PROJECT OPIOID

FOR

RX

Prescription For Change

Finding Solutions to the Opioid Crisis in our Region

RESTORE _________ LIVES

DO NOT OVERDOSE M.D. SOLUTIONS NEEDED M.D.

DEA NO. __________________________ ADDRESS THE PROBLEM

ProjectOpioid 1-407-456-0605

FORM NO. 102919
This research study could not have been possible without the input and support of many individuals and organizations within Central Florida. We would like to extend a special thank you to these companies for their incredible support.

<table>
<thead>
<tr>
<th>Page</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Table of Contents</td>
</tr>
<tr>
<td>3</td>
<td>Authors’ Page</td>
</tr>
<tr>
<td>4-5</td>
<td>A Letter From Andrae Bailey</td>
</tr>
<tr>
<td>6-7</td>
<td>Data Reference Graphic</td>
</tr>
<tr>
<td>8-9</td>
<td>The State of the Opioid Crisis</td>
</tr>
<tr>
<td>10-13</td>
<td>Prescription Opioids</td>
</tr>
<tr>
<td>14-19</td>
<td>Illicit fentanyl</td>
</tr>
<tr>
<td>20-23</td>
<td>Naloxone</td>
</tr>
<tr>
<td>24-27</td>
<td>Treatment Availability</td>
</tr>
<tr>
<td>28-31</td>
<td>Medication Assisted Treatment</td>
</tr>
<tr>
<td>32-35</td>
<td>Children</td>
</tr>
<tr>
<td>36-41</td>
<td>Opioid Reductions</td>
</tr>
<tr>
<td>42-45</td>
<td>Technology &amp; Innovation</td>
</tr>
<tr>
<td>46-49</td>
<td>Workplace Engagement</td>
</tr>
<tr>
<td>50-53</td>
<td>Criminal Justice</td>
</tr>
<tr>
<td>54-55</td>
<td>Targeted Advocacy</td>
</tr>
<tr>
<td>56-57</td>
<td>Regional Coordination</td>
</tr>
<tr>
<td>58-59</td>
<td>References</td>
</tr>
<tr>
<td>60-61</td>
<td>Definition of Terms</td>
</tr>
</tbody>
</table>
Andrae Bailey is founder and president of Change Everything, an organization committed to creating catalytic transformation for society’s most impactful and seemingly unsolvable problems. His work focuses on solving important issues like poverty and homelessness, bringing together leaders to find solutions that combine compassion with common sense. Andrae is also the founder of Rethinking Homelessness, a national initiative modeled after the work Bailey did for the cause in Central Florida. Recently, Bailey launched Project Opioid, a new business-led collaboration on the regional opioid crisis. In 2015, Andrae Bailey was named Orlando Sentinel’s Central Floridian of the Year.

Andrae is the founder of Project Opioid, a regional initiative in Orange, Osceola, and Seminole Counties seeking to create a “new frontline” on the opioid crisis by utilizing community, business and faith leaders from around Central Florida to make institutional change through new policies and legislation and to de-stigmatize Opioid Use Disorder (OUD). More than 300 leaders from the public and private sectors of Central Florida convened in January of 2019 to launch an initiative designed to address the regional opioid crisis. By using business and faith leaders, Project Opioid will make a lasting and impactful change within our community and save the lives of those forever changed by these powerful drugs.

Kendall Cortelyou-Ward, PhD is an Associate Professor and Program Director of the Healthcare Informatics Master’s Program in the Department of Health Management and Informatics at the University of Central Florida (UCF). Dr. Cortelyou-Ward also serves as the CoChair of the UCF Population Health Collaborative, focusing on population health research. She teaches health informatics and information systems courses to graduate and undergraduate students and conducts research in these areas. Dr. Cortelyou-Ward has over 15 years of professional and academic experience in healthcare management and informatics, including serving as the Workforce Director for the UCF Regional Extension Center and as a Research Analyst for the HIMSS Value Suite project. Some previous projects include an evaluation of the use of mobile apps to improve patient outcomes and determination of financial impact of hospitals on the local community. Her current research interests include patient engagement, privacy and security, mixed methods research and the value of health information technology. Dr. Cortelyou-Ward holds a PhD in public affairs with a specialization in health management research and a master’s in health administration from the University of Central Florida. She earned her Bachelor of Science in human resources from the University of Florida.
The scope of Central Florida’s opioid crisis, as it is throughout much of the state and America is staggering. It is killing our residents at historical rates and as a man-made epidemic, this drug crisis is unprecedented. I know we throw around words like “unprecedented” very casually, so let me give you a dictionary definition of the word:

“Unprecedented: adjective 1: without previous instance; never before known or experienced; unexampled or unparalleled: an unprecedented event.”

Quite simply, this is the largest public health crisis in our nation’s history, and its roots and impact are very much a Florida story. on the verge of death, is inconceivable.

The number of individuals who die every day, or are on the verge of death, is inconceivable. Opioids, nearly by themselves, have driven life expectancy down in America, Florida, and yes, in Greater Orlando. And in our region those under the age of 39 make up the majority of the death toll.

These are not people who wanted to die. They are just like us, our friends, family members, and neighbors who, for a variety of reasons, were introduced to our nation’s favorite painkiller: opioids. Many, especially teens and young adults, are being introduced to prescription opioids as “party drugs,” and finding their pathway to addiction through the medicine cabinets of their families and friends.

This playful experimentation often brings tragic long-term consequences with addiction rates reaching astonishing heights for those casually taking opioids. If you, yourself, take a 30-day prescription of opioids for any reason, you have a 1 in 3 chance of becoming fully dependent on the drug: addiction.

Others begin their drug-addiction journey at their local doctor’s office, looking for relief from long-term or even short-term pain. This might be one of the greatest tragedies of the crisis; thousands of Central Floridians who sought help for a medical problem from their trusted physician were given highly dangerous and addictive opioids with little instruction or warning. As these individuals began their usage, they also began to develop a growing tolerance.
Soon, they needed higher and higher quantities to satisfy their real physical cravings. Eventually, many lose their ability to get the dosage they need from the very medical systems that started them on this deadly path, and they are forced to turn to our streets for illicit and diverted versions of their prescription opioid.

Whatever the reason is that someone uses opioids, once they turn to the street versions of them like heroin, the ending result is catastrophic. Heroin has long been a deadly drug on the streets of communities like Central Florida taking thousands of lives in the past few decades. But now, that drug has been substituted by an opioid that is exponentially more powerful: fentanyl. It is quite literally the most powerful and profitable drug that has ever hit the streets of our community and the state of Florida.

Single handedly, fentanyl has driven the opioid-caused death rate to its current height since its introduction into Florida in 2014-2015. The death probability for those who are introduced to fentanyl is again without precedent. It is never a matter of if you will die, only a matter of when.

Those who wind up addicted to prescription opioids and no longer have it funneled by their physicians will likely cross paths with fentanyl from their search for relief from withdrawal.

Examining fentanyl's mortality rate in Central Florida is overwhelming. It is unlike anything we have ever seen before. And it requires a response that is also without precedent.

It is with this urgency and a hopeful spirit that we bring to you this data analysis and best practice overview, the Prescription for Change: Solutions to the Opioid Crisis in our Community. It is a comprehensive look at the crisis in our region, using more than 70 data sets from the most vital focus areas, and examines the scope and scale the impact has had on Central Florida. Most importantly, it focuses on solutions. We studied the best practices of what is working around America including communities that have policies and programs showing a glimpse of hope during this dark time. How do we stop the cycle of opioid dependence and overdose death? What has worked in cities across America? This report takes a close look at the answers and best practices we uncovered.

Also, our research team interviewed and learned from some of the most prolific experts working on the crisis in Florida and around the country. This report includes those findings from more than 15 industry-leading experts who, along with our research data, helped create a clear path for our community to address opioid addiction and save lives.

This most significant addition of this report comes from spending time with Central Floridians with stories of friends, family, and neighbors who have struggled with opioid addiction or ultimately died at the hands of the drugs. Sadly, these stories were not hard to find. In fact, this crisis is no longer something that affects just “them” but rather “us.” We seem to almost all now know someone, if not ourselves, who has struggled with or lost their lives to opioids.

The stories need to be heard, they need to be told. These were not “bad” people or criminals who society can simply write off as “people who make bad choices.” They are those we sit next to in the office, worship next to in church, and walk by on the street every day. They are Central Floridians who simply started on a path that can have a deadly consequence.

Our hope is that this report will serve as the foundation, or simply a first step, for Central Florida to end our opioid crisis.

