STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE (date)

CF OPERATING PROCEDURE
NO. 155 - __

CFOP for the Opioid Settlement Trust Fund

Chapter 1
Introduction to Florida's Opioid Settlement Trust Fund

Purpose and Intent

This document explains the structure of the opioid settlement funding and outlines the intent, scope, authority for oversight, utilization requirements, and approved purposes. The purpose of the Opioid Settlement Trust Fund is to abate the opioid epidemic in accordance with settlement agreements reached by the state in opioid-related litigation or bankruptcy proceedings, namely the Florida Opioid Allocation and Statewide Response Agreement Between the State of Florida (Department of Legal Affairs) and Certain Local Governments. Broadly speaking, the approved purposes include, but are not limited to, funding for opioid-related prevention, treatment, and recovery support services.

Scope

This operating procedure applies to the State of Florida, Local Governments, Managing Entities, and all other entities that receive or control opioid settlement funds, including subcontractors and subrecipients.

Authority

The Department of Children and Families (Department) includes the Office of Substance Abuse and Mental Health (SAMH), which is the single state authority on substance abuse and mental health. The program is governed by Chapters 394 and 397 of the Florida Statutes and is responsible for the oversight of a statewide system of care for the prevention, treatment, and recovery of children and adults with serious mental illnesses (SMI) or substance use disorders (SUD).

In addition to Chapter 397, Florida Statutes, all licensed SUD providers in Florida are regulated by 65D-30, Florida Administrative Code, a uniform Chapter of rules designed to ensure that individuals and families receive recovery supports, crisis services, care coordination, prevention, and treatment, when appropriate, in a manner that is recovery-oriented and least intrusive.

1. Sections 394.4573 and 394.4955, Florida Statutes, promote the development and effective implementation of a coordinated system of care.
1. Section 20.195, Florida Statutes, creates the State Opioid Settlement Trust Fund within the Department of Children and Families.
2. Sections 394.4573, and 394.9082, Florida Statutes, establish the duties for the Department and the Behavioral Health Managing Entities in planning, implementing, coordinating, and contracting for the delivery of community SUD services.

3. Section 397.335, Florida Statutes, establish the Statewide Council on Opioid Abatement within the Department of Children and Families.
4. The Florida Opioid Allocation and Statewide Response Agreement Between the State of Florida Department of Legal Affairs (Office of the Attorney General) and Certain Local Governments in the State of Florida.

Structure of the Opioid Settlement Funding

Opioid settlement funding is broadly structured into three subtypes: The City/County Fund, the Regional Fund, and the State Fund. However, since the Regional Fund is further subdivided into a Regional Fund for Qualified Counties and Regional Fund for Nonqualified Counties – both of which are distributed and administered in very different ways – it could be said that there are four distinct subtypes of opioid settlement funds, described in more detail as follows:

The City/County Fund: The City/County Fund is disbursed directly to 247 counties and municipalities (cities, towns, or villages); it does not flow through the Department of Children and Families or the Managing Entities. Cities and counties determine how these funds are expended, in accordance with the core strategies and approved uses from Schedules A and B of the Florida Opioid Allocation and Statewide Response Agreement. All plans and reports (described in more detail later) associated with opioid settlement funds, including the City/County Fund, are nonetheless required to be submitted to the Department. Receipt of Opioid settlement funds is an express acknowledgement of the obligation to report data on services funded by the Opioid Settlement. The City/County Fund is paid out to subdivisions annually in September by the Opioid Administrator in the Office of the Attorney General. According to the Office of Attorney General, unexpended monies from the City/County Fund can be carried forward from one year to the next. These funds may also be used for Fixed Capital Outlay projects that align with the core strategies and approved uses. Since the Department does not receive, control, or administer the City/County Fund, any questions about it must be directed to the Office of Attorney General.

The Regional Fund: The Regional Fund is subdivided into two separate streams: one for qualified counties and one for non-qualified counties, distinguished as follows:

- **The Regional Fund for Qualified Counties**: Qualified counties are defined as having a population of at least 300,000 individuals, an opioid task force (or similar entity), and an opioid abatement plan. There are 20 qualified counties. These 20 qualified counties are permanently designated as such (i.e., their status as qualified counties will not change in response to future changes to county population). Regional Funds for qualified counties are disbursed from the Department of Financial Services annually in September. The Regional Funds for the qualified counties do not flow through the Department or the Managing Entities. According to the Office of Attorney General, unexpended monies from the Regional Fund for Qualified Counties can be carried forward from one year to the next, and they can be used for Fixed Capital Outlay projects that align with the core strategies and approved uses from Schedules A and B of the Florida Opioid Allocation and Statewide Response Agreement.
- **The Regional Fund for Nonqualified Counties**: There are 47 non-qualified counties that receive funding through the Managing Entities (which are funded by the Department). A Managing Entity is a corporation, created pursuant to section 394.9082, Florida Statutes, under contract with the Department, to plan and manage the daily operational delivery of behavioral health services through a coordinated system of care. There are seven Managing Entities throughout the state. The Regional Fund for Nonqualified Counties, which is appropriated to the Department through the annual

General Appropriations Act (GAA), and which flows through the Department to the Managing Entities, can be used for Fixed Capital Outlays, according to the Office of the Attorney General.

