Florida's State Opioid Response (SOR) 2 Grant Project
Guidance on System Priorities, Permissible Uses, and Prohibited Uses

Background

The State Opioid Response (SOR) Grants are administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration (SAMHSA) to address the opioid crisis. Florida was awarded the first SOR grant on 9/30/2018, now referred to as SOR 1. That grant period ended on 9/29/2020, but as a result of unspent funds, the Department applied for and was awarded a no-cost extension. The no-cost extension funds from SOR 1 may be spent through September 29, 2021. Florida was awarded the second SOR grant, referred to as SOR 2, for the period of 9/30/2020 through 9/29/2022. This results in the two grants being administered concurrently.

It is important to note that the grants differ slightly and require separate reporting. Providers who are funded through the SOR 1 No Cost Extension should continue to follow the most recent *State Opioid Response (SOR) Grant Guidance System Priorities, Permissible Uses, and Prohibited Uses updated 07/01/2019* and use the Other Cost Accumulators (OCAs) assigned to the SOR 1 grant. The guidance that follows below specifically applies to SOR 2. The changes in SOR 2 as compared to SOR 1 include the funding amount, the expansion of the target population, and grant conditions based on the SAMHSA Notice of Award and the Funding Opportunity Announcement.

Purpose

The SOR 2 grant program aims to increase access to evidence-based prevention, treatment, and recovery support services that address opioid and stimulant misuse and disorders to reduce opioid- and stimulant-related deaths. This entails providing medication-assisted treatment using FDA-approved medications for treating opioid use disorders (methadone, buprenorphine, and long-acting naltrexone) and providing Motivational Interviewing, Cognitive Behavioral Therapy, and the Community Reinforcement Approach among other psychosocial services and supports, for treating stimulant use disorders.

Goals

It is estimated that 15,000 individuals with opioid or stimulant misuse or disorders (unduplicated) can be served in each of the two grant years (for a total of 30,000 individuals over the entire project period). Additionally, the Department is committed to achieving the following goals and objectives:

Goal 1: Reduce numbers and rates of opioid-caused deaths.
- Objective 1a: Distribute at least 80,000 naloxone kits per year.
- Objective 1b: Train at least 750 individuals on overdose prevention per year.

Goal 2: Prevent opioid and stimulant misuse among young people.
- Objective 2a. Serve at least 20,000 youth per year through primary prevention programs.
- Objective 2b. Generate at least 1,250,000 impressions per year through media campaigns.

Goal 3: Increase access to the most effective treatments for opioid and stimulant use disorders.
- Objective 3a. Increase new admissions to buprenorphine or methadone maintenance treatment by 10,000 per year
- Objective 3b. Increase the number of programs implementing contingency management or the community reinforcement model for individuals with stimulant use disorders. *(Note: At this time the*

Department is working to determine the extent to which contingency management models comport with Florida law. The remainder of this document will refer only to community reinforcement models until this issue is resolved.)

Goal 4: Expand access to recovery support services.

- Objective 4a. Increase the number of individuals engaged in recovery support by 10% per year.
- Objective 4b. Establish 60 additional Oxford Houses.

System Priorities

1.   ESTABLISH EMERGENCY DEPARTMENT BRIDGES TO COMMUNITY-BASED PROVIDERS, ESPECIALLY METHADONE OR BUPRENORPHINE PRESCRIBERS THROUGHT THE STATE.

Establish new hospital bridge programs between Emergency Departments (EDs) and community-based providers to link individuals with opioid or stimulant misuse or disorders identified in EDs with treatment and support services. For individuals with opioid misuse or disorders, identify and engage community-based methadone or buprenorphine maintenance providers that can provide assessments and medication maintenance *7 days a week* for patients identified or inducted in the ED. Managing Entities, community-based providers, and EDs must work together to overcome any obstacles to establishing or maintaining these programs. SOR funds can be used to hire prescribers and peers and establish telehealth programs. SOR funds can also be used to pay for incidentals for transporting patients from hospitals to community-based prescribers. The Department expects these hospital bridge programs to be established components of your system of care at this stage of the project.

