FLORIDA DEPARTMENT OF CHILDREN AND FAMILIES

State Opioid Response (SOR)-3 Project Guidance

System Priorities, Permissible, and Prohibited Uses

TABLE OF CONTENT

SECTION 1 INTRODUCTION

Background

The State Opioid Response (SOR) Grants were initially administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration (SAMHSA) to address the opioid crisis. The current use of funding is to address both opioid and stimulant disorders/misuse. Florida was awarded the first two-year SOR grant on September 30, 2018, now referred to as SOR-1. On September 30, 2020, the second two-year SOR grant (SOR-2) was awarded with an end date of September 29, 2022. On August 24, 2022, a No Cost Extension (NCE) was awarded to the Department by SAMHSA, which allows an extra 12 months to spend unexpended funds with an end date of September 29, 2023, for SOR-2. The SOR-2 Grant Guidance on System Priorities, Permissible and Prohibited Uses should still be referenced for SOR-2 grant dollars and use the Other Cost Accumulators (OCAs) assigned to the SOR-2 grant.

Florida was awarded the third two-year SOR grant, referred to as SOR-3, for the period of September 30, 2022, through September 29, 2024. Providers who are funded through SOR-3 should follow the guidance in this document, State Opioid Response (SOR)-3 Grant Guidance System Priorities, Permissible and Prohibited Uses and use the Other Cost Accumulators (OCAs) assigned to the SOR-3 grant (outlined in #16 under "permissible uses of SOR grant funds").

The guidance that follows in this document specifically applies to SOR-3 funds.

Purpose

The SOR-3 grant program will increase access to evidence-based prevention, treatment, and recovery support services that address opioid and stimulant misuse and/or disorders to reduce opioid- and stimulant-related deaths. If either stimulant or opioid misuse or disorders exist concurrently with other substance use (including alcohol and nicotine), mental health, and other complex needs all may be treated. This entails providing medication-assisted treatment using FDA-approved medications for treating opioid use disorders (methadone, buprenorphine, and long-acting naltrexone) and approved supports and evidence-based models for treating stimulant use disorders. SAMHSA expects recipients to use grant funds to implement comprehensive, integrated, high quality programs, practices, and policies that are recovery-oriented, and trauma-informed as a means of improving behavioral health. See *Appendix A* for an expanded look at this expectation.

Goals

It is estimated that 10,000 individuals with opioid or stimulant misuse or disorders (unduplicated) can be served in each of the two grant years (for a total of 20,000 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 220,000 naloxone kits per year.
- Objective 1b: Train at least 10,000 individuals on overdose prevention per year.
- Objective 1c: Increase the number of enrolled naloxone distributors by 25 each year.

Goal 2 Prevent opioid and stimulant misuse.

- Objective 2a. Serve at least 25,000 youth per year through primary prevention programs.
- Objective 2b. Generate at least 3,500,000 impressions per year through universal indirect media campaigns.

Goal 3: Increase access to the most effective treatment and recovery support services for opioid and stimulant use disorders.

- Objective 3a. Increase new admissions to buprenorphine or methadone maintenance treatment by 3,000 per year.
- Objective 3b. Implement a Contingency Management pilot program in year 2.
- Objective 3c. Establish 44 additional Oxford Houses each year (at least 10 of which will be in rural counties).
- Objective 3d. Develop and distribute a tribal contact resource guide for network service providers during year 1 and host a tribal outreach and contact webinar during year 2.

SECTION 2 SYSTEM PRIORITIES

1. **Expand emergency department bridges to community-based providers with methadone or buprenorphine prescriber capacity.** Expand hospital bridge programs between Emergency Departments (EDs) and community-based providers to link individuals with opioid misuse or disorders identified in EDs with treatment and support services. For individuals with opioid misuse or disorder, 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, peers, and establish telehealth programs. SOR funds can also be used to pay for incidentals for transporting patients from hospitals to community-based prescribers. ME's should ensure MAT providers are working to actively communicate and engage with ED physicians to overcome any medication dosage barriers. Though each community will be unique with community provider collaborations and the overall program process, there are some consistent features of hospital bridges that should be in place and are as follows in no particular order: 1) An individual enters the ED having overdosed or experienced medical needs due to opioid misuse. 2) The ED physician assesses if the individual is a candidate for medication assisted treatment. 3) If medication assisted treatment is an appropriate option, the ED physician will initiate

a conversation to gage interest offering to start the first induction before the individual is discharged. The physician will explain the available FDA approved medication. 4) The individual is connected to a peer either onsite, via phone, or video conference to help navigate the referral process to the local MAT provider. The peer will schedule an appointment with the local MAT provider and explain the transition process. 5) A naloxone kit is dispensed to the individual before discharge from the ED. The individual should leave the hospital with a naloxone kit in hand, as prescriptions often do not get filled at a community pharmacy. The Department expects hospital bridge programs to be established components of your system of care.

2. **Collaborate with the Department of Health (DOH) to implement CORE (Coordinated Opioid Recovery) at pre-selected county locations.** Partner with the DOH and local community pilot sites to implement CORE at pre-selected county locations. CORE is a collaboration between EMS, hospitals, and outpatient community providers to streamline connections to medication assisted treatment services for individuals with opioid misuse or disorder. The Department's role in CORE is to use SOR funds to pay for medication induction and maintenance for opioid use disorders or misuse, however any allowable SOR expense may be utilized.

3. **Expand current and implement additional recovery support services to sustain the continuum of care for individuals with opioid and/or stimulant disorders or misuse.** SOR funds for recovery support services are allocated to the Managing Entities through OCA MSSM5. SAMHSA has included additional recovery supports that are required for SOR-3. Recovery supports include but are not limited to: Peer supports, recovery coaches, vocational training, employment support, transportation, childcare, legal assistance, recovery community organizations, housing supports (i.e., application fees, deposits, rental assistance, utility deposits, and utility assistance), dental kits to promote oral health for individuals with OUD enrolled in treatment with buprenorphine (i.e., dental kits are limited to items such as toothpaste, toothbrush, dental floss, non-alcohol containing mouthwash, and educational information related to accessing dental care), and recovery housing.

4. **Expand treatment services to support the continuum of care for individuals with opioid and/or stimulant disorders or misuse and include an approved contingency management plan.** SOR funds for treatment and recovery support services (allocated to the Managing Entities through OCA MSSM5). SOR funds shall provide services that address opioid and/or stimulant disorders and misuse. Stimulant misuse and stimulant use disorders can involve illicit and prescription stimulants. 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 and Vivitrol for individuals with an alcohol use disorder. Likewise, SOR funds should be used to pay

for comprehensive, integrated care that addresses co-occurring mental illnesses and medical problems. Additional guidance will follow upon completion of the plan. SAMHSA has developed a Buprenorphine Quick Start Guide to provide support to providers. There is also a condensed version, Pocket Guide.

Beginning October 1, 2023, during the second year of the SOR III grant, SOR funds (OCA specification TBD) may be used to implement contingency management programs as an evidence-based treatment for substance use disorders. Contingency management is a type of behavioral therapy in which desired behaviors are reinforced. Reinforcement is often provided in the form of vouchers that can be exchanged for retail goods and services. It may also include access to the opportunity to win a prize. Two widely use approaches include The Fishbowl Method, where individuals who have earned an incentive draw a token from a fishbowl for a chance to win a prize of varying value, and Voucher-Based Reinforcement Therapy.[i] In April 2022, Florida Statutes were revised to specifically allow the Department to fund "contingency management programs authorized by a managing entity, and subject to limitations on value imposed by the Federal Government or department rule, in which participants are provided noncash incentives for positive progress in their recovery under the care of a publicly funded substance abuse treatment provider."[ii]

In September 2022, Florida received the Notice of Award for the State Opioid Response (SOR) III Project, which requires awardees to provide a contingency management plan that mitigates the risk of fraud and abuse by ensuring that providers "receive appropriate education on contingency management prior to implementation" and by providing oversight of Contingency Management "implementation and operation" as outlined in Appendix J of the SOR III Notice of Funding Opportunity. The Department has already certified that contingency management programs will meet SAMHSA's requirements. To allow adequate time to develop and implement contingency management plans compliant with SAMHSA's standards, the Department's SOR III application planned for the implementation of a CM pilot program in the second year of the grant (beginning October 1, 2023). This delay also gives SAMHSA more time to revise the contingency value limitations from the Special Terms of the Notice of Award, which currently state that, "Contingencies may be used to reward and incentivize treatment compliance. Clients may not receive contingencies totaling more than $75 per budget period [i.e., per year]. The contingency amounts are subject to change."[iii]

In order to implement a contingency management program using SOR funds beginning in October, Managing Entities shall ensure that SOR-funded contingency management programs for opioid or stimulant misuse or disorders adhere to the following terms, conditions, and restrictions:

- Implementing provider staff must have received training from an entity identified in the forthcoming Florida Contingency Management Plan to Ensure Appropriate Training and Oversight, which must be approved by SAMHSA before taking effect. The Department is currently examining the content and

costs associated with the contingency management trainings offered by PRISM Collaborative and ArenaEBP. The Department is also exploring training content associated with Pear Therapeutics' reSET-O® Prescription Digital Therapeutic Software. Contingency Management-specific training will need to meet all the expectations in Appendix J of the SOR III Notice of Funding Opportunity, e.g., it must be delivered by experienced, advanced degree holders, with opportunities to pose questions and receive answers.

- Contingencies shall be non-cash, tangible items, including vouchers or "payment of bills," that are used to reward and incentivize treatment compliance using an objective measure of progress, specifically one of the following two options:

  (1) An objective measure of substance use, such as negative urine drug tests, Breathalyzers, oral swabs, or other validated tests. Quantitative reductions in substance use, as objectively measured through a validated test, could and should also be reinforced. Negative tests and tests that reflect reduced use clearly represents positive progress in recovery.

  (2) An objective measure of successful treatment completion. Successful treatment completion is not established by merely attending a treatment session or merely participating, for example. Note that incentivizing mere attendance or participation would risk running afoul of a standard SAMHSA funding restriction stating that grant funds of any kind may not be used "to make direct payments to individuals to enter treatment or continue to participate in treatment services." An example of evidence of successful completion (and therefore evidence of positive progress) that is authorized for incentives is quiz-based completion of CBT lessons through Pear Therapeutics' reSET-O® Prescription Digital Therapeutic Software.

- A client/patient/service recipient may not receive a contingency that exceeds $15 in value. A client/patient/service recipient may not receive contingencies totaling more than $75 per year using State Opioid Response (SOR) grant funding. However, other non-SOR funding sources can be explored for braiding into contingency management programs to support total contingencies that exceed this limitation. General Revenue and Opioid Settlement dollars are currently uncapped with respect to contingency values, though details regarding the stipulations applied to these funds are currently unknown and subject to change in accordance with annual General Appropriation Acts. Guidance will be updated in the future as more information becomes available. Future modifications may approach but not exceed the $600 threshold for reporting taxable income to the Internal Revenue Service.

- No person or program will market, advertise, or promote the availability of any contingency management program incentives to induce a patient to receive any services or items from a particular provider.

- Contingency management program staff must maintain written documentation

in the patient's medical record that includes the type of contingency management model and incentives offered that are recommended by the client's licensed health care professional, a description of the incentive furnished, an explanation of the health outcome or target behavior achieved, and a tally of incentive values received by the patient to confirm that per incentive and total incentive caps are observed.

Additional details will be provided in the Department's forthcoming Contingency Management Plan to Ensure Appropriate Training and Oversight, which must be reviewed and approved by SAMHSA. SAMHSA revised a December 2022 submission deadline and, as of January 2023, has yet to announce a new submission deadline, while committing to providing states with at least 30 days advance notice of the new deadline.

Providers that are interested in starting a contingency management program in October 2023 or that would like to learn more about what SAMHSA considers the "essential elements" of a well-implemented contingency management program should consult Nancy M. Petry's (2012) Contingency Management for Substance Abuse Treatment: A Guide to Implementing This Evidence-based Practice published by the Taylor & Francis Group. Petry's publication addresses all the elements outlined in SAMHSA's Appendix J from the SOR III Notice of Funding Opportunity.

Distinguishing Contingency Management Incentives from GPRA Data Collection Incentives: SAMHSA authorizes the deployment of two conceptually distinct incentives: incentives deployed through contingency management programs in response to progress toward recovery as measured by drug tests, for example, versus incentives for participation in SAMHSA-required data collection through the GPRA Client Outcome Measures interview. While reinforcing different behaviors, these two types of non-cash incentives are both permitted through the same state statute that authorizes noncash incentives "for positive progress in recovery,"[iv] since the required GPRA Client Outcome Measures interview is the mechanism for measuring positive progress across the widest range of outcomes (e.g., number of days used, routes of administration, overdoses, living conditions, education, employment, criminal justice involvement, quality of life, social connectedness, etc.). The GPRA incentive is not reflected in the contingency management limitation of $75. The GPRA incentive is to be considered separate with defining information found in the Permissible Use of Grant Funds section of this document under Data Collection.

5. **Monitor and improve retention in care by changing discharge practices and policies with a focus on harm reduction.** 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 may not involuntarily discharge 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, individuals 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 return to use 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. Individuals being treated for OUD should be provided the same care as any person in treatment for a chronic illness. Managing opioid disorder or misuse with personalized, evidence-based medicine and non-punitive goals allows a higher chance of sustaining recovery.

6. **Increase peer capacity.** Recovery Peer Specialists provide recovery-support services, promote continued engagement in treatment and inclusion in local communities and normalize recovery language. 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 by connecting providers to support on hiring and supervising peers or 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. The Department expects ME's to actively work toward increasing peer capacity in collaboration with emerging or established peer run organizations or Recovery Community Organizations (RCOs) in their region.

The Department contracts with Faces and Voices of Recovery to provide training and technical assistance to existing and emerging RCOs as well as support communities with recovery community readiness. The Department expects MEs and RCOs to use to use training and TA support provided by Faces and Voices of Recovery.

7. **Increase access to naloxone.** Ensure that providers in your network are enrolled in the Department's Overdose Prevention Program and are providing education on overdose recognition and response, in conjunction with a minimum of two take-home naloxone kits to individuals at risk of experiencing an opioid overdose and to their loved ones that may witness an overdose. It is recommended the education and kits be provided during orientation and to anyone on a waiting list to receive services. 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.

8. **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. Managing Entities should encourage SEPs to enroll on the Department's Overdose Prevention Program.

9. **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 Recovery Oriented Quality Improvement Specialists (ROQIS), on SOR funded sites, 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.

SECTION 3 PERMISSIBLE USES OF SOR GRANT FUNDS

1. **Eligibility.** SOR-3 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). Other substance use, mental health related, or other complex needs may be addressed if the primary diagnosis is opioid or stimulant misuse or disorders. 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-3 funds must have an indication of opioid and/or stimulant use in FASAMS, either via diagnosis or substances of choice. **All new and previously discharged clients from SOR-2 will receive treatment and recovery support services utilizing SOR-3 funding.**

2. **Evidence-based treatments for stimulant use disorders and 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.

3. **FDA approved medications for opioid use disorders.** This includes methadone, long-acting injectable naltrexone, 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. It should be the patient's choice on which medication and delivery method is used.

   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 individuals 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 SORF5 must be entered into **WITS** (Web Infrastructure for Treatment Services)**.** In addition to the Vivitrol project managed by the Florida Alcohol and Drug Abuse Association, SOR funds can be used to fund Vivitrol. Any FDA approved medication listed above in section 3 can be provided using OCA code MSSM5.

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 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-3 grant funds (underlined services require additional data collection outlined in #14):
    - Aftercare.
    - Assessment.

- Care Coordination.
- Case Management.
- Crisis Support/Emergency.
- Day Care.
- Day Treatment.
- Drop In/Self-Help Centers.
- 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).
- Intensive Case Management
- 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, unless the individual has declined medications after a thorough explanation of the benefits and risks of all three FDA-approved medications. The benefits explained must include clinical findings reported in SAMHSA's TIP 63 that "methadone, extended-release injectable naltrexone (XR-NTX), and buprenorphine were each found to be more effective in reducing illicit opioid use than no medication in randomized clinical trials, which are the gold standard for demonstrating efficacy in clinical medicine. Methadone and buprenorphine treatment have also been associated with reduced risk of overdose death." This patient education and the patient declining medications must be documented in the medical record. All individuals in residential treatment must be reevaluated every 30 days to ensure they still meet level of care criteria.
- 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 return to use 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 return to use.

7. **Recovery Support.** SOR-3 funds should be used to provide recovery supports including but not limited to:
    - Peer supports.
    - Recovery coaches.
    - Vocational training.
    - Employment support.
    - Transportation.
    - Childcare.
    - Legal assistance.
    - Recovery Community Organizations.
    - Housing supports (i.e., application fees, deposits, rental assistance, utility deposits, and utility assistance).
    - Dental kits to promote oral health for individuals with OUD enrolled in treatment with buprenorphine (i.e., dental kits are limited to items such as toothpaste, toothbrush, dental floss, non-alcohol containing mouthwash, and educational information related to accessing dental care).
    - 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**.

8. **Hospital/Jail Bridge Programs.** Data collection is required for both Hospital and Jail Bridge Programs within FASAMS using MSSM5, the general OCA for treatment and recovery support services. MEs must also submit the following data elements within a summary to the SOR Project Director and SOR Data Coordinator on the **18th of each month:**
    - # of individuals screened.
    - # of individuals identified with an Opioid Use Disorder.
    - # of individuals identified with an Opioid Use Disorder that declined services.
    - # of individuals induced with buprenorphine in the ED/hospital prior to discharge.
    - # of individuals referred to treatment providers.
    - # of individuals linked to treatment providers.
    - # naloxone kits provided to individuals in-hand, prior to discharge.
    - # naloxone prescriptions provided to individuals prior to discharge.

    The ME will provide and update as needed:
    - Name and location of new hospitals that are part of a bridge program.
    - If a hospital becomes inactive.
    - Face sheet information for MAT providers that are part of a bridge program.

- Organization Name—the name of the provider organization.
- Provider Name—the name of the medication prescriber
- 7 Day Appointment Availability—Does this provider/organization offer appointments for MAT maintenance seven (7) days a week?

It should be noted that hospitals can dispense naloxone kits to patients in the hospital setting, per Florida Statutes 465.019. See Appendix B for additional details

HOSPITAL BRIDGE

Each community will have unique challenges and needs to consider when developing office procedures. However, there are consistent factors that should be in place across all Hospital Bridge Programs.

Collaboration

Efforts between hospital emergency departments, managing entities, and MAT provider must be consistent. Communication between all team members is crucial when having discussions regarding medication doses and continued MAT maintenance.

Team Roles

Emergency Room Physician	Screen/assess individuals for OUD, connect individual to the peer, induction of medication, dispense naloxone.
Peer	Provide education regarding MAT, support individual through assertive referral process, schedule an appointment with a local MAT provider.
MAT Provider	Provide accessible appointments, continued medication maintenance.
Managing Entity	Provide access to funding supporting MAT services and recovery support and ensure rapid linkage to ongoing community-based MAT services.

Process

1. An individual enters the ED having overdosed or experienced medical needs due to opioid misuse.
2. The ED physician assesses if the individual is a candidate for medication assisted treatment.
3. If medication assisted treatment is an appropriate option, the ED physician will initiate a conversation to gage interest offering to start the first induction before the individual is discharged. The physician will explain the available FDA approved medication.
4. The individual is connected to a peer either onsite, via phone, or video conference to help navigate the referral process to the local MAT provider. The

peer will schedule an appointment with the local MAT provider and explain the transition process.
5. A naloxone kit is dispensed prior to discharge from the hospital.

JAIL BRIDGE

The purpose of the Jail Bridge Program is to identify and engage individuals with opioid use disorders who are passing through jails and (1) agree to participate in MAT treatment through the Jail Bridge Program or (2) are currently receiving MAT treatment in the community and would like to continue that treatment through the Jail Bridge Program. The goal is to provide access to FDA-approved medications to individuals diagnosed with an opioid use disorder who are passing through jails. This can be done in partnerships with community MAT providers either in the jail setting or offsite at the provider location.

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 MSSM5, the general OCA for treatment and recovery support services.

Each jail will have unique challenges and needs to consider when developing procedures. However, there are consistent factors that should be in place across all Jail Bridge Programs.

Collaboration

Efforts between jail staff, managing entities, and MAT providers must be consistent. Communication between all team members is crucial when having discussions regarding medication doses and continued MAT maintenance once the individual receiving treatment is released.

1. Individual entering the jail is screen for opioid use disorder and meets the criteria for MAT services.
2. Jail Personnel initiate the conversation about MAT with the individual agreeing to participate in MAT services.
3. Education is provided surrounding the MAT process and collaboration with local providers.
4. The Individual is linked to a community provider that partners with the jail to provide MAT services.
5. The individual is inducted with FDA-approved medication either at the jail location or is transported to the MAT provider location for induction.
6. Prior to release, the individual is connected to a peer to assist with the navigation to local MAT resources. The peer or jail personnel will schedule an appointment with the local MAT provider to continue maintenance of MAT.

MAT FOR PREGNANT WOMEN

Per Chapter 65D-30.0142, providers should have policies and procedures in place to treat pregnant women. According to the American Society of Addiction Medicine (ASAM), when evaluating a pregnant woman for opioid use disorder, the first priority is to identify emergent medical conditions that require immediate action. The National Guidelines to Treat Opioid Use Disorders, last updated by ASAM in 2020, includes guidelines to assist providers when a pregnant woman makes the decision to participate in treatment. Guidelines include Treatment with methadone or buprenorphine is recommended and should be initiated as early as possible during pregnancy.

- Pregnant women who are physically dependent on opioids should receive treatment using methadone or buprenorphine rather than withdrawal management or psychosocial treatment alone.
- Care for pregnant women with opioid use disorder should be comanaged by a clinician experienced in obstetrical care and a clinician experienced in the treatment of opioid use disorder.

See the complete publication of the ASAM guidelines for further information. Providers should review Chapter 65D-30 for state standards and requirements.

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:

- Botvin LifeSkills (including the Prescription Drug Abuse Prevention Module)
- Guiding Good Choices
- Positive Action
- Teen Intervene
- Caring School Community
- Project SUCCESS
- Strengthening Families Program (for Parents and Youth 10-14)
- SPORT Prevention Plus Wellness
- Project Towards No Drug Abuse
- InShape Prevention Plus Wellness
- PAX Good Behavior Game

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, the distribution of drug deactivation pouches, and naloxone nasal spray; and which may address the risks associated with pressed, counterfeit pills that are now commonly adulterated with synthetic opioids like fentanyl.

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-3 funds should be used to support innovative telehealth strategies for rural and underserved areas.

11. **Behavioral Health Consultants (BHCs).** Behavioral Health Consultants are licensed clinicians or certified substance use professionals that support child welfare professionals. Using their clinical expertise, they assist child protective investigators and dependency case managers to build knowledge within front line staff in the identification of substance use disorders and behavioral health conditions, improve engagement with families, and improve access to treatment. There are currently 28 SOR-Funded BHC positions stationed throughout the state of Florida and two (2) SOR funded BHC's contracted through Thriving Mind. Reports regarding tasks accomplished and services provided **must be submitted on the 18th of each month** to the SOR Project Director and SOR Data Coordinator.

12. **Recovery Communities.** Allocations have been awarded to implement Recovery Community Organizations using OCA MSRC5. This allocation is intended to fund RCO development directly and may not be used to provide indirect services to build local capacity or to duplicate any services contracted through Headquarters for RCO development.

    RCOs 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.** The Department expects MEs to work collectively with emerging and existing RCOs developing contracts that promote and allow service delivery growth, and sustainability. ME's that do not have any RCOs or are not supporting the growth of current and emerging RCOs, should reach out to the SOR Project Director for guidance and support to address any identified barriers. RCOs are required to submit a monthly activity report the 18th of each month. The purpose of this report is to track activities, implementation, and progresses.

    - Recovery Capital**:** Recovery Community Organizations (RCOs) will implement use of the Recovery Capital Scale as a foundation to inform the individualized recovery planning process by developing goals among applicable domines. 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. The frequency of completing the Recovery Capital Assessment is every 30 days utilizing the Recovery Data Platform described below.

- 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.

- 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 serve as a key person in recovery-oriented system of care (ROSC) related activities that include but are not limited to on-going quality assurance and improvement activities; training and technical assistance (TA); the implementation, integration, and enhancement of recovery management approaches and services within the local system of care; and promotion of effective engagement, community inclusion, and care coordination strategies. In addition, this position will provide TA and consultation to promote the expansion of SOR funded medicated assisted treatment (MAT), care coordination services, and the effective engagement of persons into services and supports. The duties and responsibilities of ROQIS **reports and work plan must be submitted by the 15th of each month.** See Appendix C for ROQIS Guidance.

14. **Data Collection.** FASAMS Data**:** Providers must enter all patient data into the FASAMS to capture services and activities rendered for all persons receiving services funded by SOR dollars. Specifically, providers must input the following data:
    - All persons served 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. Individuals without an opioid or stimulant use disorder or 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, buprenorphine extended-release injection 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 FASAMS 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 **three (3)** data collection points (**baseline, 6 months post-intake, and 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 80% completion. Interviews can be done face-to-face, virtually or via phone. Guidance for data collection is provided below.

Data Entry: Providers must enter complete GPRA data into the WITS system for all individuals receiving SOR funds for treatment services or recovery supports. The WITS system uploads GPRA data into SAMHSA's database, SAMHSA's Performance Accountability and Reporting System (SPARS), to maintain timely reporting and accurate data to SAMHSA. This data is reported to SAMHSA quarterly. Specifically, providers must input the following data:

- All persons served identified with having an opioid and/or stimulant use disorder. **All individuals 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 individual does not qualify for SOR funding.**
- Responses to all questions identified in the GPRA and Supplemental interviews.
- All individuals who received a GPRA assessment must be entered into FASAMS under OCA MSSM5 and must also be entered into WITS.
- A $30 non-cash incentive will be provided to all SOR-3 funded individuals completing the GPRA interviews. All individuals who received a GPRA incentive must be entered into FASAMS under OCA MSSM5 under Incidentals using the procedure code IER00. It is crucial that the correct code is used as documentation must be provided to SAMHSA on the incentive utilization.
- GPRA's must be administered by program staff and questions must be asked as written with no deviation. The GPRA cannot be self-administered by the individual receiving services. Interviews may be conducted via virtual platforms if all efforts to meet face to face have been exhausted.
- All individuals who receive SOR-funded covered services underlined in the Service Array section, must have completed the **GPRA** for each of the 3 collection points.

    - 6 months post-intake data should be collected on all persons served, **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, an individual who is not located, does not count towards compliance. The 6-month follow-up starts at the 5th month mark and ends at the 8h month mark.
    - A Discharge GPRA must be completed each time an individual is discharged/transferred from SOR funding.
- Persons served will have to be administratively discharged from SOR-2 before they can be transferred to SOR-3, and a new GPRA intake interview must be completed before individuals can begin receiving SOR-3 funded services.
- An administrative discharge out of SOR-2 program will be completed, not a discharge interview. The administrative discharge requires sections A, J, and K of the GPRA form. The individual will then be enrolled into the SOR-3 program, and a new intake interview for the individual will be completed (only during their transition into SOR-3). Afterwards, the same GPRA requirements must be completed for each of the 3 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, and 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: An individual 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.

GPRA Administration Windows

Intake/Baseline:

- For residential facilities - GPRA intake/baseline interviews must be completed **within 3 days** after the individual enters the program and entered into WITS within 7 days of completion.
- For nonresidential programs - GPRA intake/baseline interviews should be entered into WITS within 1 day, but no later than **7 days** after the interview.

Follow-up (post-intake):

- The window period allowed for GPRA follow-up interviews is one month before or two months after the six (6) month anniversary date. For example, if a person completes the GPRA intake on January 1st, the six-month follow-up is due July 1st. The window to complete the follow-up opens on June 1st and closes on September 1st.

Discharge:

- 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).
- If an individual has not finished treatment, drops out, or is not present the day of discharge, the provider 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 the individual 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).

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).

Data Technical Assistance

If a WITS User requires assistance in WITS, technical assistance will be provided on a tiered level: Tier 1: Provider Organizations will provide assistance. Tier 2: ME will provide assistance. Tier 3: DCF HQ will provide assistance. Tier 4: FEI will provide assistance.

- **Tier 1: Provider Organizations**
  Each provider organization will identify a small number of staff that can provide Tier 1 help desk support to the users within that agency. Tier 1 support includes:
    - Creation of user accounts.
    - Enabling and resetting user credentials.
    - Managing the access roles of each user.
    - Providing technical assistance for functionality questions/issues.
    - Reporting functionality issues that cannot be resolved by the agency to Tier 2 support via email of phone.
    - Communicating changes to WITS/ASAM CONTINUUM to users of the system within the organization.

- **Tier 2: Managing Entity**
  Each Managing Entity will provide Tier 2 support for their contracted providers. Tier 2 support includes:
    - Accepting help desk emails/calls from Tier 1 help desk support staff at provider organizations.
    - Creation of user accounts as requested by Tier 1.
    - Enabling and resetting user credentials as requested by Tier 1.
    - Managing the access roles of each user as requested by Tier 1.
    - Providing technical assistance for functionality questions/issues.
    - Reporting functionality issues that cannot be resolved by the Tier 2 help desk team to FEI's Tier 3 Help Desk.
    - Communicating changes to WITS/ASAM CONTINUUM to users of the system within the organization.

- **Tier 3: DCF**

DCF will identify WITS Administrators that will provide the following Tier 2 support. DCF's Tier 2 support includes.:

- Accepting help desk emails/calls from the Managing Entity Tier 2 help desk support staff.
- Creation of user accounts as requested by Managing Entity Tier 2 help desk support staff.
- Enabling and resetting user credentials as requested by Managing Entity Tier 2 help desk support staff.
- Managing the access roles of each user as requested by Managing Entity Tier 2 help desk support staff.
- Providing technical assistance for functionality questions/issues.
- Reporting functionality issues that cannot be resolved by the Tier 2 help desk team to FEI's Tier 3 Help Desk.
- Communicating changes to WITS/ASAM CONTINUUM to users of the system within the organization.
- Create new agency records.
- Update existing agency records.
- Manage Code Tables.
- Manage Announcements and Alerts.
- Monitor GPRA Batch Uploads and Errors.
- Assignment of Agency Oversight to Managing Entity Tier 2 Help. Desk Support staff (note – this feature allows the Managing Entities to switch their agency context in WITS so that they can view information within each of the sub-contracted provider agencies).
- Mange Help Resource documents and links within WITS.

Accessing Data Technical Support: MEs will complete and submit a WITS ticket to hqw.samh.wits@myflfamilies.com. The SOR Data Team will review and respond to all tickets. If unable to resolve the issue identified in the ticket, DCF will communicate with FEI for additional support. See Appendix D for a copy of the ticket template. Users should utilize the WITS User Guide for troubleshooting. Contact the Data Coordinator or Project Director for a copy.

15. **Other Cost Accumulators (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 and 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**

SORF5	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.
MSRC5	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 qualified practitioners 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. Funds may NOT be used to duplicate any services being provided through Headquarter contracts or to provide indirect services to build capacity. **The OCA MSRC5 has three permissible project codes. If using the project code B1 (Network Evaluation and Development), prior approval from the SOR Project Director is necessary.**
MSSP5	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.
MSSM5	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.

Administrative OCAs		
SORR5	Admin/Regions	Allowable administrative and general program costs incurred by Regions.
MSSA5	Admin/MEs	Allowable administrative and general program costs incurred by the Managing Entities.

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)
    - IEH00 - Employment Support
    - IEP00 - Fees (for legal documents such as birth certificates, IDs, driver's license, etc.)
    - IER00-GPRA Non-Cash Incentive not to exceed $30 per GPRA interview

SECTION 4 PROHIBITED USES AND FUNDING RESTRICTIONS 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, buprenorphine, and naltrexone. 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. **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.

3. **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 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, it must be accompanied by injectable extended-release naltrexone to protect such individuals from opioid overdose in relapse and improve treatment outcomes."

4. **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.

5. **Executive salary limits**. Funds may not be used to pay the salary of an individual at a rate in excess of $203,700. This amount reflects an individual's base salary exclusive of fringe and any income that an individual may be permitted to earn outside of the duties to your organization. This salary limitation also applies to subrecipients under a SAMHSA grant or cooperative agreement.

6. **Treatment using medical marijuana.** SAMHSA grant funds may not be used to purchase, prescribe, or provide marijuana or treatment using marijuana. See, e.g., 45 CFR § 75.300(a) (requiring HHS to ensure that Federal funding is expended in full accordance with U.S. statutory and public policy requirements); 21 U.S.C. 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase, or distribution of marijuana).

7. **Meals.** Food/meals, snacks, drinks cannot be purchased with SOR funds.

8. **Other funding 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 formal grant funds, non-federal funds, third party insurance, and sliding self-pay among others that the individual can meet criteria to access those funding sources.

9. **Sub-grantee travel.** Travel is not allowable for sub-grantees unless the travel is tied to a service.

10. **Conferences.** Conference registration fees are not allowable to sub-grantees unless the expense has been detailed in the budget justification narrative and approved by SAMHSA and the Department.

11. **Promotional items.** SAMHSA grant funds may not be used for Promotional Items. Promotional items include but are not limited to clothing and commemorative items such as pens, mugs/cups, folders/folios, lanyards, and conference bags. For

additional information see, HHS Policy on the Use of Appropriated Funds for Promotional Items:

12. **Comingling of grant funds.** Per SAMHSA's Award Standard Terms and Conditions, SAMHSA funds must retain their award-specific identity − they may not be commingled with state funds or other federal funds. ["Commingling funds" typically means depositing or recording funds in a general account without the ability to identify each specific source of funds for any expenditure.].

Appendix A SAMHSA Values That Promote Positive Behavioral Health

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery oriented recipients promote partnerships with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster:

- *Health*—managing one's illnesses or symptoms and making informed healthy choices that support physical and emotional wellbeing;
- *Home*—a stable and safe place to live;
- *Purpose*—meaningful daily activities such as a job or school; and
- *Community*— supportive relationships with families, friends, and peers. Recovery oriented systems of care embrace recovery as: emerging from hope; person-driven; occurring via many pathways; holistic; supported by peers and allies; culturally based and influenced; supported through relationship and social networks; involving individual, family, and community strengths and responsibility; supported by addressing trauma; and based on respect.

Trauma-informed care recognizes and intentionally responds to the lasting adverse effects of experiencing traumatic events. Trauma-informed care is defined through six key principles: Safety: participants and staff feel physically and psychological safe; Peer support: peer support and mutual self-help as vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their lived experience; Trustworthiness and Transparency: decisions are conducted with the goal of building and maintaining trust; Collaboration and Mutuality: importance is placed on partnering and leveling power differences; Cultural, Historical, & Gender Issues: culture and gender-responsive services are offered while moving beyond stereotypes/biases; and Empowerment, Voice and Choice: organizations foster a belief in the primacy of the people who are served to heal and promote recovery from trauma.[10] It is critical recipients promote the linkage to recovery and resilience for those individuals and families impacted by trauma.

Behavioral health equity is the right to access high quality and affordable health care services and supports for all populations regardless of the individual's race, age, ethnicity, gender, disability, socioeconomic status, sexual orientation, or geographical location. By improving access to behavioral health care, promoting quality behavioral health programs and practice, and reducing persistent disparities in mental health and substance use services for underserved populations and communities, recipients can ensure that everyone has a fair and just opportunity to be as healthy as possible. In conjunction with promoting access to high quality services, behavioral health disparities can be further mitigated by addressing social determinants of health, such as social exclusion, unemployment, adverse childhood experiences, and food and housing insecurity.

***Appendix B*- FL Statute 465.019 Institutional pharmacies; permits**

(1) Any institution desiring to operate an institutional pharmacy shall apply to the department. If the board certifies that the application complies with the laws of the state and the rules of the board governing pharmacies, the department shall issue the permit.

(2) The following classes of institutional pharmacies are established:

(a) "Class I institutional pharmacies" are those institutional pharmacies in which all medicinal drugs are administered from individual prescription containers to the individual patient and in which medicinal drugs are not dispensed on the premises, except that nursing homes licensed under part II of chapter 400 may purchase medical oxygen for administration to residents. No medicinal drugs may be dispensed in a Class I institutional pharmacy.

(b) "Class II institutional pharmacies" are those institutional pharmacies which employ the services of a registered pharmacist or pharmacists who, in practicing institutional pharmacy, shall provide dispensing and consulting services on the premises to patients of that institution, for use on the premises of that institution. However, an institutional pharmacy located in an area or county included in an emergency order or proclamation of a state of emergency declared by the Governor may provide dispensing and consulting services to individuals who are not patients of the institution. However, a single dose of a medicinal drug may be obtained and administered to a patient on a valid physician's drug order under the supervision of a physician or charge nurse, consistent with good institutional practice procedures. The obtaining and administering of such single dose of a medicinal drug shall be pursuant to drug-handling procedures established by a consultant pharmacist. Medicinal drugs may be dispensed in a Class II institutional pharmacy, but only in accordance with the provisions of this section.

(c) "Modified Class II institutional pharmacies" are those institutional pharmacies in short-term, primary care treatment centers that meet all the requirements for a Class II permit, except space and equipment requirements.

(d) 1. "Class III institutional pharmacies" are those institutional pharmacies, including central distribution facilities, affiliated with a hospital that provide the same services that are authorized by a Class II institutional pharmacy permit. Class III institutional pharmacies may also:

a) Dispense, distribute, compound, and fill prescriptions for medicinal drugs.
b) Prepare prepackaged drug products.
c) Conduct other pharmaceutical services for the affiliated hospital and for entities under common control that are each permitted under this chapter to possess medicinal drugs.
d) Provide the services in sub-subparagraphs a.-c. to an entity under common control which holds an active health care clinic establishment permit as required under s. 499.01(2)(r).

2. A Class III institutional pharmacy shall maintain policies and procedures addressing:

a) The consultant pharmacist responsible for pharmaceutical services.

b) Safe practices for the preparation, dispensing, prepackaging, distribution, and transportation of medicinal drugs and prepackaged drug products.
c) Recordkeeping to monitor the movement, distribution, and transportation of medicinal drugs and prepackaged drug products.
d) Recordkeeping of pharmacy staff responsible for each step in the preparation, dispensing, prepackaging, transportation, and distribution of medicinal drugs and prepackaged drug products.

(e) Medicinal drugs and prepackaged drug products that may not be safely distributed among Class III institutional pharmacies.

(3) Medicinal drugs shall be stocked, stored, compounded, dispensed, or administered in any health care institution only when that institution has secured an institutional pharmacy permit from the department.

(4) Medicinal drugs shall be dispensed in an institutional pharmacy to outpatients only when that institution has secured a community pharmacy permit from the department. However, an individual licensed to prescribe medicinal drugs in this state may dispense up to a 24-hour supply of a medicinal drug to any patient of an emergency department of a hospital that operates a Class II or Class III institutional pharmacy, provided that the physician treating the patient in such hospital's emergency department determines that the medicinal drug is warranted and that community pharmacy services are not readily accessible, geographically, or otherwise, to the patient. Such dispensing from the emergency department must be in accordance with the procedures of the hospital. For any such patient for whom a medicinal drug is warranted for a period to exceed 24 hours, an individual licensed to prescribe such drug must dispense a 24-hour supply of such drug to the patient and must provide the patient with a prescription for such drug for use after the initial 24-hour period. The board may adopt rules necessary to carry out the provisions of this subsection.

(5) All institutional pharmacies shall be under the professional supervision of a consultant pharmacist, and the compounding and dispensing of medicinal drugs shall be done only by a licensed pharmacist. Every institutional pharmacy that employs or otherwise uses registered pharmacy technicians shall have a written policy and procedures manual specifying those duties, tasks, and functions that a registered pharmacy technician is allowed to perform.

(6) In a Class II or Class III institutional pharmacy, an institutional formulary system may be adopted with approval of the medical staff for the purpose of identifying those medicinal drugs, proprietary preparations, biologics, biosimilars, and biosimilar inter-changeable that may be dispensed by the pharmacists employed in such institution. A facility with a Class II or Class III institutional pharmacy permit which is operating under the formulary system shall establish policies and procedures for the development of the system in accordance with the joint standards of the American Hospital Association and American Society of Hospital Pharmacists for the utilization of a hospital formulary system, which formulary shall be approved by the medical staff.

Appendix C-Recovery Oriented Quality Improvement Specialist Guidance

The Recovery Oriented Quality Improvement Specialist (ROQIS) position is designed for an individual with lived experience in recovery from Substance Use Disorder(SUD). The ROQIS will serve in an administrative capacity, conducting their duties through the lens of their lived experience in recovery and navigating the behavioral health system. This position is described in the budget narrative for the State Opioid Response grant and is authorized by the Substance Abuse and Mental Health Services Administration (SAMHSA) to be provided in accordance with that description. All tasks completed by ROQIS must be in alignment with the State Opioid Response (SOR) 3 guidance document listed initiatives. For reference federal fiscal year (FFY) is as follows: September 30th- September 29th.

ROQIS serve as a key person in recovery-oriented system of care (ROSC) related activities with a primary responsibility to engage in on-going quality assurance and improvement activities and the implementation, integration, and enhancement of recovery management approaches and services within the local system of care. Other duties include but are not limited to: promotion of effective engagement, training, and technical assistance (TA), community inclusion, and care coordination strategies. In addition, this position will provide TA and consultation to promote the expansion of medicated assisted treatment (MAT), care coordination (CC) services, and the effective engagement of persons into services and supports. The duties and responsibilities of ROQIS are to support an increase of access to recovery support services, including implementation, fidelity measurement and technical support to Recovery Community Organizations, MAT providers, as well as hospital and jail bridge programs.

Quality Assurance and Improvement Activities

- Conduct Recovery Oriented Monitoring's (ROMs) on all SOR-funded facilities utilizing the process and protocols outlined within the Quality Improvement Blueprint which were developed for ROM and associated requirements of Guidance Document 35 Recovery Management Practices, (Ex. Chart reviews, interviews with persons served, provider staff interviews, and written reports.)
- Prepare and present reports and findings suitable for Executive Level briefings and include an analysis of opportunities for improvement.
- For non-SOR-funded facilities, ROQIS may assist by providing TA on SOR priorities to remain supportive and collaborative. This can include connection to harm reduction resources, RCO connections, connecting to the overdose prevention team for naloxone distributer expansion, etc.
- For monthly reporting requirements purposes, work towards the completion of a ROM report will be listed as "working on (name of the organization receiving the ROM) ROM report continued".

Technical Assistance (TA)

- Technical Assistance is designed to build the capacity of individuals, organizations, and systems to achieve desired outcomes, a multi-tiered approach along a continuum from basic to intensive. There are categories of TA:
    - **Universal:** Includes information or products, such as newsletters, guidebooks, or research syntheses.
    - **Targeted:** Includes one–time events, such as facilitating strategic planning or hosting regional workshops. Facilitating a series of conference calls on single or multiple topics that are designed around the needs. Examples" Facilitating online courses, webinar series, focused-knowledge sharing, community of practice, short-term training, replication guides.
    - **Intensive:** Includes services provided on–site and requiring an ongoing relationship between the TA provider and program or entity staff and the TA recipient. This type of TA should result in changes to policy, program, practice, or operations that support improved outcomes at one or more systems levels.
- Support Peers in overcoming challenges with Level 2 background screenings as well as challenges with certification. When applicable, link individuals to supports and services. (Date, time, person, and summary of how you supported the peer)
- Provide TA to RCOs and guide them through the process of assisting peers in overcoming challenges with Level 2 background screenings as well as challenges with certification.
- Supporting cultural improvements within service delivery of an organization's recovery orientation with TA on integration and implementation across a spectrum of systems, including recovery support services. Examples: Reviewing policies and practices, training, lending the perspective of persons with lived experience to support the integration of Recovery Management principles and practices.
- Increase the number of organizations distributing Naloxone in each region by providing TA and support through the distributer enrollment process. Minimum expectation 2 per federal fiscal year.
- Identify opportunities for improvements within SOR-funded community service provider networks by conducting Recovery Oriented Monitorings (ROMs), provide relevant ongoing TA and support facilitation of collaborative strategic planning processes among Managing Entities (MEs) and network service providers (NSPs).
- Enhance the role of peers and peer supervisors in the workforce through implementation of best-practice standards among local providers through training and TA.
- Provide support to established and emerging Recovery Community Organizations (RCOs). Identify opportunities for RCOs to work closely with managing entities, community treatment providers and other stakeholders to integrate linkage to harm reduction and recovery support services. This also includes but is not limited to: individuals leaving jails, hospitals, and treatment centers and supporting linkages through partnerships with first responders.