Andrae Bailey  
Founder,  
Project Opioid
The State of the Opioid Crisis

#1 Prescription Opioids
have flooded Central Florida/Florida

#2 Illicit Fentanyl
is rampant in communities around Florida

#3 Naloxone
Naloxone (Narcan) is being distributed and saving lives in record numbers

How Do We Help?

#4 Treatment
Availability
Treatment options, including behavioral health, are limited, and many programs do not focus on the unique harm reduction needs of those with Opioid Use Disorder.

#5 Medication Assisted Treatment
Medication Assisted Treatment is the "gold standard" for treating Opioid Use Disorder and is a combination of medication and counseling/behavioral health therapy.

#6 Children
Children exposed to opioids in-utero are born withdrawing and can have long term implications.

#7 Reductions in prescription opioids in our state are necessary but require a timely increase in alternatives and options for those with dependency and chronic pain.

#8 Workplace Engagement
The workplace can become a new frontline to help those struggling with opioids.

#9 Criminal Justice
Criminal justice must help drive regional solutions and set the tone for harm reduction and diversion.

#10 Targeted advocacy
Targeted advocacy should be ever-present for Millennials and Gen Z on the new lethal realities of drugs in our region.

Regional Coordination
Local communities need clear regional responses to the crisis that creates coordination, accountability, and results.

Technology & Innovation
Technology and innovation are needed to provide a scalable solution to the opioid crisis.
### Where Do We Go From Here?

<table>
<thead>
<tr>
<th>#</th>
<th>Where to Focus Now?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>#7</strong></td>
<td>Opioid Reductions</td>
</tr>
<tr>
<td><strong>#8</strong></td>
<td>Technology &amp; Innovation</td>
</tr>
<tr>
<td><strong>#9</strong></td>
<td>Workplace Engagement</td>
</tr>
<tr>
<td><strong>#10</strong></td>
<td>Criminal Justice</td>
</tr>
<tr>
<td><strong>#11</strong></td>
<td>Targeted advocacy</td>
</tr>
<tr>
<td><strong>#12</strong></td>
<td>Regional Coordination</td>
</tr>
</tbody>
</table>

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Reductions in prescription opioids in our state are necessary but require a timely increase in alternatives and options for those with dependency and chronic pain.

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### #4 Treatment Availability
Treatment options, including behavioral health, are limited, and many programs do not focus on the unique harm reduction needs of those with Opioid Use Disorder.

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Medication Assisted Treatment is the “gold standard” for treating Opioid Use Disorder and is a combination of medication and counseling/behavioral health therapy.

### #5 Children
Children exposed to opioids in-utero are born withdrawing and can have long term implications.
It is estimated that in 2018, 2 million people in the United States had an Opioid Use Disorder, and on average, 130 Americans died every day from an opioid overdose (HHS.gov). In 2017, opioid related deaths in the US exceeded the number of people killed in car accidents for the first time (National Safety Council). The Center for Disease Control estimates that the total economic burden of prescription opioid misuse to be approximately $78.5 billion a year in healthcare costs, lost productivity, addiction treatment, and criminal justice involvement.

In our region Orange, Osceola, and Seminole counties, there were 1,336 non-fatal opioid overdoses that presented in a hospital emergency room in 2017 and 16,138 in the state of Florida. Between January and June of 2019, the EMSTAR database reports 692 opioid overdoses, which is an increase of 7% from the same time last year. In 2017, 4,280 individuals in Florida and 378 in the region died from an opioid overdose. In 2018, the death rate rose to 413 in Orange, Osceola, and Seminole counties, a 9% increase in deaths from opioids.

While current efforts have made some progress, projections for this crisis are still not favorable, with some projections estimating 82,000 deaths nationwide by 2025, and that our current efforts will only reduce the number of deaths by 3-5% (Chen et al., 2019). To properly address this growing crisis will require the cooperation and coordination of local, state, and federal governments, which has been happening for some time, but also the private sector as well. This is a problem facing all of society and every organization or group able should do what they can to save and improve the lives of their fellow citizens.
It is essential to understand the “dual” nature of the Opioid Crisis as involving both legal prescription opioids and illegal opioids, such as heroin, sold by drug traffickers. In 2017, over 17,000 people (over one-third of the 49,000 total opioid overdose deaths nationally) resulted from a doctor-prescribed opioid. The obstacles for doctors involve insufficient training on dosage and duration, informed consent, and non-medication options. Doctors also face structural challenges, such as the economic pressure to take care of patients quickly without the time necessary to discuss other options, the lack of alternatives that are as effective as opioids for severe pain, and the lack of specialty-specific guidelines for evaluating and treating pain.

Best Practices:

- **Dr. Steven Grinstead, Addiction-Free Pain Management® System**: This pioneering treatment model helps chronic pain patients to manage their pain in a safe, recovery-oriented manner, while improving overall quality of life.

- **Dr. Graves T. Owen et al. “Evidence-based pain medicine for primary care physicians” (2018)**

  **Baylor University Medical Center**: This study builds on Centers for Disease Control Guidelines to offer primary care providers evidence-based guidelines for appropriate opioid utilization in treating chronic pain in a biopsychosocial model of pain that integrates physical, emotional, social, and cultural variables.
A Brief Synopsis

It is estimated that in 2018, 2 million people in the United States had an Opioid Use Disorder, and on average, 130 Americans died every day from an opioid overdose (HHS.gov). In the region, there were 1,336 non-fatal opioid overdoses that presented in a hospital emergency room in 2017 and 16,138 in the state of Florida. That same year, 4,280 individuals in Florida and 378 in the region died from an opioid overdose.

In 2017, opioid related deaths in the US exceeded the number of people killed in car accidents for the first time (National Safety Council). The Center for Disease Control estimates that the total economic burden of prescription opioid misuse to be approximately $78.5 billion a year in healthcare costs, lost productivity, addiction treatment, and criminal justice involvement.

Prescription Opioids in Central Florida

The number of individuals taking opioids as well as the number of prescriptions being written for legal opioids is declining, but there is still a significant supply of legal opioids in Central Florida. The number of overall prescriptions has decreased by almost 12% since 2015, when 1,230,581 prescriptions for opioids were written in Orange, Osceola, and Seminole Counties. During the first three quarters of 2019, 729,319 prescriptions were written for opioids in the region, a 12% decrease from the same period in 2018. The same trend holds true when evaluating the number of unique patients receiving a prescription for opioids. In the third quarter of 2019, 113,254 patients received a prescription for opioids from their health care provider. This is a 26% decrease from the third quarter of 2015 when 154,030 patients were prescribed an opioid. Despite the decline in prescriptions and patient counts, the number of prescriptions per patient remains relatively unchanged at 2.06.
While there are dramatically fewer patients receiving opioids and prescriptions for them today than in years past, the same precipitous decline has not been observed for opioid-related deaths, despite current efforts. In the first half of 2018, statewide, 2,773 deaths were found to be related to opioids and in 1,841 of those, opioids were the cause of death, a decrease, compared to the first half of 2017, of only 10% and 13% respectively.

Many factors contribute to opioid-related morbidity and mortality, but controlling the legal and medical availability of opioids will not, on its own, prevent a large portion of opioid-related deaths and more must be done if lives are to be saved.
It is estimated that in 2018, 2 million people in the United States had an Opioid Use Disorder, and on average, 130 Americans died every day from an opioid overdose.

- US Department of Health & Human Services, 2019
Prescription Opioids

• Increase strategies that limit first time usage of prescription opioids.

• Raise awareness about opioid alternatives for chronic pain and short-term acute relief.

• Integrate the PDMP into Electronic Health Records systems and enforce compliance with prescribing guidelines.
Over the past few years, as our state and local governments have begun to address the opioid crisis, a new, dangerous drug has taken center stage: fentanyl. Fentanyl is a synthetic opioid that is, according to the CDC, 50-100 times more potent than morphine. It is legally produced and prescribed in the form of transdermal patches and oral lozenges; that is easily diverted into misuse and abuse. Overall, the most abundant supply of fentanyl is illegally manufactured and added to other illegal opioids such as heroin. Between 2010 and 2015, the number of deaths involving synthetic opioids increased by 219% from 3,007 to 9,580, much of this increase is thought to be caused by fentanyl (CDC).

Fentanyl is also illegally produced, and the number of confiscations across the country of illicit fentanyl has seen a sharp rise in recent years. It is also shipped in from countries around the world, where it is cheaper and easier to buy than in the US (Beletsky & Davis, 2017).

