## Questions posed by MEs regarding the State Opioid Response

### Evidenced-based Treatments and Medications

1. The new grant (SOR II) will now also cover methamphetamines (stimulants). With this new development, what is allowable for treatment of those with methamphetamine-use issues?

   **Answer**: SOR II funds can be used for services that address opioid misuse, Opioid Use Disorders, stimulant misuse, or Stimulant Use Disorders. Stimulant misuse and Stimulant Use Disorders can involve illicit or prescription methamphetamine (among other kinds of stimulants). The covered service array is listed on page 6 of the Guidance Document. The evidence-based treatment practices to be provided to individuals with Stimulant Use Disorders include Motivational Interviewing, Cognitive Behavioral Therapy, and/or the Community Reinforcement Approach, as explained on pages 4-5 of the Guidance Document.

2. Can grant funds cover any medications for individuals with stimulant use disorder (studies have shown some success with Vivitrol, for example), or is it limited to therapy and incidentals, such as transportation?

   **Answer**: Since there are no FDA-approved medications to treat Stimulant Use Disorders, and since SOR funds may not be used to pay for any unapproved (or "off-label") uses for any FDA-approved medications, the remaining permissible SOR-funded services are all psychosocial services and supports, as described by the covered service array listed in the Guidance Document (including incidentals).

3. Does the grant cover any medications other than buprenorphine (or methadone, for OTPs)? For instance, clients with dual diagnosis may require assistance with mental health medications. Could funds be used to help cover those medications?

   **Answer**: Yes, SOR funds can and should be used to pay for integrated care, including treatment for co-occurring mental illnesses and medical problems, and any FDA-approved medications to treat those conditions.

### Covered Services/OCAs

4. What is the Method of Payment for MSSG3 (GPRA data collection and entry)?

   **Answer**: Like all other business costs, the Managing Entity must determine how the costs of completing the required baseline and follow up interviews are included in each subcontract's service array. Some have included the projected additional costs in rate calculations for providing on or more of the base covered services being paid with SOR funds, such as MAT or outpatient, etc. Others have elected to create a separate assessment rate for GPRAs.

5. Providers have raised the question of incentives to increase GPRA compliance rates, has the Department received any additional guidance from SAMHSA regarding the use of incentives?

   **Answer**: Although SAMHSA allows for the use of incentives, the Department still does not have the authority needed to authorize any incentives for any purpose (including GPRA compliance and Contingency Management programs). Therefore, incentives continue to not be an allowable expense at this time.

6. Historically, providers have encountered significant barriers to using SOR Child Welfare funds. Given that there is not an individual carve out of funds for SOR Child Welfare, are providers able to discontinue this program and utilize the funds for general SOR use?

   **Answer**: The change to a unified OCA MSSM3 was intended to make it easier for Managing Entities to budget for the array of service priorities funded by the SOR grant over a multi-year implementation. The Child Welfare project initiated by earlier SOR funds is a valuable program and supports the Managing Entity's contractual requirements for child welfare integration. MEs are encouraged to continue implementing all of the initiatives in the SOR Guidance.

7. Does DCF have a defined requirement for how the GPRA should be billed? Are providers allowed the discretion for how they decide to bill the GPRA – for example they can choose either MSSGP or MSSG3? Does it matter if providers bill the initial GPRA and those GPRAs during treatment under MSSGP or MSSG3?

   **Answer**: If a client is receiving treatment for an Opioid Use Disorder under SOR I continue utilizing OCA MSSGP. OCA MSSGP may not be billed for individuals with only a Stimulant Use Disorder (i.e., without a co-occurring Opioid Use Disorder). All SOR-funded services for individuals with Stimulant Use Disorders, but lacking a co-occurring Opioid Use Disorder, must be billed utilizing OCA MSSG3. If a client is receiving treatment for an Opioid Use Disorder under SOR I continue utilizing OCA MSSGP.

8. Housing continues to be a major factor in maintaining an individual's recovery, will the new grant funds allow for use to help cover housing assistance?