The State Fund: The Legislature appropriates the State Fund to the Department through annual General Appropriation Acts. According to the Office of the Attorney General, these funds may be used for Fixed Capital Outlay projects, subject to review and approval by the Department. A portion of the State Fund that flows to the Department of Children and Families goes to the seven regional Managing Entities, which are corporations under contract with the Department to manage and oversee the delivery of behavioral health services through a coordinated network of providers and partners that comprise the system of care. Both the Department and the Managing Entities, like all other parties, are required to expend opioid settlement monies on Approved Purposes and Core Strategies. Additionally, Managing Entities must expend monies from the Regional Fund for Nonqualified Counties on services for the counties within their purview that are nonqualified counties and to ensure that there are services in every county. Furthermore, to the greatest extent practicable, the Managing Entities shall endeavor to expend monies in each county or for citizens of a county in the amount of the share that a county would have received if it were a qualified county.

CHAPTER 2
OPIOID ABATEMENT FUNDING UTILIZATION REQUIREMENTS

This Chapter applies to all entities that receive and expend opioid settlement funds, including Local Governments (of any counties, cities, towns, or villages in Florida), the Department of Children and Families, the Managing Entities, and service providers.

Approved Purposes and Core Strategies

According to the Florida Opioid Allocation and Statewide Response Agreement between Local Governments and the Office of the Attorney General, opioid settlement funds may only be used for approved purposes, which include, but are not limited to, all of the opioid-related prevention, treatment, and recovery support services and opioid abatement strategies listed in Schedule A (Core Strategies) and Schedule B (Approved Uses) from Florida Opioid Allocation and Statewide Response Agreement. Local Governments may choose from the approved uses in Schedule B, but priority must be given to the core strategies in Schedule A. At this time, details regarding how to prioritize the core strategies in Schedule A are not available because the Florida Opioid Allocation and Statewide Response Agreement does not specify the minimum percentage of distributed funds that must be spent on any one of the listed strategies.

Opioid settlement funds serve individuals that misuse opioids or that have an Opioid Use Disorder (OUD). If individuals are eligible for settlement-funded services because of these conditions, then opioid settlement funds can be used to holistically treat any other co-occurring mental disorders or health problems. Opioid settlement funds can also be used for prevention services for individuals at risk of opioid misuse or OUD. Services funded by the opioid settlement must be evidence-based, individualized, comprehensive, recovery-oriented, trauma-informed, and culturally competent. Providers that treat opioid use disorders, including those that serve individuals involved in the criminal justice system or in jail, must abide by the most recently updated National Practice Guideline for the Treatment of Opioid Use Disorder from the American Society of Addiction Medicine (ASAM). ASAM guidelines are based on the most rigorous evidence available, including Randomized Controlled Trials, in addition to the collective judgment of experts.

Funds may be used for hiring service provider staff if their role is solely to support core strategies and approved uses from Schedules A and B. If said staff is not dedicated full-time exclusively to providing opioid abatement activities that align with Approved Purposes and Core Strategies, then only a portion of their time may be using opioid settlement funds, which will need to be calculated based on time spent on opioid abatement-related purposes and strategies.

Certain exceptions may apply. There are some Core Strategies (Schedule A) and Approved Uses (Schedule B) that DCF and the Managing Entities do not have statutory authority to fund or implement, or that may conflict with Florida Statutes, or the standards of care for Opioid Use Disorders:

- While Schedule B lists, “Create and/or support recovery high schools,” DCF and the Managing Entities lack the statutory authority to create high schools of any kind.

Therefore, the State Fund and Regional Fund for Nonqualified Counties may not be used for these purposes. This does not preclude Local Governments from using the City/State Fund or the Regional Fund for Qualified Counties to do so.

- While Schedule B lists, “Research on non-opioid treatment of chronic pain,” DCF and the Managing Entities lack the statutory authority to conduct research on the treatment of chronic pain. Therefore, the State Fund and Regional Fund for Nonqualified Counties may not be used for these purposes.

- While Schedule B lists, “Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids,” DCF and the Managing Entities lack the statutory authority to enforce criminal statutes that prohibit the trafficking of controlled substances or to engage in interdiction efforts, or to research such activities. Therefore, the State Fund and Regional Fund for Nonqualified Counties may not be used for these purposes.

- While Schedule A lists access to sterile syringes through syringe services programs among the core strategies, and while Schedule B lists syringe services programs (“including supplies, staffing, space”) among the approved uses, these elements may be impermissible due to a perceived conflict with s. 381.0038(4)(f), Florida Statutes, which states that, “State, county, or municipal funds may not be used to operate an exchange program. Exchange programs shall be funded through grants and donations from private resources and funds.” The Department of Children and Families will not be issuing any legal opinions or clarifying statements regarding the use of opioid settlement funds for syringes or for the operation of syringe exchange programs, however, Local Governments can solicit a formal opinion from the Office of the Attorney General if desired. Note that the potential conflict narrowly applies only to the use of opioid settlement funds *for the operation of a syringe exchange or for the purchase of syringes*. Opioid settlement funds can and should be used to provide participants in a syringe exchange program with low-barrier access to medication-assisted treatment, naloxone nasal spray kits, wound care, and a range of other ancillary healthcare services which are traditionally provided through these programs.

- While Schedule B lists “evidence-based withdrawal management services” among the approved uses, it is important to clarify that withdrawal management alone does not constitute treatment for OUD and therefore does not adhere to the American Society of Addiction Medicine (ASAM) standards of care for OUD. According to the ASAM *National Practice Guideline for the Treatment of Opioid Use Disorder (2020 Focused Update)*, “Opioid withdrawal management (i.e. detoxification) on its own, without ongoing treatment for opioid use disorder, is not a treatment method for opioid use disorder and is not recommended. Patients should be advised about the risk of relapse and other safety concerns, including increased risk of overdose and overdose death. Ongoing maintenance medication, in combination with psychosocial treatment appropriate for the patient’s needs, is the standard of care for treating opioid use disorder.” More specifically, the ASAM Guideline says, “Using methadone or buprenorphine for opioid withdrawal management is recommended over abrupt cessation of opioids.”

