have Received Overdose Education and Naloxone Reticent to Call Emergency Medical Services in the Event of Overdose? *International Journal of Drug Policy, 48*, 115-124; McLean, K. (2018). Good Samaritans vs. Predatory Peddlers: Problematizing the War on Overdose in the United States. *Journal of Crime and Justice, 41*(1), 1-13; Zadoretzky, C., McKnight, C., Bramson, H., Des Jarlais, D. Phillips, M., Hammer, M., & Cala, M. E. (2017). The New York 911 Good Samaritan Law and Opioid Overdose Prevention Among People Who Inject Drugs. *World Medical & Health Policy, 9*(3), 318-340; Follett, K. M., Council, W. R. C. P., Piscitelli, A., Parkinson, M., & Munger, F. (2014). Barriers to Calling 9-1-1 During Overdose Emergencies in a Canadian Context. *Critical Social Work, 15*(1), 18–28; Bennett, A. S., Bell, A., Tomedi, L., Hulsey, E. G., & Kral, A. H. (2011). Characteristics of an Overdose Prevention, Response, and Naloxone Distribution Program in Pittsburgh and Allegheny County, Pennsylvania. *Journal of Urban*

Health, 88(6), 1020–1030; Sherman, S. G., Gann, D. S., Scott, G., et al. (2008). A Qualitative Study of Overdose Responses among Chicago IDUs. *Harm Reduction Journal, 5*(1), 2; Pollini, R. A., McCall, L., Mehta, S. H., Celentano, D. D., Vlahov, D., & Strathdee, S. A. (2006). Response to Overdose Among Injection Drug Users. *American Journal of Preventive Medicine, 31*(3), 261-264; Seal, K. H., Downing, M., Kral, A. H., et al. (2003). Attitudes about Prescribing Take-home Naloxone to Injection Drug Users for the Management of Heroin Overdose: A Survey of Street-recruited Injectors in the San Francisco Bay Area. *Journal of Urban Health, 80*(2), 291-301; Tracy, M., Piper, T. M., Ompad, D., et al. (2005). Circumstances of Witnessed Drug Overdose in New York City: Implications for Intervention. *Drug and Alcohol Dependence, 79*, 181-190; Baca, C. T., & Grant, K. J. (2007). What Heroin Users Tell Us About Overdose. *Journal of Addictive Diseases, 26*(4), 63-68; Wagner, K. D., Harding, R. W., Kelley, R., Labus, B., Verdugo, S. R., Copulsky, E., Bowles, J. M., Mittal, M. L., & Davidson, P. J. (2019). Post-overdose Interventions Triggered by Calling 911: Centering the Perspectives of People Who Use Drugs. PLOS ONE, 14(10), e0223823. Retrieved from https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0223823.

[77] Giglio, R. E., Li, G., & DiMaggio, C. J. (2015). Effectiveness of Bystander Naloxone Administration and Overdose Education Programs: A Meta-Analysis. *Injury Epidemiology, 2*(1), 10; Clark, A. K., Wilder, C. M., & Winstanley, E. L. (2014). A Systematic Review of Community Opioid Overdose Prevention and Naloxone Distribution Programs. *Journal of Addiction Medicine, 8*(3), 153-163; McDonald, R. & Strang, J. (2016). Are Take-home Naloxone Programmes Effective? Systematic Review Utilizing Application of the Bradford Hill Criteria. *Addiction, 111*, 1177-1187; Lewis, C. R., Vo, H. T., & Fishman, M. (2017). Intranasal Naloxone and Related Strategies for Opioid Overdose Intervention by Nonmedical Personnel: A Review. *Substance Abuse and Rehabilitation, 8*, 79-95; Green, T. C., Heimer, R., & Grau, L. E. (2008). Distinguishing Signs of Opioid Overdose and Indication for Naloxone: An Evaluation of Six Overdose Training and Naloxone Distribution Programs in the United States. *Addiction, 103*, 979-989; Jones, J. D., Roux, P., Stancliff, S., Matthews, W., & Comer, S. D. (2014). Brief Overdose Education Can Significantly Increase Accurate Recognition of Opioid Overdose Among Heroin Users. *International Journal of Drug Policy, 25*, 166-170.