2.   ENSURE ALL QUALIFIED PRACTITIONERS EMPLOYED BY GRANT-FUNDED PROVIDERS HAVE OBTAINED A WAIVER TO PRESCRIBE BUPRENORPHINE.

SAMHSA requires that, "Recipients must ensure that all practitioners are eligible to obtain a DATA waiver employed by an organization receiving funding through SOR receives such a waiver." While the Department awaits additional clarification on the scope of this special term, the Department expects Managing Entities to ensure that, at minimum, all qualified practitioners (including physicians, NPs, PAs, and Clinical Nurse Specialists) within licensed addiction treatment programs that are providing addiction treatment services to SOR-funded clients have obtained a waiver to prescribe buprenorphine..

3.   EXPAND ELIGIBILTY FOR TREATMENT AND RECOVERY SUPPORT SERVICES TO ADDRESS STIMULANT MISUSE AND STIMULANT USE DISORDERS.
SOR funds for treatment and recovery support services (allocated to the Managing Entities through OCA MSSM3) shall be used to provide services that address opioid or stimulant misuse, opioid use disorders, or stimulant use disorders. Stimulant misuse and stimulant use disorders can involve illicit and prescription stimulants, including (but not limited to) cocaine, amphetamines, methamphetamines, dextroamphetamine (Adderall), methylenedioxy-methamphetamine (MDMA), methylphenidate (Ritalin), and synthetic cathinones (like alpha-PVP or MDPV). **Special terms in the Notice of Award stipulate that individuals who have no history of, or no current issues with, stimulant or opioid misuse shall not receive treatment or recovery services with SOR grant funds.** If either stimulant or opioid misuse or disorders exist concurrently with other substance use (including alcohol and nicotine), all substance use issues may be treated. This means SOR funds can be used to pay for nicotine cessation services for eligible individuals. Likewise, SOR funds should be used to pay for comprehensive, integrated care that addresses co-occurring mental illnesses and medical problems.

4. **MONITOR AND IMPROVE RETENTION IN CARE BY CHANGING DISCHARGE PRACTICES AND POLICIES.** Retention in care is an important measure of success and it should be systematically monitored and improved as a priority. Several findings and conclusions from a landmark Consensus Study Report issued by the National Academies of Sciences, Engineering, and Medicine (*Medications for Opioid Use Disorder Save Lives* available at https://doi.org/10.17226/25310), have important implications for efforts to improve retention. The report observed that, "Behavioral interventions, in addition to medical management, do not appear to be necessary as treatment in all cases." The committee concluded that, "A lack of availability or utilization of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder." In other words, an individual's refusal or unwillingness to participate in counseling does not justify involuntarily discharging them out of medication-assisted treatment or withholding OUD medications.

This mirrors the position of SAMHSA's experts within the Treatment Improvement Protocol 63, which states that, "Counseling and ancillary services should target patients' needs and shouldn't be arbitrarily required as a condition for receiving opioid use disorder medication." Buprenorphine providers are therefore discouraged from establishing arbitrary counseling requirements that can constitute a barrier to admission and retention in medication-based treatment services. Buprenorphine providers are also discouraged from involuntarily discharging individuals for not attending or participating in counseling services. Notwithstanding the provisions of section 65D-30.014(5)(0), Florida Administrative Code, which mandates a minimum of at least one counseling session every 90 days for individuals maintained on methadone, i**ndividuals should not be denied life-saving medications just because they are not ready to engage in therapy, counseling, or AA/NA groups.**

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

5. **BUILD PEER CAPACITY.** Recovery Peer Specialists provide recovery-support services, promote continued engagement in treatment and inclusion in local communities. MEs will identify opportunities within their network which promote the expansion of peer-based recovery support services and recovery communities while enhancing the role of peers in the workforce. If providers within the network have been slow to hire peers, then Managing Entities should consider getting more involved, perhaps by developing peer-run organizations in their network, which ideally should be on-call and available to engage overdose victims in hospitals 7 days a week. ED officials are looking to the Managing Entities and their networks to have peers involved in bridge programs when needed.