It takes one milligram of fentanyl, roughly the size of one grain of sugar, to induce a potent high for an adult. Likewise, only two milligrams of fentanyl, the amount of just two grains of sugar, is powerful enough to kill an adult. The rising opioid caused death rate is directly related to the rise of incoming fentanyl in the last four years, as it is finding its way into many other illicit drugs and causing accidental overdoses. Even in 2018, when opioid-related (not opioid-caused) deaths dropped a few points, fentanyl-caused deaths continued to climb. When compared to other highly addictive medically prescribed painkillers, like morphine, fentanyl can be up to 100 times more potent to the human body. The low cost of producing it, the ease in funneling it into countries like the U.S., the high profits it yields for dealers, and its microscopic sizes make it that much harder to combat.

Primarily funneled in from China and sold on the “dark web,” fentanyl is inexpensive to produce while the strength of it, in minuscule amounts, is incredibly powerful. The profit margin that it affords to drug dealers is enormously high compared to other illegal opioids because fentanyl is so inexpensive and so powerful, dealers will cut it into other drugs like cocaine. Those buying street drugs for years may purchase their drug from a trusted street dealer, where both parties are unaware that the manufacturer has now added fentanyl into the mix to escalate the power of the drug while lowering production costs. Such scenarios have led to the rise of opioid-related deaths.
The Central Florida region has seen a significant increase of fentanyl according to both law enforcement and the medical examiner. So far, in 2019, 2,281 grams of fentanyl have been seized in Orange County alone, this is a 739% increase compared to 2016 when only 7 grams were taken (Orange County Fentanyl).

During this same time period, the number of deaths caused by fentanyl, in Orange County, increased by 672%, from 11 in 2016 deaths to 85 in 2018 (Orange County Fentanyl).

In Seminole County, in the first half of 2019 over two-thirds, 69% of Seminole county’s overdose deaths were caused by fentanyl, compared to 21% in 2016 (ME data).

Statewide fentanyl was the leading cause of drug overdose deaths in the first half of 2018, killing 1,101 individuals and contributing to the death of 184 more. This is an increase of 54% between this same time period in 2017 when 834 decedents had fentanyl in their body and deaths caused by fentanyl increased by 64%.

What We Can’t Ignore
What We Need To Do

Fentanyl is a serious threat to the citizens of Florida, and a coordinated, community approach to reducing the harm it can cause is needed. Essential to this strategy is education of the heightened dangers of fentanyl for everyone, but in particular Millennials and Generation Z who are at a heightened risk for death from exposure to fentanyl. The criminal justice system can also help to slow the influx of this dangerous drug by increasing penalties for those distributing and dealing fentanyl.

Data Findings

- So far in 2019, 2,281 grams of fentanyl have been seized in Orange County alone, this is a 739% increase compared to 2016.
- The number of deaths caused by fentanyl, in Orange County, increased by 672%, from 11 in 2016 deaths to 85 in 2018.
- Statewide fentanyl was the leading cause of drug overdose deaths in the first half of 2018, killing 1,101 individuals and contributing to the death of 184 more, an increase of 54% since 2017.

NOTE: Information is based on DEA data. Every person reacts differently. Heroin in doses as little as 3mg or less have been known to cause death.
People who use street drugs often don’t even know they’re taking fentanyl.

-Sherman, 2018

While prescription opioids and heroin were the leading sources of opioid deaths from 1999 through 2012, since 2013 illegal fentanyl has been the fastest-growing source of overdose, killing over 40,000 people across the United States and Canada last year, with the death rate continuing to rise precipitously year over year. Many of the deaths are occurring from counterfeit drugs (such as Oxycontin), cocaine, and other drugs laced with fentanyl.

Best Practices:
• The State of Maryland has distributed tens of thousands of free fentanyl test strips through county health departments and local organizations to allow drug users to test either cocaine or heroin for the presence of fentanyl.
• DanceSafe, a nonprofit public health organization promoting health and safety within the nightlife and electronic music community, has created compelling public awareness media, such as “The Coke Challenge” video to call attention to fentanyl risks, that should be a model for effective public awareness.
Illicit fentanyl

• Focus community strategies to interventions targeted to combat the heightened dangers of illicit fentanyl.

• Support criminal justice and law enforcement partners in shaping tougher penalties for those distributing and dealing in fentanyl.

• Educate Millennials and Generation Z (age 16-39) on the unique and imminent dangers associated with fentanyl usage.
...since 2013 illegal fentanyl has been the fastest source of overdose, killing over 40,000 people in the US and Canada.”

- Nelson, 2019
Naloxone, commonly known under its brand name Narcan, is an opioid antagonist, meaning it is capable of rapidly reversing the effects of an opioid overdose, particularly respiratory depression. It is a lifesaving drug that can often be the first step on the long-term road to recovery for someone suffering from Opioid Use Disorder (OUD). It is available in forms that can be administered intramuscularly via an injection and an intranasal spray. Law enforcement, first responders, and other organizations across the country have quickly adopted naloxone and are incorporating it into their basic training. Public training on how to administer naloxone is becoming more frequent so that the average citizen can properly administer it before first responders arrive. The more available naloxone is and the higher the number of people trained to deliver it; more lives will be saved as a result.

Florida’s state government, in 2017, passed a standing order for naloxone, as many states have, meaning that it can be obtained from a participating pharmacy without a physician’s prescription by anyone so that private citizens could keep naloxone on hand for themselves or their loved ones. In theory, this standing order increases the overall availability of naloxone, but some research has raised questions regarding the actual increase in availability that these orders alone produce (Cressman et al., 2017). Pharmacists must be educated on the process, and laws of the standing order and pharmacies must keep it in stock. Despite this, cost and availability remain significant barriers to obtaining naloxone for the public, particularly the more easily administered auto-injector and intranasal forms.
Between 2016 and 2018, the Orange County Police and Fire Department increased their Narcan deployments by 20% to 2,300. Also between 2016 and 2018, deployments of Narcan increased by 16% to 444 in Seminole County. In the state of Florida between 2017 and 2018, just a single year, the total number of Narcan units distributed in the state of Florida increased by 179%, from 43,000 to 122,000.

Data Findings

• Between 2016 and 2018, the Orange County Police and Fire Department increased their Narcan deployments by 20% to 2,300

• Between 2016 and 2018, deployments of Narcan increased by 16% to 444 in Seminole County

• In the state of Florida between 2017 and 2018, just a single year, the total number of Narcan units distributed in the state of Florida increased by 179%, from 43,000 to 122,000

What We Can't Ignore

Naloxone has been saving thousands of lives from an opioid-induced death every year. Local leaders and governments must seek to make naloxone just as widespread and prevalent in communities, as opioids have been and are today. Naloxone is thoroughly safe in the hands of any individual, just as it is when injected/inhaled, and is very easy to use. For those suffering from an addiction to opioids, or have someone close to them who is, Narcan should be kept on hand or close by at all times. The life-saving drug is inexpensive, simple to use, and powerful enough to rescue someone from an overdose stemming from an opioid like heroin.

What We Need To Do

Perhaps the biggest challenge with respect to opioids is that they remain an essential source of pain relief and a practical lifeline for millions of American suffering in severe, chronic pain. Unfortunately, the pendulum swing in DEA and state medical board enforcement has led to a dramatic reduction in the number of doctors willing to continue to prescribing even to legitimate patients. In April 2019, the FDA identified harm resulting to patients from physicians’ sudden discontinuation of opioid medications and called for labelling changes to guide prescribers on the need for gradual, individualized tapering. Cutting patients off abruptly has been shown to increase suffering by legitimate patients, driving some to suicide and others to seek alternative, illegal sources of drugs on the street. To avoid the worsening of this problem, it is critical to develop specialty-specific guidelines that create safe zones for prescribing and for state medical boards and federal enforcement to modulate enforcement to reduce the climate of fear that has been created for physician prescribers.
Orange County Fire deployed 2,359 units of Narcan in 2018.

-Orange County Fire and Rescue, 2019
Naloxone

• Equip all law enforcement, first responders and other front line personnel that encounter those in danger of overdose death with Naloxone.

• Advocate for the expansion of Naloxone in its current form, Narcan, to be more widely distributed among those in the general public who want access.

• Increase protections for “Good Samaritan” laws that protect individuals deploying Naloxone to extend beyond current limited stakeholders.
Behavioral health and treatment resources specifically designed to help those suffering from Opioid Use Disorder are limited. One of the most needed resources is helping the thousands of Floridians dealing with Opioid Use Disorder is treatment programs that can enable a willing individual to wean themselves off of opioid use in a controlled environment. But while few parameters are in place to restrain the onslaught of opioids, conversely, treatment options to counteract addiction and abuse are difficult to find.