- While Schedule B lists “funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD” among the approved uses, subsequent changes to federal law repealed the requirement for special training and a waiver for authorized prescribers to prescribe buprenorphine to treat OUD.

- While Schedule B lists, “Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas,” the Department does not have statutory authority to use monies from the State Fund for educational or training incentives or loan repayment programs.

Prioritization of Funding

Qualified counties, non-qualified counties, municipalities, [service providers] and Managing Entities are required to expend the funding on approved purposes listed in Schedules A and B of the Florida Opioid Allocation and Statewide Response Agreement. Qualified counties, non-qualified counties, municipalities, and Managing Entities shall prioritize the following services and initiatives:

1. **Medication Assisted Treatment**: The clinical standard of care for the treatment of Opioid Use Disorder is medication-assisted treatment (MAT) using one of three types of FDA-approved products, namely methadone, buprenorphine-based products (including long-acting injectables), and long-acting, injectable naltrexone. All service providers that receive opioid settlement funds must permit continuation in MAT for as long as the authorized prescriber determines that the medication is clinically beneficial. Furthermore, while counseling and support services must be available for and offered to patients, providers shall not require mandatory counseling participation or mandatory self-help group participation as a condition of initiating or continuing medications that treat OUD, except those established by methadone providers and applied to individuals on methadone as required in 65D-30.0142(2)(q), Florida Administrative Code.

2. **Coordinated Opioid Recovery (CORE) Network of Addiction Care:** The essential component of the Coordinated Opioid Recovery (CORE) network of addiction care model is 24-7, low-barrier access to buprenorphine induction services that address withdrawal and cravings, confer a protective effect against overdose, and begin the path to recovery. The CORE model includes the use of specialized EMS protocols for overdose and acute withdrawal, transport to an Emergency Department-based addiction stabilization center with experts in addiction medicine willing to initiate buprenorphine treatment, and peer support specialists to help with engagement and linkage to long-term, individualized, integrated treatment. The Department’s contract Guidance #14 describes the CORE model and associated requirements in more detail: https://www.myflfamilies.com/document/54331.

3. **Hospital Bridge Programs**: Individuals with OUD can access buprenorphine induction before discharge from hospitals that are not currently part of the CORE network, with a buprenorphine prescription and peer engagement for a warm handoff serving as the bridge to a community-based provider offering long-term, integrated, MAT. The primary components of the Hospital Bridge Program include initiation of buprenorphine before discharge, with a “bridge” prescription for enough medication to support individuals until they

can be linked to a long-term MAT provider in the community, with peer engagement throughout. Individuals may be 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, explain the transition process, provide general support during the entire process, and assist in a warm hand-off to the local MAT provider. An emergency opioid antagonist or antidote should be dispensed, not merely prescribed, prior to discharge from the hospital for all individuals entering an ED for opioid overdose or misuse, regardless of whether they agreed to participate in MAT.

4. **Peer Supports and Recovery Community Organizations**: Recovery Community Organizations (RCOs) are independent, non-profit organizations led and governed by representatives of local communities of recovery. RCOs provide certified peer recovery support services, in addition to recovery-focused community education and outreach. RCOs work closely with community treatment providers and other stakeholders to provide outreach, information and referrals, wellness recovery centers, and other recovery support services. Peers and RCOs will work closely with hospitals and long-term community-based providers participating in the Coordinated Opioid Recovery (CORE) network model and Hospital Bridge programs. Both programs utilize the peer workforce to provide care coordination and engage the individual in on-going treatment and recovery support.

Claw Back and Recoupment

In order to avoid any attempts to claw back or recoup monies due to impermissible uses, all entities that received opioid settlement funds, including Local Governments, Managing Entities, and all subcontractors or subrecipients, must only use them for Approved Purposes and Core Strategies, and shall return any funds that are not utilized for Approved Purposes or Core Strategies.

Administrative Costs

Municipalities and counties may take no more than a 5 percent administrative fee from any funds they receive or control from the City/County Fund. Qualified counties may take no more than a 5 percent administrative fee from their share of the Regional Fund for Qualified Counties. The State may take no more than a 5 percent administrative fee from the State Fund. Managing Entities may not take any administrative fees from the Regional Fund for Nonqualified Counties. Administrative costs (also known as “indirect costs”) are costs incurred for common or joint objectives which cannot be readily and specifically identified with the approved uses of the opioid settlement funds, but are necessary to the operations of an organization, for example, the cost of operating and maintaining facilities, depreciation, and administrative salaries. Administrative costs, as defined here, excludes attorney fees. Any indirect cost rates must be evaluated for reasonableness and for allowability and must be allocated consistently. Recipients of opioid settlement funds must be able to demonstrate that any indirect costs are not duplicated elsewhere as direct costs.

Local Match:

Local matching funds (meaning funds received from governing bodies of local governments including city commissions and county commissions) are not required from any entity as a condition of receiving opioid settlement funds. Whether opioid settlement funds can be counted as matching funds for other programs or purposes will depend on the terms, conditions, rules, and statutes that apply to those programs and are therefore beyond the scope of this CFOP.