6. **ENSURE ACCESS TO NALOXONE.** Ensure that providers in your network are enrolled in the Department's Overdose Prevention Program and are providing take-home naloxone kits to individuals at risk of experiencing an opioid overdose and to their loved ones that may witness an overdose. Managing Entities should also engage hospital emergency departments, homeless service organizations, harm reduction programs, recovery support organizations, Fire/EMS departments (for naloxone leave-behind programs), and other community-based organizations that provide direct services to people who use drugs to enroll in the program and distribute naloxone to at-risk individuals. Providers do not have to contract with Managing Entities or the Department to enroll in the program and distribute naloxone.

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

8. **RECOVERY ORIENTED QUALITY IMPROVEMENT MONITORING FOR PRACTICES AND POLICIES.** This process uses evidence-based measures of recovery principles and applies them to monitor service provider organizations. The process involves the MEs conducting provider site visits accompanied by department staff including the regional ROQI to ensure patient needs are being met which includes facility reviews, employee interviews, persons served interviews, and medical record reviews. With ongoing technical assistance and collaboration, the goal is for providers to operate at scores of 4 and above across all recovery domains which involve the following: Meeting Basic Needs, Comprehensive Services, Medication Assisted Treatment (MAT), Strengths Based Approach, Customization and Choice, Opportunity to Engage in Self -Determination, Network Supports/Community Integration, and Recovery Focus.

Permissible Uses of SOR Grant Funds

1. **ELIGIBILITY.** SOR 2 funds must be used to serve indigent, uninsured, and underinsured individuals with opioid use disorders (or who are misusing opioids) or stimulant use disorders (or who are misusing stimulants). Individuals with opioid use disorders receiving SOR-funded services are expected to be maintained on an FDA-approved medication (either methadone, buprenorphine, or long-acting injectable naltrexone). Every individual served with SOR 2 funds must have an indication of opioid and/or stimulant use in FASAMS, either via diagnosis or substances of choice. Clients currently receiving treatment and recovery support services under SOR I will continue to utilize NCE funds for treatment and recovery support services until the end of the NCE period or exhaustion of funding, whichever comes first. **All new and previously discharged clients will receive treatment and recovery support services utilizing SOR 2 funding.**

2. **EVIDENCE-BASED TREATMENTS FOR STIMULANT USE DISORDERS AND STIMULANT MISUSE**. Currently, there are no FDA-approved medications to treat stimulant use disorders, so relevant evidence-based services are all psychosocial interventions. Providers are authorized to implement any of the following treatment programs for stimulant use disorders, alone or in combination: Community Reinforcement Approach, Motivational Interviewing, and Cognitive Behavioral Therapy. Until further notice, providers may not use SOR 2 grant funds to pay for the contingencies or incentives used in Contingency Management programs.

3. **FDA-APPROVED MEDICATIONS FOR OPIOID USE DISORDERS**. This includes methadone, buprenorphine products, including single-entity buprenorphine products, buprenorphine/naloxone tablets, films, buccal preparations, long-acting injectable buprenorphine products, and buprenorphine implants (Probuphine). Probuphine is a six-month implant that may offer improved patient convenience from not needing to take medication daily, and it avoids the possibility of a pill or film being lost or stolen.

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

- For patients who opt to receive Vivitrol and are currently in an inpatient or residential treatment setting, where medication compliance can be monitored, and oral naltrexone may be a more cost-effective option. For this instance, it is expected that the patients will be transitioned to Vivitrol prior to or upon discharge from an inpatient or residential treatment setting.
- As a placeholder for patients wanting to start Vivitrol treatment until the first injection is made available.
- To conduct a naltrexone challenge to ensure patients are opioid-free prior to receiving a Vivitrol injection to avoid precipitated withdrawal.
- To ensure patients do not have a naltrexone allergy prior to receiving a Vivitrol injection.