While often controversial, effective Opioid Use Disorder programs may implement harm reduction methods that are designed to make drug use safer, rather than eliminate use. Although the ideology is often understood - those who are abusing drugs will continue to do so, whether their addiction forces them to or they willingly continue with misuse - it can certainly be difficult to embrace if or when proven true.

Research has found that harm reduction methods that help make opioid abuse significantly safer can help start the path to an overall solution. For some individuals, it may be the only option they can willingly consider when dealing with an opioid that is “stronger” than they are.

Substance Use Treatment Facilities

There are many ways that patients can receive substance use treatment, including inpatient treatment, residential programs, partial hospitalization/day treatment, outpatient and intensive outpatient programs, and opioid treatment programs. These substance use treatment facilities are accredited by the Department of Children and Families (DCF) and surveyed by SAMSHA for services provided. There is a total of 58 substance use treatment facilities in Orange, Osceola, and Seminole Counties, and 580 in the state of Florida. In the region, the majority of these facilities are outpatient (46), while only 3 (all in Orange County) provide hospital-based substance use treatment. This trend is similar to one at the state level, where 80% of the facilities in the state of Florida are outpatient, and only approximately 10% are hospital-based.

The mechanisms of funding for substance use treatment varies across the region and across the state of Florida. In the region, 98% of the facilities accept cash/self-pay, and 69% accept private health insurance. Traditional public funding sources such as Medicare and Medicaid are not widely accepted in these substance use facilities. Medicaid is accepted at less than half of the facilities in the region (43%) and only 40% of the facilities at the state level, while Medicare is a payment option at only 22% of facilities at both the regional and state level. Additional public funds are available through special federal (42%) and state-financed (26%) programs in the region and the state. Very few facilities offer payment assistance at either the regional (19%) or state (16%) levels, but slightly more offer payment options on a sliding scale based on income (36% regional, 38% state).
There is little patient-level data for substance use treatment across all payers, but some trends can be determined by evaluating the data that is available. The Treatment Episode Data Set (TEDS) provides insight into the patients seeking treatment using state alcohol/drug funds including federal block grants. The TEDS data show that in the state of Florida, between 2016 and 2017, heroin outpaced “other opiates” as the primary substance used in Opioid Use Disorder. Overall, TEDS admissions for Opioid Use Disorder, including heroin and other opiates, increased 95% between 2016 and 2018. The TEDS data also shows that patients admitted for heroin were mostly male (61%), white (86%), non-Hispanic (78%), and between 26 and 35 years of age (50%). Patients admitted with “other opiate” as primary substance were mainly female (52%), also white (89%), non-Hispanic (79%) and between 26 and 35 years old (50%). (TEDS)
Treatment Availability

• Work with behavioral health partners to adopt harm reduction strategies for those suffering with Opioid Use Disorder that may differ from those used to treat for other substance use disorders.

• Focus on an expansion of scalable, outpatient programs.

• Drive investments toward evidence based, outcome driven, best practice treatment options for the opioid crisis.
Mental Health Facilities

Similar to Substance Use Facilities, Mental Health Facilities’ services vary widely, as does the setting in which these services are provided. There are 61 facilities in the region that offer mental health treatment; of those, 41% offer outpatient services and approximately 30% offer telehealth services. Services are also available inpatient hospital (13%), residential (18%), and partial hospitalization/day treatment (13%). It is important to note that the coexistence of both mental health and substance use disorder is a co-occurring disorder and the capacity to meet the needs of these patients is limited in our region. Only 16 of the 61 mental health treatment facilities (26%) provides treatment for co-occurring mental health issues/serious emotional disturbance and substance use disorder.

Mental Health Facilities can also be financed through a variety of mechanisms, most commonly mental health facilities in Orange, Osceola, and Seminole counties take private health insurance (60%) and Medicaid (58%) or are self-pay (71%). Only 11% of facilities in the region offer payment assistance, and 20% have a sliding scale which offers discounts on treatment based on household income.
Focus Area 5

Medication Assisted Treatment

Medications like buprenorphine, methadone, and naltrexone are proven pharmacological treatments for Opioid Use Disorder (OUD). These are FDA approved medications that serve as the basis of treating this chronic, relapsing, brain disease. The agonist drugs, buprenorphine, and methadone activate opioid receptors in the brain, preventing painful opioid withdrawal symptoms without causing euphoria; naltrexone blocks the effects of opioids. Medication Assisted Treatment (MAT) quells cravings and allows patients to stabilize their physical dependency. This stability enables MAT patients to better receive psychosocial behavioral therapy to ultimately achieve healthy social, psychological, and lifestyle changes.

MAT also leads to 50% diminished mortality from a fatal overdose. Without medication treatment, individuals with OUD are at high risk for overdose and death. (MAT Expansion Project, 2016) Patients who receive these medications have higher treatment retention rates and better long-term outcomes or are also less likely to inject drugs and transmit or contract infectious diseases. Despite the compelling evidence that MAT can help many people recover from opioid addiction, these proven medications remain greatly underutilized. MAT has been proven to save lives, improve quality of life, and lower medical costs, but remains inaccessible to almost 90% of the people it could help. (Elitzer, 2017)

What is MAT?

Modern addiction medicine treats Opioid Use Disorder (OUD) as a chronic disease, since long-term opioid use can permanently change brain chemistry function and, as with other chronic diseases, there is no cure, meaning patients can require long-term management of relapse and remission. Medication Assisted Treatment (MAT) is the use of medications, such as methadone, buprenorphine, or naltrexone, in combination with counseling and behavioral therapies to help prevent symptoms of opioid withdrawal and to assist patients in their recovery from Opioid Use Disorder. MAT works best when it is combined with ancillary treatment strategies like counseling and social support with fixed, safe, and predictable doses of medications.
Buprenorphine is particularly unique as a partial opioid receptor agonist, meaning it acts on some opioid receptors (those involved with pain, motivation, and cravings), but its moderate activity level limits respiratory suppression, the leading cause of overdose death associated with full agonists like heroin, fentanyl, and oxycodone. MAT is the most successful treatment modality in preventing long-term relapse (Connery, 2015). When used on patients as a long-term support method, it is found to reduce their chances of an opioid-caused death by half, and largely contributes to an overall healthier relationship with addictive substances of various categories.

However, the National Academy of Medicine in their 2019 report state plainly that “Medication based treatment is effective across all treatment settings studied to date. Withholding or failing to have available all classes of FDA-approved medication for the treatment of Opioid Use Disorder in any health care or criminal justice setting is denying appropriate medical treatment. Therefore, to withhold treatment or to deny social services to individuals receiving MAT is unethical.”

Sources of MAT

MAT is typically accessed from one of two primary sources. Only federally waivered providers in private or public clinics can prescribe buprenorphine. Also, through SAMSHA designated Opioid Treatment Programs (OTPs), will typically prescribe methadone, but will occasionally prescribe buprenorphine to select patients. Many methadone clinics require patients to attend daily to receive treatment. This can mean long, burdensome commutes at odd hours, which can conflict with professional, familial, or caregiving responsibilities. (Wolfe, 2010) Those who live in rural areas, for example, may have to drive hours to receive care. Treatment is more successful when these obstacles are not placed in the way. Buprenorphine does not require daily attendance to receive treatment because of its better safety profile over methadone. This makes it more convenient for patients to carry out medication based treatment with buprenorphine and can contribute to improved medication adherence.

To prescribe buprenorphine for Opioid Use Disorder, providers must first obtain a special waiver from the DEA. The current requirements to obtain this waiver to prescribe buprenorphine under the Drug Addiction Treatment Act (DATA 2000) place limits on the medical community’s capacity to respond to the needs of opioid dependent individuals. The DATA 2000 regulatory framework was implemented before the current wave of opioid addiction. The limitations of the legislation and regulations were intended to preserve safety and to promote comprehensive care. However, the need for buprenorphine has grown exponentially, while the supply of waived prescribers pales in comparison. Researchers in policy have noted that the waiver requirements are burdensome and reduce prescribing. They have also suggested that deregulating buprenorphine would help in reducing stigma associated with treating OUD. (Haffajee, 2018)
Availability of MAT

Despite the evidence that MAT is effective, only 10% - 20% of Americans seeking treatment can access it. Barriers to MAT include a shortage of primary care buprenorphine prescribers, addiction specialists, and opioid treatment programs; lack of patient funding, restrictive health plan authorization requirements; lack of sufficient behavioral health workforce; stigma (leading patients to avoid opioid treatment programs); and lack of provider knowledge and training. (Knudsen, 2011) Confronting these major barriers to the use of medications to treat Opioid Use Disorder is critical to addressing the opioid crisis.