Fixed Capital Outlays

According to the Department of Financial Services' 2022 Reference Guide for State Expenditures, a Fixed Capital Outlay (FCO) is “an appropriation category for the purchase of real property (land, buildings, including appurtenances, fixtures and fixed equipment, structures, etc.), including additions, replacements, major repairs and renovations to real property which materially extend its useful life or materially improve or change its functional use and including furniture and equipment necessary to furnish and operate a new or improved facility, when appropriated by the Legislature in the fixed capital outlay appropriation category.” Motor vehicle purchases are not included in the definition of FCO, but other statutes and rules apply to the procurement of motor vehicles, as explained the Reference Guide for State Expenditures. The City/State Fund can be used for Fixed Capital Outlay projects that align with the Core Strategies and approved uses outlined Schedule A or Schedule B in the Florida Opioid Allocation and Statewide Response Agreement. The Regional Fund for Qualified Counties, which the Department does not receive or control, may also be used for Fixed Capital Outlay projects that align with the Core Strategies and Approved Uses. According to the Office of the Attorney General, the Regional Fund for Nonqualified Counties, which is appropriated through the annual General Appropriation Act (GAA), and which flows through the Department and the Managing Entities, can also be used for Fixed Capital Outlays. FCO proposals for projects to be funded with the Regional Fund for Nonqualified Counties must be provided by the Managing Entities and will be subject to review and approval by the Department.

Reverting or Carrying Forward Unexpended Funds

According to the Office of Attorney General, unexpended monies from both the City/County Fund and the Regional Fund for Qualified Counties can be carried forward from one year to the next. Unexpended monies from the Regional Fund for Nonqualified Counties will count toward the 8 percent cap on the amount of state funds that the Managing Entities can carry forward pursuant to s. 394.9082(9)(a), Florida Statutes, which states that, “A contract established between the department and a managing entity under this section shall be funded by general revenue, other applicable state funds, or applicable federal funding sources. A managing entity may carry forward documented unexpended state funds from one fiscal year to the next, but the cumulative amount carried forward may not exceed 8 percent of the annual amount of the contract. Any unexpended state funds in excess of that percentage shall be returned to the department. The funds carried forward may not be used in a way that would increase future recurring obligations or for any program or service that was not authorized under the existing contract with the department.” Unexpended state funds that exceed the 8 percent cap are reverted back to the Department and may be subsequently repurposed and reallocated.

Data Collection and Reporting through the Florida Opioid Implementation and Financial Reporting System (FOIFRS)

According to the Florida Opioid Allocation and Statewide Response Agreement, Local Governments (counties and cities/municipalities) must provide DCF with information about how they intend to expend opioid settlement funds, how they actually expend opioid settlement funds, and the effectiveness of those expenditures. It also states that, “Local Governments shall respond and provide documents to any reasonable requests from the State or Opioid Abatement Taskforce or Council for data or information about programs receiving Opioid Funds.” Additionally, “At all reasonable times for as long as records are maintained, persons duly authorized by State or Local Government auditors shall be allowed full access to and the right to examine any of the contracts and related records and documents, regardless of the form in which kept.” Finally, all parties to the Florida Opioid Allocation and Statewide Response

Agreement “agree to cooperate fully and execute any and all supplementary documents and to take all additional actions which may be reasonably necessary or appropriate to give full force and effect to the basic terms and intent of this Agreement.”

At this time, the Department will not issue any formal notices of approval or disapproval in response to any submitted plans or reports. However, the Florida Opioid Allocation and Statewide Response Agreement states that, “Any one or more of the Local Governments or the State may object to an allocation or expenditure of Opioid Funds solely on the basis that the allocation or expenditure at issue (a) is inconsistent with the Approved Purposes; (b) is inconsistent with the distribution scheme…; (c) violates the limitations set forth herein with respect to administrative costs...There shall be no other basis for bringing an objection to the approval of an allocation or expenditure of Opioid Funds.” Furthermore, while the Statewide Council on Opioid Abatement will receive and review submitted plans and reports, they will not be issuing any formal notices of approval or disapproval. The Council will only advise the State and Local Governments and make recommendations regarding how funds should be prioritized and spent in the coming fiscal year.

Counties, cities, and service providers that receive any opioid settlement funds, will use the Florida Opioid Implementation and Financial Reporting System (FOIFRS) as the platform for submitting Implementation Plans, Financial Reports, and service records. Services funded out of the opioid settlement *will not* be reported into the Department’s Financial and Services Accountability Management System (FASAMS). The FOIFRS will be available under the Resources tab at www.FloridaOpioidSettlement.com. The FOIFRS will offer a secure platform for uploading, validating, and reviewing data. According to the FOIFRS User Manual, users designated as County/Municipality Submitters will have the ability to report financial expenditures and upload implementation plan documents specific to their designated county or municipality. Users designated as County/Municipality Read-Only will have the ability to view uploaded implementation plans and financial expenditures entered by County/Municipality Submitters for their designated county or municipality.

Access to FOIFRS user accounts is facilitated by a prospective user sending an access request email to HQW.SAMH.Opioid.Data.Access.Support@myflfamilies.com. The Opioid Data Access Support team will respond to the request with a link to the Access Request Form. Both County/Municipality and Provider users will complete the Access Request Form and include the required information for onboarding. Once all required information is submitted and verified, the user's Okta authentication, FOIFRS and/or FTP Sharefile account will be established. Subsequently, an instructional email will be sent to guide users on accessing the application. Users will be sent an email with instructions on setting up their Okta account using the email account they provided on the Access Request Form. Users will also be provided with the URL to sign into the FOIFRS application using their Okta credentials. The Okta login window reads “APP LAUNCHER” at the top.