4.   LONG-ACTING NALTREXONE (VIVITROL).   The Florida Alcohol and Drug Abuse Association (FADAA) will continue to fund Vivitrol injections and the associated screening, assessment, and medical costs. SOR funds can be used for the list of covered services below to support individuals receiving Vivitrol, except for Assessment, Medical Services and Medication-Assisted Treatment. Vivitrol providers that are not contracted Network Service Providers under an ME and only provide Vivitrol services will refer patients with stimulant use disorders to their local ME to provide treatment and recovery support services. Services using OCA code SORF3 must be entered into WITS.

5.   DEDUCTIBLES AND CO-PAYS. SOR funds are intended to reduce or eliminate treatment costs which may serve as a barrier to accessing care among uninsured and underinsured individuals. Funds may be used to offset deductibles and co-pays among eligible individuals who are underinsured, meaning they have health insurance coverage, but they are subject to behavioral health service exclusions, limitations/caps, and out-of-pocket expenses for deductibles and co-pays. The Department still expects Managing Entities to ensure that their providers are billing third-party payors and other forms of insurance, including Medicaid and private insurance, for eligible behavioral health services, so that limited state funds can be used for persons with no other means. However, Managing Entities have the flexibility to use SOR funds to address affordability when it presents a barrier to access or retention among underinsured individuals.

6.   SERVICE ARRAY. Indigent, uninsured, and underinsured individuals with opioid use disorders (or who are misusing opioids) who are or will be receiving methadone, buprenorphine, or naltrexone maintenance treatment, as well as individuals with stimulant use disorders (or who are misusing stimulants) can also have the following services paid for using SOR 2 grant funds (underlined services require additional data collection outlined in #14):
- Aftercare
- Assessment
- Case Management
- Crisis Support/Emergency
- Day Care
- Day Treatment
- Incidental Expenses (excluding direct payments to individuals to enter into, or continue to participate in, prevention or treatment services)
- Outreach (to identify and link individuals with opioid use disorders to medication-assisted treatment providers and to connect individuals with stimulant use disorders to treatment and recovery support services)
- Intervention
- Medical Services
- Medication Assisted Treatment
- Outpatient
- Information and Referral
- In-Home and On-Site

- Respite
- Recovery Support
- Supported Employment
- Supportive Housing/Living
- Residential I and II- Individuals with opioid use disorders may only be served in Residential Levels I and II if they are inducted on methadone, buprenorphine, or naltrexone, and their level of care must be reevaluated every 15 days.
- Inpatient Detoxification and Outpatient Detoxification- Per the grant FOA, medical withdrawal (detoxification) is not the standard of care for opioid use disorders, is associated with a very high relapse rate, and significantly increases an individual's risk for opioid overdose and death if opioid use is resumed. Therefore, medical withdrawal (detoxification) when done in isolation is not an evidence-based practice for OUD. If medical withdrawal (detoxification) is performed on individuals with an opioid use disorder, it must be accompanied by injectable extended-release naltrexone (Vivitrol) to protect such individuals from opioid overdose when they relapse.

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

7. **HOSPITAL BRIDGE PROGRAMS:** Data collection is required for Emergency Department Bridge programs within FASAMS using MSSM3, the general OCA for treatment and recovery support services. The following data elements must be submitted to the SOR lead epidemiologist on the 18th of each month:
- # of individuals screened
- # of individuals induced with buprenorphine in the ED/hospital prior to discharge
- # of individuals referred to treatment providers
- # of individuals linked to treatment providers