In the Central Florida region, in 2017, there were only 175 DATA waivered physicians, 108 of which were capped at 30 patients, 59 at 200, and 8 at 275, meaning that the total theoretical capacity these physicians could provide for was 17,240 patients per year (DEA). This number climbed rather dramatically in 2019 to 261 waivered physicians. It is important to note that research shows that practitioners rarely use all of their waivers. However, the estimate for those patients suffering from an Opioid Use Disorder in the region is at least fifty to sixty thousand people. This shows a severe deficit of OUD treatment providers in the region.

Among the 17 licensed substance abuse providers that provide MAT in Orange, Osceola, and Seminole counties, the majority of patients are receiving methadone (2,416), while 246 patients are receiving buprenorphine, and 257 receive naltrexone (Vivitrol). These same facilities offer care in a variety of settings including outpatient, residential, in-patient, and intensive outpatient.

DATA waivered physicians are not the only source of OUD treatment; SAMHSA certified opioid treatment programs contribute a large portion of the supply of MAT throughout the state but primarily in the form of methadone. Across the state of Florida, SAMSHA certified treatment programs have been treating a growing number of patients year to year, treating 19,548 in 2017 compared to 13,760 in 2016 with MAT (SAMSHA). These facilities have a total capacity of 25,661 and ran an average daily census of 11,758, whereas in Central Florida there is a capacity of 1,949 patients and an average daily census of 1,073. The vast majority, 94%, of these patients were treated with methadone (SAMSHA). In total 24,216 patients were served methadone in 2017 and 2019 in the state of Florida (DCF). Despite this, there is an estimated unmet need for treatment of at least 2,481 patients in the region and 9,027 statewide.

**Harry Nelson**

Author

Medication Assisted Treatment

Medication Assisted Treatment (MAT) has emerged as the linchpin of effective, evidence-based treatment for opioid addiction, and yet its availability remains far too limited nationally. According to the 2017 Presidential Opioid Commission Report, only ten percent (10%) of treatment programs nationally offered any form of MAT. The obstacles have included both federal limitations on who prescribes it and how it is prescribed, as well as lingering stigmatization of MAT in some parts of the recovery community. Based on the data that MAT is saving lives, it should be an urgent priority to expand access to the maximal extent.

**Best Practices:**

- **California MAT Access Points Project:** California is funding new MAT start-up activity, as well as MAT enhancement efforts in at 200+ existing MAT sites to purchase equipment, train staff, recruit staff, and support related expenses. In addition to existing physician, hospital, and narcotic treatment program funding, the project is seeking to increase access in emergency departments, jails, tribal health center, and community mental health centers.

- **Vermont:** Vermont has increased MAT prescribing by a variety of strategies, including engaging primary care physicians and small practices and embedding nursing and counselling services into primary care for high risk patient populations.
Medication Assisted Treatment

• Increase the number of providers with the DEA X waiver certification to distribute Buprenorphine to those with Opioid Use Disorder.

• Establish Medication Assisted Treatment as an established institutional best practice, for all hospitals, treatment providers, behavioral health partners and all those working with those with physical dependence to opioids.

• Educate leaders from the public, private and independent sectors on Medically Based Treatment as the gold standard for opioid addiction.

RESTORE ___________ LIVES
_________________________________________ M.D. ________________ M.D.

DO NOT OVERDOSE SOLUTIONS NEEDED

DEA NO. _________________________

ADDRESS THE PROBLEM

ProjectOpioid 1-407-456-0605

FORM NO. 102919
The stigma and associated laws and policies opioid use, especially while pregnant, is a significant barrier preventing an adequate response to NAS.

What We Should Know

The opioid crisis does not discriminate by age; What We Cannot Ignore individuals of every age are affected, including unborn children. Children in-utero are particularly susceptible to the opioid use of their mother, leading to a myriad of potential short- and long-term risks for the child. Because these infants are born withdrawing from the opioids, they have what is called Neonatal Abstinence Syndrome (NAS), which includes a variety of dangerous symptoms and puts them at risk for many issues throughout their life span. These risks include but are not limited to low-birth-weight, premature birth, congenital disabilities, and all the various symptoms common to withdrawal from addictive substances (McQueen, 2016). The long-term impacts these children face include slowed mental and physical development, decreased motor function, and abnormal neurological regulation (Logan, Brown, & Hayes, 2013). Many of these children will live with the burden their parent’s opioid use for their entire lives.

What We Cannot Ignore

Nationwide, from 2000 to 2012, the incidence of NAS increased by 383%, and around 80% of all NAS hospital charges were covered by Medicaid (Ko, 2016). In 2018 1,475 children were born with NAS in Florida, of those 1,278 were paid for by Medicaid (87%). NAS babies spend a much longer time, 16 days on average, in the hospital compared to babies born without NAS, who spend just 2.4 on average (AHA Data). In 2014, nationwide NAS cost state Medicaid programs $462 million, an increase from $65.4 million in 2004 (Winkelman et al., 2018).

“The stigma and associated laws and policies opioid use, especially while pregnant, is a significant barrier preventing an adequate response to NAS.”
What We Need To Do

To effectively prevent and treat NAS, we must promote policies that encourage women who are using drugs to seek care and to reduce the stigma associated with substance use disorders. Evidence suggests that pregnant women who are using drugs find policies threatening, and they report being discouraged from receiving regular prenatal care to protect the fetus from the effects of the opioids they are using (Stone, 2015). The stigma and associated laws and policies opioid use, especially while pregnant, are significant barriers preventing an adequate response to NAS. Another barrier to treatment is the requirement for prior authorization for the treatment of OUD outlined by AHCA for Medicaid and private insurance plans.

Other policies that could improve the outcome of babies impacted by NAS are universal screening of pregnant women and babies (urine and meconium), the development of a longitudinal patient tracking system that follows babies born with NAS and provides them with coordinated care, and post-partum education for mothers.

Data on Neonatal Abstinence Syndrome (NAS) is difficult to track as a consequence of non-standard coding and reporting practices around the country. Best estimates are that, nationally, opioid use by pregnant women has led to a 500-600% increase in the incidence of NAS over the past two decades, with over 8,000 cases per 1,000 hospital births, which translates to a baby born every 15 minutes who is experiencing opioid withdrawal. (CDC/NIH) Florida is in the middle of the states, with rates as much as four times higher in NAS hotspots like West Virginia, Maine, and Vermont. In addition to the significant expense of Neonatal Intensive Care Unit (NICU) stays while babies wean off of opioid dependence, NAS babies are also more at risk of low birthweight, respiratory complications, and behavioral health challenges. There is similarly a lack of reliable national data to compare the thousands of children growing up in foster care, with grandparents as a result of parental addiction, or with parents struggling with addiction. These problems are widespread, profound, and one of the most hidden aspects of the Opioid Crisis.

Best Practices:
The best practices in reducing rates of NAS, as well as addressing the needs of younger children at risk from parental use are Maternal, Infant, and Early Childhood Home Visiting Programs, many funded by grants from the federal Health Resources and Services Administration (HRSA). These include a variety of models combining home visitations to identify needs and provide support, such as:

- **Maine’s evidence-based Family Home Visiting Model and Bridging Programs,** which provide individualized support to families struggling with opioid use, including family-driven, strengths-based wraparound planning. Maine has also developed the “Snuggles” guidelines to improve and make uniform quality medical care and outcomes for infants with prenatal opioid exposure, including a provider checklist for care.

- **Colorado’s Special Connections Program,** which helps pregnant women with alcohol and drug abuse problems to have healthier pregnancies and healthier babies by providing case management, individual and group counseling, and health education.
Children

• Promote policies that encourage women who are using drugs to seek care and to reduce the stigma associated with substance use disorders.

• Coordinate universal screening for Opioid Use Disorder of pregnant women and babies (urine and meconium).

• Develop a longitudinal patient tracking system that follows babies born with NAS and provides them with coordinated care.
“TEDS admissions for Opioid Use Disorder, including heroin and other opiates, increased 95% between 2016 and 2018.”