X12 837 files will be submitted to the Department through a batch process to reduce administrative burdens. A recording of the 837 training will be made available in the future on the Florida Opioid Settlement website. Counties, cities, and provides must ensure secure data sharing, confidentiality, and privacy in accordance with all applicable rules and statutes. All data contained within the Florida Opioid Implementation and Financial Reporting System (FOIFRS) is sensitive and privileged information and shall be handled accordingly. To maintain the integrity of this information, the records will be accorded proper management and security, and will only

be accessed and used by authorized personnel in accordance with state and federal law. Managing Entities will require completion of HIPAA and Department security training modules before being granted access to any direct or subcontracted staff. Regular data audits should be conducted to ensure data integrity and identify any discrepancies or errors for timely correction.

Implementation Plans (also called "local abatement plans" in the FAQ and the FOIFRS User Manual)

- **What are they? Under what authority are they required?**
  - According to s. 397.335(4)(e), Florida Statutes, "By June 30 of each year, each county, municipality, managing entity, or state agency that receives settlement funds from an opioid settlement shall provide information to the council related to how it intends to use settlement funds and how it intends to collect data regarding its use of funds."
  - According to the Florida Opioid Allocation and Statewide Response Agreement, "Prior to July 1st of each year, the State and each of the Local Governments shall provide information to DCF about how they intend to expend Opioid Funds in the upcoming fiscal year."
  - According to the Florida Opioid Allocation and Statewide Response Agreement, "The State and Local Governments shall receive and report expenditures, service utilization data, demographic information, and national outcome measures…"
- **Is there a template or form?**
  - Not at this time, but the FAQ notes that the Department is still developing templates which we will be made available on www.FlordiaOpioidSettlement.com.
- **When are they due?**
  - According to the statute that governs the Council: June 30 annually.
- **Who submits them?**
  - Counties and municipalities.
  - According to the FAQ, "Counties can have more than one plan if they submit one plan for their regional funds and another if they submit one for the city/county funds. Additionally, cities within a county will submit plans for their city/county funds."
- **How are they submitted?**
  - Plans will be submitted through the Florida Opioid Implementation and Financial Reporting System (FOIFRS) using the following link: hqw.samh.opioid.settlement.inquiry@myflfamilies.com

Annual Progress Reports

- **What are they? Under what authority are they required?**
  - According to s. 397.335(f), Florida Statutes, "By August 31 of each year, each county, municipality, managing entity, or state agency that receives settlement funds from an opioid settlement must provide information to the Council related to its expenditure of settlement funds and the results obtained from those expenditures.
- **Is there a template or form?**
  - Not at this time.
- **When are they due?**
  - According to the statute that governs the Council: August 31 annually.
- **Who submits them?**

- Counties, cities, and Managing Entities.
- **How are they submitted?**

Annual Financial Reports

- **What are they? Under what authority are they required?**
  - According to s. 397.335(f), Florida Statutes, "By August 31 of each year, each county, municipality, managing entity, or state agency that receives settlement funds from an opioid settlement must provide information to the Council related to its expenditure of settlement funds and the results obtained from those expenditures.
  - According to the Florida Opioid Allocation and Statewide Response Agreement, "The State and each of the Local Governments shall report its expenditures to DCF no later than August 31st for the previous fiscal year."
  - According to the Florida Opioid Allocation and Statewide Response Agreement, "The State and Local Governments shall receive and report expenditures, service utilization data, demographic information, and national outcome measures…"
  - According to the FOIFRS User Manual, counties and municipalities will report both budgeted allocations and expenditures.
- **Is there a template or form?**
  - Yes.
- **When are they due?**
  - According to the statute that governs the Council: August 31 annually.
- **Who submits them?**
  - Counties and cities.
- **How are they submitted?**
  - In FOIFRS, County/Municipality Submitters will choose the appropriate quarter-ending date and input expenditures. After entering the quarter and the amount of the expenditure, Submitters can identify the funded strategy from a menu with options from Schedule A (Core Strategies) and Schedule B (Approved Uses). Submitters will also provide a "concise description of the strategy or approved use." The description is limited to 500 characters in length.

837 Files

- **What are they? Under what authority are they required?**
  - Electronic Data Exchange (EDI) 837 file is an electronic form used by healthcare providers to submit claims to payors. Most providers that have Electronic Health Records use 837 files to submit data for payment. More specifically, an "837P" or and "837I" will be used. If a provider does not have the ability to submit an 837 file at this time, then there will be a Phase 2 webinar at a later date on how to submit.
  - According to the Florida Opioid Allocation and Statewide Response Agreement, "The State and Local Governments shall receive and report expenditures, service utilization data, demographic information, and national outcome measures…"
  - According to the DCF 837 Professional Health Care Claim Companion Guide, the following data elements, among others, are part of the X12N 837 Professional Loop:
    - Various billing provider descriptive information
    - Various descriptive information on Payers

        - Member Policy Numbers (including a Pregnancy Indicator)
        - Claim information
        - Health Care Diagnosis Code
        - Service Facility information
        - National Drug Codes
- **Is there a template or form?**
    - Yes. These are 837 forms that should be familiar to treatment providers that seek reimbursement through Medicaid.
- **When are they due?**
    - The 18th of every month [Note from IT Project Manager, "Based on the number of providers these files could be large. OITS would like to receive files more often than once a month, if possible."]
- **Who submits them?**
    - Only providers will submit service data using the 837 file format (not cities, or counties). According to the DCF 837 Professional Health Care Claim Companion Guide, "All required segments within the 837 Institutional transactions must always be sent by the community provider and received by the Department."
- **How are they submitted?**
    - According to the training video titled, "Provider – Opioid Data 837 File Webinar," providers will log into ShareFile and place X12 837 files into separate, designated folders for each provider. Providers will only be able to upload to, and see within, their own specific folders. The URL to the ShareFile folder locations will be provided upon completion of the access request documentation as part of the provider onboarding process.
    - According to the DCF 837 Professional Health Care Claim Companion Guide, "DCF currently supports FTP with SSL. Transaction files can be uploaded into an assigned folder on the ShareFile.