8. **JAIL BRIDGE PROGRAMS:** SAMHSA promotes the use of SOR funds to provide treatment transition and coverage for individuals reentering communities from criminal justice settings or other rehabilitative settings. Services can start in the jail, with a smooth transition to community services upon release. Data collection is required for Jail Bridge programs within FASAMS using MSSM3, the general OCA for treatment and recovery support services. The following data elements must be sent to the SOR lead epidemiologist by the 18th of each month:
- # of individuals screened
- # of individuals receiving MAT in jail prior to discharge and the type of MAT
- # of individuals referred to community services
- # of individuals linked to community services

9. **PREVENTION:** The primary prevention services funded under this project must have evidence of effectiveness at preventing opioid misuse, stimulant misuse, or other illicit drug use. Regarding standards for evidence, the Department looked for statistically significant reductions in opioid misuse, stimulant misuse, or use of other illicit drugs, relative to comparison or control groups, as documented in peer-reviewed publications reporting on experimental or quasi-experimental program evaluation designs. The list of approved, evidence-based programs that providers can choose from include: (1) Botvin LifeSkills Training; (2) Strengthening Families Program (for Parents and Youth 10-14); (3) Caring School Community; (4) Guiding Good Choices; (5) InShape Prevention Plus Wellness; (6) PAX Good Behavior Game; (7) Positive Action; (8) Project SUCCESS; (9) Project

Towards No Drug Abuse; (10) SPORT Prevention Plus Wellness; (11) Teen Intervene; (12) Media campaigns targeting prescription opioid or stimulant misuse with messages about safe use, safe storage, and safe disposal, disseminated through various mediums (e.g., websites, television, radio, billboards, social media, direct mail, etc.), which may be coupled with prescription drug take-back boxes and events and the distribution of drug deactivation pouches.. Managing Entities must request to implement evidence-based programs not listed here, for review and approval by the Department's Prevention Coordinator prior to providing services, according to the standards for evidence mentioned above. All prevention services must be entered into the Department's Performance Based Prevention System by the 15th of the month.

10. **TELEHEALTH:** SOR funds should be used to support innovative telehealth strategies for rural and underserved areas. Furthermore, due to social distancing restrictions, the use of telehealth is being promoted and allowed by SAMHSA during the COVID-19 pandemic.

11. **Behavioral Health Consultants (BHCs):** BHCs will provide clinical expertise and assist with the identification of parents with opioid disorders in the child welfare system through consulting and collaborating with Child Protective Investigators (CPIs) to build expertise with front line staff, to improve engagement with families, and improve access to treatment. BHCs are licensed therapists and there are currently 20 positions situated throughout the state of Florida. Reports regarding tasks accomplished and services provided must be submitted on the 18th of each month.

12. **RECOVERY COMMUNITIES.** Allocations have been awarded to implement recovery community organizations. These organizations organize recovery-focused advocacy activities, carry out recovery-focused community education, outreach, and peer-based recovery support services. Recovery communities will work closely with community treatment providers and other stakeholders to provide harm reduction and recovery support services. Services must be submitted to FASAMS by the 18th of each month.

RECOVERY CAPITAL: Recovery Community Organizations (RCOs) will implement use of the Recovery Capital Scale as a component of the recovery planning process. Recovery capital is conceptually linked to natural recovery, solution-focused therapy, strengths-based case management, recovery management, resilience and protective factors, wellness and sustained recovery. The Recovery Capital Scale will be completed jointly by the Recovery Peer Specialist and the individual at the time of enrollment and will identify areas for improvement, change, and recovery goal setting. The resulting score can be monitored for improvement over time.

BRIEF ASSESSMENT of RECOVERY CAPITAL (BARC-10): The BARC-10 is a strength-based measure that is completed via self-report to assess the level of broader personal, social, physical, and professional resources in an individual's environment that are used to initiate and sustain recovery, including structural supports such as a recovery-supportive living space and community relationships. The frequency of completing the Recovery Capital Assessment is every 60 and 90 days utilizing the Recovery Data Platform described below.