-TEDS, 2018
Pressure and accountability are on the rise for pharmaceutical companies and physicians who have played a key role in causing the widespread opioid epidemic. The fear of lawsuits and public opinion has done its job in lowering the volume of opioids that are prescribed every day throughout the country. Unfortunately, while the prescription volume drops, the usage volume has continued to increase. Studies show that once an individual is addicted to opioids, it is common for them to turn to heroin and fentanyl to continue their addiction if opioids are no longer available (Bonniem 2017) and that those with an Opioid Use Disorder are 40 times more likely to use heroin than someone without OUD (Jones, Logan, Gladden & Bohm, 2015).

Reducing the number of initial opioid prescriptions for those patients considered “opioid naïve” is an essential part of ending the epidemic, but it must be paired with simultaneous effort in producing alternative options for those with OUD. There are many chronic pain patients that use opioids in a measurable manner that do not suffer the psychosocial harms of addiction. We must respect this group of patients dependent on their medications and resolve not to have them forcibly tapered or abruptly cut off from their regular supply of medications.

Those seeking an opioid prescription may find it an easier route to heroin than those seeking programs and support, and many practitioners do not understand the critical difference between addiction and dependence. And those that are just starting to be cut off from their doctors will be forced to suffer at higher levels as withdrawal symptoms rise and add adverse effects to their family, work, and social lives. Even those dependent on opioids to offset severe pain, as their prescribed drug was intended to do, may find that the illicit alternatives like heroin and fentanyl are the only viable options to deal with the lack of support, understanding, or answers from their physician.
Estimates of the number of individuals suffering from Opioid Use Disorder (OUD) varies widely depending on the source of the estimation, and methodology applied. The Department of Children and Families, using the National Survey on Drug Use and Health (NSDUH), which is an annual survey conducted by the Substance Abuse and Mental Health Service Administration (SAMSHA). The NSDUH defines Pain Reliever Misuse or Disorder as “any use of prescription pain medications not directed by a doctor, including use without a prescription of one’s own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor” (NSDUH, 2019). Similarly, the NSDUH measures the number of individuals that have used heroin in the past year. In both cases, the NSDUH produces an estimation of the percentage of individuals in a given population (i.e., county) that are either misusing pain relievers and/or have used heroin in the past year. This percentage is then applied to the population of counties and the state of Florida to obtain an estimated demand for opioid treatment programs.

The NSDUH estimates that 3.71% of the population of Orange and Osceola Counties and 3.47% of Seminole County have used pain relievers in a non-medical capacity in the past year. When applied to the population of each county, it estimated that there are 63,729 individuals misusing pain relievers in Orange, Osceola, and Seminole Counties. The estimation for heroin use is much lower, at .31% of the population of Orange and Osceola, and .25% of Seminole County. When applied to the population of the counties, it is estimated that 5,177 individuals have used heroin in the last year. When these numbers are taken together, it is estimated that there are 68,906 individuals in the region that suffer from pain reliever use disorder and/or heroin use disorder. When this same methodology is applied to the state of Florida in totality, it is estimated that there are 636,935 suffering from pain reliever use disorder and/or heroin disorder.

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Opioid Reductions

Perhaps the biggest challenge with respect to opioids is that they remain an essential source of pain relief and a practical lifeline for millions of American suffering in severe, chronic pain. Unfortunately, the pendulum swing in DEA and state medical board enforcement has led to a dramatic reduction in the number of doctors willing to continue to prescribing even to legitimate patients. In April 2019, the FDA identified harm resulting to patients from physicians’ sudden discontinuation of opioid medications and called for labelling changes to guide prescribers on the need for gradual, individualized tapering. Cutting patients off abruptly has been shown to increase suffering by legitimate patients, driving some to suicide and others to seek alternative, illegal sources of drugs on the street. To avoid the worsening of this problem, it is critical to develop specialty-specific guidelines that create safe zones for prescribing and for state medical boards and federal enforcement to modulate enforcement to reduce the climate of fear that has been created for physician prescribers.
A standard method to measure the amount of opioids in a community is the Morphine Milligram Equivalents (MME) prescribed to patients in the region. This variable provides a measure of the strength of the opioids in the community. Much like the total number of prescriptions and patient count, the MME for Orange, Osceola, and Seminole Counties has decreased 31% from over 1,480,000,000 in 2016 to 1,028,000,000 in 2018.

The most recent numbers from the Prescription Drug Monitoring Program (PDMP) indicate and even more significant decline when comparing the first three quarters of 2018 with the 2019 MME from 834,282,431 for Q1-3 of 2018 to 557,415,861 for the same time in 2019.

The opioid singularity helps explain the complex problem that is the opioid crisis. PDMP programs, short for Prescription Drug Monitoring Programs, medication-assisted treatment, and accessible naloxone are some of the critical components to the solution, but only when expertly paired with a decline in initial opioid prescriptions for those patients deemed opioid naïve. Hospitals and providers need to provide better education to patients offered opioids as part of their pain management strategies.
Illicit Opioids

Measuring the illegal supply of opioids is very difficult, if not impossible, as authorities only confiscate a small portion of these drugs, there are many different points of origin, and most moves throughout the state and counties undetected. As examples, some part of legally prescribed opioids are diverted into the illegal supply, some opioids can be synthetically produced, and much is smuggled across the country from various places, foreign and domestic (Humphreys, Caulkin, & Felbab-Brown, 2018).

Illegal sources of these drugs are also significantly more dangerous, particularly with regard to risk of long term harm and potential death, as the dosage is highly variable and they can contain “cutting agents,” additives meant to artificially extend a seller’s supply, which can pose a serious risk to users (Pacula & Powell, 2018).

Currently, one method is being taken while another equally important method is being neglected. Those who have become addicted to opioids, without a justifiable need for their long-term use, should be carefully assessed individually and be considered for gentle tapering or referral to treatment without abrupt cessation of their medications. This is a complex task that needs further research and evidence to better guide practice. These patients should also be afforded compassionate care and resources that allow them to rehabilitate and begin living free of opioid addiction. This is the solution that Central Florida must work towards to end the regional opioid epidemic and death toll.

While current efforts have made some progress, projections for this crisis are still not favorable, with some projections estimating 82,000 deaths nationwide by 2025, and that our current efforts will only reduce the number of deaths by 3-5% (Chen et al., 2019). To properly address this growing crisis will require the cooperation and coordination of local, state, and federal governments, which has been happening for some time, but also the private sector as well. This is a problem facing all of society and every organization or group able should do what they can to save and improve the lives of their fellow citizens.
Opioid Reductions

• Treat those who have used opioids for extended periods of time as a vulnerable population in the opioid crisis.

• Rapidly explore the expansion of options for long term chronic pain management for those with new limitations and challenges in receiving opioids.

• Target previous opioid users for timely and rapid interventions to prevent diversion from legal prescription opioids to illicit street opioids.
More than 17,000 of the 47,600 opioid-related deaths in 2017 involved prescription opioids (the majority of those deaths, however, were from nonprescription opioids).

- Dowell, Compton and Giroir, 2019
There is insufficient capacity to provide Medication Assisted Treatment to the estimated 68,906 individuals in the region that suffer from pain reliever use disorder and/or heroin use disorder (NSDUH). The increased use of technology holds the key to the expansion of Medication Assisted Treatment in the state of Florida. Florida is one of six states that now allow telemedicine prescribing of controlled substances, such as buprenorphine, without a prior in-person visit. This change in the legislature enables DATA waivered prescribers to begin Medication Assisted Treatment to patients with Opioid Use Disorder regardless of their geographic location or transportation needs. By capitalizing on this change in the law, patients with limited mobility could access MAT which is currently unavailable.

In addition to accessing the medications needed for successful MAT, telehealth can also expand access to behavioral health therapies. Telehealth is being used in a variety of settings to provide counseling services to patients all over the country with good outcomes. This is particularly true in the treatment of addictive behaviors (Gross, Morland, et al, 2013).

One of the biggest challenges of the opioid epidemic has been identifying individuals suffering from OUD before they overdose. The use of technology can improve our ability to identify and target those suffering using data retrieved from online search engines. Much like advertisers use search data to customize ads, advocates can use this same data to target potential patients with targeted education and outreach.

While Florida has had a working Prescription Drug Monitoring Program (PDMP) since 2011 and recently began sharing data with the Military Health System’s PDMP, additional sharing of prescribing data would help curb overprescribing. In addition to prescribing data, real-time data on fatalities, overdoses, law enforcement, naloxone use, and treatment is needed to adequately monitor the current status of the epidemic.
Telehealth resources can play an essential role in expanding access to care and treatment, both by enabling patients to be treated by healthcare providers via digital interface, and also in encouraging the use of digital therapeutics, such as smartphone applications and web-based resources to support wellness.

Best Practices:
- **Catasys**: Catasys utilizes data analytics to identify health plan members with untreated behavioral health conditions and offers its integrated, multimodal, longitudinal OnTrak™ program to improve health and reduce medical expense.
- **Self-Help Works**: Self-Help Works offers evidence-based cognitive behavioral training online to support employee health.

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**Project Opioid’s Community Engagement Model**

"**Risk Continuum**"
Techology & Innovation

• Explore “disruptive technology” to reshape a patient centered pathway to treatment.

• Applying developed technologies from other industries to locate, connect, and navigate those who are struggling with opioid dependence.

• Reshape and harness regional coordination for treatment through “crowd sourced” information sharing and targeted human capital.
One of the biggest challenges of the opioid epidemic has been identifying individuals suffering from OUD before they overdose.

-Ward, 2019
Local businesses, small and large, have a unique ability to help communities with the opioid epidemic and drastically reduce the death toll. Employers can play an essential role in assisting those in the workforce with OUD get the help they needed. Employers can also ensure their work environment is equipped and prepared with the tools and knowledge to address an employee’s struggle with opioids or even an overdose in the workplace.

Of the 70,067 drug overdose deaths in the US in 2017, 95% of them occurred among the working age population. While it is unknown how many of these individuals were employed at the time of their death, one can assume that many of them were a part of the workforce. The prevalence of employees using illicit opioids is also high. The National Survey of Drug Use and Health (NSDUH) estimates that 66.7% of the individuals that reported illicit drug use are also employed. Employees suffering from OUD can have a significant impact on productivity. The NSDUH also reports that employees with pain medication use disorder miss an average of 29 days per year, in comparison to 9.5 days for employees in recovery from substance use disorder and 10.5 for most employees. (CDC, 2017)

In 2017, the National Safety Council surveyed over 500 HR decision-makers on their perceptions and experiences with prescription drugs and the policies and procedures they have for dealing with issues as they arise. This survey was representative of organizations with 50 or more employees and focused on operations in the US only. Findings indicate that employers are feeling the impact of prescription drug use, including absenteeism, use of prescription pain relievers at work, and positive drug tests. The survey also indicates that employers agree that prescription drug misuse is a disease that requires treatment (71%), but also feel that it is a justifiable reason to fire an employee (65%). The survey also found that only 24% of organizations offer workplace training about prescription drugs.
Currently, the front line tasked with decreasing the opioid epidemic and saving lives from deadly overdoses are EMTs and law enforcement. Often, opioid addiction is never adequately addressed until an overdose occurs and the front line is called in. This is why communities like Central Florida must establish a new frontline to address the crisis locally, and businesses can, and should, lead the way on this issue. 50% of business owners say that their offices or HR departments are not prepared to spot the signs of Opioid Use Disorder or adequately address the needs of an employee is struggling in their workplace. Filling that gap can be a crucial solution to end the pervasive level to which the opioid crisis has spread. Just as the crisis affects churches, schools, and families, businesses have a unique ability and responsibility to address the crisis from within their walls.

Workplace wellness is a grossly underutilized resource nationally for addressing opioid and other drug use, as well as frequent accompanying issues, such as mental health or stress-related disorders. In addition to creating more effective resources for employees with full-blown addictive disorders, there are important opportunities to improve education and workforce culture to raise awareness, remove stigma, and make people who are struggling feel supported.

Best Practices:

• Ernst & Young: EY’s “R U OK?” campaign focuses on addiction and mental illness awareness within the framework of company culture and values. The campaign seeks to open meaningful, nonintrusive conversations about helpful resources.

• Nelson Hardiman: NH’s “Vulnerability” initiative focuses on training leaders to model vulnerability to the workforce and integrating educational programs on stress management, mental health, and addiction into workplace wellness.

The New Frontline
Workplace Engagement

• Establish clear strategies for companies to adopt for their employees in relation to the opioid crisis.

• Solicit corporate leaders to begin to change the culture and conversation inside their companies to encourage openness and support for those seeking treatment.

• Educate HR professionals inside companies to expand their Employee Assistance Programs, Insurance, and Pharmacy offerings to support employees with Opioid Use Disorder.
Employers agree that prescription drug misuse is a disease that requires treatment (71%), but also feel that it is a justifiable reason to fire an employee (65%).

-National Safety Council, 2017
Law enforcement is uniquely positioned to take an active role in the opioid crisis in communities. Their role as both protector and enforcer provides a duality that is not present in other positions and professional industries. Every day, law enforcement officers are among the first people to encounter someone who has overdosed, and their knowledge and ability to provide care can be the difference between life and death. They are also tasked with the proactive prevention of illegal drug use and can be a link to treatment for Opioid Use Disorder through corrections-based programming. The role and training of law enforcement officers are an integral part of the solution to the opioid crisis.

Law enforcement officers are among a small group of professionals who understand the depth and scope of the opioid epidemic, as they address its deadly consequences every day. Their service exposure and risk do not stop short of illicit opioid use, such as the cases involving heroin and fentanyl, but they’re frequently the first to arrive on the scene of a prescription opioid overdose as well. First responders in Seminole County equipped and trained with naloxone deployed the opioid antagonist 392 times in 2018. This number includes firefighters, deputy sheriffs, and city police officers. Overall, this was a decrease from 2017, but law enforcement deployment saw a 36% increase from 2017.

Education and training should not end at the proper protocol in addressing emergencies. Government and agency leadership should ensure adequate training on all facets of the epidemic, including nuances and stigmas surrounding an individual’s use of opioids. Another essential element of the law enforcement role in the opioid epidemic is the likelihood of future overdoses or cases of relapse while in the recovery process. The ultimate goal of our frontlines in this crisis, after research and an understanding and implementation of best practices, should be to reduce the number of fatal overdoses. Law enforcement can make immediate changes in how opioid overdoses are addressed and handled and should continue to lead the way for communities and their fight, as the current frontline.
Beginning in January 2020, Florida will become one of the first states in the county to require the implementation and utilization of Best Practice Standards in Adult Drug Courts. Adherence to these standards, which are currently being revised, will be required for drug courts to receive funding.

Lastly, law enforcement should and take a close look at how the crisis is being addressed with those who are already under their close watch in correctional settings. Much like the deficiency in bringing help to those who need it outside of imprisonment, government and health officials have implemented very little to help bring aid to the incarcerated before it’s too late. Likewise, compassion must meet the science behind issuing painkillers and opioids to those under government care, and the consideration of harm reduction strategies, including opioid alternatives like buprenorphine, needs to be understood and ultimately implemented to those who are incarcerated with opioid addictions. Locally, Seminole County has one of the few corrections-based MAT programs in the state of Florida, providing naltrexone injections to incarcerated people prior to their release back to society, as well as providing the opportunity for oral naltrexone options. (Seminole County)

Law enforcement, alongside first responders and the medical community, has been faithfully serving as our community’s frontline for the growing opioid crisis. They play a unique role that can have a significant impact because of their proximity to the addiction and overdose situations and can serve as key leaders in driving education, change, and solutions to communities in need.

The fight against opioids has created new challenges for law enforcement. In addition to interdiction of illegal opioid trafficking (including identification of on-the-ground traffickers, use of Craigslist and other websites for buying and selling drugs, and drugs flowing in from China and elsewhere through U.S. mail), there is a critical need for law enforcement to collaborate with treatment resources. While a punitive approach is necessary for drug traffickers, the most promising data in the country comes from cities that are developing models to divert drug users in possession of small quantities of illegal drugs for personal use to treatment.

**Best Practices:**

- **Dayton, Ohio:** Dayton Police have moved to a coordinated, community partnership of calling and visiting drug users shortly after an overdose to offer support and encourage people to seek treatment.

- **Seattle, Washington:** Seattle’s Law Enforcement Assisted Diversion (LEAD) model gives police officers discretion to refer people caught in illegal possession of opioids for personal use to social workers and treatment resources, in lieu of arrest.
Criminal Justice

• Educate all stakeholders in the criminal justice system on all facets of the epidemic.

• Expand the availability of evidence based, medication assisted treatment in jails.

• Equip all members of the criminal justice system with Narcan.
So far in 2019, 2,281 grams of fentanyl have been seized in Orange County alone, this is a 739% increase compared to 2016.

-Orange County, 2019
Targeted Advocacy

Millennials, those who are 24-38 years old, and Gen-Z, those who are teens up to 24 years old, make up the majority (51%) of opioid-caused deaths in Orange, Osceola, and Seminole Counties in 2018. Research shows that prescription opioids play an integral role in drug initiation sequencing for Millennials, much more so than other generations. This generation of young adults is more likely to transition from marijuana to opioids than previous generations who were more likely to transition to cocaine. (Wall, Cheslack-Postava, Hu, Feng, Griesler & Kanel, 2018).

Generational differences exist in treatment characteristics, as well. Using a longitudinal dataset, Rezai-Zadeh (2019) and colleagues found that Millennials are more likely to be readmitted for treatment than their Gen X or Baby Boomer counterparts, despite most often receiving opioid maintenance therapy as their initial treatment option. Millennials clients also showed more treatment avoidance than others in the study. In the state of Florida, persons aged 25-34 years were more likely than any other age group to experience any kind of drug non-fatal overdose, including opioid-involved overdoses (Florida Department of Health).

Given these findings, advocacy campaigns and treatment options need to meet them where they are most comfortable, which is often online. Both Millennials and Generation Zs typically use social media, but often different platforms, with the younger generation preferring Instagram and Snapchat as opposed to Facebook. Research shows that social medial, phone apps, and texting are the preferred method to distribute recovery support to these generations. (Curtis, Ashford, Magnuson & Ryan-Pettes, 2019).

“Millennials and Gen Z make up the majority of opioid-caused deaths”
Targeted Advocacy

- Target those in the age groups below 39 years of age on the dangers of illicit fentanyl.

- Create culturally relevant communication strategies that are Millennial and Generation Z focused.

- Expand messaging beyond the abstinence based “Just Say No” campaign-storage is previous used to facilitate more critically nuanced decision making on drug use.

- Increase dialogue on the underlying societal causation associated with the opioid crisis with a renewed focus on mental health.

RESTORE __________ LIVES

_________________________________________ M.D. ________________________________ M.D.

DO NOT OVERDOSE SOLUTIONS NEEDED

DEA NO. ____________________________

ADDRESS THE PROBLEM

ProjectOpioid 1-407-456-0605

FORM NO. 102919
The opioid epidemic is impacting the entire nation, but a regional approach to addressing it can be the solution that ultimately ends the crisis and slows the overall death toll. This approach means local government, business, faith, and non-profit leaders, among others, must combine resources, effort, and goals in fixing the crisis on a community level. Coordinated local efforts must meet the national accountability taking place for real change to occur with opioid abuse.

Currently, specific institutions are being held accountable for their role in enabling opioid abuse to reach crisis levels, such as the medical field and pharmaceutical companies. However, in reaching a person who is addicted and needs help, whether self-aware or not, advocacy, education, and resources must be supplied to all sectors of their life. This strategy empowers all: pastors can significantly impact their congregations when they join forces with the community, teachers can learn how to spot signs of drug abuse in their students, and families can apply their new-found knowledge to their home life as part of a concerted effort.

The amount of unique effort the alignment and involvement across varied sectors will involve cannot be overstated. It is undoubtedly a challenging undertaking as examples across the nation have shown, but the results continually produced a “best practice” model.
Regional Coordination

- Work towards a “coordinated system” that is patient centered for those struggling with opioids.

- Create new and expanded data sharing between key stakeholders creating an increase in harm reduction and recovery options available.

- Develop written and “adopted” community goals and tactics on the opioid crisis between all key public, private and independent sector top stakeholders that sets measurable goals, targets investments and holds everyone accountable to results.
References


Curtis BL, Ashford RD, Magnuson KI, Ryan-Pettes SR

Delivery of Evidence-Based Psychotherapy via Video Telehealth Daniel F. Gros & Leslie A. Morland & Carolyn J. Greene & Ron Acierno & Martha Strachan & Leonard E. Egede & Peter W. Tuerk & Hugh Myrick & B. Christopher Frueh


“Opioids in the Workplace: Data | NIOSH | CDC.” Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, www.cdc.gov/niosh/topics/opioids/data.html.
Definition of Terms

**Medication Assisted Treatment**- Medication assisted treatment (MAT) is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders and can help some people to sustain recovery. (SAMSHA)

**Opioid**- Opioids are a class of drugs that include the illegal drug heroin, synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone (OxyContin®), hydrocodone (Vicodin®), codeine, morphine, and many others. (NIDA)

**Prescription Drug Monitoring Program (PDMP)**- A prescription drug monitoring program (PDMP) is an electronic database that tracks controlled substance prescriptions in a state. PDMPs can provide health authorities with timely information about prescribing and patient behaviors that contribute to the epidemic and facilitate a nimble and targeted response. (CDC)

**Substance Abuse**- Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drug. (WHO)

**Drug Misuse**- Use of a substance for a purpose not consistent with legal or medical guidelines, as in the non-medical use of prescription medications. (WHO)

**Dependence**- Dependence is a strong desire or sense of compulsion to take a substance, a difficulty in controlling its use, the presence of a physiological withdrawal state, tolerance of the use of the drug, neglect of alternative pleasures and interests and persistent use of the drug, despite harm to oneself and others. (WHO)

**Opioid Use Disorder**- The DSM-5 defines Opioid Use Disorder as a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by at least two out of 11 criteria within a 12-month period. (DSM-5)

**Addiction**- Addiction is a complex condition, a brain disease that is manifested by compulsive substance use despite harmful consequences. People with addiction (severe substance use disorder) have an intense focus on using a certain substance(s), such as alcohol or drugs, to the point that it takes over their life. They keep using alcohol or a drug even when they know it will cause problems. (APA)

**Fentanyl**- Fentanyl is a powerful synthetic opioid that is similar to morphine but is 50 to 100 times more potent. It is a prescription drug that is also made and used illegally. (NIDA)

**Neonatal Abstinence Syndrome**- Neonatal abstinence syndrome (also called NAS) is a group of conditions caused when a baby withdraws from certain drugs he’s exposed to in the womb before birth. NAS is most often caused when a woman takes drugs called opioids during pregnancy. (March of Dimes)
**Narcan/Naloxone**- Naloxone is a medication designed to rapidly reverse opioid overdose. It is an opioid antagonist—meaning that it binds to opioid receptors and can reverse and block the effects of other opioids. It can very quickly restore normal respiration to a person whose breathing has slowed or stopped as a result of overdosing with heroin or prescription opioid pain medications. (NIDA)

**Buprenorphine**- Approved for clinical use in October 2002 by the Food and Drug Administration (FDA), medications such as buprenorphine, in combination with counseling and behavioral therapies, provide a whole-patient approach to the treatment of opioid dependency. When taken as prescribed, buprenorphine is safe and effective. Unlike methadone treatment, which must be performed in a highly structured clinic, buprenorphine is the first medication to treat opioid dependency that is permitted to be prescribed or dispensed in physician offices. (SAMHSA)

**Methadone**- Methadone is a medication used in medication-assisted treatment (MAT) to treat Opioid Use Disorder (OUD). Methadone is a long-acting mu-opioid receptor full agonist, a schedule II controlled medication. (SAMHSA)

**Naltrexone (Vivitrol)**- Naltrexone is a medication approved by the Food and Drug Administration (FDA) to treat Opioid Use Disorders and alcohol use disorders. It comes in a pill form or as an injectable. The pill form of naltrexone (ReVia, Depade) can be taken at 50 mg once per day. The injectable extended-release form of the drug (Vivitrol) is administered at 380 mg intramuscular once a month. Naltrexone can be prescribed by any health care provider who is licensed to prescribe medications. To reduce the risk of precipitated withdrawal, patients are warned to abstain from illegal opioids and opioid medication for a minimum of 7-10 days before starting naltrexone. If switching from methadone to naltrexone, the patient has to be completely withdrawn from the opioids. (SAMHSA)

**Opioid Treatment**- The dispensing of an opioid agonist treatment medication, along with a comprehensive range of medical and rehabilitative services, when clinically necessary, to an individual to alleviate the adverse medical, psychological, or physical effects incident to opiate addiction. (The Joint Commission)

**Opioid overdose**- Due to their effect on the part of the brain which regulates breathing, opioids in high doses can cause respiratory depression and death. An opioid overdose can be identified by a combination of three signs and symptoms referred to as the “opioid overdose triad.” The symptoms of the triad are 1) pinpoint pupils, 2) unconsciousness, 3) respiratory depression. (WHO)

**Opioid Dependence**- Opioid dependence develops after a period of regular use of opioids, with the time required varying according to the quantity, frequency, and route of administration, as well as factors of individual vulnerability and the context in which drug use occurs. Opioid dependence is not just a heavy use of the drug but a complex health connotation that has social, psychological and biological determinants and consequences, including changes in the brain. It is not a weakness of character or will. (WHO)