Monitoring Reports

- **What are they? Under what authority are they required?**
    - According to the Florida Opioid Allocation and Statewide Response Agreement, "In any award or grant to any provider, the State and Local Governments shall ensure that each provider acknowledges its awareness of its obligations under law and shall audit, supervise, or review each provider's performance routinely, at least one every year."
    - According to the Florida Opioid Allocation and Statewide Response Agreement, "Local Governments shall implement a monitoring process that will demonstrate oversight and corrective action in the case of non-compliance, for all providers that receive Opioid Funds." This includes a requirement to, "Provide DCF and the Opioid Abatement Taskforce or Council with access to the monitoring reports."
- **Is there a template or form?**
    - Not at this time.
- **When are they due?**
    - ??
- **Who submits them?**
    - Counties and cities.
- **How are they submitted?**
    - ??

Accountability, Audits, and Performance Reviews:

According to the Florida Opioid Allocation and Statewide Response Agreement, "The State and Local Governments shall have and follow their existing policies and practices for accounting and auditing, including policies related to whistleblowers and avoiding fraud, waste, and abuse." Additionally, "In any award or grant to any provider, the State and Local Governments shall ensure that each provider acknowledges its awareness of its obligations under law and shall audit, supervise, or review each provider's performance routinely, at least one every year."

Additionally, "At all reasonable times for as long as records are maintained, persons duly authorized by State or Local Government auditors shall be allowed full access to and the right to examine any of the contracts and related records and documents, regardless of the form in which kept." All providers and parties must comply and cooperate immediately with any inspections, reviews, investigations, or audits deemed necessary by the Office of the Inspector General or the State. This applies to any investigation, audit, inspection, review or hearing.

The State of Florida may audit entities that receive or control opioid settlement funds to ensure compliance with this operating procedure and any guidelines or procedures established by the State of Florida…Entities that receive or control opioid settlement funds shall cooperate with any such audits and provide access to all records, documents, and other information related to the use of such funds…Any deviation from this operating procedure and any guidelines or procedures established by the State of Florida shall be reported to the Department immediately at: HQW.SAMH.Opioid.Settlement.Inquiry@myflfamilies.com.

Local Governments shall report to the State of Florida on the use of Opioid Funds in accordance with this operating procedure and any policies, guidelines or procedures established by the State of Florida. The State of Florida may audit Local Governments to ensure compliance with this policy and any guidelines or procedures established by the State of Florida. Local Governments shall cooperate with any such audits and provide access to all records, documents, and other information related to the use of Opioid Funds. Any funds that are not utilized for Approved Purposes shall be returned to the State of Florida. Any deviation from this operating procedure and any guidelines or procedures established by the State of Florida shall be reported to the State of Florida immediately via email to: HQW.SAMH.Opioid.Settlement.Inquiry@myflfamilies.com. Local Governments shall implement a monitoring process that will demonstrate oversight and corrective action in the case of non-compliance, for all providers that receive Opioid Funds. Monitoring shall include oversight of any contractual requirements, the production of a monitoring report based, in part, on the use of standardized monitoring tools, and the creation of correction action plans when necessary.

The State and Local Governments shall ensure that any provider or sub-recipient of Opioid Funds at a minimum complies with the following:

1. Any provider shall establish and maintain books, records, and documents (including electronic storage media) sufficient to reflect all income and expenditures of Opioid Funds. Upon demand, at no additional cost to the State or Local Government, any provider will facilitate the duplication and transfer of any records or documents during the term that it receives any Opioid Funds and the required retention period for the State or Local Government. These records shall be made available at all reasonable times for

inspection, review, copying, or audit by Federal, State, or other personnel duly authorized by the State or Local Government.

2. Any provider shall retain and maintain all client records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to the use of the Opioid Funds during the term of its receipt of Opioid Funds and retained for a period of six (6) years after its ceases to receive Opioid Funds or longer when required by law. In the event an audit is required by the State or Local Governments, records shall be retained for a minimum period of six (6) years after the audit report is issued or until resolution of any audit findings or litigation based on the terms of any award or contract.
3. At all reasonable times for as long as records are maintained, persons duly authorized by State or Local Government auditors shall be allowed full access to and the right to examine any of the contracts and related records and documents, regardless of the form in which kept.
4. A financial and compliance audit shall be performed annually and provided to the State.
5. All providers shall comply and cooperate immediately with any inspections, reviews, investigations, or audits deemed necessary by The Office of the Inspector General section 20.055, Florida Statute, or the State.
6. No record may be withheld, nor may any provider attempt to limit the scope of any of the foregoing inspections, reviews, copying, transfers, or audits based on any claim that any record is exempt from public inspection or is confidential, proprietary or trade secret in nature; provided, however, that this provision does not limit any exemption to public inspection or copying to any such record.]

CHAPTER 5

CORE STRATEGIES

Qualified Counties, Non-Qualified Counties and Managing Entities must prioritize evidenced-based Core Strategies addressing the needs of persons with OUD and co-occurring SUD/mental disorders before implementing other Approved Uses.

5-1. Priority Populations.