RECOVERY Data Platform (RDP): RDP is a cloud-based software platform that aids RCOs with the tools and assessments needed to effectively implement peer recovery support programs. The RDP houses all assessments and interviews conducted via the recovery capital assessment scale, recovery planning process, and/or BARC-10. Through the use of RDP's reporting and scheduling tools, it allows better service outcomes for individuals in recovery. RCOs receiving one of the grant funded RDP licenses must enter data into RDP by the 18th of each month.

13. **Recovery Oriented Quality Improvement Specialist (ROQIS):** ROQIS will promote the advancement of recovery-oriented system related policies, concepts, and practices. ROQIS will collaboratively work with MEs to conduct Recovery Oriented Quality Improvement monitoring activities as a part of MEs routine MAT network service provider (NSP) monitoring. ROQIS will report findings of recovery-oriented monitoring. ROQIS will provide follow-up training and technical assistance to NSPs to implement or enhance recovery management approaches

and practices. ROQIS will provide training and technical assistance in concert with MEs to support and expand peer-based recovery services among NSPs and RCOs. Reporting is required monthly to record and report on outcomes which involves providing a detailed summary of activities and all other tasks performed during the previous month. Reports must be submitted by the 15th of each month.

14.   DATA COLLECTION

FASAMS DATA: Providers must enter all patient data into the FASAMS to capture services and activities rendered for all SOR patients. Specifically, providers must input the following data:

- All patients must either have an opioid and/or stimulant use disorder in FASAMS or have an opioid or stimulant as their primary, secondary, or tertiary drug of choice, or both. Patients without an opioid or stimulant listed as a drug of choice do not qualify for SOR funding.
- All services rendered.
- All MAT modifiers (methadone, buprenorphine mono, buprenorphine combo, and injection or oral naltrexone). **Note: All individuals with opioid use disorders receiving SOR funded services must have the MAT modifier attached to service events listed in FASAMS, even if the medication itself is not being provided by the same provider of the service being entered.**
- All other FASASMS data requirements apply.

GPRA DATA: The Government Performance and Results Modernization Act of 2010 (GPRA) is a federal mandate which requires all SAMHSA grantees to collect and report performance data using approved measurement tools. Providers of treatment and recovery support services (which are underlined in the Service Array section) will be required to collect data at <u>five</u> data collection points (**baseline, 6 months post-intake, discharge, 3-months post-discharge, and 6-months post-discharge**) using the CSAT GPRA. The target completion rate is 100%; meaning programs must attempt to follow-up with all individuals. However, SAMHSA expects the state to achieve a minimum 6-months post-intake follow-up rate of completion of 80%. **Any interview that is not conducted via face-to-face or virtual interview, will not count towards compliance.** Guidance for data collection is provided below.

DATA ENTRY: Providers must enter all patient data into the WITS system for all SOR patients. The WITS system feeds into SAMHSA's data entry system, SPARS to maintain timely reporting and accurate data to SAMHSA. Specifically, providers must input the following data:

- All patients identified with having an opioid and/or stimulant use disorder (**Note: All patients need to have an opioid/stimulant use disorder checked within the WITS system to qualify for funding. Checking unknown or don't know means the patient does not qualify for SOR funding.)**
- Responses to all questions identified in the GPRA and Supplemental interviews.
- All patients also entered into FASAMS under OCA MSSM3 must be entered into WITS.
- **GPRA and GPRA Supplemental forms** must be administered by program/clinical staff and questions must be asked as written with no deviation. The GPRA cannot be self-administered by the patient. Due to social distancing restrictions regarding COVID-19, SAMHSA is allowing interviews to be conducted via virtual platforms. However, once social distancing restrictions are lifted, and SAMHSA returns to conducting interviews via face-to-fact contact, updated guidance will be disseminated.
- All individuals who receive SOR-funded covered services underlined in the Service Array section, must have completed **GPRA and GPRA Supplemental forms** for each of the 5 collection points.
  - 6 months post-intake data should be collected on all patients, regardless of whether an individual drops out of the program prior to the 6 months. When a program cannot follow-up with an

individual, the program must use the GPRA tool to report that the individual was not located. Furthermore, a patient who is not located, does not count towards compliance.
  o A Discharge GPRA must be completed each time an individual is discharged/transferred from SOR funding.