   **Answer**: SOR II funds can be used to pay for housing needs under the Incidentals covered service and using procedure code "IEC00 – Housing" as noted on page 11 of the Guidance Document.

Denial of Care

9. Are OUD patients still required to be on a MAT medication (or pending to begin that treatment) in order to receive assistance from SOR?

   **Answer**: Yes, Medication Assisted Treatment (MAT) using one of the FDA-approved medications for the maintenance treatment of Opioid Use Disorder (methadone, buprenorphine/naloxone products/buprenorphine products including sublingual tablets/film, buccal film, and extended release, long-acting injectable buprenorphine formulations and injectable naltrexone) is a required activity per the terms of the grant award.

10. If a client is being treated for Opioid Use Disorder funded under SOR I or SOR II and refuses MAT, can s/he continue to be treated until their treatment is completed?

    **Answer**: MAT is the standard of care for treating Opioid Use Disorders and a required activity per the terms of the SOR grant. However, in the rare event that a client with an Opioid Use Disorder does not wish to take a medication, but is otherwise eligible to receive other treatment and recovery support services under the SOR grant, then SAMHSA's response to SOR FAQs clearly states that, "Clients should not be turned away from the provision of services if they elect not to receive MAT." If an individual with

an Opioid Use Disorder declines medications, there should be documentation in the chart that MAT education was provided, but the individual declined.

## Recovery Community Organizations

11. Has DCF identified any preferred best practices and service array that RCO providers should utilize? Do those best practices and service array align with those advocated by the National Recovery Institute?

    **Answer**: RCO's credibility and effectiveness depends on their ability to be accountable and responsive to the community they work with and to be responsive to the communities' identified needs. Providing recovery support services, outreach, information and referral, including linkage to services; such services align with the National Recovery Institute's best practices.

12. How is an RCO defined by the Department in terms of composition (corporate/board structure) and services provided? Is there a litmus test for what constitutes an RCO for contracting purposes?

    **Answer**: Faces and Voices of Recovery (FAVOR) defines one of the 8 criteria for RCOs as, "An RCO is a non-profit with current 501c3 status." The organization is peer-led. More than 50% of the Board of Directors self-identify as people in recovery from their own substance use disorders.

    Services Provided: RCOs organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, and/or provide peer-based recovery support services. RCOs that offer services to individuals and their families, focus on peer-based, non-clinical recovery support services. RCOs bridge the gap between clinical treatment episodes and long-term recovery through the provision of peer-based recovery support services. RCOs work with individuals at all stages of recovery, allowing individuals who are actively using to begin their journey in a judgement free space. RCO staff and volunteers do NOT provide addiction counseling or related clinical services. Other distinctive characteristics of RCOs are their conscious effort to achieve cultural diversity, with an emphasis on leadership development within the recovery community, and by supporting multiple pathways of recovery.

13. Is there any distinction between a Peer-Run organization and an RCO?

    **Answer**: RCOs are peer-run organizations. The distinction is that in an RCO more than 50% of the Board of Directors self-identify as people in recovery from their own substance use disorders.

14. Can MEs direct funding to contracted peer organizations that are not identified as existing, emerging or early interest RCOs but who have an established track record of success in working with substance use consumers and who have interest in achieving RCO designation in the future?

    **Answer**: Yes, SOR funding for Recovery Support Services may be used, as described in State Opioid Response Grant OCAs. Peer organizations who express interest in becoming an RCO are encouraged to seek training and Technical Assistance (TA) from FAVOR.

15. What is the Department's expectation once funds are no longer available to support these services and the ME cannot sustain these program(s)?

**Answer**: The Department expects Managing Entities to promote …" the development and effective implementation of a coordinated system of care pursuant to ss. 394.4573 …" That statute includes "(l) Recovery support, including, but not limited to, support for competitive employment, educational attainment, independent living skills development, family support and education, wellness management and self-care, and assistance in obtaining housing that meets the individual's needs." When an RCO funded initially by SOR becomes a successful component of the system, Managing Entities are encouraged to approach sustainability issues with existing resources before the expiration of the SOR project period in 2022. RCOs then become an integrated part of the ME's array of network service providers.

16. Must the organization MEs contract with for RCO services have any specific certifications or accreditations?

    **Answer**: An RCO is not required to obtain CAPRSS Accreditation, but it is a recommended best practice when delivering Peer Recovery Support Services for individuals with substance use disorders.

17. If we cannot identify a certified or accredited RCO that we find appropriate for funding, may we contract with a non-accredited/certified organization and require the attainment of accreditation or certification within a specified period?

    **Answer**: Yes, RCOs are encouraged to pursue accreditation as a best practice standard.

18. If the Department requires accreditation/certification, can the "emerging" or "early interest" RCO use the SOR Funds to pay for application fees, trainings, certificates needed to become accredited/certified?

    **Answer**: Yes. SOR funds may be used to pay fees for CAPRSS accreditation. See Rules 65E-14.019 and 65E-14.020, F.A.C. regarding the possibility of operational start-up costs for new services.

19. Given that this is SOR funding, must service recipients have opioid use disorder or must the services target this population?

    **Answer**: Individuals receiving SOR-funded assistance through an RCO must have a history of opioid or stimulant misuse or disorders.

20. The Chart 8 states the use of the Recovery Capital Scale is required. Will DCF offer trainings to both the ME and to our RCO?

    **Answer**: The Recovery Capital Scale is 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. Regarding training, the Department intends to partner with the Southern Addiction Technology Transfer Center (SATTC) to provide training on utilization of the Recovery Capital Scale and the Recovery Planning Process.

21. Will RCOs be required to conduct GPRAs?

    **Answer**: Yes.

22. May we distribute RCO funding amongst several organizations, or is there a preference for us to limit the number of providers?

    **Answer**: Funding allocated for RCOs may be distributed to more than one organization that meets the criteria of an RCO.

23. What will be/are the reporting requirements for RCOs (i.e., FASAMS, Manual Reports etc.)

    **Answer**: RCOs will be required to submit monthly activity reports. RCOs receiving SOR funding may also have an opportunity to have access to FAVOR's, Recovery Data Platform (RDP). 10 licenses (100 users) have been purchased to access the RDP system to input and maintain client data.

24. Please define "grass roots," "participatory process," and "authenticity of voice". We would like to know how to measure such things if we are using adherence to these principles as a metric for the selection of a provider(s).

    **Answer**: Community engagement is **grassroots** and reflective of the community served. The organization provides opportunities for all community members to get involved in volunteering, participating in activities, and planning events and programs. Examples of ways to engage local communities of recovery are visible on the website and evident in program delivery. **Participatory process** is understood, valued and evident in the design and implementation of outreach, programs and services. Participatory Processes are specific methods employed to achieve active participation by all members of a group in a decision-making process. **Authenticity of voice** is a strong, authentic, compelling voice; the expression of identity, guided by vision, and achieved through mastery. These work together as a part of the lifelong process of growth and discovery. Developing an authentic voice is the result of lifelong layers of learning, experimentation, and failure.

25. Will our RCO be a recipient of the RDP license? If not, will DCF allow the use of the RCO allocations to pay for this license(s).

    **Answer**: RCOs receiving SOR funding may have an opportunity to have access to FAVOR's, Recovery Data Platform (RDP). RCOs can use SOR funds to purchase a user license for the RDP system; however, 10 licenses (100 users) have been purchased for RCOs to access the RDP system.

26. Recovery Data Platform: This tool assists in achieving better outcomes, how so? Will DCF offer trainings to both the ME and to our RCO?

    **Answer**: The Recovery Data Platform provides a different perspective on data collection, and answers the specific question, "What happens to outcomes when participants engage in Recovery Support Services?" The RDP data demonstrate a clear correlation between involvement with Peer Recovery Support Services and improvements in broad categories of social determinants of health, like stable housing, employment, decreased involvement in criminal justice, etc. Recovery Capital scores increase and evidence-based measures of distress like the Outcome Rating Scale show marked decreases in difficulty experienced by the individual receiving services. The software is a critical tool in measuring the pace and performance of the recovery process.

Yes. Recovery Data Platform Training sessions will prepare participants to utilize the RDP. This includes the beginner who is barely familiar with web-based software to the seasoned pro. The training is divided into skill groups and is part of a larger strategy we would like to employ in the state to ensure as much outcome collection as possible.

## Prevention

27. Can coalitions receive the dollars for Goal 2: Prevent opioid and stimulant misuse among young people; Objective 2b. Generate at least 1,250,000 impressions per year through media campaigns?

    **Answer**: Yes, Managing Entities have the discretion to select entities/organizations that they find qualified to deliver the approved evidence-based prevention programs and media campaigns listed and described in the SOR II application and Guidance Document.

28. Can any of these funds be used for data/information gathering to support the evaluation and reporting requirements as noted in the document?

    **Answer**: SOR II funds may not be used to pay for evaluations or research.

29. Regarding media campaigns targeting prescription opioid or stimulant misuse (based on Utah's Use Only as Directed with modifications to add prescription stimulant-specific content as needed), can providers use other research based/documented strategies?

    **Answer**: Yes, providers may use strategies "Based on Utah's Use Only as Directed campaign". The campaign should target prescription opioid and/or prescription stimulant misuse with educational messages about safe use, safe storage, and safe disposal, disseminated through various mediums (e.g., websites, television, radio, billboards, social media, direct mail, etc.). These campaigns may be coupled with prescription drug take-back boxes and events and the distribution of drug deactivation pouches. Entities implementing these campaigns are encouraged to consult any research that might help them improve implementation. Request to use new (not previously identified in the SOR Guidance) evidenced-based programs should be emailed and approved by Walesca Marrero at: walesca.marrero@myflfamilies.com

## GPRA

30. If a client successfully completes their episode of care in less than 6 months and the 6-month GPRA is completed post discharge, does that client count as compliant?

    **Answer**: Yes, clients that successfully complete their episode of care in less than 6 months are compliant if the 6-month follow-up interview is completed within the 5 – 8-month window period after the initial intake into the SOR program.

31. If a client has an opioid use disorder and is receiving treatment utilizing SOR I funding, why discharge to treat the stimulant use disorder separately in SOR II?

    **Answer**: After more careful consideration of the need to expend SOR I No Cost Extension funds, please disregard earlier verbal guidance. Moving forward, providers with clients that are enrolled in SOR I that have both Opioid Use Disorder and Stimulant Use Disorder must wait until completion of the 6-month follow-up interview to maintain the SAMHSA required 80% compliance rate under SOR I NCE. At that

point, providers can transfer clients from SOR I to SOR II funding, after administratively discharging the client from SOR I and then initiating a new episode of care and GPRA intake within the SOR II program.

32. What are the covered services for those with stimulant use disorder?

**Answer**: Below are listed the covered services for clients with a Stimulant Use Disorder:

- 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
- Intervention
- Medical Services
- 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.

33. Do our administrators need to set up a separate SOR II program in WITS?

**Answer**: No, FEI has assigned SOR II programs to all providers that were listed under SOR I. If MEs contract with a new provider at that time, administrators would need to create a separate program for SOR II.

34. If an individual is discharged on May 1st, and returns August 1st to receive help with his/her stimulant use, do we need to complete the SOR I GPRA episode prior to initiating a SOR II episode?

**Answer**: If a client returns for treatment of his/her Stimulant Use Disorder after being discharged from treatment under SOR I, before the client may begin receiving treatment and recovery services under SOR II, all five data collection point must be completed before a new episode of care can be initiated. If

the client returns for treatment at another agency location, the agency must contact the ME to have the initial agency complete the consent and referral process. If the agency is not located within the ME, the ME would contact HQ and HQ will contact the agency location to complete the consent and referral process.

35. Is this correct: For individuals with an Opioid Use Disorder but no co-occurring Stimulant Use Disorder, continue to use SOR I; for individuals with an Opioid Use Disorder and a co-occurring Stimulant Use Disorder combo, use SOR II?

    **Answer**: Clients who are currently receiving treatment and recovery support services under SOR I will continue to receive treatment and recovery support services under SOR I NCE funding. All new and previously discharged clients, with an Opioid Use Disorder and/or Stimulant Use Disorder diagnosis, will receive SOR funded treatment and recovery support services under SOR II.

36. Can we complete the post discharge interviews early?

    **Answer**: Yes, but the Department advises against this because the data is used to report out on outcomes during the 3 and 6-month post discharge interviews.

37. Does the stimulant disorder need to be primary and opioid secondary?

    **Answer**: The client's Stimulant Use Disorder and/or Opioid Use Disorder can be either the primary, secondary, or tertiary diagnosis.

38. Client starts SOR I in detox at Agency A. Client is discharged from Agency A and sends client to Agency B. Right now, Agency B cannot enter the client or do a triage until Agency A completes and discharges. Will that be modified?

    **Answer**: Agency A would not complete the GPRA Discharge. Agency A would complete the Consent and Referral process (it's important that on the Referral, the Program selected is the one the client is in – as in SOR I or SOR II), the receiving agency B would accept, be able to move on and do the remaining GPRAs. Agency B can continue right where Agency A left off. Agency B would contact the Managing Entity. If Agency A is under the same ME, then the ME must contact the Agency A to have them complete the consent and referral process. If Agency A is **NOT** under the same ME, the ME would contact HQ and HQ will contact the agency location to complete the consent and referral process.

39. If the patient is deceased at the time of follow up, what is the process?

    **Answer**: If the Client is deceased at the time of the follow-up, select "No" to the question "Was the interview conducted?". There will be a drop down allowing you to select that the client was deceased at the time of interview. This will **NOT** negatively affect compliance.

40. The initial GPRA needs to be completed how soon after it is decided the client is being put into SOR I or SOR II?

    **Answer**: To comply with the requirement to collect GPRA data at intake/admission, residential programs must collect GPRA data on each client as soon as possible after intake but no later than 3 days after the client officially enters the substance abuse treatment program. All types of outpatient programs must

collect GPRA data on each client as soon as possible after assessment or intake but no later than 4 days after the client officially enters the treatment program.

41. Is it correct that if the follow-up interview can't be completed because the client can't be located or refuses to be interviewed, it counts as non-compliance? Is there a way to create a report to segregate those out?

    **Answer**: Yes, the interview MUST be conducted within the 5 to 8-month window period to be considered compliant, barring the client being deceased at the time of follow-up. There is no way to create a report to segregate the interviews; however, in WITS the provider can utilize the Follow-Due Summary tab to identify the 6-month follow-up interviews that are compliant, non-compliant, due, and new.

42. Is there a way to receive notifications for GPRAs being due?

    **Answer**: Yes, the new data dashboard in WITS will provide this information to all providers and MEs. There is also a report available in the agency tab.

43. Do we enter the encounter if we are successful in conducting the follow-up GPRA?

    **Answer**: No, the encounters are to record unsuccessful attempts to contact the client.

44. If an individual has an opioid use disorder as primary, with stimulant secondary or tertiary, does s/he still need to be entered into SOR II and not SOR I?

    **Answer**: All new and previously discharged individuals regardless of Opioid Use Disorder and/or Stimulant Use Disorder diagnosis should be enrolled and receive treatment and recovery support services under SOR II.

45. If a patient is discharged from SOR I funding, and a new episode starts under SOR II does that mean that they do not follow-up 3-month and 6-month post discharge under SOR II?

    **Answer**: Clients that are currently receiving treatment and recovery support services under SOR I will continue to utilize SOR I NCE funds. If the client is discharged and returns to treatment later, the 3-month and 6-month post discharge must be completed prior to enrolling the client into SOR II to close out the episode of care. Now, if the client is administratively discharged from SOR I because all SOR I NCE funds have been exhausted, the 3-month and 6-month post discharge are not required because that client would be immediately enrolled into the SOR II program to continue their treatment services. At that time, all five data collection points must be completed under SOR II.