Qualified Counties, Non-Qualified Counties and Managing Entities shall serve the following populations:

1. Those with OUD and co-occurring mental health disorders or SUDs.
2. Youth at risk for opioid use/misuse.
3. Pregnant women with SUD who do not qualify for Medicaid.
4. People in recovery from OUD and any co-occurring SUD/MH condition.
5. People at risk of developing an OUD and any co-occurring SUD/MH conditions.
6. Persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system.
7. Pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (NAS).

5-2. Core Strategies.

Qualified Counties, Non-Qualified Counties and Managing Entities Core Strategies shall include programs in the following areas:

1. Naloxone or other FDA-approved medication to reverse opioid overdoses.
    a. Expand training for first responders, schools, community support groups and families.
    b. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.
2. Medication-assisted treatment and other opioid-related treatment.
    a. Increase the provision of MAT to non-Medicaid eligible or uninsured individuals.
    b. Provide education to school-based and youth-focused programs that discourage or prevent misuse.
    c. Provide MAT education and awareness training to healthcare providers, Emergency Medical Technicians (EMT), law enforcement, and other first responders.
    d. Treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication with other support services.
3. Pregnant & Postpartum Women.
    a. Expand screening, brief intervention, and referral to treatment (SBIRT) services to non-- Medicaid eligible or uninsured pregnant women.
    b. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring OUD and other substance use disorder SUD/MH disorders for uninsured individuals; and

c. Provide comprehensive wrap-around services to individuals with OUD including housing, transportation, job placement/training, and childcare.

4. Expanding Treatment for Neonatal Abstinence Syndrome.
    a. Expand comprehensive evidence-based care for NAS babies.
    b. Expand services for better continuum of care with infant-need dyad.
    c. Expand long-term treatment and services for medical monitoring of NAS babies and their families.
5. Expansion of Warm Hand-off to Treatment and Recovery Services.
    a. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.
    b. Increase warm hand-offs to transition to treatment and recovery services. Incorporate the role of peer specialists in transition services to provide peer support to individuals prior to, during, and after clinical services to facilitate access to a continuum of care and array of community-based treatment and recovery supports.
    c. Broaden scope of recovery services to include co-occurring SUD or mental health conditions.
    d. Provide comprehensive wrap-around services to individuals in recovery including housing, transportation, job placement/training, and childcare.
    e. Hire additional social workers or other behavioral health workers to facilitate expansions above.
6. Treatment for Incarcerated Population.
    a. Provide evidence-based treatment and recovery support including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system.
    b. Increase funding for jails to provide treatment to inmates with OUD.
7. Prevention Programs.
    a. Prevention programs shall be implemented in accordance with 65D-30.013, Florida Administrative Code.
    b. Funding for media campaigns to prevent opioid use. For example, “The Facts. Your Future.” or the Food and Drug Administration’s “Real Cost” campaign to prevent youth from misusing tobacco.
    c. Funding for evidence-based prevention programs in schools.
    d. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing).
    e. Funding for community drug disposal programs.
    f. Funding and training for first responders to participate in pre-arrest diversion programs, post- overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.
8. Supporting Syringe Service Programs.
    a. Provide comprehensive syringe services programs (SSPs) with more wrap-around services including linkage to OUD treatment, access to sterile syringes, and linkage to care and treatment of infectious diseases.
    b. Naloxone or other FDA-approved drugs to reverse opioid overdoses.

CHAPTER 6
APPROVED USES

Qualified Counties, Non-Qualified Counties and Managing Entities may choose from among the strategies listed below for treatment and recovery support services to persons with OUD and co-occurring SUD/mental health conditions and their families. Qualified Counties, Non-Qualified Counties and Managing Entities shall prioritize evidence-based practices when selecting interventions and shall prioritize coordination and collaboration and emphasize evaluation and continuous improvement.

6-1. Treatment of Opioid Use Disorder.

Supporting treatment of OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Expand availability of treatment, including all forms of MAT approved by the U.S. FDA.
2. Support and reimburse evidence-based services that adhere to the ASAM continuum of care.
3. Expand telehealth to increase access to treatment, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.
4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence- informed practices such as adequate methadone dosing and low threshold approaches to treatment.
5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.
6. Treatment of trauma for individuals (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.
7. Support evidence-based withdrawal management services.
8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including tele mentoring to assist community-based providers in rural or underserved areas.
9. Support workforce development for addiction professionals.
10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH conditions, including but not limited to training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.
12. Provide funding and training for clinicians to prescribe MAT for OUD and provide technical assistance and professional support to clinicians.

13. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.
14. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

6-2. <u>Support people in treatment and recovery.</u>

Support individual pathways of treatment and recovery support, using evidenced-based practices to promote greater decision making within the service relationship, along with an emphasis on empowering individuals to self-manage their own recovery and identify their personal life and treatment goals while increasing their recovery capital. Evidence-based, informed programs or strategies may include, but are not limited to, the following:

1. Provide comprehensive wrap-around services, including housing, transportation, education, job placement, job training, or childcare.
2. Provide the full continuum of care of treatment and recovery including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.
3. Provide counseling, peer support, recovery-focused case management and residential treatment with access to medications for those who need it.
4. Provide access to housing, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA approved medication with other support services.
5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons.
6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services.
7. Provide or support transportation to treatment or recovery programs or services.
8. Provide employment training or educational services for persons in treatment or recovery.
9. Identify successful recovery programs from groups such as physicians, aviation pilots, and collegiate recovery programs and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.
10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.
11. Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals, including reducing stigma.
12. Support stigma reduction efforts regarding treatment and support, including reducing the stigma on effective treatment.
13. Create or support culturally appropriate services and programs for persons, including new Americans.
14. Create and/or support recovery high schools.
15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

6-3. <u>Connect people who need help to the help they need (connections to care).</u>