- Provide support to increase access to recovery support services, including implementation, fidelity measurement and technical support to Recovery Community Organizations, MAT providers, as well as hospital and jail bridge programs.

Reporting Requirements

- ROQIS will prepare and submit reports and findings suitable for Executive Level briefings and include an analysis of opportunities for improvement following Recovery Oriented Monitoring's (ROMs) utilizing the process and protocols outlined within the Quality Improvement Blueprint which were developed for ROM and associated requirements of Guidance Document 35 Recovery Management Practices, (Ex. Chart reviews, interviews with persons served, provider staff interviews, and written reports.)
- ROQIS will submit a yearly report outlining Network Services Providers (NSPs) identified opportunities for improvements, as identified through the ROM process, combined with a summary of their action plans for improvements. Report shall also outline TA provided by ROQIS and/or Managing Entity (ME) and document any progress towards improvements outlined in the summary. Reports and findings shall be suitable for Executive Level briefings and reports, including an analysis of opportunities for improvement and document any challenges towards achieving positive outcomes. Reports will be submitted to Headquarters role by May 31st of each calendar year.
- Monthly reports are due the 18th of each month by the end of the business day. Monthly reports shall include trainings, technical assistance and support, community meetings, time spent on monitorings and reports, and other duties as assigned. For each training a sign-in sheet must be included, and SAMHSA's profession type domains must be listed for each individual in attendance. For technical assistance documentation must be kept, including name, time, date, and purpose of support.
- Create and facilitate a regional committee inclusive of MAT peers, individuals receiving MAT services, and family members of individuals in need of or receiving MAT services to have meaningful inclusion in identifying cultural disparities, social determinants of health and systemic barriers that impede access to care while focusing on the development of strategies and completing a strategic plan utilizing a ROSC framework addressing inclusion and improvement to those populations. These peers can be identified through NSPs providing MAT services, RCOs, and hospital and jail bridge programs. Report summaries will be due at the end of each FFY.

Trainings

- ROQIS facilitation of peer trainings will be intentional and specific. As of fiscal year 2022/2023, trainings will be supplemental to the MEs' trainings for peer specialists.

- Statewide trainings will need to be approved by both the Region and Headquarters, to ensure that regional priorities are addressed. An approved list of trainings is listed below. Any other trainings need to be approved. If asked to provide support for a training from Headquarters, HQs will reach out to the regional SAMH director/supervisory team. If asked to provide support from a stakeholder (ex. Florida Certification Board, Peer Support Coalition, etc.), it will be the ROQIS responsibility to ask the supervisor and Headquarters role.
- The goal is to attain certificates in train the trainer, and to train RCO's and other community stakeholders with the intent of creating sustainability and capacity building within the region.
- Utilize approved sign-in sheet when providing any (virtual or in person) trainings to include topic of training, date, time, location, employment profession type demographics. If the attendance demographic is "other" please specify to the profession type in attendance.
- Provide a minimum of three cross-systems training and TA on implementation, accessing, supporting, and integration of sustainable recovery supports. Including but not limited to: Office of Child and Family Wellbeing (OCFW), Department of Juvenile Justice (DJJ), Florida Department of Corrections (FDOC), Department of Health (DOH), U.S. Department of Veteran's Affairs (VA), Department of Education (DOE), National Association on Mental Illness (NAMI) or other mental health affiliates.
- These trainings shall include SOR-related topics and can include but are not limited to: ROSC, Peer Services, Recovery Support Services, RCO implementation, Recovery Management, Recovery Planning, Peer Supervision, Medication Assisted Treatment and Stigma Reduction, Wellness Recovery Action Plans (WRAP), Peer Utilization in Healthcare Settings, eCPR, and Harm Reduction.
- Connect and support Overdose Prevention Team to train organizational staff on naloxone when supporting an organization in becoming a distributer.

Appendix D WITS Ticket Template

Ticket Submission Instructions:

1. Complete each section below with detailed information on the problem or error encountered in WITS.
2. Include a screen shot showing the error to copy/paste on the second page of this ticket. (Instructions for capturing that data can be found on page 2.)
3. Send the ticket to HQW.SAMH.WITS@myflfamilies.com. The Department has set a password on this ticket template document. Do **NOT** change the password. Send all WITS related correspondence to the email above.

DCF WITS Ticket

Template for Managing Entities

Reporter Information Name and email of Managing Entity or Department staff initiating ticket and will be corresponding with FEI until resolved.	
Name: Click or tap here to enter text.	Email: Click or tap here to enter text.
Ticket Information Provider/user information requesting support.	
Agency: Click or tap here to enter text.	Facility: Click or tap here to enter text.
Staff User ID: Click or tap here to enter text.	Date of Reported: Click or tap here to enter text.
Reported Issue: Click or tap here to enter text.	
Any error encountered: Click or tap here to enter text.	
Screen issue was encountered: Click or tap here to enter text.	
UCN for record in question: Click or tap here to enter text.	

Screen Shot Instructions: There are three (3) options for capturing a screen shot. Below are instructions for all options.

Option 1—Web Capture-Edge Browser ONLY-right click, select web capture option, draw a box with your mouse around the information you are capturing, select copy, save, and attach below

Option 2—Print Screen-on your keyboard select print screen button, paste in box below, if cropping is necessary right click photo and save, open with Paint, crop as needed, and attach below.

Option 3—Snipping Tool-Select snipping tool from your computer applications, once the application opens, select new in the top left screen of the snipping tool box, move your mouse to select the information you would like to snip, save to your computer, and attach below.

Attach screen shot here. You may add more than one.

[i] Substance Abuse and Mental Health Services Administration. (2020). *Treatment of Stimulant Use Disorders*. SAMHSA Publication No. PEP20-06-01-001. Retrieved from https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-06-01-001.pdf.

[ii] Section 394.76(7), Florida Statutes. See also Senate Bill 704, 2022 Florida Legislature: https://flsenate.gov/Session/Bill/2022/704.

[iii] Substance Abuse and Mental Health Services Administration. (2022). Notice of Award FAIN# H79TI085766 – Florida's State Opioid Response III Project.

[iv] Section 394.76(7), Florida Statutes. See also Senate Bill 704, 2022 Florida Legislature: https://flsenate.gov/Session/Bill/2022/704.