46. If a patient discharges before 6 months, are we still just conducting the discharge interview followed by the 3- and 6-month post discharges?

    **Answer**: The 6-month follow-up interview must be conducted regardless of when the client is discharged. The 6-month follow-up interview can be completed 5 to 8 months after the initial GPRA intake/baseline data collection. Providers are also required to complete the 3-and 6-month post discharges interviews.

47. If a patient discharges at month 6, is a 6-month AND discharge interview expected to be conducted?

**Answer**: Yes. There may be cases when a client is discharged within the window period for which the 6-month GPRA follow-up interview is due. In other words, if a discharge is completed anywhere between 5 and 8 months after GPRA intake/baseline, this interview may be used as a GPRA follow-up interview. In these cases, you must still enter data for both the GPRA discharge and the 6-month GPRA follow-up interviews. Conduct the interview using these guidelines: conduct an interview by completing the appropriate items in Section A, indicating that an interview was conducted; otherwise, you will not be able to enter the responses into the system for each section. You may conduct the GPRA interviews simultaneously, completing all sections, including Sections I, J, and K. You will then enter the data into the system as two records: one for discharge with Sections J and K, so that the service provided is documented in the GPRA system; and the other for follow-up with Section I, so that the follow-up status is documented in the GPRA system.

If the client's GPRA discharge interview from the program occurs during the 6-month follow-up window, and you have already conducted the GPRA follow-up interview, you will need to do a separate GPRA discharge interview.

48. What if the patient drops out of treatment? How are 6-month interviews supposed to be conducted?

**Answer**: Providers should collect 6-month follow-up data on all clients, regardless of whether a client drops out of the program. It is important for providers to collect as much contact information during the initial GPRA intake including collateral contact. The provider must make attempts to contact the client. When a provider cannot follow-up on a client, the provider is encouraged to record and comment all encounter attempts in the WITS system.

49. What happens if the 6-month follow-up interview is completed outside of the window?

**Answer**: If you locate a client for the 6-month GPRA follow-up before 5 months after the initial GPRA data collection or 9 plus months after the initial GPRA data collection, you may conduct a GPRA follow-up interview, but the data from the GPRA follow-up interview would be non-compliant.

50. In closing out the episode of care, wouldn't the patient still need to go through all levels of GPRA interviews with provider 1?

**Answer**: Yes, to successfully close out an episode of care, providers must complete all five data collection points/interviews. If the client is referred to a new location, the new provider should contact the ME to get the initial agency to initiate a consent and referral. Once the consent and referral are created, the receiving agency would accept, be able to move on and do the remaining GPRAs. If the client is discharged from treatment with Agency A and shows up to Agency B to receive treatment, Agency A must complete all five data collection points to successfully close out the episode of care. Afterwards, the receiving provider will contact the ME to have Agency A initiate a consent and referral. If the client is administratively discharged from treatment and recovery due to exhaustion of SOR I NCE funds or ending of the NCE grant period, the post discharge interviews are not required because the client is technically still receiving treatment services.

51. If a client successfully completes treatment under SOR I with both an opioid and stimulant use disorder, would the provider still need to enroll the client into SOR II?

    **Answer**: If a client has successfully completed treatment, then they would be discharged. The client would only be enrolled into SOR II, if they were returning to seek treatment.

52. If providers have an individual that completed the GPRA cycle and need to be re-opened without duplicating, would we have the individual open a new program enrollment keeping the same treatment episode?

    **Answer**: Yes, the provider would open a new episode of care and enroll the client into SOR II. At that time a new GPRA intake is required, and the remaining GPRA data collection points including 6-month follow-up, discharge, and 3-and 6-month post discharge interviews. Clients are only counted once toward our target numbers served regardless of the number of GPRA intakes. The same client ID number should be used, regardless of the number of times, the client presents for services.