The main goal of person-centered care is to improve individual outcomes. Person-centered care helps find suitable ways to help individuals communicate their needs and improves their quality of care, promoting recovery and independence. Providing connections to person-centered support utilizing evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat or refer if necessary.
2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.
3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.
4. Purchase automated versions of SBIRT and support ongoing costs of the technology.
5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.
6. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.
7. Support hospital programs that transition persons into clinically appropriate follow-up care through a bridge clinic or similar approach.
8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments.
9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate schemes following an opioid overdose or other opioid- related adverse event.
10. Provide funding for recovery peer specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care.
11. Increase warm hand-offs to transition to treatment and recovery services. Incorporate the role of peer specialists in transition services to provide peer support to individuals prior to, during, and after clinical services to facilitate access to a continuum of care and array of community-based treatment and recovery supports.
12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.
13. Develop and support best practices on addressing OUD in the workplace.
14. Support assistance programs for health care providers with OUD.
15. Engage non-profits and the faith community as a system to support outreach for treatment.
16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

6-4. <u>Address the needs of criminal-justice-involved persons.</u>

Many individuals who come in contact with the criminal or juvenile justice system have a mental or substance use disorder. Upon release from incarceration, individuals with behavioral health

conditions face many barriers to successful re-entry into the community. They may lack health care, job skills, education, and stable housing—such gaps may jeopardize their recovery and increase their probability of relapse and rearrest. Addressing persons involved in, at risk of becoming involved in, or transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies, including established strategies such as:
    a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI).
    b. Active outreach strategies such as the Drug Abuse Response Team (DART) model.
    c. "Naloxone Plus" strategies work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services.
    d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model.
    e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network, or the Chicago Westside Narcotics Diversion to Treatment Initiative.
    f. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.
    g. Support pre-trial services that connect individuals to evidence-informed treatment, including MAT, and related services.
    h. Support treatment and recovery courts that provide evidence-based options.
    i. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals incarcerated in jail or prison.
    j. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals who are leaving jail or prison, have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.
    k. Support critical time interventions (CTIs), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.
    l. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

6-5. <u>Address the needs of pregnant or parenting women and their families, including babies with neonatal abstinence syndrome.</u>

Address the needs of pregnant or parenting women and the needs of their families, including babies with NAS, through evidence-based or evidence-informed programs or strategies that may include, but are not limited to the following:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women or women who could become pregnant and other measures to educate and provide support to families affected by NAS.
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women.
3. Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment.
4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; expand long-term treatment and services for medical monitoring of NAS babies and their families.
5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.
6. Child and family supports for parenting.
7. Enhanced family supports and childcare services for parents.
8. Provide enhanced support for children and family members suffering trauma because of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.
9. Offer home-based wrap-around including but not limited to parent skills training.
10. Support for Children's Services by funding additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

6-6. <u>Prevention.</u>

1. <u>Prevent misuse of opioids.</u> Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:
    a. Fund media campaigns to prevent opioid misuse.
    b. Corrective advertising or affirmative public education campaigns based on evidence.
    c. Public education relating to drug disposal.
    d. Drug take-back disposal or destruction programs.

    Fund community anti-drug coalitions that engage in drug prevention efforts.

    e. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by Substance Abuse Mental Health Services Administration.
    f. Engage non-profits and faith-based communities as systems to support prevention.
    g. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families,

school employees, school athletic programs, parent-teacher and student associations, and others.

h. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.
i. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.
j. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.
k. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or other drug misuse.

2. Prevent overdose deaths and other harms (harm reduction). Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence- based or evidence-informed programs or strategies that may include, but are not limited to, the following:
    a. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, individuals at high risk of overdose, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the public.
    b. provide free naloxone to anyone in the community.
    c. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the public.
    d. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.
    e. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.
    f. Public education relating to emergency responses to overdoses.
    g. Public education relating to immunity and Good Samaritan laws.
    h. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.
    i. SSP and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.
    j. Expand access to testing and treatment for infectious diseases such as Human Immunodeficiency Virus (HIV) and Hepatitis C resulting from intravenous opioid use.
    k. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to

persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

l. Provide training in harm reduction strategies to health care providers, students, peer recovery specialists, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

m. Support screening for fentanyl in routine clinical toxicology testing.

6-7. Other Approved Strategies.

1. First responders. In addition to items in sections 7-4, 7-5, and 7-10 relating to first responders, support the following:
    a. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.
    b. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

2. Leadership, strategic planning and coordination. Support efforts to provide leadership, planning, coordination, facilitation, training, and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:
    a. Statewide, regional, local, or community planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services; to support training and technical assistance; or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
    b. A dashboard to share reports, recommendations, or plans to spend opioid settlement funds; to show how opioid settlement funds have been spent; to report program or strategy outcomes; or to track, share, or visualize key opioid-related or health-related indicators and supports as identified through collaborative statewide, regional, local, or community processes.
    c. Monitoring, surveillance, and evaluation of opioid abatement programs and strategies.
    d. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.
    e. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.
    f. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.
    g. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.
    h. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.
    i. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and

any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

j. Provide resources to staff government oversight and management of opioid abatement programs.

6-8. Training.

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.
2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).
3. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.
4. Continuing Medical Education (CME) on appropriate prescribing of opioids.
5. Educate Dispensers on appropriate opioid dispensing.

6-9. Research.

Support opioid abatement research that may include, but is not limited to, the following:

1. Research non-opioid treatment of chronic pain.
2. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.
3. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.
4. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.
5. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g., Hawaii HOPE and Dakota 24/7).
6. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.
7. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.
8. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.