[78] University of Miami, Miller School of Medicine. (2019). IDEA Exchange DOH Quarterly Report (July 12, 2019).

[79] Walley, A. Y., Xuan, Z., Hackman, H. H., Quinn, E., Doe-Simkins, M., Sorensen-Alawad, A., et al. (2013). Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis. *BMJ, 346*, f174.

[80] Naumann, R.B., Durrance, C.P., Ranapurwala, S.I., Austin, A.E., Proescholdbell, S., Childs, R., Marshall, S.W., Kansagra, S., & Shanahan, M.E. (2019). Impact of a Community-Based Naloxone Distribution Program on Opioid Overdose Death Rates. *Drug and Alcohol Dependence, 204*.

[81] Doe-Simkins, M., Walley, A. Y., Epstein, A., & Moyer, P. (2009). Saved by the Nose: Bystander-administered Intransal Naloxone Hydrochloride for Opioid Overdose. *American Journal of Public Health, 99*, 788-791; Enteen, L., Bauer, J., McLean, R., Wheeler, E., Huriaux, E., Kral, A. H., et al. (2010). Overdose Prevention and Naloxone Prescription for Opioid Users in San Francisco. *Journal of Urban Health, 87*, 931-941; Maxwell, S., Bigg, D., Stanczykiewicz, K., & Carlberg-Racich, S. (2006). Prescribing Naloxone to Actively Injecting Heroin Users: A Program to Reduce Heroin Overdose Deaths. *Journal of Addictive Diseases, 25*, 89-96; Davidson, P. J., Wheeler, E., Proudfoot, J., Xu, R., & Wagner, K. D. (2015). Naloxone Distribution to Drug Users in California and Opioid-Related Overdose Deaths. *Drug and Alcohol Dependence, 156*, e2-e101.

[82] Keane, C., Egan, J. E., Hawk, M. (2018). Effects of Naloxone Distribution to Likely Bystanders: Results of an Agent-Based Model. *International Journal of Drug Policy, 55*, 61-69.

[83] Townsend, T., Blostein, F., Doan, T., Madson-Olson, S., Galecki, P., & Hutton, D. W. (2019). Cost-Effectiveness Analysis of Alternative Naloxone Distribution Strategies: First Responder and Lay Distribution in the United States. *International Journal of Drug Policy* (in press).

[84] Bennett, A. S., Bell, A., Doe-Simkins, M., Elliott, L, Pouget, E., & Davis, C. (2018). From Peers to Lay Bystanders: Findings from a Decade of Naloxone Distribution in Pittsburgh, PA. *Journal of Psychoactive Drugs, 50*(3), 240-246.

[85] Seal, K. H., Thawley, R., Gee, L., Bamberger, J., Kral, A. H., Ciccarone, D., Downing, M., & Edlin, B. R. (2005). Naloxone Distribution and Cardiopulmonary Resuscitation Training for injection Drug Users to Prevent Heroin Overdose Death: A Pilot Intervention Study. *Journal of Urban Health, 82*(2), 303-311; Maxwell, S., Bigg, D., Stanczykiewicz, K., & Carlberg-Racich, S. (2006). Prescribing Naloxone to Actively Injecting Heroin Users: A Program

to Reduce Heroin Overdose Deaths. *Journal of Addictive Diseases, 25*(3), 89-96; Wagner, K. D., Valente, T. W., Casanova, M., Partovi, S. M., Mendenhall, B. M., Hundley, J. H., Gonzalez, M., & Unger, J. B. (2010). Evaluation of an Overdose Prevention and Response Programme for Injection Drug Users in the Skid Row Area of Los Angeles, CA. *International Journal of Drug Policy, 21*, 186-193; Doe-Simkins, M., Quinn, E., Xuan, Z., Sorensen-Alawad, A., Hackman, H., Ozonoff, A., & Walley, A. (2014). Overdose Rescues by Trained and Untrained Participants and Change in Opioid Use Among Substance-Using Participants in Overdose Education and Naloxone Distribution Programs: A Retrospective Cohort Study. *BMC Public Health, 14*(297); Jones, J. D., Campbell, A., Metz, V. E., & Comer, S. D. (2017). No Evidence of Compensatory Drug Use Risk Behavior Among Heroin Users After Receiving Take-home Naloxone. *Addictive Behaviors, 71*, 104-106; Marco, C. A., Trautman, W., Cook, A., Mann, D., Rasp, J., Perkins, O., & Ballester, M. (2018). Naloxone Use Among Emergency Department Patients with Opioid Overdose. *Journal of Emergency Medicine, 55*(1), 64-70.

[86] Jakubowski, A., Pappas, A., Isaacsohn, L., Castillo, F., Masyukova, M., Silvera, R., Holaday, L., Raush, E., Farooq, S., Veltri, K. T., Cunningham, C. O., & Bachhuber, M. A. (2019). Development and Evaluation of a Pilot Overdose Education and Naloxone Distribution Program for Hospitalized General Medical Patients. *Substance Abuse, 40*(1).

[87] Florida Hospital Association. (2017). FHA Guidance on Implementing House Bill 249 – Opioid Use and Prescribing in Emergency Departments.

[88] Vivolo-Kantor AM, Seth P. Gladden, RM et al. Vital Signs: Trends in Emergency Department Visits for Suspected Opioid Overdoses-United States. July 2016

[89] D-onofrio G. Chawarski MC O'connor PG et al Emergency Department Initiated Buprenorphine for Opioid Dependence with Continuation to Primary Care: Outcomes During and After Intervention

[90] Her0bert Duber, MD, MPH, Isabel Barta, MD, MBA, Eric Cloe-Pena, MD, MPH, et al, Identification, Management, and Transition of Care for Patients with Opioid Use Disorder in the Emergency Department, Ann Emerg Med.2018 October

[91] Laws of Florida. (2018). *Chapter 2018-13 – Committee Substitute for Committee Substitute for House Bill No. 21*. Retrieved from http://laws.flrules.org/2018/13.

[92] Washington/Baltimore High Intensity Drug Trafficking Area. (2018). *Overdose Spike Response Framework: A Companion Guide for ODMAP Stakeholders*. Retrieved from www.odmap.org/Content/docs/ODMap-Overdose-Response-Framework-2018-3.29.18.pdf.

[93] https://www.acgme.org/

[94] Mark Fontaine, Executive Advisor, Florida Behavioral Health Association

[95] Examining State Legislative Strategies to Enhance MH/SUD Parity Enforcement, Gabrielle de la Gueronniere, Legal Action Center

[96] Parity Tracking Project: Making Parity a Reality, Executive Summary, Ellen Weber, Legal Action Center, National Center on Addiction and Substance Abuse, Treatment Research Institute

[97] Evaluating State Mental Health and Addiction Parity Statutes: State Report Cards; The Mental Health Parity and Addiction Equity Act 10th Anniversary; Parity Track; October 3. 2018

[98] http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/Contracts/2019-02-01/Exhibit_II_A-MMA_2019-02-01.pdf

[99] http://ahca.myflorida.com/Medicaid/statewide_mc/model_health_FY18-23.shtml

[100] Bazazi AR, Yokell M, Fu JJ, Rich JD, Zaller ND. Illicit use of buprenorphine/naloxone among injecting and noninjecting opioid users. J Addict Med. 2011;5(3):175-180. doi:10.1097/ADM.0b013e3182034e31

[101] Richert T, Johnson B. Long-term self-treatment with methadone or buprenorphine as a response to barriers to opioid substitution treatment: the case of Sweden. Harm Reduct J. 2015;12:1. doi:10.1186/s12954- 015-0037-2

[102] Carroll JJ, Rich JD, Green TC. The More Things Change: Buprenorphine/naloxone Diversion Continues While Treatment Remains Inaccessible. J Addict Med. August 2018. doi:10.1097/ADM.0000000000000436

[103] Reif S, Creedon TB, Horgan CM, Stewart MT, Garnick DW. Commercial Health Plan Coverage of Selected Treatments for Opioid Use Disorders from 2003 to 2014. J Psychoactive Drugs. 2017;49(2):102-110. doi:10.1080/02791072.2017.1300360

[104] Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States An introduction for public heath, law enforcement, local organizations, and others striving to serve their community Authors: Jennifer J. Carroll, PhD, MPH; Traci C. Green, PhD, MSc; and Rita K. Noonan, PhD https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf

[105] Association of State and Territorial Health Officials http://www.astho.org/prevention/nas-neonatal-abstinence-report/

[106] Johnston A, Mandell T, Meyer M. "Treatment of opioid dependence during pregnancy: Vermont guidelines." Available at http://www.uvm.edu/medicine/vchip/documents/ICONFULLTREATMENTGUIDELINESFINAL.pdf.

[107] Guttmacher Institute. "State policies in brief: Substance abuse during pregnancy." Available at Http://www.guttmacher.org/statecenter/spibs/spib_SADP.pdf.

[108] Association of State and Territorial Health Officials http://www.astho.org/prevention/nas-neonatal-abstinence-report/

[109] Young N, Gardner S, Otero C, et al. "Substance-exposed infants: State responses to the problem." Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at http://www.ncsacw.samhsa.gov/files/Substance-Exposed-Infants.pdf.

[110] ACOG Committee on Health Care for Underserved Women and American Society of Addiction Medicine. "Committee opinion number 524: Opioid abuse, dependence, and addiction in pregnancy." Obstet Gynecol. 2012. 119(5):1070-6.

[111] Whalen J, Mathews AW. Cigna Ends Preauthorization for Medication to Treat Opioid Addiction. Wall Street Journal. http://www.wsj.com/articles/cigna-ends-preauthorization-for-medication-to-treat-opioid-addiction-1477064103. Published October 21, 2016. Accessed November 2, 2017.

[112] Recovery Community Organization Toolkit, Faces and Voices of Recovery

[113] Recovery Community Organizations in Florida (map); All in Florida: A Recovery Project, Florida Alcohol and Drug Abuse Association, November 2019

[114] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. What are peer recovery support services?

[115] Recovery Peer Specialists – An Overview (power-point); Department of Children and Families; July 23, 2019

[116] SB 900 Bill Analysis and Fiscal Impact Statement, The Florida Senate; Committee on Children, Families, and Elder Affairs; March 8, 2019.

[117] Florida Senate Appropriations Committee, Senate Bill 528 Legislative Bill Analysis (April 17, 2019).

[118] https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2018-Interim-Drug-Report-FINAL.aspx

[119] Rate of Fentanyl Positivity Among Urine Drug Test Results Positive for Cocaine or Methamphetamine; Leah LaRue, PharmD, PMP[1]; Robert K. Twillman, PhD[2]; Eric Dawson, PharmD[1]; et alPenn Whitley, BA[1]; Melissa A. Frasco, PhD[1]; Angela Huskey, PharmD, CPE[1]; Maria G. Guevara, PharmD, CPE[1];*JAMA Netw Open.* 2019;2(4):e192851. doi:10.1001/jamanetworkopen.2019.2851

[120] https://www.cdc.gov/drugoverdose/data/otherdrugs.html

[121] https://www.mcclatchydc.com/news/politics-governement/white-house/article234149267.html