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Secretary

State Opioid Response 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 approved 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 Department was awarded a third two-year SOR grant, referred to as SOR-3, for the period of September 30, 2022, through September 29, 2024. On September 29, 2024, a no cost extension was approved by SAMHSA, which allowed the Department an additional 12 months to expend unobligated funds with an end date of September 29, 2025, for SOR-3.

On September 24, 2024, the Department was awarded the fourth SOR grant (SOR-4) with a project period of September 30, 2024, through September 29, 2027, extending the project to three years. Providers who are funded through the SOR-3 no cost extension or SOR-4 must follow the guidance in this document, the SOR Grant Resource Guide, and use the Other Cost Accumulators (OCAs) assigned to both grants (outlined in Section 3, #15).

Purpose

The purpose of the SOR grant funds are to increase access to evidence-based prevention, treatment, and recovery support services that address opioid and stimulant misuse and/or use disorders to reduce opioid- and stimulant-related fatalities. If either stimulant or opioid misuse or use disorders exist concurrently with other substance use (including alcohol and nicotine) or mental health, all may be treated using SOR 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 year (for a total of 20,000 individuals over the entire project period of SOR-3 and 30,000 individuals for SOR-4). Additionally, the Department is committed to achieving the following goals and objectives:

SOR-3 Goals

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.

SOR-4 Goals

Goal 1: Reduce numbers and rates of opioid-caused deaths.

- Objective 1a: Distribute at a minimum 350,000 kits of FDA-approved medication to reverse an opioid overdose per year.
- Objective 1b: Train at least 25,000 individuals on overdose prevention per year.

Goal 2: Increase access to the most effective treatment of opioid and stimulant use disorders.

- Objective 2a: Increase new admissions for medication assisted treatment for opioid use disorders by 3,000 per year, including the expansion of easy access to buprenorphine through on-demand mobile and bridge programs.
- Objective 2b: Expand provider capacity of providers who can prescribe medication to treat opioid use disorders (MOUD).
- Objective 2c: Expand provider capacity to address stimulant misuse and use disorders through evidence-based treatment models.

Goal 3: Increase access to treatment and recovery support services to youth with an opioid or stimulant use disorder.

- Objective 3a: Increase workforce capacity of treatment and recovery support providers serving youth with a diagnosis of an opioid or stimulant use disorders and other cooccurring substance use disorders.
- Objective 3b: Expand recovery community organizations to include youth voice by end of year two.

Goal 4: Expand recovery support services.

- Objective 4a: Establish 44 additional Oxford Houses each year. Oxford Houses provide a supportive, substance-free living environment that is crucial for long-term recovery.
- Objective 4b: Increase workforce capacity of certified recovery peer specialists by 10 percent per year.

Goal 5: Prevent opioid and stimulant misuse.

- Objective 5a: Serve at least 30,000 youth per year through primary prevention programs.
- Objective 5b: Generate at least 3,500,000 impressions per year through universal indirect media campaigns.

System Priorities

1. **Expand bridge programs to increase easy access to medication for treatment of opioid use disorders (MOUD).** SOR 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. Managing Entities (MEs) should ensure community providers prescribing MOUD are working to actively communicate and engage with bridge physicians (emergency departments and jail) to overcome any medication dosage barriers. Additional information on bridge program expectations can be found in Section 3.8.

    a. Expand hospital bridge programs between emergency departments (EDs) and community-based providers to link individuals with opioid misuse or use disorders (OUD), identified in EDs, with treatment and recovery support services. Through this connection, individuals with an OUD will engage with community-based methadone or buprenorphine maintenance providers that can provide assessments and medication maintenance seven days a week. MEs, community-based providers, and EDs must work together to overcome obstacles in establishing or maintaining programs. MEs can partner with peer-run organizations within networks, which are ideally accessible on-call and equipped to assist individuals experiencing overdoses in EDs seven days a week. ED officials rely on MEs and their networks to ensure peers' participation in hospital bridge programs.

    b. Expand jail bridge programs between local county jails and community-based providers to link individuals with opioid misuse or OUD, identified in the jail, with treatment and recovery support services. Through this connection, individuals with an OUD will engage with community-based methadone or buprenorphine maintenance providers to continue treatment upon re-entry into the community. MEs, community-based providers, and county jails must work together to overcome obstacles in establishing or maintaining programs.

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.** SOR funds for recovery support services are allocated to the MEs through designated OCAs for each grant. Recovery supports include but are not limited to: peer supports, recovery coaches, vocational training, employment support, transportation, childcare, recovery community organizations, recovery housing, and 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).

3. **Expand treatment services to support the continuum of care for individuals with opioid and/or stimulant use disorders or misuse.** SOR funds for treatment services are allocated to the MEs through designated OCAs. SOR 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 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 funds can be used to pay for nicotine cessation services for eligible individuals and Vivitrol® for individuals with an alcohol use disorder. Likewise, SOR funds can be used to pay for comprehensive, integrated care that addresses co-occurring mental illnesses. SAMHSA has developed a Buprenorphine Quick Start Guide to provide support to providers, and a condensed version, Pocket Guide. Expanding the workforce capacity for providers serving individuals with opioid and stimulant use disorders as well as providers serving the youth population, is a priority and objective for the SOR-4 grant.

4. **Monitor and improve retention in care by changing discharge practices and policies with a focus on person-centered care.** 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. MOUD providers may not involuntarily discharge individuals for not attending or participating in counseling services. Notwithstanding the provisions of section 65D-30.0142, Florida Administrative Code, which mandates for individuals receiving methadone, a minimum of one counseling session per week shall be provided to individuals through the first 90 days, two counseling sessions per month to individuals who have been in treatment for at least 91 days and up to one year, and one counseling session per month to individuals who have been in treatment for longer than one year. 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 an 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, normalize recovery language, and bring a valuable perspective making deep connections with the individuals they support. The ME should identify 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, the MEs should be more involved by providing or connecting providers to support on hiring and supervising peers. 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.

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 medical or health related providers such as EDs, rural health clinics, fire/emergency medical service departments (for naloxone leave-behind programs). Outreach efforts should also focus on colleges or universities, homeless service organizations, risk reduction programs, recovery support organizations, and other community-based organizations that provide direct services to individuals with substance use disorders 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. **Improve the quality of policies and practices through recovery-oriented monitoring.** This process uses evidence-based measures of recovery principles and applies them to monitoring 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 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, MOUD, Strengths Based Approach, Customization and Choice, Opportunity to Engage in Self-Determination, Network Supports/Community Integration, and Recovery Focus. Appendix B provides additional information on the role of the ROQIS.

In addition to the monitoring as described above, provider site visits will be conducted by the Department to ensure all grant activities fall within the requirements, limitations, and allowability of the grant.

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Section 3

Permissible Uses of State Opioid Response Grant Funds

1. **Eligibility**. SOR 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).

    a) Every individual served with SOR 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), via diagnosis.

    b) Providers must assist eligible uninsured individuals with applying for health insurance. If appropriate, consider other systems from which a potential service recipient may be eligible. Examples include Veterans Health Administration or senior services.

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 of which medication and delivery method is used. All data should be entered in FASAMS using the correct OCA and covered service to ensure data collection is accurate and expenses align with the SAMHSA approved budget.

    MEs are required to ensure all qualified practitioners who serve clients with substance use disorders and are employed by an organization receiving funding through SOR meet the Medication Access and Training Expansion (MATE) Act requirements as delineated in Section 1263 of the Consolidated Appropriations Act, 2023.

SOR 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 funds may be used to purchase oral naltrexone for the specific instances outlined below:

a) 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.
b) As a placeholder for individuals wanting to start Vivitrol® treatment until the first injection is made available.
c) To conduct a naltrexone challenge to ensure individuals are opioid-free prior to receiving a Vivitrol® injection to avoid precipitated withdrawal.
d) To ensure individuals do not have a naltrexone allergy prior to receiving a Vivitrol® injection.
e) For individuals with a diagnosis of stimulant use disorder with co-occurring needs that are appropriate for naltrexone treatment.

4. **Long-acting naltrexone (Vivitrol®).** The Florida Alcohol and Drug Abuse Association (FADAA) will continue to fund Vivitrol® injections and the associated screening, assessment, and medical costs. SOR funds can be used for the list of covered services below to support individuals receiving Vivitrol®, except for Assessment, Medical Services and MOUD. Vivitrol® providers that are not contracted network service providers under an ME, and only provide Vivitrol® services, will refer individuals with stimulant use disorders to the local ME to provide treatment and recovery support services.

   In addition to the Vivitrol® project managed by FADAA, SOR funds allocated through the ME can be used to fund Vivitrol®. Any FDA-approved medication listed above in Section 3 can be provided using the appropriate designated OCAs.

5. **Deductibles and co-pays.** SOR 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 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 grant funds (underlined services require additional data collection outlined in #14):

a) Aftercare.
b) Assessment.
c) Care Coordination.
d) Case Management.
e) Crisis Support/Emergency.
f) Day Care.
g) Day Treatment.
h) Drop In/Self-Help Centers.
i) Incidental Expenses.*
j) Outreach.
k) HIV Testing and Referral to Treatment (HIV Early Intervention Services).
l) Intensive Case Management.
m) Intervention.
n) Medical Services.
o) Medication Assisted Treatment.
p) Outpatient.
q) Information and Referral.
r) In-Home and On-Site.
s) Respite.
t) Recovery Support.
u) Supported Employment.
v) Supportive Housing/Living.
w) 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 Chapter 65D-30.007, F.A.C. Standards for Residential Treatment, to ensure they still meet level of care criteria.
x) 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.

*Items reported under incidentals that are considered treatment and recovery support services, will require a Government Performance and Results Act of 2010 (GPRA). Examples of such items include but are not limited to medication to treat opioid use disorders, targeted case management, peer support, and other substance abuse services. If you are uncertain if a GPRA should be completed on a person receiving services or recovery support, please request technical assistance from the State Opioid Response Project Director.

Noted Change—SOR-4 funds may not be used to pay for inpatient detoxification.

SOR-4 ONLY

SOR-4 added the following when clinically indicated:

- Provide testing for HIV, viral hepatitis, and sexually transmitted infections (STIs) (e.g., syphilis) and warm hand-off referrals to appropriate treatment to those testing positive.
- When there are no other sources of funding available, provide testing for potential complications of OUD or stimulant use disorder. These tests include a complete blood count (CBC), international normalized ratio (INR), and a comprehensive metabolic panel (CMP).
- Provide vaccinations for hepatitis A and B, or appropriate referrals. Where the individual has not already received the recommended vaccinations below, provide and/or refer to vaccination services. Recommended vaccinations include, but are not limited to:
    - Hepatitis A.
    - Hepatitis B.
    - Meningococcal.
    - Pneumococcal (pneumonia).
    - Human papillomavirus (HPV) (for those up to age 26).
    - Tetanus, diphtheria, and pertussis (Tap); and
    - Zoster (shingles) (for those ages 18 and older).

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

7. **Recovery Support Services.** SOR funds should be used to provide recovery support services including but not limited to:

a) Peer supports.
b) Recovery coaches.
c) Vocational training.
d) Employment support.
e) Transportation.
f) Childcare.
g) Recovery Community Organizations.
h) Housing supports. SOR-3 funds can be used for application fees, deposits, rental assistance, utility deposits, and utility assistance. **SOR-4 funds are designated exclusively for recovery home needs but cannot cover application fees, deposits, or rental assistance**. Both SOR-3 and SOR-4 funds can be utilized for furniture, kitchenware, bedding, and cleaning supplies.
i) 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).
j) 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 MOUD, 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. MEs must submit a Bridge Program report as outlined in the SOR Guidance Document due on the 18th of each month**.**

a) 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 MOUD providers must be consistent and is crucial when having discussions regarding medication doses and continued MOUD 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 MOUD appointment process, supports individuals through the referral process, schedules an appointment with a local MOUD provider.

- MOUD Provider - Provides accessible appointments, continues medication maintenance and other necessary treatments and recovery support services.
- ME - Provides access to funds supporting treatment services including MOUD and recovery supports and ensures rapid linkage to ongoing community-based MOUD 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 use/misuse.
2. The ED physician assesses if the individual is a candidate for MOUD.
3. If MOUD is an appropriate option, the ED physician initiates a conversation to gauge interest offering to start the first induction before the individual is discharged. The physician will explain 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 MOUD provider. The peer schedules an appointment with a local MOUD provider, explains the transition process, provides general support during the entire process, and assists in a warm hand-off to a local MOUD provider. If the individual declines MOUD, 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 MOUD.

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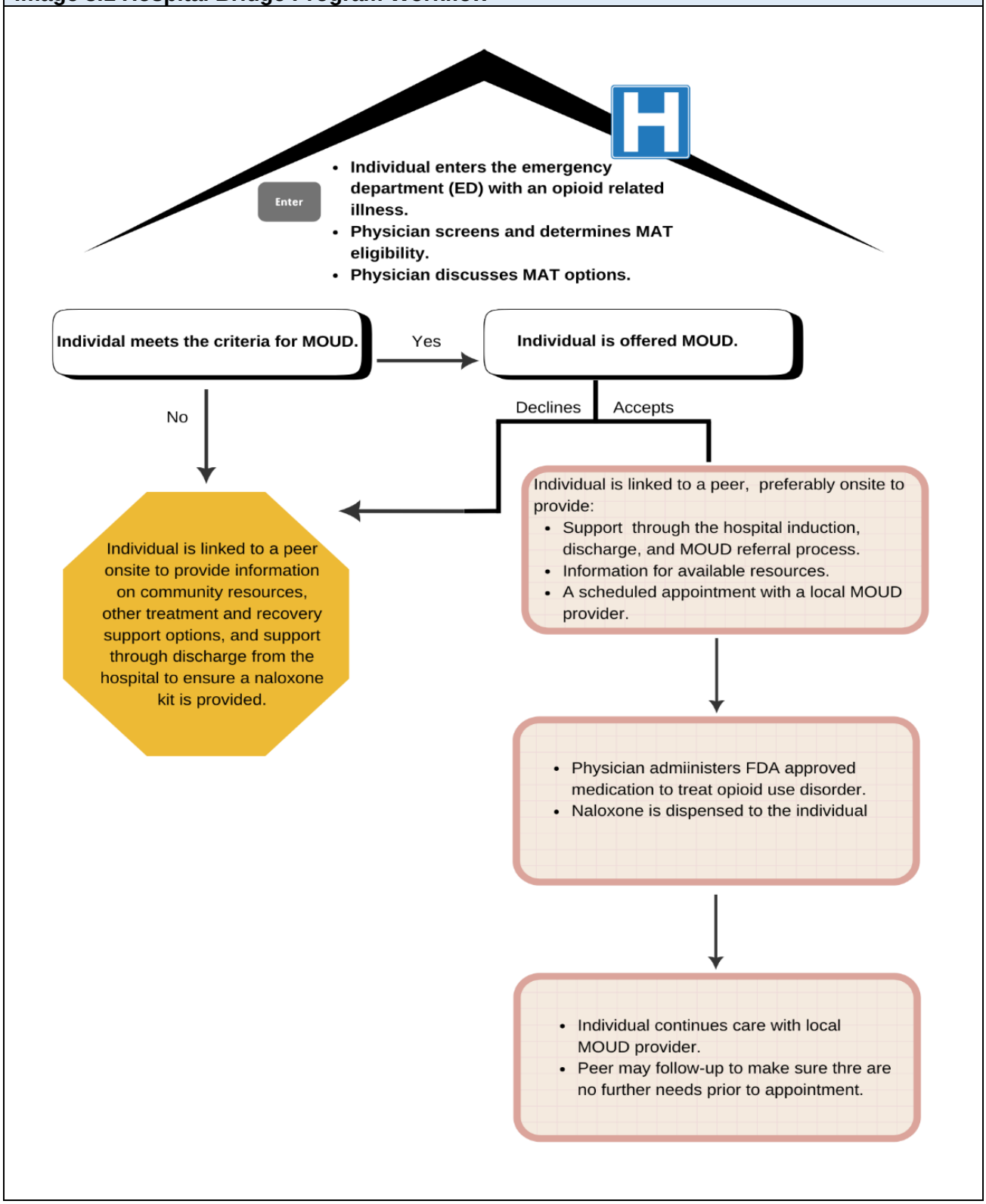
Image 3.1 illustrates an example of a hospital bridge program workflow.

Image 3.1 Hospital Bridge Program Workflow



b) **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 MOUD treatment through a jail bridge program or (2) are currently receiving MOUD 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 to be successfully linked to a community provider upon re-entry. This can be done in partnership with community MOUD providers either in the jail setting or offsite at the provider location.

SAMHSA promotes the use of SOR funds to provide treatment transition and coverage for individuals reentering communities from criminal justice settings or other rehabilitative settings. Services can start in the jail, with a smooth transition to community services upon release. Each jail will have unique needs to consider when developing 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 MOUD providers must be consistent and is crucial when having discussions regarding medication doses and continued MOUD maintenance once the individual receiving treatment is released.

<u>Team Members</u>

Team roles within jails or correctional facilities may differ based on program structure, as well as established policies or protocols. However key team members can generally be identified as follows:

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

The structure of a jail bridge program may vary depending on the specific protocols of the correctional facility, but certain essential features must be present for it to be recognized as a jail bridge program:

1. Individuals entering the facility are screened for opioid use disorder and assessed for eligibility to receive MOUD services.
2. Jail personnel initiate discussions about MOUD services with individuals, who then agree to participate in the program.
3. Comprehensive education is provided regarding the MOUD process, including the importance of collaboration with local healthcare providers.
4. The individual is referred to a community-based provider partnered with the jail to deliver MOUD services.
5. The individual undergoes induction with FDA-approved medication either at the jail or at the provider's facility, depending on the program's logistics.

6. Prior to reentry into the community, the individual is connected with a peer navigator to facilitate access to local MOUD resources. The peer or jail personnel schedules a follow-up appointment with the local MOUD provider to ensure continuity of care.

c) Medication to Treat Opioid Use Disorder 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. Technical assistance is available for bridge programs or treatment of pregnant or parenting women from Peer Prescriber Mentors (PPMs). PPMs are funded by SOR with oversight contracted through the Florida Association of Drug and Alcohol Abuse. Appendix D provides additional information on accessing this support.

9. **Prevention.** The primary prevention services funded under SOR 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 prevention 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 and SOR Project Director 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.** SOR funds should be used to support innovative telehealth strategies for rural and underserved areas.

11. **Behavioral Health Consultants.** Behavioral Health Consultants (BHCs) are highly qualified professionals, including licensed clinicians, certified substance use specialists, or individuals with a master's degree in a behavioral health related field. They provide essential support and expertise to 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 39 SOR funded BHC positions stationed throughout the state and two SOR 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. 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 services contracted through the Department for RCO development**.

RCOs focus on advocacy and support related to **substance use and recovery**, rather than mental health. 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 risk 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 C for a list of current RCO serving locations.

a) 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.

b) 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.

13. Recovery Oriented Quality Improvement Specialist (ROQIS). 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 funded MOUD, 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 B for ROQIS guidance.

14. Data Collection. Data collection is required for grant reporting.

a) FASAMS Data: Providers must enter all individuals served data into FASAMS to capture services and activities rendered for all individuals receiving services funded by SOR. Specifically, providers must input the following data:

- All individuals served must have primary, secondary, or tertiary opioid and/or stimulant use disorder in FASAMS or have an opioid or stimulant identified as a drug of choice. 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 MOUD 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 MOUD 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**.** Modifier details can be seen in Table 3.2.
- All other FASAMS data requirements apply.