- All SOR 1 No Cost Extension (NCE) funds must be used before transferring active patients over to SOR 2. Patients will have to be administratively discharged from SOR 1 before they can be transferred to SOR 2, and a new GPRA intake interview must be completed before patients can begin receiving SOR 2 funded services.
- An administrative discharge out of SOR 1 program will be completed, not a discharge interview. The administrative discharge requires sections A, J & K of the GPRA form. The patient will then be enrolled into the SOR 2 program, and a new intake interview for the patient will be completed (only during their transition into SOR 2). Afterwards, the same requirements must be completed, **GPRA and GPRA Supplemental forms,** for each of the 5 collection points.
- If an individual is discharged from a treatment episode and the individual then returns to re-enroll in a new SOR-funded treatment episode, a new data collection timeline must be started.
  EX: An individual is discharged "Left on own against staff advice with satisfactory progress" at 4 months post intake with a baseline having been completed. Individual re-enrolls 2 months later. A new baseline **MUST** be completed and continued on a new data collection timeline (for 6 months post-intake, discharge, 3-months post-discharge, and 6-months post-discharge). With the previous GPRA timeline discontinued.
- If an individual leaves SOR funding and is transferred within the same episode of care to another funding source they **MUST** complete a discharge at that time and GPRAs at subsequent data collection points. If the same individual returns (transferred back) within a certain time point to SOR funding they **do not** have to complete a new Baseline. Follow the guidance below for these situations:
- If an individual is transferred to another funding source and is transferred back to SOR funding between 0-6 months post-intake they must continue the timeline and at 6 months post-baseline complete the 6 months post-baseline GPRA.
- If an individual is transferred to another funding source between 0-6 months post-intake and is transferred back to SOR funding after 6 months post-intake they must start a new timeline with a Baseline tool.
  EX: Patient completes baseline, transferred to other funding source at 2 months post intake, completes discharge, transferred back at 7 months post intake, patient must complete new baseline and start new timeline.

WINDOWS FOR GPRA ADMINISTRATION:

- Intake/Baseline:
  o For residential facilities - GPRA intake/baseline interviews must be completed **within 3 days** after the individual enters the program.
  o For nonresidential programs - GPRA intake/baseline interviews must be completed **within 4 days** after the patient enters the program.
- Follow-up (post-intake and post-discharge):
  o The window period allowed for GPRA follow-up interviews is one month before the (3 or 6 month) anniversary date and up to two months after the (3 or 6 month) anniversary date.
- Discharge:
  o Discharge interviews must be completed on the day of discharge, regardless of length of stay in the program (i.e. 1-day length of treatment still needs a discharge GPRA completed)

- o If an individual has not finished treatment, drops out, or is not present the day of discharge, the project will have 14 days after discharge to find the individual and conduct the in-person discharge interview. If the interview has not been conducted by day 15, conduct an administrative discharge. For an administrative discharge when the interview is not conducted, interviewers must complete the first four items in Section A (Patient ID, Patient Type, Contract/Grant ID, Interview Type), Section J (Discharge), and Section K (Services Received) and mark that the interview was not completed.

