SHEVAUN L. HARRIS
Secretary

State Opioid Response III Grant Resource Guide

Florida Department of Children and Families
Office of Substance Abuse and Mental Health

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Section 1

Background, Purpose, and Goals

Background

The State Opioid Response (SOR) grants were initially administered by the United States 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. The Florida Department of Children and Families (Department) was awarded the first two-year SOR grant on September 30, 2018, referred to as SOR-1. On September 30, 2020, the second two-year SOR grant, referred to as SOR-2, was awarded with an end date of September 29, 2022. On August 24, 2022, a no-cost extension was awarded to the Department by SAMHSA, which allowed for an additional 12 months to expend unobligated funds with an end date of September 29, 2023, for SOR-2. The SOR-2 Grant Guidance on System Priorities, Permissible and Prohibited Uses will continue to be referenced for SOR-2 grant funds and use the Other Cost Accumulators (OCAs) assigned to the SOR-2 grant.

The Department 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 must follow the guidance in this document, the SOR-3 Grant Resource Guide, and use the OCAs assigned to the SOR-3 grant (outlined in Section 3, #15).

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

Purpose

The purpose of the SOR-3 grant funds are to 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 fatalities. If either stimulant or opioid misuse or disorders exist concurrently with other substance use (including alcohol and nicotine), mental health, or medical problems, all may be treated using the SOR-3 funds. This includes providing medication-assisted treatment (MAT) using Food and Drug Administration (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 requires 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.

Goals

It is estimated that 10,000 individuals with opioid or stimulant misuse or use 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 two.
- Objective 3c. Establish 44 additional Oxford Houses each year (at least 10 of which will be in rural areas).
- Objective 3d. Develop and distribute a tribal contact resource guide for network service providers during year one and host a tribal outreach and contact webinar during year two.

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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 use disorders, identified in EDs, with treatment and support services. For individuals with opioid misuse or use disorder, connect and engage community-based methadone or buprenorphine maintenance providers that can provide assessments and medication maintenance seven days a week for individuals identified or inducted in the EDs. Managing Entities (MEs), community-based providers, and EDs must work together to overcome obstacles in establishing or maintaining programs. The SOR-3 funds can be used to hire prescribers, peers, or establish telehealth programs, and can be used to pay for incidentals for transporting individuals from hospitals to community-based prescribers. MEs ensure MAT providers are working to actively communicate and engage with ED physicians to overcome any medication dosage barriers. Though each community is unique with provider collaborations and overall program process, hospital bridge programs are required to incorporate the following features: 1) An individual enters the ED having overdosed or experiencing medical needs due to opioid use or misuse. 2) The ED physician assesses if the individual is a candidate for MAT. 3) If MAT is an appropriate option, the ED physician initiates conversation to gage interest, offering to start the first induction before the individual is discharged. The physician explains the available FDA approved medications. 4) The individual is connected to a peer either onsite, via phone, or video conference, to help navigate the referral process to a local MAT provider and provide support through the initial induction at the hospital. The peer schedules an appointment with a local MAT provider, explains the transition process, provides general support during the entire process, and assists in a warm hand-off to a local MAT provider. 5) A naloxone kit is dispensed to the individual before discharge from the ED. The individual is to leave the hospital with a naloxone kit in hand regardless of the decision to participate in treatment. The Department expects hospital bridge programs to be established components of systems of care.

2. **Expand current and implement additional recovery support services to sustain the continuum of care for individuals with opioid and/or stimulant use disorders or misuse.** The SOR-3 funds for recovery support services are allocated to the MEs through OCAs MSSM6 and MSRC6. 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 an opioid use

disorder 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.

3. **Expand treatment services to support the continuum of care for individuals with opioid and/or stimulant use disorders or misuse.** The SOR-3 funds for treatment services are allocated to the MEs through OCA MSSM6. The SOR-3 funds shall provide services that address opioid and/or stimulant use 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 the SOR-3 grant funds. If either stimulant or opioid misuse or use disorders exist concurrently with other substance use (including alcohol and nicotine), all substance use issues may be treated. This means the SOR-3 funds can be used to pay for nicotine cessation services for eligible individuals and Vivitrol® for individuals with an alcohol use disorder. Likewise, the SOR-3 funds can be used to pay for comprehensive, integrated care that addresses co-occurring mental illnesses and medical problems. SAMHSA has developed a Buprenorphine Quick Start Guide to provide support to providers, and a condensed version, Pocket Guide. The Department is developing a pilot program for contingency management implementation. More information will be available at a later date.

4. **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 must be systematically monitored and improved as a priority. SAMHSA's experts state within the Treatment Improvement Protocol 63 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 discouraged from establishing arbitrary counseling requirements that can constitute a barrier to admission and retention in medication-based treatment services. The MAT 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 potentially life-saving medications because individuals are not ready to engage in therapy, counseling, or Alcoholics Anonymous and Narcotics Anonymous groups.

   An additional 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 opioid use disorder should be provided the same care as any individual 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.

5. **Increase peer capacity.** Recovery Peer Specialists provide recovery-support services, promote continued engagement in treatment and inclusion in local communities, and normalize recovery language. The ME identifies opportunities within networks 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 experienced challenges in hiring peers, then MEs are to get more involved by providing or connecting providers to support on hiring and supervising peers. MEs can develop peer-run organizations within networks, which ideally are on-call and available to engage individuals experiencing an overdose in EDs seven days a week. ED officials look to the MEs and networks to have peers involved in hospital bridge programs. The Department requires MEs to actively work toward increasing peer capacity in collaboration with emerging or established peer run organizations or Recovery Community Organizations (RCOs) in applicable regions. The Department contracts with Faces and Voices of Recovery to provide training and technical assistance to existing and emerging RCOs as well as to support communities with recovery community readiness. The Department expects MEs and RCOs to use the training and technical assistance support provided by Faces and Voices of Recovery.

6. **Increase access to naloxone.** Ensure that providers in networks 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 no cost take-home naloxone kits to individuals at risk of experiencing an opioid overdose or to loved ones that may witness an overdose. The education and kits must be provided during orientation and to anyone on a waiting list to receive services. MEs should engage EDs, homeless service organizations, harm reduction programs, recovery support organizations, fire/emergency medical service departments (for naloxone leave-behind programs), and other community-based organizations that provide direct services to individuals with substance use disorder to enroll in the program and distribute naloxone to at-risk individuals. Providers do not have to contract with MEs or the Department to enroll in the program and distribute free naloxone.

7. **Partner with local syringe exchange programs.** The Florida Legislature passed Senate Bill 366 during the 2019 session, effective July 1, 2019, that allows county commissions to authorize syringe exchange programs (SEPs) through local ordinances. Entities eligible to operate a SEP include hospitals licensed under Chapter 365, Florida Statutes (F.S.), health care clinics licensed under Part X of Chapter 400, F.S., accredited medical schools, licensed addictions receiving facilities as defined in section 397.311(26)(a)1, F.S., and 501(c)(3) HIV/AIDS service organizations. MEs and network providers are to collaborate with local SEPs, or support as they become established, to ensure that SEP participants seeking substance use treatment services are immediately linked to services, and that MAT maintenance is available to participants with opioid use disorders who are seeking treatment. MEs are to encourage SEPs to enroll in the Department's Overdose Prevention Program.

8. **Improve the quality of policies and practices through recovery oriented monitoring.** 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 (ROQISs), on SOR-3 funded sites, to ensure individuals needs are being met which includes facility reviews, employee interviews, individuals served interviews, and medical record reviews. With ongoing technical assistance and collaboration, the goal is for providers to operate at scores of four and above across all recovery domains which involve the following: Meeting Basic Needs, Comprehensive Services, MAT, Strengths Based Approach, Customization and Choice, Opportunity to Engage in Self -Determination, Network Supports/Community Integration, and Recovery Focus.

9. **Increase housing and housing supports.** The SOR-3 funds are to be prioritized to support the Housing Initiative in areas identified as having the greatest need for individuals with an opioid or stimulant use disorder or co-occurring mental health disorders. Housing and housing support services can be provided through the following two allowable services under the additional funding from the SOR grant.

    - **Incidentals** - Temporary expenses incurred to facilitate continuing treatment and community stabilization. Allowable purchases include housing assistance and housing subsidies (such as rent).
    - **Supportive Housing** - An evidence-based approach to assist individuals in the selection of the housing of their choice. These services provide the necessary supports to transition into independent community living and assure continued successful living in the community.

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Section 3

Permissible Uses of State Opioid Response Grant Funds

1. **Eligibility**. The 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 the Department's data system, the Financial and Services Accountability Management System (FASAMS), either via diagnosis or substances of choice. All new and previously discharged individuals 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 and injectable buprenorphine products. It should be the individual's choice on which medication and delivery method is used.

   SOR-3 funds cannot be used to purchase oral naltrexone to be used as a maintenance medication as it is not FDA approved to treat opioid use disorder. However, SOR-3 funds may be used to purchase oral naltrexone for the specific instances outlined below:

   - For individuals 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 individuals wanting to start Vivitrol® treatment until the first injection is made available.

- To conduct a naltrexone challenge to ensure individuals are opioid-free prior to receiving a Vivitrol® injection to avoid precipitated withdrawal.
- To ensure individuals 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. The SOR-3 funds can be used for the list of covered services below to support individuals receiving Vivitrol®, except for Assessment, Medical Services and MAT. Vivitrol® providers that are not contracted network service providers under a ME, and only provide Vivitrol® services, will refer individuals with stimulant use disorders to the local ME to provide treatment and recovery support services. Services using OCA code SORF6 must be entered into the Web Infrastructure for Treatment Services (WITS)**.** In addition to the Vivitrol® project managed by FADAA, SOR-3 funds allocated through the ME can be used to fund Vivitrol®. Any FDA approved medication listed above in Section 3 can be provided using OCA code MSSM6.

5. **Deductibles and co-pays.** The SOR-3 funds are intended to reduce or eliminate treatment costs which may serve as barriers 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, large deductibles, or co-pays. The Department continues to expect MEs to ensure that 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 are used for individuals with no other means. MEs do have the flexibility to use SOR-3 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) are permissible to have the following services paid for using SOR-3 grant funds (<u>underlined</u> services require additional data collection outlined in #14):
   - <u>Aftercare.</u>
   - Assessment.
   - <u>Care Coordination</u>.
   - <u>Case Management.</u>
   - Crisis Support/Emergency.
   - Day Care.
   - <u>Day Treatment.</u>

- Drop In/Self-Help Centers.
- Incidental Expenses.
- Outreach.
- HIV Testing and Referral to Treatment (HIV Early Intervention 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 Levels I Through IV - Individuals with opioid use disorders may only be served in Residential Levels I and II if 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." The individual education and the individual declining medications must be documented in the medical record. All individuals in residential treatment must be reevaluated every 30 days for Residential Levels I through III and every 90 days for Residential Level IV, per Rule 65D-30, to ensure they still meet level of care criteria.
- Inpatient Detoxification and Outpatient Detoxification - Per the grant Notice of Funding Opportunity, 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 opioid use disorder. 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 if they return to use.

Additional details on covered services can be found in Section 6.

7. **Recovery Support Services.** The SOR-3 funds should be used to provide recovery support services 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 opioid use disorder 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 MEs must ensure that recovery housing supported under this grant is through houses that are certified by the Florida Association of Recovery Residences and do not exclude individuals who are receiving MAT, unless the house is operated by an entity under contract with a ME or by Oxford House, Inc. See Appendix A for current Oxford House locations.

Recovery support services are available using the approved covered services as detailed in Section 6.

8. **Bridge Programs.** Data collection is required for both hospital and jail bridge programs within FASAMS using MSSM6, the general OCA for treatment and recovery support services. MEs must submit a Bridge Program report as outlined in the SOR-3 Guidance Document due on the 18th of each month**.** Information regarding dispensing naloxone kits while in the hospital setting can be found in section 465.019, F.S. See Appendix B for additional details.

    Hospital Bridge

    Each community will have unique needs to consider when developing hospital bridge program policies and procedures. However, there are consistent factors to be in place across all hospital bridge programs.

    Communication between hospital EDs, MEs, and MAT providers must be consistent and are crucial when having discussions regarding medication doses and continued MAT maintenance.

    Team Roles

- Emergency Room Physician - Screens/assesses individuals for opioid use disorder, connects individuals to peers, induction of medication, dispenses naloxone.
- Peer - Provides education regarding MAT appointment process, supports individuals through the referral process, schedules an appointment with a local MAT provider.
- MAT Provider - Provides accessible appointments, continues medication maintenance and other necessary treatments and recovery support services.
- ME - Provides access to funds supporting treatment services including MAT and recovery supports and ensures rapid linkage to ongoing community-based MAT services. See Appendix C for a list of current hospital bridge program locations.

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 MAT.
3. If MAT is an appropriate option, the ED physician initiates 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 a local MAT provider. The peer schedules an appointment with a local MAT provider, explains the transition process, provides general support during the entire process, and assists in a warm hand-off to a local MAT provider. If the individual declines MAT, the peer provides community resources and support until discharge.
5. A naloxone kit is dispensed prior to discharge from the hospital for all individuals entering an ED for opioid misuse, regardless of whether or not they agree to MAT.

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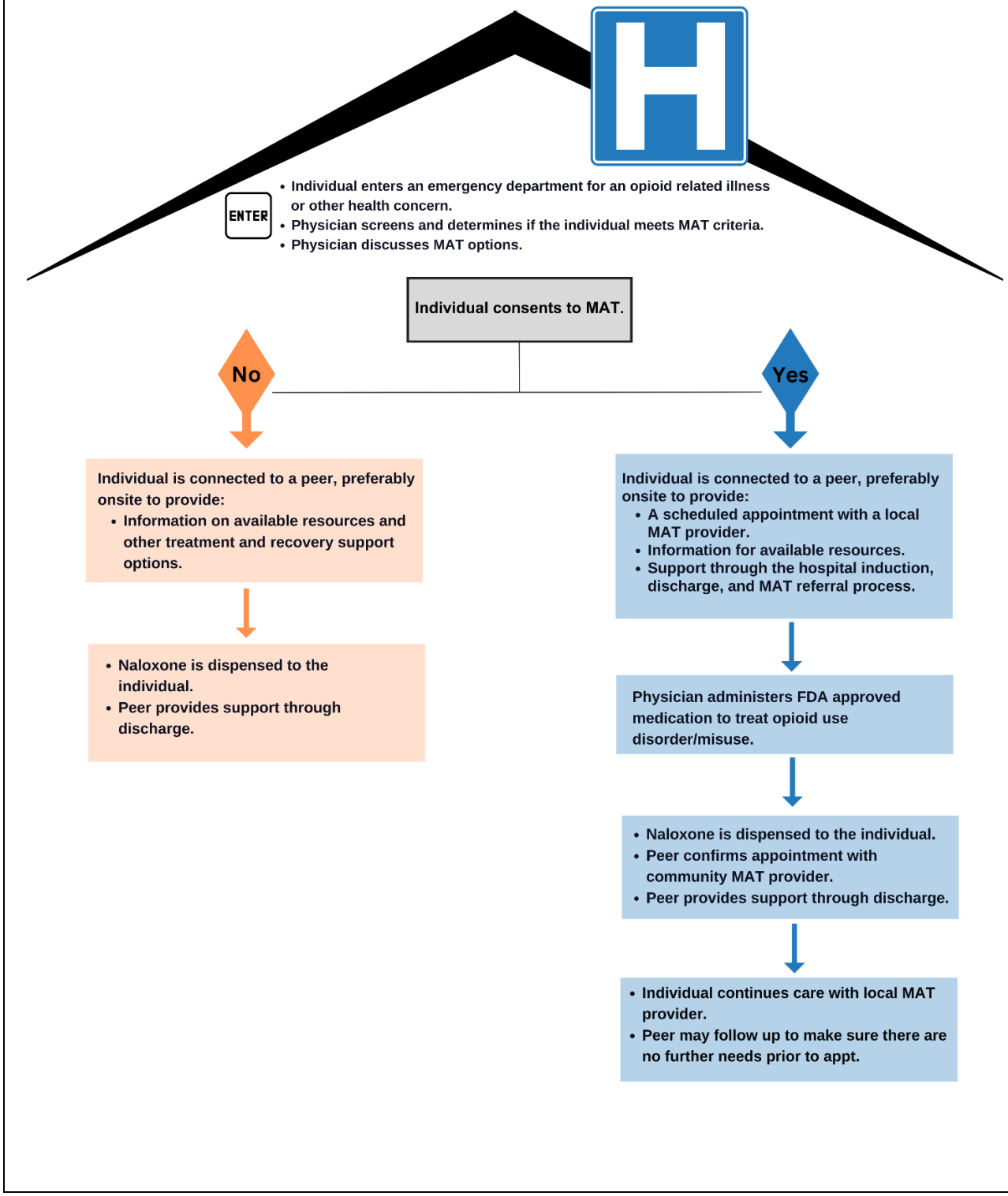
Image 3.1 illustrates an example of a hospital bridge program workflow.

Image 3.1 Hospital Bridge Program Workflow



Jail Bridge

The purpose of a 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 a jail bridge program or (2) are currently receiving MAT treatment in the community and would like to continue that treatment through a 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 partnership with community MAT providers either in the jail setting or offsite at the provider location.

SAMHSA promotes the use of SOR-3 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 MSSM6, the general OCA for treatment and recovery support services.

Each jail will have unique needs to consider when developing a jail bridge program policies and procedures. However, there are consistent factors to be in place across all jail bridge programs.

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

<u>Team Members</u>

Team roles at jails/corrections facilities may vary depending on how the program is structured and policies or protocols in place, however team members can be identified.

- Jail/Correctional Facility
- Peers
- MAT Providers
- MEs

The process of how a jail bridge program flows will greatly be based on jail/correctional facility protocols. However, key features must be consistent in order to be considered a jail bridge program.

1. Individual entering the jail is screened 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 schedules an appointment with the local MAT provider to continue maintenance of MAT.

Medication-Assisted Treatment for Pregnant Women

Per Chapter 65D-30.0142, Florida Administrative Code, providers are required to 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 are to receive treatment using methadone or buprenorphine rather than withdrawal management or psychosocial treatment alone.
- Care for pregnant women with opioid use disorder are to 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, Florida Administrative Code, for state standards and requirements.

9. **Prevention.** The primary prevention services funded under SOR-3 must have evidence of effectiveness at preventing opioid misuse, stimulant misuse, or other illicit drug use. Regarding standards for evidence, the Department looks 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 following are a list of approved, evidence-based programs that providers can choose from:

· Botvin LifeSkills
· Guiding Good Choices
· Positive Action
· Teen Intervene
· Caring School Community
· Project SUCCESS
· Strengthening Families Program
· SPORT Prevention Plus Wellness
· Project Towards No Drug Abuse
· InShape Prevention Plus Wellness
· PAX Good Behavior Game

The SOR-3 funds can be used for media campaigns targeting prescription opioid or stimulant misuse with messages about safe use, safe storage, and safe disposal. Messaging may be 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 FDA approved opioid antagonist medications used to reverse an overdose; the message may address the risks associated with pressed, counterfeit pills that could be adulterated with synthetic opioids like fentanyl.

MEs must request to implement evidence-based programs not on the provided list 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 18th of the month.

10. **Telehealth.** The SOR-3 funds should be used to support innovative telehealth strategies for rural and underserved areas.

11. **Behavioral Health Consultants.** The Behavioral Health Consultants (BHCs) are licensed clinicians or certified substance use professionals that support child welfare professionals. Using clinical expertise, BHCs 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-3 funded BHC positions stationed throughout the state and two SOR-3 funded BHCs contracted through Thriving Mind South Florida. 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 RCOs using OCA MSRC6. 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 the Department for RCO development.

RCOs organize recovery-focused advocacy activities, carry out recovery-focused community education, outreach, and peer-based recovery support services. RCOs 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. MEs 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 progress. See Appendix D for a list of current RCO serving locations.

- Recovery Capital**:** RCOs will implement use of the Recovery Capital Scale as a foundation to inform the individualized recovery planning process by developing goals among applicable domains. 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 with 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: The Brief Assessment of Recovery Capital (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: The Recovery Data Platform (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 SOR funded RDP licenses must enter data into RDP by the 18th of each month.

13. **Recovery Oriented Quality Improvement Specialist.** The ROQISs serve as key individuals in recovery-oriented systems of care related activities that include, but are not limited to, ongoing quality assurance and improvement activities; training and technical assistance; 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, ROQISs provide technical assistance and consultation to promote the expansion of SOR-3 funded MAT, care coordination services, and the effective engagement of individuals into services and supports. ROQIS's reports and work plans must be submitted by the 15th of each month. See Appendix E for ROQIS guidance.

14. **Data Collection.** FASAMS Data**:** Providers must enter all individuals served data into the FASAMS to capture services and activities rendered for all individuals receiving services funded by SOR-3 funds. Specifically, providers must input the following data:
    - All individuals served must either have an opioid and/or stimulant use disorder in FASAMS or have an opioid or stimulant as 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.

    Government Performance and Results Modernization Act of 2010 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 data collection points (baseline, six-months post-intake, and discharge) using the Center for Substance Abuse Treatment's GPRA. The target completion rate is 100 percent; meaning programs must attempt to follow-up with all individuals. However, SAMHSA expects the state to achieve a minimum six-months post-intake follow-up rate of 80 percent completion. Guidance for data collection is provided below.

    Data Entry: Providers must enter complete GPRA data into the WITS system for all individuals receiving SOR-3 funds for treatment services or recovery supports. The WITS system uploads GPRA data into SAMHSA's database, SAMHSA's Performance Accountability and Reporting System, to maintain timely reporting and accurate data to SAMHSA. This data is reported quarterly. Specifically, providers must input the following data:
    - All individuals 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 do not know means the individual does not qualify for SOR-3 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 MSSM6 and must also be entered into WITS.
    - A $30 non-cash incentive may be provided to all SOR-3 funded individuals completing the six-month follow-up GPRA interview. All individuals who receive

a GPRA incentive must be entered into FASAMS under OCA MSSM6 or OCA MSRC6 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.

- GPRAs 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 or by phone, if all efforts to meet in-person have been exhausted.
- All individuals who receive SOR-3 funded covered services underlined in the service array section, must have completed the GPRA for each of the three collection points.
    - Six-months post-intake data should be collected on all individuals served, regardless of whether an individual drops out of the program prior to the six-month mark. When a program cannot follow-up with an individual, the program must use the GPRA tool to report that the individual was not located. The six-month follow-up starts at the fifth-month mark and ends at the eight-month mark. This window allows three-months for the six-month follow-up GPRA to be completed. The Department recommends completing the six-month follow-up as early as possible.
    - A discharge GPRA must be completed each time an individual is discharged/transferred from SOR funding.
- Individuals 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 (first four items), 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 transition into SOR-3). Afterwards, the same GPRA requirements must be completed for each of the three collection points.
- If an individual is discharged from a treatment episode and the individual then returns to re-enroll in a new SOR-3 funded treatment episode, a new data collection timeline must be started.

  Example: An individual is discharged, left on own against staff advice with satisfactory progress, at four-months post intake with a baseline having been completed. Individual re-enrolls two-months later. A new baseline MUST be completed and continued on a new data collection timeline (for six-months post-intake, and discharge). With the previous GPRA timeline discontinued.

- If an individual receiving SOR-3 funded services 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-3 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-3 funding between zero- to six-months post-intake they must continue the timeline and at six-months post-baseline complete the six-months post-baseline GPRA.
- If an individual is transferred to another funding source between zero- to six-months post-intake and is transferred back to SOR-3 funding after six-months post-intake they must start a new timeline with a baseline tool.

Example: An individual completes baseline, transferred to other funding source at two-months post intake, completes discharge, transferred back at seven-months post intake, individual must complete new baseline and start new timeline.

GPRA Administration Windows

Intake/Baseline:

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

Six-Month Follow-Up (post-intake):

- The time period allowed for GPRA follow-up interviews is one-month before or two-months after the six-month anniversary date. For example, if an individual completes the GPRA intake on the first of January, the six-month follow-up is due on the first of July. The window to complete the follow-up opens on the first of June and closes on the first of September.

Discharge:

- Discharge interviews must be completed on the day of discharge, regardless of length of stay in the program (i.e., one-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).

<u>Data Technical Assistance</u>

If a WITS user requires assistance in WITS, technical assistance will be provided on a tiered level: Tier 1: Provider Organizations. Tier 2: ME. Tier 3: Department Headquarters. Tier 4: FEI Support Staff.

- **Tier 1: Provider Organizations**
  Each provider organization will identify a limited 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 organization to Tier 2 support via email or phone.
  - Communicating changes to WITS/ASAM CONTINUUM to users of the system within the organization.

- **Tier 2: ME**
  Each ME will provide Tier 2 support for 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 the Department's Tier 3 Help Desk.
- Communicating changes to WITS/ASAM CONTINUUM to users of the system within the ME and provider organizations.

- **Tier 3: Department Headquarters**
  The Department will identify WITS administrators that will provide the following Tier 3 support. Tier 3 support includes:
  - Accepting help desk emails/calls from the ME Tier 2 help desk support staff.
  - Creation of user accounts as requested by ME Tier 2 help desk support staff.
  - Enabling and resetting user credentials as requested by ME Tier 2 help desk support staff.
  - Managing the access roles of each user as requested by ME Tier 2 help desk support staff.
  - Providing technical assistance for functionality questions/issues.
  - Reporting functionality issues that cannot be resolved by the Tier 3 help desk team to FEI's Tier 4 Help Desk.
  - Communicating changes to WITS/ASAM CONTINUUM to users of the system within the Department, MEs, and provider organizations.
  - Submit requests to create new provider accounts to FEI.
  - Update existing provider records as requested by the ME.
  - Manage code tables.
  - Manage announcements and alerts.
  - Monitor GPRA batch uploads and errors.
  - Assignment of agency oversight to ME Tier 2 Help Desk support staff (note – this feature allows the MEs to switch their agency context in WITS so that they can view information within each of the sub-contracted provider agencies).
  - Manage 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, the Department will communicate with FEI for additional support if necessary. See Appendix F 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.** Correct documentation and reporting of services and associated costs is critical for timely and accurate reporting to federal funders, leadership, and other stakeholders. Table 3.2 provides an overview of SOR-3 OCAs

which must be used for allowable costs for each respective service. Please refer to DCF Chart 8 System for details.

Table 3.2 SOR-3 Grant OCAs		
OCA	**Short Description**	**Purpose**
SORF6	Vivitrol®/ FADAA	Allowable cost of funds provided to the FADAA for naltrexone extended-release injectable medication (Vivitrol®) and associated services, such as assessment and medical services.
MSRC6	RCOs/MEs	Allowable costs of implementing 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 youth 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 MAT; 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 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 Department contracts or to provide indirect services to build capacity. *The OCA MSRC6 has three permissible project codes.*
MSSP6	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.

MSSM6	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, MAT for opioid use disorders or evidence-based programs (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.
ME Administrative OCAs		
MSSA6	Admin/MEs	Allowable administrative and general program costs incurred by the MEs.

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.

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Section 4

Prohibited Uses and Funding Restrictions of State Opioid Response Grant Funds

1. **Denial of care.** Funds may not be used by any provider that denies any eligible individual access to the program because of the 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 individuals served.** Funds **may not** be used to make direct payments to individuals to induce them to enter prevention, treatment, or recovery support 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 opioid use disorder. 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 $212,100. 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 the organization. The salary limitation also applies to subrecipients under a SAMHSA grant or cooperative agreement.

6. **Treatment using medical marijuana.** SOR-3 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 the Department of Health and Human Services to ensure that Federal funding is expended in full accordance with United States 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, and drinks cannot be purchased with SOR-3 funds.

8. **Other funding sources.** The SOR-3 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.** The SOR-3 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, the Department of Health and Human Services Policy on the Use of Appropriated Funds for Promotional Items.

12. **Commingling of grant funds.** Per SAMHSA's Award Standard Terms and Conditions, SAMHSA funds must retain 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.].

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Section 5

The purpose of this section is to provide additional information and guidance if necessary, regarding non-cash incentives for GPRA engagement. The guidance provided in this section does not replace the current policies or procedures of MEs or network service providers used for incentive purchasing and documentation or GPRA engagement.

State Opioid Response Non-Cash Incentives

All SOR-3 funded treatment and recovery support service providers are required to collect and report data so that SAMHSA can meet its obligations under the GPRA. Recipients are expected to complete a GPRA intake interview on all individuals utilizing SOR-3 funds for treatment and recovery support services and are also expected to achieve a six-month follow-up rate of 80 percent. Providers may provide up to a $30 non-cash incentive to individuals who participate in data collection for the six-month follow-up interval.

What type of non-cash incentives can be purchased?

Providers may purchase a non-cash incentive (e.g., Visa, Mastercard®, merchant gift card) up to the amount of $30. For consistency and ease, providers are encouraged to purchase the same brand of incentive every time (e.g., only Visa gift cards). Keep in mind that merchant-specific gift cards can only be redeemed at a particular merchant/store (e.g., a specific gas station, restaurant, or retailer) and may limit use. While being consistent, providers can also provide options to allow individuals to select based on the need if purchasing merchant-specific cards (e.g., gas or groceries).

Where can non-cash incentives be purchased?

Non-cash incentives can be purchased online or from a local retailer (e.g., Kroger or Walmart).

What if there is a purchase or activation fee?

Visa or Mastercard® gift cards require a purchase or activation fee, which can cost anywhere from $3 to $5 depending on where they are purchased. The SOR funds can pay for this fee, however the total cannot exceed $30 to reimburse for the cost of both the gift card and activation fee (Example: If there is a $5 activation fee, the value of the card would not exceed $25, bringing the total to $30).

How many non-cash incentives can be purchased at a time?

Providers are not encouraged to purchase gift cards or other non-cash incentives in bulk

due to being susceptible to theft, fraud, or misappropriation and lack the audit trail that exists with a check or other forms of payment. Given this, it is best practice to purchase non-cash incentives in smaller quantities on a regular basis, depending on the frequency with which your program completes GPRA interviews. For example, if your agency completes 50, GPRA interviews within six-months, provider could purchase 10 gift cards every month or 20 gift cards on a bi-monthly basis to ensure an adequate supply on hand. Providers should establish internal policies and procedures related to monitoring and maintaining inventory and secure storage.

Non-Cash Incentive Distribution and Tracking

How should non-cash incentive distribution be tracked?

Upon purchase of the non-cash incentives, providers should log the following information in a spreadsheet:

- 16-digit card number on the front of the card.
- Card expiration date.
- Pin number (on the back).
- Purchase date.
- The phone number for card services or customer service (in the event of lost or stolen cards).

Before issuing a non-cash incentive, providers should enter the following information about the individual to be able to track which incentive received and how it was issued:

- Recipient information (e.g., Last Name, First Name).
- *Optional* phone contact information.
- Current Mailing Address (Street, City, State, Zip Code).
- GPRA interview completion status and date the interview was completed.
- Date the incentive was issued to the individual, who issued it, and how the incentive was issued (in-person or mailed).

Example:

Name	Phone/Mailing Address	GPRA Date	Date Issued	Delivery Method	Staff	Description	Card number	Card ex. Date	Card Pin	Purchase date	Card services#
Rachel Green	555-555-7777	5/3/233	5/3/2023	In-person	Monica Bing	Publix card $30	7777-8888-9999-8888	12/2024	4545	4/8/2023	800-777-8888
Elaine Benis	41 Main St Orlando, FL 32554	5/5/23	5/5/2023	Mailed	Joe Swanson	Walmart card $30	4444-8888-9999-3333	12/2026	5555	4/12/2023	800-777-6666

Is it required for individuals to sign a receipt?

Individuals who complete any GPRA interview are eligible for the non-cash incentive, and it is recommended there is a signed receipt confirming the incentive was provided.

Providers should retain a copy of the receipt for records and offer a copy to the recipient.

Individuals who complete the six-month follow-up virtually or by telephone and who will be issued a non-cash incentive via United States Mail should also sign a receipt for auditing purposes.

What if the six-month follow-up is completed virtually or by telephone?

Providers are allowed to mail the non-cash incentive directly to individuals. The incentive should be sent along with an explanation of the reason the individual is receiving the incentive. Alternatively, programs may establish a process by which the individual is instructed to contact program staff upon receipt of the gift card, request that the individual return a signed receipt form, usage of a QR form, or other internet links for verification. Return of any hard copy information will require that the individual be sent an organization addressed, stamped envelope along with the gift card and receipt form. Providers need to have a policy in place if they use SOR-3 funding for incentives. Providers can either revise existing policies or develop new policies and procedures to verify receipt of incentives.

Missing/Lost/Stolen Gift Cards

What if the individual claims that they never received the gift card (via mail carrier)?

Providers should check internal tracking spreadsheet to confirm the date the card was mailed and verify that the incentive was sent to the correct address.

For Visa, Mastercard®, or other gift cards:

- If the card was **not** sent to the correct address, contact Visa or Mastercard® with the 16-digit card number, PIN number, and expiration date and request to cancel the card.
- If sent to the correct address but less than two weeks ago, ask the individual reach out again if the card has not been received after the two-week post-mailing window.
- If sent to the correct address but past the two-week mark, check the balance of the gift card online or by phone using the full card number, PIN number, and expiration date. Providers may inform individuals of the balance (if spent down) and let them respond. If the individual insists that they did not receive the card, providers should request Visa or Mastercard® to cancel the card.

What if an individual claims that the gift card was lost or stolen?

If the individual acknowledges that they received the gift card but claims that it was lost or stolen, providers should check the balance on the gift card online or by phone using the full card number, PIN number, and expiration date. Providers may inform the individual of the balance (if spent down) and let them respond. If the individual insists that the card was lost or stolen, providers should request to cancel the card (if Visa or Mastercard®).

Is it possible to issue a replacement incentive if it is never received, lost, or stolen?

Providers can choose to offer the *option* of issuing a maximum one-time replacement incentive to an individual. Providers should develop policies about whether to issue replacement incentives, under what circumstances, what conditions must be satisfied for a replacement incentive to be issued, and procedures for how the replacement incentive will be issued. For example, providers may opt to send the gift card via certified mail with a return receipt requested for added security, allow the individual to pick up the card, or have staff deliver the card to the individual, if feasible. If the replacement incentive is lost, stolen, or never received, the individual should not be issued multiple replacements.

Invoicing For Incentives

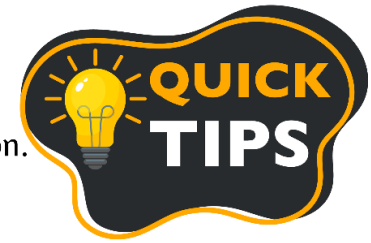
In order for the grant to pay for incentives, providers must use the OCA MSSM6 or MSRC6 (FADAA-SORF6) and covered service number 28 for incidentals using the procedure code IER00. This process allows SOR personnel to track the expense, ensuring not to exceed the five percent cap allowable for data collection. Each individual receiving treatment or recovery support services funded through SOR-3, is eligible to receive the incentive for the six-month follow-up GPRA.

GPRA Provider Guide

Provider Information

SAMHSA awarded the SOR grant to provide treatment and recovery support services to individuals with opioid and stimulant misuse or use disorders. A requirement of the SOR grant is to administer the GPRA Survey to individuals receiving grant-funded treatment. The GPRA, which stands for Government Performance and Results Act, is a data collection tool designed to capture the effectiveness of federally funded programs. Below is a sample of how to explain the data collection process to individuals you are serving.

"Your treatment or recovery support services are funded by the State Opioid Response (SOR) Grant, on behalf of the State of Florida. One requirement of this grant is to survey individuals receiving treatment at certain points in their recovery journey. Your participation in these surveys helps Florida collect the data needed to ensure continued funding for treatment. The information that you share during your survey will be kept confidential and will help to improve future services. The surveys are conducted at three intervals. The baseline or initial survey takes place at intake. There is a follow-up conducted at six-months and a survey that takes place at discharge. By participating in the follow-up survey, you will receive a $30 gift card. The interview takes about 30 minutes and can be done in person or virtually but should be done face to face."



- Use language to encourage participation.
- Highlight the importance of their feedback.
- Provide a visual handout with GPRA information.
- Explain the process.

GPRA Timeline

Table 5.1 illustrates the required sections of the GPRA per the timeline. The table also reflects sections to complete if the survey is conducted in-person, virtually, or by telephone.

Table 5.1 GPRA Sections per Timeline

Section	Intake	Follow-Up		Discharge	
	Interview Conducted	Interview Conducted	Interview Not Conducted	Interview Conducted	Interview Not Conducted
A. Record Management	Y	Y	Y	Y	Y
A. Record Management – Demographics	Y				
B. Substance Use	Y	Y		Y	
B. Planned Services	Y				
C. Living Conditions	Y	Y		Y	
D. Education, Employment, Income	Y	Y		Y	
E. Legal	Y	Y		Y	
F. Mental and Physical Health Problems and Treatment/Recovery	Y	Y		Y	
G. Social Connectedness	Y	Y		Y	
~~H. Program Specific Questions~~					
I. Follow-Up Status		Y	Y		
J. Discharge Status				Y	Y
K. Services Received w/Grant Funds				Y	Y

Section H is not a SOR grant requirement.

The information below may be used to further explain the GPRA to individuals when providing details.

What is the GPRA Client Outcome Measures Tool? SAMHSA administers the SOR grant which has been awarded to Florida since 2018. SAMHSA requires SOR grantees to

administer the GPRA Client Outcome Measures Tool (GPRA Survey) to fulfill the reporting requirement. The GPRA Client Outcome Measures Tool was developed for program management to essentially ensure that programs are effective and working to help individuals as intended.

Why do I have to complete this survey? Participation is very valuable and the only way to gain first-hand knowledge on the effectiveness of treatment and recovery support services. The feedback collected can help to identify services gaps or additional needs in the state as well as the country as SAMHSA reviews reporting at the national level.

When do I complete this survey? The survey is conducted at three different times to gather information at intake through when individuals are discharged from services.

- Baseline: A baseline.
- Survey is done when an individual begins working with a provider.
- Six-month follow-up: A six-month follow-up can take place within a 90-day window, a month before the six-month mark and up to a month after.
- Discharge: A final survey is completed at discharge.

How long will the survey take? The GPRA Survey is conducted by providers and can take between 25 and 35 minutes to complete.

Is there an incentive to complete this survey? For completing the six-month follow-up GPRA Survey, individuals receive a $30 gift card.

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Section 6

Covered Services

Funds allocated through the SOR-3 grant are done so through OCAs with approved covered services. See Table 6.1 for covered services available for OCA MSSM6 and MSRC6.

Table 6.1 OCA Covered Services

MSSM6	
01	Assessment
02	Case Management
04	Crisis Support/Emergency
05	Day Care
06	Day Treatment
08	In-Home and On-Site
10	Intensive Case Management
11	Intervention
12	Medical Services
13	Medication Assisted Treatment
14	Outpatient
15	Outreach
18	Residential Level I
19	Residential Level II
20	Residential Level III
21	Residential Level IV
22	Respite Services
24	Substance Abuse Inpatient Detoxification
25	Supportive Employment
26	Supported Housing/Living
28	Incidental Expenses
29	Aftercare
30	Information and Referral
32	Substance Abuse Outpatient Detoxification
35	Outpatient -Group
36	Room and Board with Supervision Level I
37	Room and Board with Supervision Level II
38	Room and Board with Supervision Level III
42	Intervention - Group
43	Aftercare - Group
46	Recovery Support
47	Recovery Support -Group
53	HIV Early Intervention
52	Care Coordination
54	Room and Board with Supervision Level IV

MSRC6	
07	Drop-in/Self-Help Center
12	Medical Services*
13	Medication-Assisted Treatment*
15	Outreach
28	Incidental Expenses
30	Information and Referral
46	Recovery Support
47	Recovery Support -Group

**See section 3 details on eligibility requirements.*

Table 6.2 provides a description of each covered service as stated in 65D-30.021, Florida Administrative Code.

Table 6.2 Covered Service Description

Number	Title	Description
01	Assessment	Includes the systematic collection and integrated review of individual-specific data, such as examinations and evaluations. This data is gathered, analyzed, monitored, and documented to develop individualized plans of care and to monitor recovery. Assessment specifically includes efforts to identify the individual's key medical and psychological needs, competency to consent to treatment, history of mental illness or substance use, and indicators of co-occurring conditions, as well as clinically significant neurological deficits, traumatic brain injury, organicity, physical disability, developmental disability, need for assistive devices, physical or sexual abuse, and trauma.
02	Case Management	Case management services consist of activities that identify the individual's needs, plan services, link the service system with the individual, coordinate the various system components, monitor service delivery, and evaluate the effect of the services received. This covered service shall include clinical supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of the service.
04	Crisis Support/ Emergency	This non-residential care is generally available twenty-four hours per day, seven days per week, or some other specific time period, to intervene in a crisis or provide emergency care. Examples include crisis/emergency screening, mobile response, telephone or telehealth crisis support, and emergency walk-in.
05	Day Care	Day care services, in a non-residential group setting, provide for the care of children of individuals who are participating in mental health or substance use treatment services. In a residential setting, day care services provide for the residential and care-related costs of a youth living with a parent receiving residential services. This covered service must be provided in conjunction with another covered service provided to an individual 18 years of age or older.
06	Day Treatment	Day treatment services provide a structured schedule of non-residential interventions to assist individuals to attain skills and behaviors needed to function successfully in living, learning, work, and social environments. Activities emphasize rehabilitation, treatment, activities of daily living, and education services, using multidisciplinary teams to provide integrated programs of academic, therapeutic, and family services. For mental health programs, day treatment services must be provided for four or more consecutive hours per day. Substance abuse programs must follow the standards set forth in rules 65D-30.0081 and 65D-30.009, Florida Administrative Code.
07	Drop-In Center	Community centers, such as drop-in centers or recovery community organizations, provide a range of opportunities for individuals with a history of mental health and/or substance use disorders to independently develop, operate, and participate in social, recreational, self-help, harm reduction, and networking activities. **This covered service may not be provided to an individual less than 18 years of age.**

08	In-Home and On-Site	Therapeutic services and supports, including early childhood mental health consultation, are rendered for individuals and families in non-provider settings such as nursing homes, assisted living facilities, residences, schools, detention centers, commitment settings, foster homes, day care centers, and other community settings.
10	Intensive Case Management	Services are generally offered to individuals who are being discharged from an acute care setting, and need more professional care, and have contingency needs to remain in a less restrictive setting. The services include the same components as case management as described in subparagraph (4)(d)1, of this rule, but are provided at a higher intensity and frequency, and with lower caseloads per case manager sufficient to meet the needs of the individuals in treatment.
11	Intervention	Intervention services focus on reducing risk factors generally associated with the progression of substance use and mental health disorders. Intervention is accomplished through early identification of individuals at risk, performing basic individual assessments, and providing supportive services, which emphasize short-term counseling and referral. These services are targeted toward individuals and families. This covered service shall include clinical supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service.
12	Medical Services	Medical services provide primary psychiatric care, therapy, and medication administration provided by an individual licensed under the state of Florida to provide the specific service rendered. Medical services improve the functioning or prevent further deterioration of individuals with mental health or substance abuse problems, including mental status assessment. Medical services are usually provided on a regular schedule, with arrangements for non-scheduled visits during times of increased stress or crisis.
13	Medication-Assisted Treatment	FDA approved medication including Buprenorphine, Methadone, and Naltrexone.
14	Outpatient	Outpatient services provide clinical interventions to improve the functioning or prevent further deterioration of individuals with mental health and/or substance abuse use disorders. These services are usually provided on a regularly scheduled basis by appointment, with arrangements made for non-scheduled visits during times of increased stress or crisis. Outpatient services may be provided to an individual or in a group setting. The maximum number of individuals allowed in a group session is 15. This covered service shall include clinical supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service.
15	Outreach	Outreach services are provided through a formal program to both individuals and the community. Community services include education, identification, and linkage with high-risk groups. Outreach services for individuals: encourage, educate, and engage prospective individuals who show an indication of substance use and mental health disorders or needs. Individual enrollment is not included in outreach services.
18	Residential Level I	Licensed services provide a structured, live-in, non-hospital setting with supervision on a twenty-four hours per day, seven days per week basis. For adult mental health, Residential Treatment Facilities Level IA and IB, as defined in Rule 65E-4.016, Florida Administrative Code, are reported under this covered service. For youth with serious emotional disturbances, Level 1

		services are the most intensive and restrictive level of residential therapeutic intervention provided in a non-hospital or non-crisis stabilization setting. Residential Treatment Centers, as defined in Rule 65E-9.002, Florida Administrative Code, are reported under this covered service. For substance use treatment, Residential Level 1, as defined in Rule 65D-30.007, Florida Administrative Code, provides a range of assessment, treatment, rehabilitation, and ancillary services in an intensive therapeutic environment, with an emphasis on treatment, and may include formal school and adult education programs.
19	Residential Level II	Level II facilities are licensed, structured rehabilitation-oriented group facilities that have twenty-four hours per day, seven days per week, supervision. Level II facilities house individuals who have significant deficits in independent living skills and need extensive support and supervision. For adults with mental health disorders, Residential Treatment Facilities Level II, as defined in Rule 65E-4.016, Florida Administrative Code, are reported under this covered service. For youth with serious emotional disturbances, Level II services provide intensive therapeutic behavioral and treatment interventions. Therapeutic Foster Homes are reported under this covered service. For substance use treatment, Level II, as defined in Rule 65D-30.007, Florida Administrative Code, services provide a range of assessment, treatment, rehabilitation, and ancillary services in a less intensive therapeutic environment with an emphasis on rehabilitation and may include formal school and adult educational programs.
20	Residential Level III	Licensed facilities provide twenty-four hours per day, seven days per week supervised residential alternatives to individuals who have developed a moderate functional capacity for independent living. For adults with a mental health disorder, Residential Treatment Facilities Level III, as defined in Rule 65E-4.016, Florida Administrative Code, are reported under this covered service. For substance use treatment, Level III, as defined in Rule 65D-30.007, Florida Administrative Code, provides a range of assessment, rehabilitation, treatment, and ancillary services on a long-term, continuing care basis where, depending upon the characteristics of the individuals served, the emphasis is on rehabilitation or treatment.
21	Residential Level IV	This type of facility may have less than twenty-four hours per day, seven days per week on-premises supervision. The facility is primarily a support service and, as such, treatment services are not included in this covered service, although such treatment services may be provided as needed through other covered services. Level IV includes satellite apartments, satellite group homes, and therapeutic foster homes. For adults with a mental illness, Residential Treatment Facilities Level IV, as defined in paragraph 65E-4.016, Florida Administrative Code, are reported under this covered service. For substance use treatment, Level IV, as defined in Rule 65D-30.007, Florida Administrative Code, provides a range of assessment, rehabilitation, treatment, and ancillary services on a long-term, continuing care basis where, depending upon the characteristics of the individuals served, the emphasis is on rehabilitation or treatment.
22	Respite Services	Respite care services support the family or other primary care giver by providing time-limited, temporary relief, including overnight stays, from the ongoing responsibility of care giving.
24	Substance Abuse	Programs utilize medical and clinical procedures to assist adults, and adolescents with substance use disorders in efforts to withdraw from the

	Inpatient Detoxification	physical effects of substance use. Residential detoxification and addiction receiving facilities provide emergency screening, evaluation, short-term stabilization, and treatment in a medically supervised.
25	Supportive Employment	Supported employment is an evidence-based approach that assists individuals with gaining competitive integrated employment. Supported employment can be a team-based approach and focuses on the full range of community jobs that match the job seeker's strengths and preferences. Job supports are individualized and include job development, job placement, and long-term job coaching.
26	Supported Housing/Living	Supported housing/living is an evidence-based approach to assist individuals with substance use and mental illness in the selection of permanent housing. Services also provide the necessary supports to transition into independent community living and assure continued successful living in the community. For youth with mental health challenges, supported living services are a process which assist adolescents in selecting and maintaining housing arrangements and provides services, such as training in independent living skills, to assure successful transition to independent living or with roommates in the community. For substance use treatment, services provide for the housing and monitoring of recipients who are participating in non-residential services, individuals who have completed or are completing substance use treatment, and those individuals who need assistance and support in independent or supervised living within a "live-in" environment.
28	Incidental Expenses	This covered service reports temporary expenses incurred to facilitate continuing treatment and community stabilization when no other resources are available. All incidental expenses shall be authorized by the ME. Allowable purchases under this covered service includes transportation, childcare, housing assistance clothing, educational services, vocational services, medical care, housing subsidies, pharmaceuticals and other incidentals as approved by the Department or ME.
29	Aftercare	Aftercare activities occur after a treatment level of care is completed and include activities such as supportive counseling, life skills training, and relapse prevention for individuals with mental illness or substance use disorders to assist in ongoing recovery. Aftercare services help individuals, families, and pro-social support systems reinforce a healthy living environment.
30	Information and Referral	Services maintain information about resources in the community, link individuals who need assistance with appropriate service providers and provide information about agencies and organizations that offer services. The information and referral process is comprised of: being readily available for contact by the individual, assisting the individual with determining which resources are needed, providing referral to appropriate resources, and follow-up to ensure the individual's needs have been met, where appropriate.
32	Substance Abuse Outpatient Detoxification	Services utilize medication or a psychosocial counseling regimen that assists recipients in efforts to withdraw from the physiological and psychological effects of addictive substances.
35	Outpatient - Group	Outpatient services provide clinical interventions to improve the functioning or prevent further deterioration of individuals with mental health and/or substance use disorders. These services are usually provided on a regularly scheduled basis by appointment, with arrangements made for non-scheduled

		visits during times of increased stress or crisis. Outpatient services may be provided to an individual or in a group setting. The maximum number of individuals allowed in a group session is 15. This covered service shall include clinical supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service.
36	Room and Board with Supervision Level I	This covered service solely provides for room and board with supervision on a twenty-four hours per day, seven days per week basis. It corresponds to Residential Level I as defined in paragraph (4)(dd) of this rule.
37	Room and Board with Supervision Level II	This covered service solely provides for room and board with supervision on a twenty-four hours per day, seven days per week basis. Room and board corresponds to Residential Level II as defined in paragraph (4)(ee) of this rule. This covered service is not applicable for provider facilities which meet the definition of an Institute for Mental Disease as defined by Title 42 CFR, Part 435.1010.
38	Room and Board with Supervision Level III	This covered service solely provides for room and board with supervision on a twenty-four hours per day, seven days per week basis, corresponding to Residential Level III as defined in paragraph (4)(ff) of this rule.
42	Intervention - Group	Intervention services focus on reducing risk factors generally associated with the progression of substance use and mental health disorders. Intervention is accomplished through early identification of individuals at risk, performing basic individual assessments, and providing supportive services, which emphasize short-term counseling and referral. These services are targeted toward individuals and families. This covered service shall include clinical supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service.
43	Aftercare - Group	Aftercare activities occur after a treatment level of care is completed and include activities such as supportive counseling, life skills training, and relapse prevention for individuals with mental health or substance use disorders to assist in ongoing recovery. Aftercare services help individuals, families, and pro-social support systems reinforce a healthy living environment.
46	Recovery Support	This covered service is comprised of nonclinical activities that assist individuals and families in recovering from substance use and mental health disorders. Activities include social support, linkage to and coordination among service providers, life skills training, recovery planning, coaching, education on mental health and substance use disorders, assisting individuals using digital therapeutics approved by the United States Food and Drug Administration, and other supports that facilitate increasing recovery capital and wellness contributing to an improved quality of life. Recovery capital is the individual, family, social, community resources and natural supports that promote recovery. These activities may be provided prior to, during, and after treatment. These services support and coach an adult or youth and family to regain or develop skills to live, work and learn successfully in the community. This covered service shall include supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service, or by a certified peer specialist who has at least two years of full-time experience as a peer

		specialist at a licensed behavioral health organization. **This covered service must be provided by a Certified Recovery Peer Specialist pursuant to section 397.417, F.S.**
47	Recovery Support - Group	This covered service is comprised of nonclinical activities that assist individuals and families in recovering from substance use and mental health disorders. Activities include social support, linkage to and coordination among service providers, life skills training, recovery planning, coaching, education on mental health and substance use disorders, assisting individuals using digital therapeutics approved by the United States Food and Drug Administration, and other supports that facilitate increasing recovery capital and wellness contributing to an improved quality of life. Recovery capital is the individual, family, social, community resources and natural supports that promote recovery. These activities may be provided prior to, during, and after treatment. These services support and coach an adult or youth and family to regain or develop skills to live, work and learn successfully in the community. This covered service shall include supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service, or by a certified peer specialist who has at least two years of full-time experience as a peer specialist at a licensed behavioral health organization. **This covered service must be provided by a Certified Recovery Peer Specialist pursuant to section 397.417, F.S.**
52	Care Coordination	Care coordination is a time-limited service that assists individuals with behavioral health conditions who are not effectively engaged with case management or other behavioral health services and supports for a successful transition to appropriate levels of care. Once engagement in the necessary community-based services is verified, care coordination services are terminated.
53	HIV Early Intervention	This covered service is a bundled service package to provide Human Immunodeficiency Virus (HIV) Early Intervention Services in accordance with 65D-30.004, Florida Administrative Code. Allowable HIV Early Intervention Services may include one or any combination of the following activities: a) Pretest counseling, b) Posttest counseling, c) Tests to confirm the presence of HIV, d) Tests to diagnose the extent of the deficiency in the immune system, e) Tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and conditions arising from HIV, including tests for hepatitis C (when provided to individuals with HIV), f) Therapeutic measures for preventing and treating the deterioration of the immune system and conditions arising from HIV, and g) Linkages to diagnostic tests, therapeutic measures, and HIV specific support services.
54	Room and Board with Supervision Level IV	This covered service solely provides for room and board with supervision on a twenty-four hours per day, seven days per week basis. It corresponds to Respite Services as defined in this rule.

Appendix A — Oxford House Locations

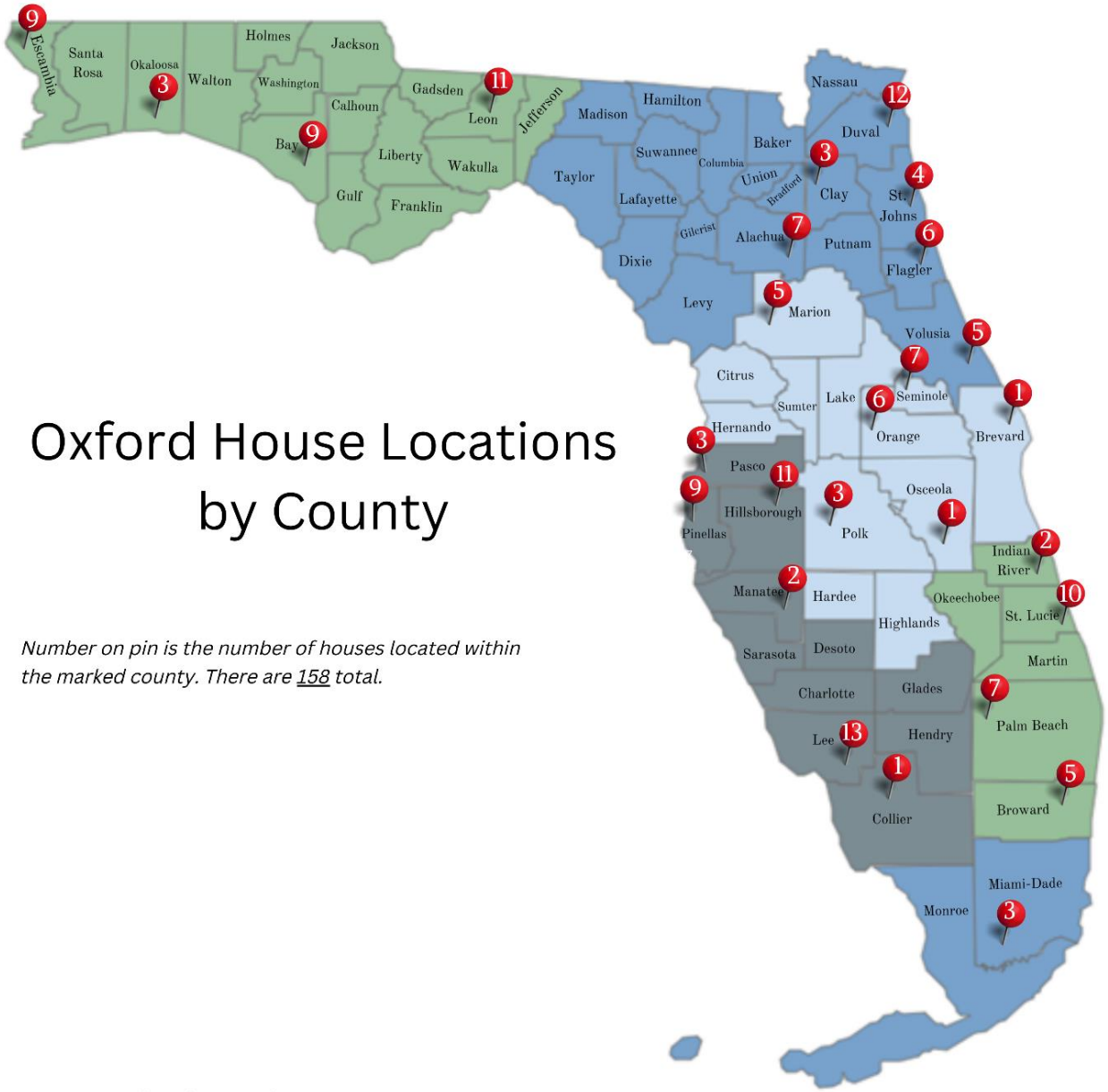
M=Men W=Women M/C=Men with Children W/C=Women with Children

County	House Name	City Location	Population	Bed Capacity
Alachua	Peace Garden	Gainesville	M	10
Alachua	Esther Lane	Gainesville	W	11
Alachua	Ohana 1st	Gainesville	M	9
Alachua	Millhopper	Gainesville	M	8
Alachua	Gail	Gainesville	W/C	10
Alachua	Glades	Gainesville	M	10
Alachua	Hazel Heights	Gainesville	M	9
Bay	Emerald Coast	Panama City	M	9
Bay	Panama City	Panama City	M	8
Bay	Mako	Panama City	M	10
Bay	Sugar Palms	Panama City	W/C	9
Bay	Sand Dollar	Panama City Bch	M	10
Bay	Blackwater	Panama City	M	10
Bay	Angel Sun	Panama City	M	11
Bay	Honesty	Panama City	M	9
Bay	Wahoo	Panama City	M	9
Brevard	Space Coast	Palm Bay	W/C	10
Broward	Happy Destiny	Ft. Lauderdale	W/C	9
Broward	Gardenia	Ft. Lauderdale	W/C	10
Broward	Great Reality	Lauderhill	M	10
Broward	Miracles	Deerfield Bch	M	10
Broward	Actions	Pompano Bch	W/C	12
Clay	Orange Park	Orange Park	M	10
Clay	Whippoorwill	Orange Park	W/C	10
Clay	Sabal	Orange Park	M/C	11
Collier	Sawfish	Naples	M	10
Duval	Freedom Court	Jacksonville	M	8
Duval	Magnolia Park	Jacksonville	W/C	9
Duval	Raising Hill	Jacksonville	M	9
Duval	Mill Cove	Jacksonville	M	8
Duval	Jax	Jacksonville	M	10
Duval	Jaguar	Jacksonville	W	9
Duval	Koala	Jacksonville	W/C	8
Duval	Perseus	Jacksonville	M	7
Duval	Manatee	Jacksonville	M	11
Duval	Morning Dove	Jacksonville	W	11

Duval	Seashore	Jacksonville Bch	M	8
Duval	Timucuan	Jacksonville	M	6
Escambia	Glo	Pensacola	M	8
Escambia	Ashton	Pensacola	W/C	8
Escambia	Cain	Pensacola	M	9
Escambia	Tabicat	Pensacola	W/C	9
Escambia	Danny	Pensacola	M	8
Escambia	Gwendolyn	Pensacola	W	10
Escambia	Waltham	Pensacola	M	7
Escambia	Stancil	Pensacola	W	9
Escambia	Capri	Pensacola	M	11
Flagler	Spring Board	Palm Coast	W	10
Flagler	Pine Lakes	Palm Coast	M	10
Flagler	Seahorse	Palm Coast	M	10
Flagler	Palm Cove	Palm Coast	W	8
Flagler	Driftwood	Palm Coast	M	9
Flagler	Hibiscus	Palm Coast	W/C	9
Hillsborough	Breeze	Tampa	M	8
Hillsborough	Orange Blossom	Tampa	W	9
Hillsborough	Waves	Tampa	W	8
Hillsborough	Stingray	Tampa	M	7
Hillsborough	Buccaneers	Tampa	M	11
Hillsborough	Nautilus	Tampa	M	8
Hillsborough	Lightning	Tampa	W	12
Hillsborough	Apogee	Brandon	M	8
Hillsborough	Rip Tide	Temple Terrace	M	7
Hillsborough	Swordfish	Sarasota	M	10
Hillsborough	Aqua Reef	Sarasota	W/C	11
Indian River	Cabana	Vero Bch	W/C	12
Indian River	Bungalow	Vero Bch	M	10
Lee	Manta Ray	Ft. Myers	M	10
Lee	Cobia	Ft. Myers	W	8
Lee	Mermaid Cove	Ft. Myers	W/C	12
Lee	Barracuda	Cape Coral	M	10
Lee	Amberjack	Cape Coral	W	8
Lee	Tarpon Point	Cape Coral	M	10
Lee	Mahi	Cape Coral	W	8
Lee	Coralwood	Cape Coral	M	6
Lee	Flamingo	Cape Coral	W	7
Lee	Kingfish	Cape Coral	M	9
Lee	Starfish	Cape Coral	M	10

Lee	Mangrove	Cape Coral	M	7
Lee	Chiquita	Cape Coral	M	8
Leon	Westworld	Tallahassee	M	9
Leon	Apalachee	Tallahassee	W	8
Leon	Sherwood Forest	Tallahassee	W	8
Leon	Temperance	Tallahassee	M	14
Leon	Noles	Tallahassee	M	8
Leon	Leon	Tallahassee	W	10
Leon	Tallahassee	Tallahassee	M	8
Leon	Panhandle	Tallahassee	M	9
Leon	Premier	Tallahassee	W/C	10
Leon	Firefly	Tallahassee	M	9
Leon	Naranja	Tallahassee	W/C	9
Manatee	Yellowtail	Bradenton	M	8
Manatee	Redfish Cove	Bradenton	M	11
Marion	Epona	Ocala	W/C	9
Marion	Impact	Ocala	M	9
Marion	Vesta	Ocala	W/C	8
Marion	Fauna	Ocala	W	8
Marion	Pharaoh	Ocala	M	7
Miami-Dade	Iguana	Miami Gardens	M	9
Miami-Dade	Tangelo	Miami Gardens	W/C	12
Miami-Dade	Ackee	Miami	M	10
Okaloosa	Flounder	Crestview	M	9
Okaloosa	Sunset Bay	Crestview	W/C	8
Okaloosa	Okaloosa	Ft Walton Bch	M	10
Orange	Kiwi	Apopka	W	8
Orange	417	Orlando	M	10
Orange	Marlin Rose	Orlando	M	8
Orange	Sapphire	Orlando	W	8
Orange	Banyan	Winter Park	M	8
Orange	Hummingbird	Winter Park	W	8
Osceola	Epic Start	Kissimmee	M	8
Palm Beach	Mango	Lantana	W	6
Palm Beach	Pineapple	West Palm Bch	M	8
Palm Beach	Dolphin	Riviera Bch	M	8
Palm Beach	Endless Summer	Lake Park	W/C	12
Palm Beach	Papaya	West Palm Bch	M	10
Palm Beach	Improv	West Palm Bch	M	8
Palm Beach	Avocado	N Palm Beach	M	9
Pasco	Land O'Lakes	Land O' Lakes	W	7

Pasco	Peace River	Port Richey	M	10
Pasco	Gulf Oasis	Port Richey	M	10
Pinellas	Hurricane	Seminole	M	7
Pinellas	Tsunami	Seminole	M	9
Pinellas	Pinellas	St. Petersburg	M	10
Pinellas	Tidal Wave	St. Petersburg	M	10
Pinellas	Heat Wave	St. Petersburg	W/C	9
Pinellas	Southern Light	St. Petersburg	M	10
Pinellas	Vertex	St. Petersburg	M	10
Pinellas	Gulf Bay	Largo	M	8
Pinellas	Green Flash	Clearwater	W/C	8
Polk	Kayak	Winter Haven	M	9
Polk	Paddle Boat	Winter Haven	W/C	8
Polk	Sailboat	Lakeland	M	9
Seminole	Key Lime	Altamonte Springs	M	8
Seminole	Dragon Fruit	Altamonte Springs	M	8
Seminole	Oni	Altamonte Springs	M	11
Seminole	Lando	Altamonte Springs	W/C	8
Seminole	Devotion	Altamonte Springs	M	10
Seminole	Angler	Altamonte Springs	M	8
Seminole	Scarlet Sage	Sanford	M	8
St. Johns	Ancient City	St Augustine	M/C	8
St. Johns	San Sebastian	St Augustine	M	9
St. Johns	Dreamcatcher	St Augustine	W/C	9
St. Johns	Matanzas	St Augustine	M	10
St. Lucie	Hammock	Fort Pierce	M	10
St. Lucie	Clusia	Port St. Lucie	W	11
St. Lucie	Sandcastle	Port St. Lucie	M	7
St. Lucie	Lucie	Port St. Lucie	W/C	8
St. Lucie	Everglade	Port St. Lucie	M	10
St. Lucie	Vista Nueva	Port St. Lucie	M	9
St. Lucie	No Reservations	Port St. Lucie	W/C	9
St. Lucie	Sea Breeze	Port St. Lucie	M	10
St. Lucie	Sandpiper	Port St. Lucie	M	11
St. Lucie	Treasure Coast	Port St. Lucie	W	8
Volusia	Sandy Bottom	Daytona	M	10
Volusia	Checkered Flag	Daytona	M	11
Volusia	Shining Beacon	Port Orange	W/C	11
Volusia	Deep Creek	Deltona	M	11
Volusia	Shanti	Deland	M/C	10



Oxford House Locations by County

Number on pin is the number of houses located within the marked county. There are 158 total.

Updated November 2023

Michael McKeogh, Regional Manager
michael.mckeogh@oxfordhouse.org
601-402-6864

Lori Holtzclaw, Director of Field Services
lori.holtzclaw@oxfordhouse.org
504-430-8554

Appendix B — Section 465.019, Florida Statutes, 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 — Hospital Bridge Programs

Managing Entity	Hospital	County
Northwest Florida Health Network	Ascension Sacred Heart	Bay
Lutheran Services Florida	UF Shands	Alachua
	UF Health Psychiatric Hospital (VISTA)	Alachua
	North Florida Regional HCA	Alachua
	Bravera Health Citrus Hills ER	Citrus
	Bravera Health Seven Rivers	Citrus
	HCA Citrus Memorial Hospital	Citrus
	St. Vincent's Clay	Clay
	HSA Orange Park Medical Center	Clay
	HCA FL Lake City	Columbia
	Ascension St. Vincent's - Southside	Duval
	Baptist Medical Center, North	Duval
	Advent Health Palm Coast	Flagler
	Baptist Medical Center, Nassau	Nassau
	Flagler Hospital/Flagler Health+	St Johns
	Halifax Health Daytona Beach	Volusia
	Advent Health New Smyrna Beach	Volusia
Central Florida Behavioral Health Network	Naples Community Hospital Healthcare System	Collier
	Physicians Regional Medical Center	Collier
	Tampa General	Hillsborough
	St. Joseph's	Hillsborough
	South FL Baptist	Hillsborough
	Morton Plant North Bay	Pasco
	BayCare South Florida	Pasco
	St. Anthony's	Pinellas
	Bayfront	Pinellas
	Morton Plant	Pinellas
	Mease Dunedin Hospital	Pinellas
	Lakeland Regional Hospital	Polk
	Lake Wales Medical Center	Polk
	Winter Have Bay Care	Polk
	Davenport Advent Health	Polk
	Advent Health - South Orlando	Orange
	Advent Health – Winter Park	Orange
	Advent Health - East Orlando	Orange

Central Florida Cares Health System	Advent Health - Apopka	Orange
	Advent Health-Celebration	Osceola
	Advent Health-Kissimmee	Osceola
	Osceola Regional Hospital	Osceola
	Advent Health - Altamonte	Seminole
Southeast Florida Behavioral Health Network	Cleveland Clinic	Indian River
	Cleveland Clinic-North	Martin
	Cleveland Clinic-South	Martin
	JFK, JFK North-ASU	Palm Beach
	Cleveland Clinic-Tradition	St. Lucie
	Cleveland Clinic - SLW ER	St. Lucie
Broward Behavioral Health Coalition	Broward Health/North Broward Hospital District	Broward
	Memorial Regional/South Broward Hospital District	Broward
Thriving Mind South Florida	Jackson Behavioral Health Hospital	Miami-Dade

Appendix D — State Opioid Response Funded Recovery Community Organizations

This list may not be current as new RCOs continue to develop.
Last updated September 20, 2023.

County or Counties	Recovery Community Organization	ME
Broward	Fellowship RCO	BBHC
Broward	South Florida Wellness Network	BBHC
Dixie	Rise Up for Recovery	LSF
Flagler	Open Arms Recovery Advocates	LSF
Hernando	The Hope Shot	CFBHN
Hillsborough	Hillsborough Recovery Coalition	CFBHN
Lee	Kimmie's Recovery Zone	CFBHN
Marion	Zero Hour Life Center	LSF
Miami-Dade	Miami Recovery Project	TMSF
Orange	Recovery Connections of Central Florida	CFCHS
Osceola, Brevard, Seminole	RASE Project	CFCHS
Palm Beach, Duval	Rebel Recovery	SEFBHN
Pinellas, Hillsborough, Pasco	Recovery Epicenter Foundation	CFBHN
Port St. Lucie, Okeechobee	Rite Life Services	SEFBHN
Polk	Polk for Recovery	CFBHN
Putnam	Recovery Point Palatka	LSF
Volusia	Volusia Recovery Alliance	LSF

Appendix E — Recovery Oriented Quality Improvement Specialist

The ROQIS position is designed for an individual with lived experience in recovery from a substance use disorder. The ROQIS serve in an administrative capacity, conducting duties through the lens of lived experience in recovery and navigating the behavioral health system. This position is described in the budget narrative for the SOR-3 grant and is authorized by SAMHSA to be provided in accordance with that description.

The ROQIS serves as a key individual in recovery-oriented system of care related activities with a primary responsibility to engage in ongoing quality assurance and improvement activities and the implementation, integration, and enhancement of recovery management approaches and services within the local system of care. Duties include but are not limited to promotion of effective engagement, training, and technical assistance, community inclusion, and care coordination strategies as well as collaborating with MEs to conduct Recovery Oriented Monitoring's on all SOR funded facilities.

Facilitation of peer trainings will be intentional and specific. As of Fiscal Year 2022-2023, trainings are supplemental to the MEs' trainings for peer specialists. Statewide trainings need to be approved by both the region and the Department, to ensure that regional priorities are addressed. The goal is to attain certificates in train the trainer, and to train RCOs and other community stakeholders with the intent of creating sustainability and capacity building within the region.

Appendix F — Web Infrastructure for Treatment Services (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 MEs

Reporter Information Name and email of ME 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 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 - Select the print screen button on your keyboard, 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 computer applications, once the application opens, select new in the top left screen of the snipping toolbox, move mouse to select the information to snip, save to computer, and attach below.

Attach screen shot here. Multiples may be added.

Appendix G — Questions and Answers

SOR-3 Guidance Document Questions and Answers

The questions below were received from MEs and providers during or following the guidance overview on March 24, 2023.

1. **Is the $30 gift incentive for all types of GPRA interviews (three data collection points) or only for the six-month follow-up GPRA which is the key to the compliance rate?**

   The non-cash incentive may be used for the six-month follow-up interview. Examples of a non-cash incentive: gas card, gift card, pre-paid credit card.

2. **The guidance provided states "A $30 non-cash incentive will be provided to all SOR-3 funded individuals completing the GPRA interviews." Is this required that the incentive be provided to everyone receiving services for completing GPRAs? Is it optional?**

   The Department encourages all providers use the GPRA incentives to increase engagement and GPRA compliance. If a provider declines to offer the GPRA incentives to individuals receiving services funded under the SOR-3 grant and the provider has a GPRA completion compliance rate under 80 percent, a detailed explanation is required along with a data improvement plan identifying strategies to increase the GPRA compliance rate.

3. **References to supplemental GPRA (post discharge interviews) have been removed. Is this no longer required?**

   The three required interviews are: intake, six-month follow-up, and discharge. The supplemental post discharge interviews are no longer required.

4. **The language provided regarding timelines for intake and follow-up now dictates when data needs to be entered into WITS, whereas before it stated when the data needed to be *collected*. This is important for cases where some providers might collect something on paper and then enter into WITS at a later date. Just confirming that this is a requirement.**

   Data should be entered into WITS within the noted parameters of the guidance document, no later than seven days after the interview. WITS uploads the GPRA data to SAMHSA's database. All data must be entered timely to remain up to date and accurate for reporting deadlines. *This timeline does not apply during the transition of the expired GPRA tool to the new tool as data input was not available through WITS*

as the system was being updated to accommodate the new tool. A timeline to put in data collected with the paper GPRA has been communicated to each ME.

5. **Is the contingency program allowable to all providers across the state?**

   The Department is developing a contingency management plan for implementation. More information will be available at a later date.

6. **Is the contingency program separate from the incentive program to keep individuals engaged in treatment?**

   The Department is developing a contingency management plan for implementation. More information will be available at a later date. Note that incentivizing mere attendance or participation would risk violating 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."

7. **For the purposes of providing training on contingency management, what is considered an "experienced, advanced degree holder"?**

   The specific language in the Notice of Funding Opportunity states "Training should be delivered by an advanced degree holder who is experienced in the implementation of evidence-based contingency management activities." An advanced degree is a post-graduate degree. A master's degree and doctorate are examples of an advanced degree. The contingency management plan will provide additional information. The Department is developing a contingency management plan for implementation. More information will be available at a later date.

8. **Under Recovery Communities, Recovery Data Platform: 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. Question: Are RCOs required to utilize RDP, or can other documentation/tracking systems be utilized? Are RCOs considered out of compliance if they do not utilize RDP?**

   RCOs are not required to use the RDP and are not out of compliance if they choose not to use the platform.

9. **Under hospital/jail bridge, a data collection requirement is "number of naloxone kits provided to individuals in-hand, prior to discharge." Per one provider, some hospitals do not have a license to dispense Narcan® on site. Several jails have the same issue or barriers to jails allowing Narcan® distribution. Recommend that this barrier be addressed / recognized in guidance document.**

   Naloxone should be dispensed by the hospital. While it is true that, "Medicinal drugs shall be dispensed in an institutional pharmacy to outpatients only when that institution has secured a community pharmacy permit," as noted in section 465.019(4)(a), F.S. There is, however, the exception: "…medicinal drugs may be dispensed by a hospital that operates a Class II or Class III institutional pharmacy to a patient of the hospital's ED or a hospital inpatient upon discharge if a prescriber…treating the patient in such hospital determines that the medicinal drug is warranted and that community pharmacy services are not readily accessible, geographically or otherwise, to the patient." Additional details can be found in Appendix C of the guidance document. Hospitals can obtain naloxone kits at no cost from the Department by contacting the Overdose Prevention Program.

10. **Under jail bridge it states, "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." Question/Feedback:**

    a. **Some jails (either admin staff or contracted medical staff) do not allow MAT in the jail. Barriers to transportation or unwillingness of jail staff to transport does not allow individuals to obtain MAT offsite while still incarcerated. In such cases, can individuals be counted as part of a jail bridge program if MAT is not provided at time of incarceration?**

       No. Jails that do not accommodate the provision of MAT cannot be considered part of a jail bridge program. Outreach to Correction leadership may help eliminate barriers to engage the implementation of those programs.

    b. **Can numbers still be counted through, Recovery Support Services (peer services / outreach) and links to MAT after discharge? In other words, can providers be considered as having a jail bridge program if no MAT is provided while individuals are incarcerated?**

       Jails that do not accommodate the provision of MAT cannot be considered part of a jail bridge program. All team members must be part of the collaboration to be considered a hospital or jail bridge program.

Bridge Program	Team Members
Hospital Bridge	Hospital Local MAT Providers MEs
Jail Bridge	Jail/Correctional Facility Local MAT Providers MEs

11. **For hospital/jail bridge, is the expectation that GPRAs be conducted since this is billed under SOR? The concern is that these interventions are brief and do not allow for ongoing services and follow-up.**

    The GPRA would be completed by the local MAT provider once the individual has been linked and services initiated. For example, if an individual engages at the hospital and is inducted with medication, a peer then schedules an appointment with a local MAT provider to continue treatment. The MAT provider would complete the GPRA during the intake process which typically would take place during that first appointment.

12. **Can legal fees be used to help individuals with lived experience in recovery, who would like to become a peer specialist, who have trouble passing the Level II background check. Would legal assistance for them be available?**

    SOR grant funds may be used for copies of certified court records, up to $300, maximum per individual, per grant award. Certified copies may cost $1 to $2 per page depending on the county. There is also a certification fee that may be charged ranging $2 to $5.

13. **Would the SOR-3 funds be available for use to provide transportation of individuals attending appointments on an ongoing basis or are funds more specific to covering one-time transportation incidentals to transport an individual to a provider appointment (covering a taxi fare versus dedicated transportation staff).**

    SOR funds can be used for transportation as a last resort once all other funding avenues have been exhausted. Additionally, SAMHSA recently offered the following suggestions to states interested in using SOR funds to address transportation barriers: “Possible program models that can be supported by SOR funds to improve access to prevention, treatment, and recovery support services include: Working with existing public transit systems to expand services beyond the traditional ‘fixed route system’ to include a variety of other models such as ridesharing, volunteer models, and mobility management models; voucher models - sometimes called ‘taxi vouchers,’ using tickets or coupons that eligible riders can offer to participating transportation providers in exchange for a ride; coordinated services models –

agencies working together to share resources; and mobility on demand – integrating and connecting pre-existing modes of transportation."[1]

14. **Explain more information about sub-grantee travel that must be tied to a service.**

    As stated in the SOR-3 Notice of Funding Opportunity, "Recipients and sub-awardees must use SAMHSA's grant funds primarily to support direct services." The SOR-3 Notice of Funding Opportunity also requires states to, "Make use of the SAMHSA-funded SOR/Tribal Opioid Response Technical Assistance/Training resources to assist in providing training and technical assistance on evidence-based practices to healthcare providers and others in your state who will render services to individuals with OUD and/or stimulant use disorders." They emphasize that, "Although workforce development is an allowable use of grant funds, SAMHSA expects that priority will be given to service provision and prevention activities. Recipients will be expected to utilize the training and education resources which SAMHSA provides at no cost to the grant." This is part of the rationale for why all travel must be tied to a service or a full budget approved by SAMHSA submitted with the grant application. This information was clarified through the grant officer on February 1, 2023.

15. **Under the eligibility section it now states, "Other substance use, mental health related, or other complex needs may be addressed if the primary diagnosis is opioid or stimulant misuse or disorders." This appears to now limit such things to only individuals who have opioid use disorder or stimulant use disorder as the primary diagnosis.**

    SOR-3 grant funding is for individuals with opioid or stimulant misuse or use disorders. Other behavioral health or complex needs can be addressed, as long as there is a diagnosis related to opioid or stimulant misuse or use disorders which can be primary, secondary, or tertiary. Additional information can be found in the Notice of Funding Opportunity. The information outlined within the question has been revised to reflect the appropriate language.

16. **What is the guidance for prevention dollars used for media campaign?**

    SOR-3 funded media campaigns should target 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

[1] Substance Abuse and Mental Health Services Administration. (2023). Letter from Assistant Secretary for Mental Health and Substance Use to State Mental Health Commissioners and Single State Authority Directors (March 30, 2023).

may address the risks associated with pressed, counterfeit pills that are now commonly adulterated with synthetic opioids like fentanyl.

17. **Can Vivitrol® be used by providers outside of FADAA? How can an individual qualify for Vivitrol® if they only have stimulant use disorder?**

- Vivitrol® can be accessed through FADAA or through the ME using the OCA MSSM6.
- An individual with a stimulant use disorder may qualify for Vivitrol® if that individual is being treated for opioid use disorder or an alcohol disorder. SOR-3 funds can be used to treat behavioral health or other complex needs identified through the primary treatment of an opioid or stimulant use disorder. If an individual enters treatment for a stimulant use disorder and during the course of that treatment voices the desire to treat alcohol dependance, Vivitrol® may be an acceptable treatment option for the alcohol related need.