Table 3.2 Medication to Treat Opioid Use Disorders Modifiers

Code	Description	Guidance
S1	Buprenorphine	To designate person receiving State Opioid Response (SOR) grant-funded services as taking Buprenorphine Mono medication, regardless of fund source for the medication.
S2	Methadone	To designate person receiving State Opioid Response (SOR) grant-funded services as taking Methadone medication, regardless of fund source for the medication.
S3	Naltrexone Injectable	To designate person receiving State Opioid Response (SOR) grant-funded services as taking Naltrexone Injectable medication, regardless of fund source for the medication.
S4	Buprenorphine Combo	To designate person receiving State Opioid Response (SOR) grant-funded services as taking Buprenorphine Combo medication, regardless of fund source for the medication.
S5	Naltrexone Oral	To designate person receiving State Opioid Response (SOR) grant-funded services as taking Naltrexone oral medication, regardless of fund source for the medication.
S6	Buprenorphine Extended-Release Injection (i.e., Sublocade or Brixadi)	To designate person receiving State Opioid Response (SOR) grant-funded services as taking Buprenorphine Extended-Release Injection (Sublocade or Brixadi) medication, regardless of fund source for the medication.

b) <u>Government Performance and Results Act of 2010 Data:</u> The Government Performance and Results 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 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.

1. Data Entry: Providers must enter complete GPRA data into the WITS system for all individuals receiving SOR funds for treatment services or recovery supports. The WITS system uploads GPRA data into SAMHSA's database, SAMHSA's Performance Accountability and Reporting System (SPARS), to maintain timely reporting and accurate data to SAMHSA. This data is reported quarterly. Specifically, providers must input the following data:
    - All individuals must 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 funding.**
    - Responses to all questions identified in the GPRA.
    - All individuals who received a GPRA assessment must be entered into FASAMS under the appropriate OCA and must also be entered into WITS. Additional information on OCAs can be found in section six of this document.
    - A $30 non-cash incentive may be provided to all SOR funded individuals completing the six-month follow-up GPRA interview. All individuals who receive a GPRA incentive must be entered into FASAMS under the appropriate OCA under covered service 28 (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-funded covered services underlined in the service array section, must have completed the GPRA for each of the three collection points.
    - Intake/baseline data should be collected within four days of the individual's enrollment into services.
    - 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.

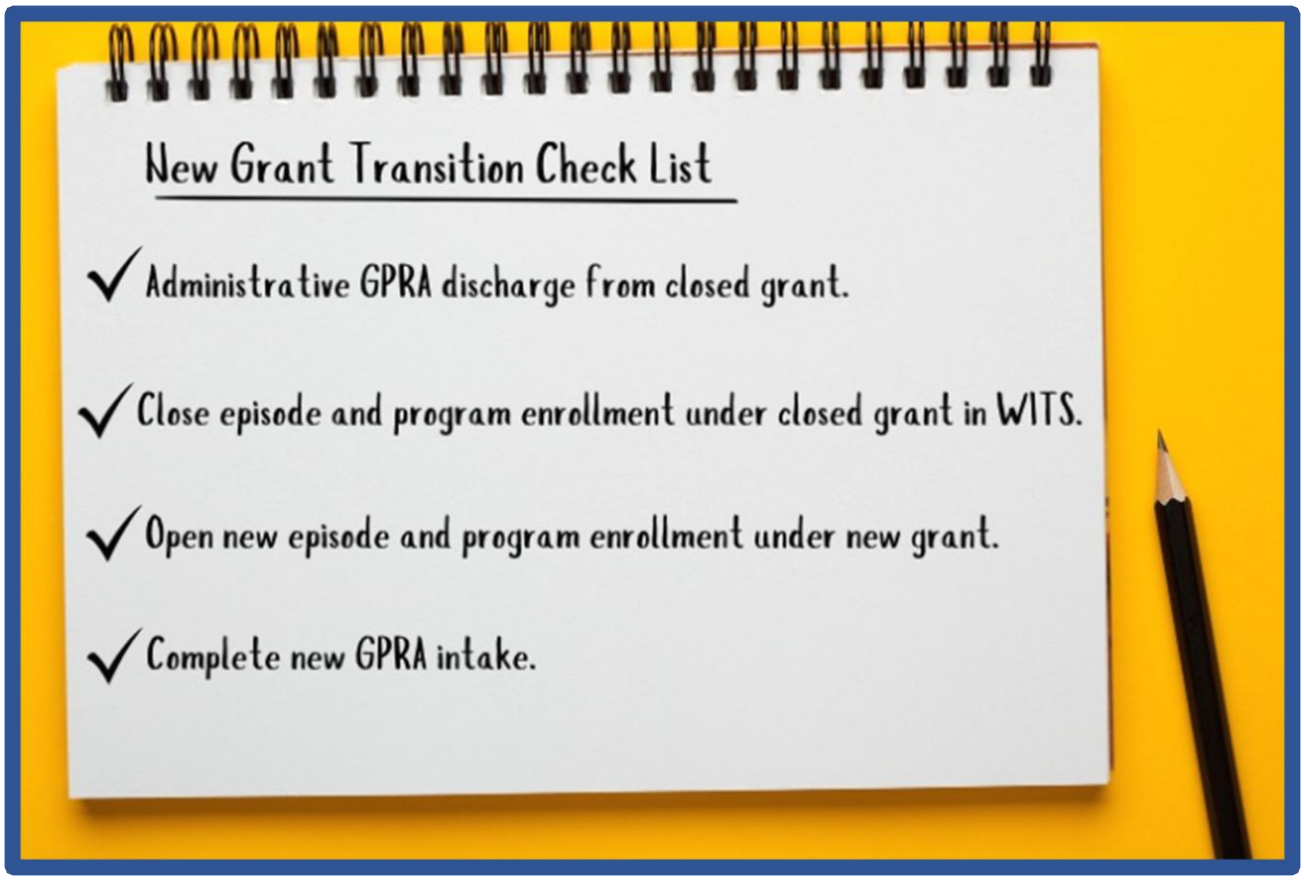
- A discharge GPRA must be completed each time an individual is discharged/transferred from SOR funding.
- If an individual is discharged from a treatment episode and the individual then returns to re-enroll in a new SOR-funded treatment episode, a new data collection timeline must be started.

Example: If someone leaves the program against staff advice after four months, with a baseline assessment already completed, and then comes back two months later, then a new baseline assessment MUST be done when they re-enroll. Their data will then be collected on a new timeline—six months from their new intake date and at discharge. The old GPRA data timeline from their previous enrollment will no longer be used.

- If an individual receiving SOR-funded services switches to a different funding source during the same episode of care, they MUST complete a discharge GPRA and continue with follow-up GPRAs at the required intervals. However, if they return to SOR funding within a certain timeframe, they don't need to fill out a new baseline GPRA. Follow the guidance below for these situations:
    - If an individual switches to another funding source and then returns to SOR funding within six months after intake, they should stay on the same timeline and complete the six-month post-baseline GPRA as scheduled.
    - If an individual switches to another funding source within the first six months after intake and then returns to SOR funding after six months post-intake, they must begin a new timeline and complete a new baseline GPRA.

Example: If an individual completes a baseline, switches to another funding source at two months post-intake, completes a discharge, and then returns to SOR funding at seven months post-intake, they need to start fresh with a new baseline and begin a new timeline.

2. Transitioning to a New Grant. Individuals must be administratively discharged from a closed grant before being transferred to a new grant. The administrative GPRA discharge requires sections A (first four items), J, and K of the GPRA to be completed. The individual will then be enrolled into the new SOR grant program and a new intake interview for the individual will be completed. Subsequently, the same GPRA requirements must be completed for the six-month follow-up and discharge. The follow-up timeline will start with the new GPRA intake date.



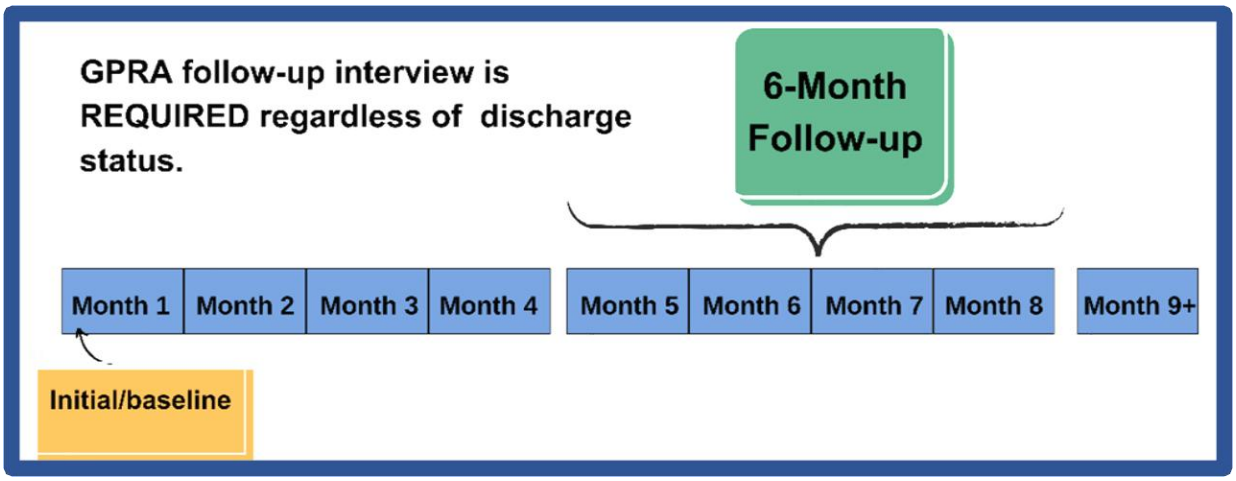
3. GPRA Administration Windows

Intake/Baseline:

- For residential facilities - GPRA intake/baseline interviews are required to be completed within three days after the individual enters the program and entered into WITS no later than seven days after the interview is completed.
- For nonresidential programs - GPRA intake/baseline interviews are required to be completed within four days of program enrollment and entered into WITS no later than seven days after the interview is completed.

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.



4. 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.
5. 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).

6. 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).

c) <u>Data Technical Assistance.</u> If a WITS user needs technical assistance in WITS, support is provided through the following four tiers listed below.

- **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 in WITS 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.
  - Creation of staff members 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.
  - Assign new programs.
  - Add new facilities for existing providers.
  - Lock/unlock user access.
  - 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 in WITS 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 in WITS 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.

- **Tier 4: FEI Support.** If the Department is unable to resolve a WITS ticket, the ticket will be sent to FEI for support.

d) **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 E 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.

e) **Overdose Prevention Program.** Providers enrolled in the Overdose Prevention Program to distribute naloxone and provide overdose prevention training, are required to submit monthly reports that include the following information: 1) Total number of reported overdose reversals. 2) Total number of naloxone kits distributed. 3) Total number of overdose prevention trainings facilitated with a copy of sign-in sheets. 4) Total number of individuals trained on overdose prevention.

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 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 Grant OCAs September 30, 2024 - September 29, 2025			
Grant	**OCA**	**Description**	**Purpose**
SOR-4	SORF7	Vivitrol®/ FADAA	Allowable cost of funds provided to FADAA for naltrexone extended-release injectable medication (Vivitrol®) and associated services, such as assessment and medical services.
SOR-4	MSRC7	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 MOUD; 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.
SOR-3 NCE	MSCN6		
SOR-4	MSSP7	Prevention/MEs	Allowable costs incurred by MEs for primary prevention programs included in the pre-approved media campaign and list, and other evidence-based programs which have been reviewed and approved by the Department.
SOR-3 NCE	MSPN6		
SOR-4	MSSM7	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, MOUD for opioid use disorders or evidence-based programs (EBPs) for stimulant use disorders (Community Reinforcement Approach, Cognitive Behavioral Therapy, or Motivational Interviewing).
SOR-3 NCE	MSMN6		
ME Administrative OCAs			
SOR-4	MSSA7	Admin/MEs	Allowable administrative and general program costs incurred by the MEs.
SOR-3 NCE	MSAN6		

16. **Incidentals.** Providers using incidental funds must report what they are purchasing using the allowable procedure codes associated with covered service 28 and maintain supporting documentation. The Table below provides details on allowable and unallowable activities per grant. Items marked by asterisk (*) have limitations. <u>All incidental purchases must be tied to a treatment or recovery plan as an identified need.</u>

Table 3.3 Use of Incidental Expenditures		
Expense/Code	**SOR-3**	**SOR-4**
IE001—Incidentals.	No	No
IE100—Psychotropic Medications.	Yes	Yes
IE101—IDP Psychotropic Medications.	Yes	Yes
IE200—Medication Management Services.	Yes	Yes
IE300—Mental Health Counseling.	Yes	Yes
IE400—Substance Abuse Services.	Yes	Yes
IEA00—Food	No	No
IEC00—Housing.	Yes	Yes*
IED01—Electricity	Yes	Yes
IED02—Water/Sewer.	Yes	Yes
IED03—Telephone.	Yes*	Yes*
IED04—Heating Oil.	Yes	Yes
IED05—Natural or LP Gas.	Yes	Yes
IEE00—Transportation.	Yes	Yes
IEF00—Primary Care.	Yes	Yes
IEF01—Dental Services.	No	No
IEF02—Vision Services.	Yes*	Yes*
IEF03—Adjunct Health Services.	Yes	Yes
IEF04—Co-Pays.	Yes	Yes
IEG00—Service Animal Support.	No	No
IEG01—Purchase of Service Animal.	No	No
IEG02—Service Animal Supplies.	No	No
IEG03—Service Animal Veterinary Services.	No	No
IEH00—Employment Support.	Yes	Yes
IEH01—Work Tools.	No	No
IEH02—Work Clothes.	No	No
IEI00—Crafts and Hobbies.	Yes	Yes
IEJ00—Computers and related items.	No	No
IEJ01—Computer Equipment.	No	No
IEJ02—Printer.	No	No
IEJ03—Software.	No	No
IEJ04—Supplies.	Yes*	Yes*
IEJ05—Internet Service.	Yes*	Yes*
IEK00—Furniture and Home Equipment.	Yes*	Yes*
IEM00—Personal Services.	No	No
IEN00—Entertainment.	No	No
IEP01—Birth Certificate.	Yes	Yes
IEP02—Identification Cards.	Yes	Yes
IEP03—Guardianship Fees.	No	No

IEQ00—Childcare.	Yes*	Yes*
IER00—GPRA Non-Cash Incentive not to exceed $30.	Yes	Yes

- *Housing from SOR-4 can only fund recovery home needs.*
- *Telephone services for landlines are allowable. Cellular services or phones are **NOT** allowable.*
- *Childcare is allowable when necessary for caregiver to attend/participate in treatment.*
- *Vision services may be provided, when necessary, with providers assisting uninsured clients in securing health insurance and exploring eligibility for support through other systems, such as the Veterans Health Administration or senior services.*
- *Necessary furniture may be acquired at a reasonable cost, defined as expenditures that align with prudent and competitive business practices.*
- *Allowable supplies may include pots/pans, dishes, and cleaning supplies.*

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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 expended through the award or a subaward by any agency which would deny any eligible client, patient, or individual access to their program because of their use of FDA approved medications for the treatment of substance use disorders (e.g., methadone; buprenorphine products, including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations; naltrexone products, including extended-release and oral formulations; or long-acting products, such as extended release injectable or buprenorphine.). Specifically, patients must be allowed to participate in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program and ordered by a practitioner who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual's OUD. Similarly, medications available by prescription or office-based injection must be permitted if it is appropriately authorized through prescription or administration by a licensed prescriber or provider. In all cases, MOUD must be permitted to be continued for as long as the prescriber or treatment provider, in conjunction with the patient, determines that the medication is clinically beneficial. Recipients must ensure that clients will not be compelled to no longer use MOUD as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

2. **Housing.** SOR-4 funds may not be used for housing other than recovery housing, which includes application fees and security deposits.

3. **Health Care Professional Incentives.** Funds may not be utilized to provide incentives to any Health Care Professionals for receipt of any type of Professional Development Training.

4. **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.

5. **Limits on detoxification services.** Funds may not be used to provide inpatient treatment or hospital-based detoxification services.

   Residential services are not considered to be inpatient or hospital-based 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."

6. **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.

7. **Executive salary limits**. Funds may not be used to pay the salary of an individual at a rate more than $221,900. 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.

8. **Treatment using medical marijuana.** Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder and stimulant use disorder.

   Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

9. **Syringes**. Funds may not be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug.

10. **Meals.** SOR funds may not be used to purchase food/meals, snacks, or drinks.

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

12. **Sub-grantee travel.** Travel is not allowable for sub-grantees unless the travel is tied to a service. If a Managing Entity would like to submit a travel budget for SAMHSA approval, they may do so by providing the detailed budget and justification to the SOR Project Director to include in the initial grant application, continuation application, or carry-over request to SAMHSA. This only applies to Managing Entities, not to Network Service Providers.

13. **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 the Department.

14. **Promotional items.** The SOR 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.

15. **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.

16. **Acknowledgement of Federal Funding.** Any training, event, publication, press release, and documents such as tool kits, resource guides, websites, and presentations funded in total or partial by the grant, must include the following disclaimer:

    "Funding for this <(enter type of event-training, workshop, activity) > was made possible by federal grant<(enter appropriate grant number SOR4 is #TI087842 and SOR3 is #TI085766)>. The views expressed in written materials or publications and by speakers, facilitators, and moderators do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government."

    An example of this disclaimer can be seen on page two of this resource guide.

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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-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 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., Publix 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 a provider completes 50 GPRA interviews within six-months, the 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 was 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 F/U Date	Date Issued	Delivery Method	Staff	Description-include card type, card#, expiration date, pin#, purchase date, and card services phone number
Rachel Green	555-555-7777	3/3/2025	3/3/2025	In-person	Monica Bing	$30 Publix card, #777-8888-9999-8888, Ex. 12/31/2025. Pin#2354, Purchased on 2/8/2025, Card Service # 800-777-8888
Elaine Benes	41 S. Main Street, Orlando FL 32554	3/5/2025	3/12/2025	Mailed	Joe Swanson	$30 Walmart card, #4444-8888-6666-1111, ex. 12/31/2026, Pin#4545, Purchased on 2/20/2025, Card Service # 800-777-6644

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 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 their 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

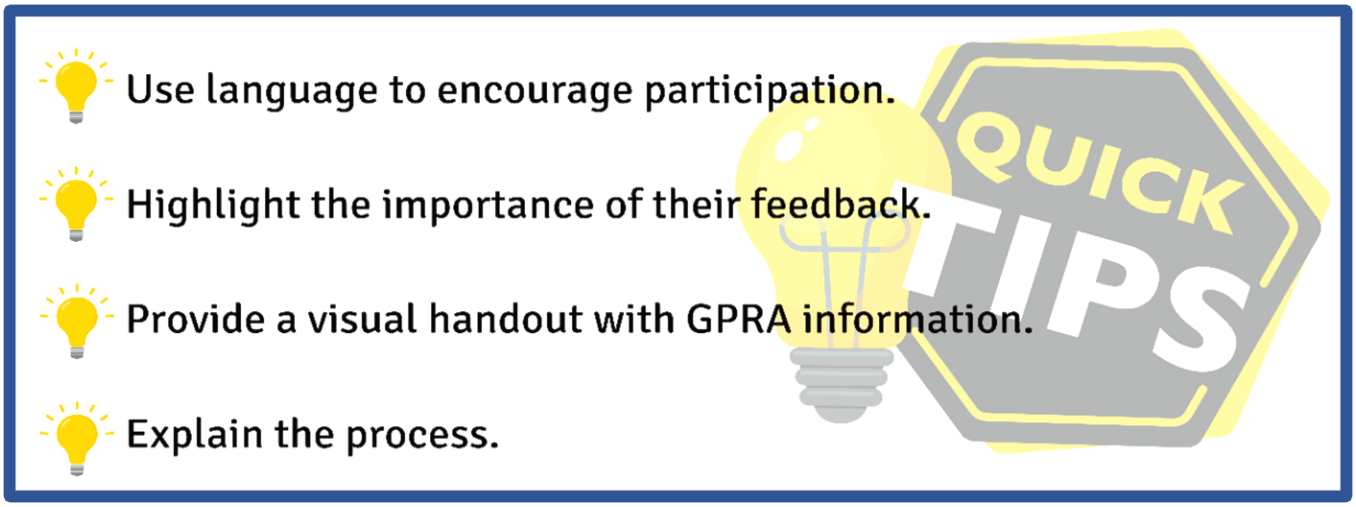
For the grant to pay for incentives, providers must use the OCAs MSMN6, MSCN6, MSSM7, or MSRC7 and covered service number 28 for incidentals using the procedure code IER00. This process allows SOR personnel to track the expense. Everyone receiving treatment or recovery support services funded through SOR, 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 six-month 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."



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**	
Was an interview conducted?	**Yes**	**Yes**	**No**	**Yes**	**No**
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/Physical Health Problems and Treatment/Recovery	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/Intake: 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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Covered Services and Project Codes

Funds allocated through the SOR grant are done so through OCAs with approved covered services. See Table 6.1 for available OCAs and covered services. Noted changes include the removal of inpatient detox. Per the grant terms and conditions, inpatient detox is an unallowable activity. SOR-4 housing support must be tied to a recovery home.

Table 6.1 OCA Covered Services

MSSM7 and MMNC6	
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

MSRC and MRNC6	
07	Drop-in/Self-Help Center
12	Medical Services*
13	Medication-Assisted Treatment*
15	Outreach
22	Respite
28	Incidental Expenses
30	Information and Referral
46	Recovery Support
47	Recovery Support - Group

**See Section 3 details on eligibility requirements.*

**All SOR-4 housing support must be tied to recovery housing.*

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, risk 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 42	Intervention 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.
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 35	Outpatient Outpatient Group	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.
25	Supportive Employment	Supportive employment is an evidence-based approach that assists individuals with gaining competitive integrated employment. Supportive 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. **OCA MSSM7 may only pay for housing for recovery homes.**
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 (SOR-4 funds recovery housing needs only), educational services, vocational services, and other incidentals as approved by the Department.
29 43	Aftercare 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 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 are 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.
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 correspond 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.
46 47	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 Support Group	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

*Funded with Opioid Settlement dollars.

County	House	City	Population	Capacity
Alachua	Grace Landing*	Gainesville	Women w/Children	8
Alachua	Nahi*	Gainesville	Men	7
Alachua	Dhira*	Gainesville	Men	10
Alachua	Esther Lane	Gainesville	Women	11
Alachua	Gail	Gainesville	Women w/Children	10
Alachua	Glades	Gainesville	Men	10
Alachua	Hazel Heights	Gainesville	Men	9
Alachua	Millhopper	Gainesville	Men	8
Alachua	Ohana 1st	Gainesville	Men	9
Alachua	Peace Garden	Gainesville	Men	10
Bay	Angel Sun	Panama City	Men	11
Bay	Blackwater	Panama City	Men	10
Bay	Eclipse	Panama City Beach	Men	9
Bay	Emerald Coast	Panama City	Men	9
Bay	Honesty	Panama City	Men	9
Bay	Mako	Panama City	Men	10
Bay	Panama City	Panama City	Men	8
Bay	Sand Dollar	Panama City Beach	Men	10
Bay	Storms End	Panama City	Women	8
Bay	Sugar Palms	Panama City	Women w/Children	9
Bay	Summer Haven	Panama City	Women	9
Bay	Wahoo	Panama City	Men	9
Bay	Pine Terrace	Panama City	Men	8
Bay	Calypso	Panama City	Men	8
Brevard	Comet	Palm Bay	Men	8
Brevard	Luminary	Palm Bay	Women w/Children	8
Brevard	Space Coast	Palm Bay	Women w/Children	10
Broward	Actions	Pompano Beach	Women w/Children	12
Broward	Ascher	Lauderhill	Men	10
Broward	Gardenia	Ft. Lauderdale	Women w/Children	10
Broward	Great Reality	Lauderhill	Men	10
Broward	Happy Destiny	Ft. Lauderdale	Women w/Children	9
Broward	Miracles	Deerfield Beach	Men	10
Broward	Courage Cove	Ft. Lauderdale	Women w/Children	11
Broward	Sea Dragon	Ft. Lauderdale	Men	10
Charlotte	Charlotte Harbor	Port Charlotte	Women	8

Charlotte	Pufferfish	Port Charlotte	Men	10
Clay	Laurel Grove	Orange Park	Women	8
Clay	Oakleaf	Orange Park	Men	9
Clay	Orange Park	Orange Park	Men	10
Clay	Sabal	Orange Park	Men w/Children	11
Clay	Whippoorwill	Orange Park	Women w/Children	10
Collier	Sawfish	Naples	Men	10
Duval	Freedom Court	Jacksonville	Men	8
Duval	Jaguar	Jacksonville	Women	9
Duval	Jax	Jacksonville	Men	10
Duval	Koala	Jacksonville	Women w/Children	8
Duval	Magnolia Park	Jacksonville	Women w/Children	9
Duval	Manatee	Jacksonville	Men	11
Duval	Mill Cove	Jacksonville	Men	8
Duval	Morning Dove	Jacksonville	Women	11
Duval	Perseus	Jacksonville	Men	7
Duval	Puma	Jacksonville	Men	9
Duval	Raising Hill	Jacksonville	Men	9
Duval	Royal Pines	Jacksonville	Men	8
Duval	Seashore	Jacksonville Beach	Men	8
Duval	Sunshine	Jacksonville	Women w/Children	9
Duval	Timucuan	Jacksonville	Men	6
Escambia	Armadillo	Pensacola	Men w/Children	8
Escambia	Ashton	Pensacola	Women w/Children	8
Escambia	Cain	Pensacola	Men	9
Escambia	Capri	Pensacola	Men	11
Escambia	Danny	Pensacola	Men	8
Escambia	Glo	Pensacola	Men	8
Escambia	Gwendolyn	Pensacola	Women	10
Escambia	Myrtle Grove	Pensacola	Men	9
Escambia	New Beginnings	Pensacola	Women	7
Escambia	Stancil	Pensacola	Women	9
Escambia	Tabicat	Pensacola	Women w/Children	9
Escambia	Waltham	Pensacola	Men	7
Escambia	Precedent*	Pensacola	Women	9
Escambia	Panther	Pensacola	Men	6
Flagler	Driftwood	Palm Coast	Men	9
Flagler	Gator Landing	Palm Coast	Men	8
Flagler	Royal Palm*	Palm Coast	Women w/Children	8
Flagler	Hibiscus	Palm Coast	Women w/Children	9
Flagler	Palm Cove	Palm Coast	Women	8

Flagler	Pine Lakes	Palm Coast	Men	10
Flagler	Seahorse	Palm Coast	Men	10
Flagler	Spring Board	Palm Coast	Women	10
Flagler	Belle Terre*	Palm Coast	Men	8
Hernando	Island Park*	Spring Hill	Men	10
Hernando	Weeki Wachee*	Spring Hill	Men	9
Hernando	Nature Coast	Spring Hill	Women w/Children	10
Hillsborough	Apogee	Brandon	Men	8
Hillsborough	Breeze	Tampa	Men	8
Hillsborough	Buccaneers	Tampa	Men	11
Hillsborough	Bolts*	Temple Terrace	Men	12
Hillsborough	Lightning	Tampa	Women	12
Hillsborough	Nautilus	Tampa	Men	8
Hillsborough	Orange Blossom	Tampa	Women	9
Hillsborough	Palm Tree	Tampa	Men	8
Hillsborough	Rip Tide	Temple Terrace	Men	7
Hillsborough	Stingray	Tampa	Men	7
Hillsborough	Sun Kissed	Tampa	Women	7
Hillsborough	Treasure Chest	Tampa	Men	6
Hillsborough	Waves	Tampa	Women	8
Hillsborough	Zeno	Tampa	Men	8
Indian River	Bungalow	Vero Beach	Men	10
Indian River	Cabana	Vero Beach	Women w/Children	12
Indian River	Snapdragon*	Vero Beach	Women	9
Lake	Dragon Fire	Lady Lake	Men	7
Lake	Flora	Fruitland Park	Men	10
Lake	Lady Lake*	Lady Lake	Women	8
Lake	Nymeria	Fruitland Park	Women	9
Lake	Indigo	Fruitland Park	Women	9
Lee	Amberjack	Cape Coral	Women	8
Lee	Barracuda	Cape Coral	Men	10
Lee	Beachy Keen	Cape Coral	Women	10
Lee	Bluefish	Fort Myers	Men	6
Lee	Chiquita	Cape Coral	Men	8
Lee	Cobia	Ft. Myers	Women w/Children	8
Lee	Coralwood	Cape Coral	Men	6
Lee	Flamingo	Cape Coral	Women	7
Lee	Kingfish	Cape Coral	Men	9
Lee	Angelfish*	Cape Coral	Women w/Children	11
Lee	Mahi	Cape Coral	Women	8
Lee	Ocean Breeze*	Cape Coral	Men	10

Lee	Mangrove	Cape Coral	Men	7
Lee	Manta Ray	Ft. Myers	Men	10
Lee	Mermaid Cove	Ft. Myers	Women w/Children	12
Lee	Starfish	Cape Coral	Men	10
Lee	Tarpon Point	Cape Coral	Men	10
Lee	Jellyfish Cove*	Ft. Myers	Men	8
Leon	Apalachee	Tallahassee	Women	8
Leon	Firefly	Tallahassee	Men	9
Leon	Gator Cove	Tallahassee	Men	11
Leon	Leon	Tallahassee	Women	7
Leon	Garnet*	Tallahassee	Women	8
Leon	Naranja	Tallahassee	Women w/Children	9
Leon	Noles	Tallahassee	Men	8
Leon	Panhandle	Tallahassee	Men	9
Leon	Premier	Tallahassee	Women w/Children	10
Leon	Sherwood Forest	Tallahassee	Women	8
Leon	Tallahassee	Tallahassee	Men	8
Leon	Temperance	Tallahassee	Men	14
Leon	Westworld	Tallahassee	Men	9
Leon	Heritage Hill*	Tallahassee	Men	8
Manatee	Ladyfish	Bradenton	Women w/Children	11
Manatee	Redfish Cove	Bradenton	Men	11
Manatee	Yellowtail	Bradenton	Men	8
Marion	352	Ocala	Men	8
Marion	Cala	Ocala	Women	7
Marion	Epona	Ocala	Women w/Children	9
Marion	Fauna	Ocala	Women	8
Marion	Freyja	Ocala	Women w/Children	8
Marion	Impact	Ocala	Men	9
Marion	Monolith*	Ocala	Men	11
Marion	Pharaoh	Ocala	Men	7
Marion	Vesta	Ocala	Women w/Children	8
Marion	Astra	Ocala	Men	8
Miami-Dade	Ackee	Miami	Men	10
Miami-Dade	Iguana	Miami Gardens	Men	9
Miami-Dade	Oikos	Cutler Bay	Women	8
Miami-Dade	Coconut Bay*	Miami	Men	12
Miami-Dade	Tangelo	Miami Gardens	Women w/Children	12
Miami-Dade	Chopani*	Cutler Bay	Men	8
Okaloosa	Crusader	Fort Walton Beach	Men	10
Okaloosa	Flounder	Crestview	Women	9

Okaloosa	Okaloosa	Fort Walton Beach	Men	10
Okaloosa	Copperhead*	Fort Walton Beach	Women	8
Okaloosa	Sunset Bay	Crestview	Women w/Children	8
Orange	417	Orlando	Men	10
Orange	Kiwi	Apopka	Men	10
Orange	Marlin Rose	Orlando	Men	8
Orange	Orange Grove	Apopka	Men w/Children	10
Orange	Magic*	Orlando	Men	10
Orange	Sandhill Crossing*	Maitland	Women w/Children	9
Orange	Spanish Galleon*	Orlando	Men	9
Orange	Sapphire	Orlando	Women	8
Orange	Fort Gatlin	Orlando	Men	11
Orange	Ibis	WinterPark	Women	9
Osceola	Anole	Kissimmee	Men	8
Osceola	Epic Start	Kissimmee	Men	8
Osceola	Tiger Shark*	Kissimmee	Men	10
Osceola	Star Fruit*	Kissimmee	Women w/Children	8
Palm Beach	Avocado	N Palm Beach	Men	9
Palm Beach	Dolphin	Riviera Beach	Men	8
Palm Beach	Endless Summer	Lake Park	Women w/Children	12
Palm Beach	Improv	West Palm Beach	Men	11
Palm Beach	Mango	Lantana	Women w/Children	6
Palm Beach	Papaya	West Palm Beach	Men	10
Palm Beach	Pineapple	West Palm Beach	Men	8
Palm Beach	Bondad*	West Palm Beach	Men	8
Palm Beach	Renacer	Riviera Beach	Women	8
Pasco	Gulf Oasis	Port Richey	Men	10
Pasco	Land O'Lakes	Land O' Lakes	Women	7
Pasco	Peace River	Port Richey	Men	10
Pasco	Grace Valley*	New Port Richey	Women	8
Pinellas	Green Flash	Clearwater	Women w/Children	8
Pinellas	Gulf Bay	Largo	Men	8
Pinellas	Heat Wave	St. Petersburg	Women w/Children	9
Pinellas	Hurricane	Seminole	Men	7
Pinellas	Pinellas	St. Petersburg	Men	10
Pinellas	Pinnacle	St. Petersburg	Men	9
Pinellas	Skyway	St. Petersburg	Men	12
Pinellas	Southern Light	St. Petersburg	Men	10
Pinellas	Thresher	Clearwater	Women	9
Pinellas	Tidal Wave	St. Petersburg	Men	10
Pinellas	Tsunami	Seminole	Men	9

Pinellas	Vertex	St. Petersburg	Men	10
Pinellas	Oracle*	Pinellas Park	Men	11
Polk	Kayak	Winter Haven	Men	9
Polk	Lifeboat	Lakeland	Men	7
Polk	Opimist	Winter Haven	Women w/Children	9
Polk	Paddle Boat	Winter Haven	Women w/Children	8
Polk	Sailboat	Lakeland	Men	9
Polk	Anhinga*	Winter Haven	Men	6
Polk	Free Bird*	Winter Haven	Men	9
Polk	Meadowlands	Lakeland	Women	8
Polk	Brigantine*	Winter Haven	Men	8
Sarasota	Aqua Reef	Sarasota	Women w/Children	11
Sarasota	Caspian	Sarasota	Men	6
Sarasota	Pelagic	Sarasota	Men	6
Sarasota	Sea Turtle	Sarasota	Women	8
Sarasota	Swordfish	Sarasota	Men	10
Seminole	Angler	Altamonte Spg	Men	8
Seminole	Banyan	Winter Park	Men	8
Seminole	Devotion	Altamonte Spg	Men	10
Seminole	Dragon Fruit	Altamonte Spg	Men	8
Seminole	Hummingbird	Winter Park	Women	8
Seminole	Key Lime	Altamonte Spg	Men	8
Seminole	Lando	Altamonte Spg	Women w/Children	8
Seminole	Oni	Altamonte Spg	Men	11
Seminole	Scarlet Sage	Sanford	Men	8
Seminole	Silkworth*	Sanford	Men	10
Seminole	Amenti*	Casselberry	Women w/Children	7
Seminole	Chaim	Altamonte Spg	Men	7
St. Johns	Ancient City	St Augustine	Men w/Children	8
St. Johns	Dreamcatcher	St Augustine	Women w/Children	9
St. Johns	Matanzas	St Augustine	Men	10
St. Johns	Oyster Creek	St. Augustine	Men	9
St. Johns	San Sebastian	St Augustine	Men	9
St. Johns	Salt Run*	St. Augustine	Women	8
St. Johns	Sawgrass*	Ponte Vedra	Women	6
St. Johns	Olde Town	St. Augustine	Men	8
St. Johns	Castillo	St. Augustine	Men	8
St. Lucie	Clusia	Port St. Lucie	Women w/Children	11
St. Lucie	Everglade	Port St. Lucie	Men	10
St. Lucie	Hammock	Fort Pierce	Men	10
St. Lucie	Lucie	Port St. Lucie	Women w/Children	8

St. Lucie	No Reservations	Port St. Lucie	Women w/Children	9
St. Lucie	Sandcastle	Port St. Lucie	Men	7
St. Lucie	Sandpiper	Port St. Lucie	Men	9
St. Lucie	Sea Breeze	Port St. Lucie	Men	10
St. Lucie	Sunrise City*	Fort Pierce	Women w/Children	10
St. Lucie	Treasure Coast	Port St. Lucie	Women	8
St. Lucie	Vista Nueva	Port St. Lucie	Men	9
St. Lucie	Abacus	Port St. Lucie	Men	9
Volusia	Blue Topaz	Daytona Beach	Women w/Children	9
Volusia	Checkered Flag	Daytona	Men	11
Volusia	Deep Creek	Deltona	Men	11
Volusia	Priya	Deland	Women w/Children	11
Volusia	Sandy Bottom	Daytona	Men	10
Volusia	Shanti	Deland	Men w/Children	10
Volusia	Shining Beacon	Port Orange	Women w/Children	11
Volusia	Tigers Eye*	South Daytona	Women w/Children	7
Volusia	Amistad	Deltona	Men	10

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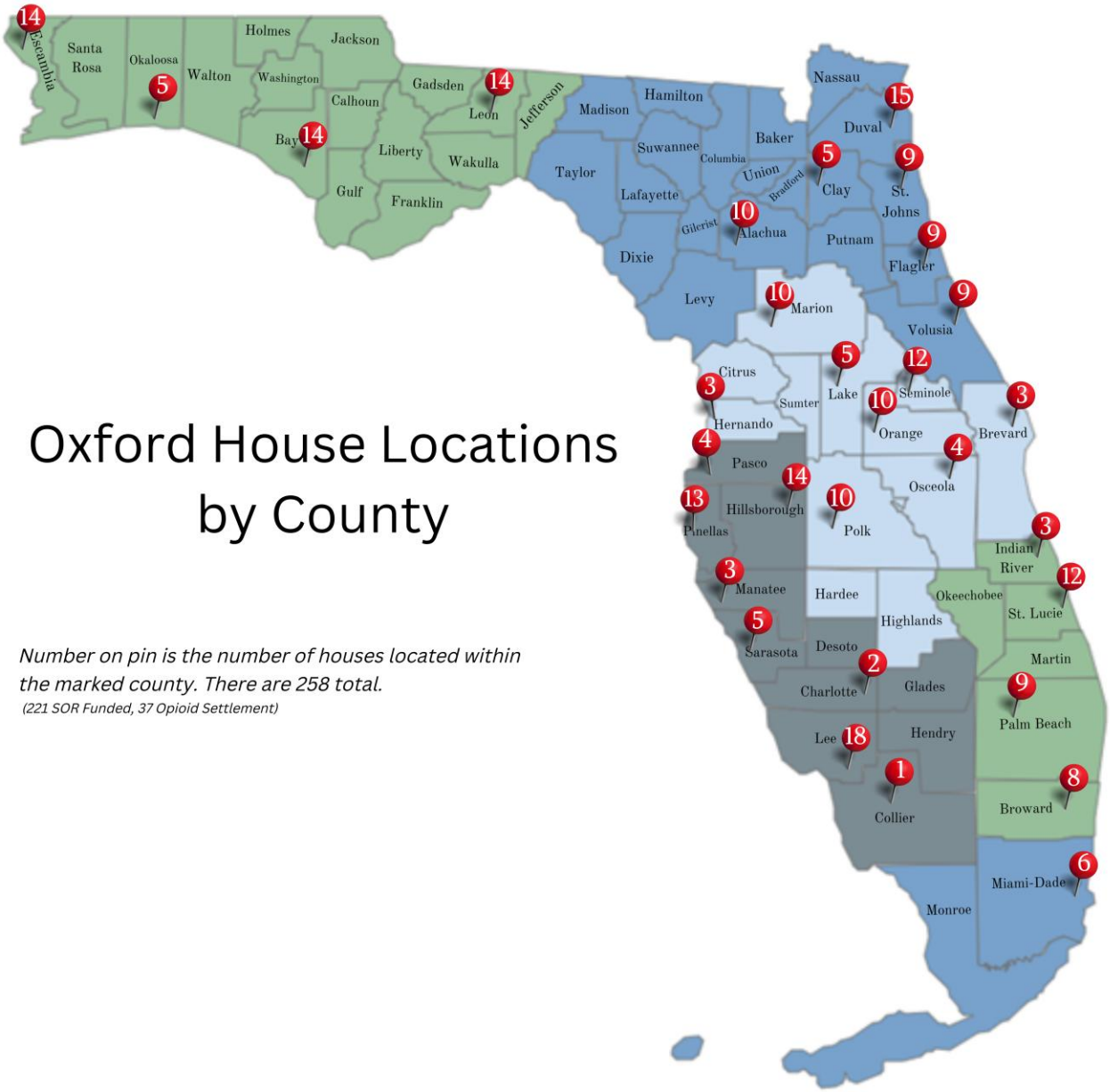

Oxford House Locations by County

Number on pin is the number of houses located within the marked county. There are 258 total.

(221 SOR Funded, 37 Opioid Settlement)

Through April 2025

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 — Recovery Oriented Quality Improvement Specialist (ROQIS)

Who is a ROQIS?

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

What are the expectations of a ROQIS?

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

Quality Assurance and Improvement Activities

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

Technical Assistance (TA)

- Technical Assistance aims to strengthen the skills and abilities of individuals, organizations, and systems to help them achieve their goals. It offers varying levels of support, ranging from foundational guidance to more in-depth, tailored assistance. The type of TA provided by the ROQIS is broken down into the following categories:
    - Universal Support- Involves disseminating broadly accessible information and resources designed for a wide audience without focusing on specific groups or individuals. This could include creating newsletters, publishing guidebooks, synthesizing research, delivering untargeted presentations to diverse groups, maintaining websites, and engaging with audiences through social media platforms. The intended outcomes often include increasing awareness and understanding of research, boosting motivation to act, and encouraging the application of interventions. This approach ensures that key information is widely available and encourages inclusive engagement.
    - Targeted Support: Involves delivering focused, tailored activities designed to address specific needs. These may include single events like strategic planning sessions or regional workshops, as well as a series of connected activities, such as conference calls on one or multiple topics. Examples of targeted support include facilitating online courses, hosting webinar series, organizing focused knowledge-sharing sessions, building communities of practice, conducting short-term training, or developing replication guides. The desired outcomes often aim to enhance participants' capacity to effectively implement and apply interventions. This approach ensures that the support provided is practical, applicable, and aligned with identified goals.
    - Intensive Support: Involves providing on-site services that require a continuous relationship between the technical assistance provider and the recipient organization or program staff. This type of support is designed to bring about significant changes in policies, programs, practices, or operations, resulting in improved outcomes across one or more system levels. Examples include ongoing consultations with specific communities, states, or systems. The intended outcomes often focus on enabling the intended users to effectively adopt and integrate interventions into their day-to-day practices. This approach ensures a deep and lasting impact on the recipient's operations and goals.
- Support peers in overcoming challenges with level 2 background screenings as well as challenges with certification. When applicable, link individuals to supports and services (and document the date, time, person, and summary of how you supported the peer).
- Provide TA to RCOs and guide them through the process of assisting peers in overcoming challenges with level 2 background screenings as well as challenges with certification.
- Supporting cultural improvements within service delivery of an organization’s recovery orientation with TA on integration and implementation across a spectrum of systems, including recovery support services. Examples: reviewing policies and practices, training,

lending the perspective of persons with lived experience to support the integration of Recovery Management principles and practices.

- Increase the number of organizations distributing naloxone in each region by providing TA and support through the distributor enrollment process. Minimum expectation 2 per federal fiscal year.
- Identify opportunities for improvements within SOR-funded community service provider networks by conducting Recovery Oriented Monitorings (ROMs), provide relevant ongoing TA and support facilitation of collaborative strategic planning processes among Managing Entities (MEs) and network service providers (NSPs).
- Enhance the role of peers and peer supervisors in the workforce through implementation of best-practice standards among local providers through training and TA.
- Provide support to established and emerging Recovery Community Organizations (RCOs). Identify opportunities for RCOs to work closely with managing entities, community treatment providers and other stakeholders to integrate linkage to risk reduction and recovery support services. This also includes but is not limited to: individuals leaving jails, hospitals, and treatment centers and supporting linkages through partnerships with first responders.
- Provide support to increase access to recovery support services, including implementation, fidelity measurement and technical support to Recovery Community Organizations, MAT providers, as well as hospital and jail bridge programs.

<u>Reporting Requirements</u>

- ROQISs will prepare and submit reports and findings suitable for executive level briefings and include an analysis of opportunities for improvement following Recovery Oriented Monitoring's (ROMs) utilizing the process and protocols outlined within the Quality Improvement Blueprint which were developed for ROM and associated requirements of Guidance Document 35 Recovery Management Practices, (ex. chart reviews, interviews with persons served, provider staff interviews, and written reports.)
- ROQISs will submit a yearly report outlining Network Services Providers (NSPs) identified opportunities for improvements, as identified through the ROM process, combined with a summary of their action plans for improvements. Report shall also outline TA provided by ROQISs and/or Managing Entities (MEs) and document any progress towards improvements outlined in the summary. Reports and findings shall be suitable for executive level briefings and reports, including an analysis of opportunities for improvement and document any challenges towards achieving positive outcomes. Reports will be submitted to headquarters by May 31st of each calendar year.
- Monthly reports are due the 18th of each month by the end of the business day. Monthly reports shall include trainings, technical assistance and support, community meetings, time spent on monitorings and reports, and other duties as assigned. For each training a sign-in sheet must be included, and SAMHSA's profession type domains must be listed for everyone in attendance. For technical assistance documentation must be kept, including name, time, date, and purpose of support.

- Establish a regional committee that includes individuals using MAT, peers with MAT experience, and family members of those who need or use MAT. The committee will work together to identify challenges that make it difficult to access care, including systemic barriers and other contributing factors. The goal is to develop strategies and create a detailed plan using a ROSC approach to address and improve access for these groups. Committee members can be recruited through network service providers offering MAT, RCOs, and hospital or jail bridge programs. A summary of the committee's work will be submitted at the end of each Federal Fiscal Year (FFY).

Trainings

- ROQIS facilitation of peer trainings will be intentional and specific. As of fiscal year 2022/2023, trainings will be supplemental to the MEs' trainings for peer specialists.
- Statewide trainings will need to be approved by both the region and headquarters, to ensure that regional priorities are addressed. An approved list of trainings is listed below. Any other trainings need to be approved. If asked to provide support for a training from headquarters (HQs), HQs will reach out to the regional SAMH director/supervisory team. If asked to provide support from a stakeholder (ex. Florida Certification Board, Peer Support Coalition, etc.), it will be the ROQIS' responsibility to ask the supervisor.
- 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.
- Utilize approved sign-in sheet when providing any (virtual or in person) trainings to include topic of training, date, time, location, employment profession type demographics. If the attendance demographic is "other" please specify to the profession type in attendance.
- Provide a minimum of three cross-systems training and TA on implementation, accessing, supporting, and integration of sustainable recovery supports. Including but not limited to: Office of Child and Family Wellbeing (OCFW), Department of Juvenile Justice (DJJ), Florida Department of Corrections (FDOC), Department of Health (DOH), U.S. Department of Veteran's Affairs (VA), Department of Education (DOE), National Association on Mental Illness (NAMI) or other mental health affiliates.
- These trainings shall include SOR-related topics and can include but are not limited to: ROSC, Peer Services, Recovery Support Services, RCO implementation, Recovery Management, Recovery Planning, Peer Supervision, Medication Assisted Treatment and Stigma Reduction, Wellness Recovery Action Plans (WRAP), Peer Utilization in Healthcare Settings, eCPR, and Risk Reduction.
- Connect and support the Overdose Prevention Team to train organizational staff on naloxone when supporting an organization in becoming a distributor.

Community Meetings and Events

- Attendance at community meetings should add value and enhance knowledge, skills, and abilities.

- As a Department employee, and the regional face of ROSC, attending community meetings will play an integral role in building supports and networks within a ROQIS' community. Each event attended should be intentional to provide information and education or outreach. Other events may be attended for learning purposes, if relevant to the work and that the information gained can be applied and utilized to enhance the ROQIS' role within the community.
- All meetings shall be documented to include time, date, name of meeting, and purpose; meeting agendas shall be saved and archived if available.
- There may be times when another Department employee asks for you to step in and cover a meeting where Department presence is requested. Please list these opportunities as "other tasks as assigned".
- For the purposes of gathering feedback or providing the community with supports needed, a ROQIS may conduct a ROSC-related community event or meeting when applicable.

Deliverables

- Submit Recovery Oriented Monitoring reports. ROMs will be conducted in collaboration with the MEs in alignment with the MEs current monitoring schedule. If a need is identified, targeted ROMs can be conducted. Collaborative reports will be uploaded into the ROQIS folder.
- ROQISs will submit an annual report outlining NSPs identified opportunities for improvements combined with a summary of their action plans for improvements. The report shall also outline technical assistance provided by the ROQIS and/or ME and demonstrate any progress.
- Increase access to recovery supports. ROQIS will contribute to the increase of recovery services, including implementation and technical support to RCOs. This can include but is not limited to, expansion of hospital or jail bridge programs, recovery community organizations, and medication assisted treatment peer specialists.
- Provide a minimum of three cross-systems ROSC-related, SOR-specific trainings and TA on implementation, accessing, supporting, and integrating sustainable recovery supports per FFY. Including but not limited to: OCFW, DJJ, VA, DOC, DOH, DOE, NAMI or other mental health affiliates.
- ROQISs will increase number of organizations distributing naloxone in each region due to offering technical assistance and support through the enrollment process and staff training when applicable. Naloxone distributors linkage as well as connecting to the Overdose Prevention Team to conduct staff training when applicable. Minimum expectation is 2 per FFY.
- Create and facilitate a regional committee inclusive of MAT peers, individuals receiving MAT services, and family members of individuals in need of or receiving MAT services to have meaningful inclusion while focusing on the development of strategies and completing a strategic plan utilizing a ROSC framework addressing inclusion and improvement to those populations. These peers can be identified through NSPs providing

MAT services, RCOs, and hospital and jail bridge programs. Report summaries will be due at the end of each FFY.

Monthly reports shall be submitted by the 18th of each month.

ROQISs will complete regional action plans, outlining goals and creating next steps. These action plans should be created to be implemented in tandem with the Managing Entity's action plans.

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Appendix C — SOR Bridge Programs

This list is subject to change.

Hospital Bridge Programs

Managing Entity	Hospital	County
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
	Baptist Main Downtown	Clay
	Baptist Hospital/Clay	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
	Ascension St. Johns	St. Johns
	Halifax Health Daytona Beach	Volusia
	Advent Health New Smyrna Beach	Volusia
	Advent Health-Deland	Volusia
	Fish Memorial	Volusia
Central Florida Behavioral Health Network	Naples Community Hospital Healthcare System	Collier
	Physicians Regional Medical Center	Collier
	Tampa General*	Hillsborough
	St. Joseph's Hospital *	Hillsborough
	BayCare South Florida	Hillsborough
	St. Joseph's Hospital *	Hillsborough
	Tampa General*	Hillsborough
	Morton Plant North Bay*	Pasco
	Morton Plant North Bay*	Pasco
	St. Anthony's	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
Central Florida Cares Health System	Advent Health- South Orlando	Orange
	Advent Health- Winter Park	Orange
	Advent Health- East Orlando	Orange
	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- Addiction Stabilization Unit (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

Jail Bridge Programs

Managing Entity	Jail	County
Lutheran Services Florida	Clay County Jail	Clay
	Flagler County Jail	Flagler
	Hernando County Jail	Hernando
	Nassau County Jail and Detention Center	Nassau
	Saint Johns County Jail	Saint Johns
	Volusia County Branch Jail	Volusia
Central Florida Behavioral Health Network	Charlotte County Jail	Charlotte
Central Florida Cares Health System	Osceola County Corrections	Osceola
	Indian River County Jail	Indian River
	IRC Jail/TCCH	Indian River

Southeast Florida Behavioral Health Network	Martin County Jail	Martin
	Okeechobee County Jail	Okeechobee
	Belle Glade West Detention Center	Palm Beach
	Palm Beach County Sheriff's Office	Palm Beach
	Saint Lucie County Jail	Saint Lucie
Broward Behavioral Health Coalition	Broward County Jail	Broward

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Appendix D — Peer Provider Mentor Program

The Peer Prescriber Mentor Program focuses on expanding easy access to FDA approved medications for treatment of opioid use disorders to individuals passing through hospital emergency departments or correctional facilities. Peer prescriber mentors are specially trained physicians in opioid use disorder and medication assisted treatment who serve as peer mentors to other physicians and professionals. There are currently eight physicians contracted though the Florida Alcohol and Drug Abuse Association (FADAA). oversee the program. The Department contacts with the Florida Alcohol and Drug Abuse Association to oversee the program.

Consultation—Peer prescriber mentors are available to provide scheduled or real-time consultation to a group or one on one to physicians and other professionals on best practices for bridge program implementation, expansion, medication assisted treatment, and working with special populations such as pregnant women.

Training—Peer prescriber mentors can provide training on the needs and requirements of successful bridge programs. Training can include efforts to reduce the stigma surrounding medication assisted treatment and best practices to treat opioid use disorders. Mentors can tailor the training to the requested need.

Technical Assistance—Peer prescriber mentors can assist in the develop of policies and procedures to help build sustainable bridge programs and can assist with other identified site needs.

Contact Diana Snyder for information or to request technical assistance via email diana@floridabha.org.

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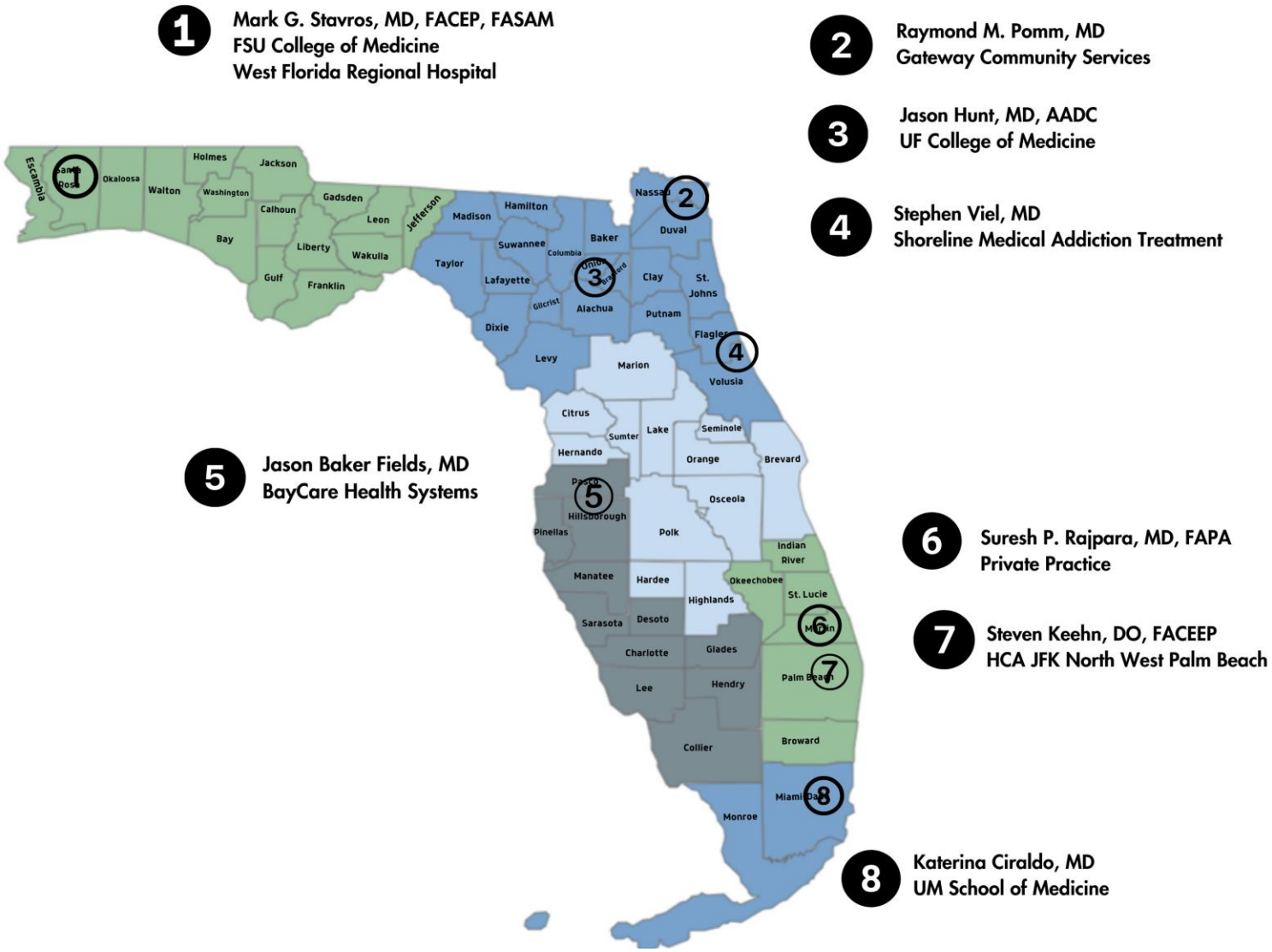
Peer Prescriber Mentors are available to provide support across all regions within the state. This map indicates the geographical locations of each physician.



Appendix E— Web Infrastructure for Treatment Services (WITS) Ticket Template for Managing Entities

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.

Reporter Information Name and email of Managing Entity or Department staff initiating ticket and will be corresponding with FEI and/or DCF until resolved.	
Name:	Email:
Ticket Information Provider/user information requesting support.	
Agency:	Facility:
Staff Name:	Staff User ID:
Staff Email:	Date Reported:
UCN:	
Reported Issue:	
Error Encountered:	
Screen issue description (add screen shot per instructions below):	

Ticket Status The Department will provide updated information or requests for additional information.
☐ Resolved ☐ Additional Information Needed ☐ FEI Support Requested Additional Information:

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

Option 1—Web Capture
Option 2—Print Screen
Option 3—Snipping Tool