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

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

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

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

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

State Opioid Response Grant OCAs		
OCA	**Short Description**	**Purpose**
SORR3	Admin/Regions	Allowable administrative and general program costs incurred by Regions.
SORF3	Vivitrol/FADAA	Allowable cost of funds provided to the Florida Alcohol and Drug Abuse Association for naltrexone extended-release injectable medication (Vivitrol) and associated services, such as assessment and medical services, to treat opioid use disorders.
MSRC3	RCOs/MEs	Allowable costs of implementing Recovery Community Organizations (RCOs). Funds may be utilized for startup costs and ongoing services, including outreach, information and referral, recovery support, and incidental expenses. These services can be flexibly staged and may be provided prior to, during, and after treatment. They are designed to support and coach an adult or child and family to regain or develop skills to live, work, and learn successfully in the community. Funds under this OCA may also be used for medical services and medication assisted treatment, however, this only applies to RCOs that use the hub and spoke model where RCOs are paying DATA waivered primary care physicians that are providing medication management for their uninsured participants. RCOs will also implement use of the Recovery Capital Scale as a component of the recovery planning process.
MSSA3	Admin/MEs	Allowable administrative and general program costs incurred by the Managing Entities.

MSSP3	Prevention/MEs	Allowable costs incurred by MEs for Primary Prevention programs included in the pre-approved list, and other evidence-based programs which have been reviewed and approved by the Department.
MSSM3	Treatment and Recovery Support Services/MEs	Allowable costs of treatment and recovery support services for individuals with opioid use disorders (or who are misusing opioids) or stimulant use disorders (or who are misusing stimulants) incurred by MEs. This includes allowable costs to support hospital bridge programs, including outreach to engage individuals in treatment and initiation of, or linkage to, medication-assisted treatment for opioid use disorders or EBPs for stimulant use disorders (Community Reinforcement Approach, Cognitive Behavioral Therapy, or Motivational Interviewing). This also includes treatment and recovery support services provided through the child welfare programs previously funded under SOR.
MSSG3	GPRA/MEs	Allowable costs incurred by MEs for provider data collection and entry associated with the GPRA.

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

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

Prohibited Uses of SOR Grant Funds:

1. **DENIAL OF CARE.** Funds may not be used by any provider that denies any eligible individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders, namely methadone and buprenorphine. In all cases, MAT must be permitted to be continued for as long as the prescriber determines that the medication is clinically beneficial. **Providers must assure that individuals will not be compelled to no longer use MAT as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.**

2. **DATA Waiver Training.** Procurement of DATA waiver training is not an allowable use of SOR funds as this training is offered free of charge from SAMHSA at pcssnow.org. No funding may be used to procure DATA waiver training by recipients or subrecipients of SOR funding. SOR funds shall not be utilized to provide incentives to any Health Care Professional for receipt of a DATA Waiver or any type of professional development training.

3. **DIRECT PAYMENTS TO PERSONS SERVED.** Funds **may not** be used to make direct payments to individuals to induce them to enter prevention or treatment services.

4. **LIMITS ON DETOXIFICATION SERVICES.** Funds may not be used to provide detoxification services unless it is part of the transition to extended release naltrexone (Vivitrol). As previously noted, SAMHSA has declared that, "Medical withdrawal (detoxification) is not the standard of care for opioid use disorders, is associated with a very high relapse rare, and significantly increases an individual's risk for opioid overdose and death if opioid use is resumed. Therefore, medical withdrawal(detoxification) when done in isolation is not an evidence-based practice for OUD. If medical withdrawal (detoxification) is performed, it must be accompanied by injectable extended-release naltrexone to protect such individuals from opioid overdose in relapse and improve treatment outcomes."

5. **CONSTRUCTION:** Funds may not be used to pay for the purchase or construction of any building or structure to house any part of the program.

6. **EXECUTIVE SALARY LIMITS.** Funds may not be used to pay the salary of an individual at a rate in excess of $197,300.

7. **OTHER PAYER SOURCES:** SOR funds shall not be utilized for services that can be supported through other accessible sources of funding such as other federal discretionary and formula grant funds, (e.g. HHS, CDC, CMS, HRSA, and SAMHSA), DOJ (OJP/BJA) and non-federal funds, 3rd party insurance, and sliding scale self-pay among others.

8. **TREATMENT USING MEDICAL MARIJUANA:** Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders.