Coordinated Opioid Recovery (CORE) Network of Addiction Care

Contract Reference: Contract Exhibit A. Administration C-1.23

Authority: Section 394.9082, F.S. C-1.2.3.25

Frequency: Service data submissions are updated daily; all others are due monthly by the 18th. Coordinated Opioid Recovery (CORE) Network Data and Narrative reports are due quarterly.

I. Definitions

1. **24-7 Access Point**: A 24-7 access point can be an Emergency Department (ED), Emergency Medical Services (EMS) or a Central Receiving Facility (CRF). All 24-7 access points must provide immediate buprenorphine products or other medication assisted treatment (MAT) when clinically appropriate, without a requirement for a higher level of care with a continuation plan until the patient has established care at the receiving clinic, preventing a lapse in treatment. The 24-7 access point can recommend a higher level of care but will still offer lifesaving treatment in an outpatient setting if the patient refuses a higher level of care.
2. **Receiving Clinic**: A receiving clinic is the provider in the community providing long-term MAT medication assisted treatment (MAT). A receiving clinic can be a substance use only provider, a Federally Qualified Health Center (FQHC) or a Community Behavioral Health Center (CBHC) that treats all patients regardless of ability to pay and receives all patients from the 24-7 access point to continue MAT services indefinitely in an outpatient setting. Transportation should be made available to patients if this is a barrier to treatment. The receiving clinic may recommend a higher level of care for the patient but will not stop treatment if the patient refuses the recommendation. Receiving clinics serve as a substance use medical home for lifelong care providing MAT, substance use therapy, psychiatry, and primary care. If the receiving clinic does not provide primary care, including health and dental care, they must partner with a provider that offers those services to the individual.
3. **Recovery Support**: These include peer support services, social determinants of health (supportive housing, supportive employment, transportation, drop-in centers, recovery community organizations, aftercare, and legal services). Recovery Supports must have coordinated relationships with the 24-7 access points and receiving clinics.
4. **Warms Handoff**: The patient must continue lifesaving buprenorphine or other MAT until handed off to the receiving clinic from the 24-7 access point with no lapse in care. Peer supports, case managers, care coordinators, or nurse coordinators can be utilized. Facilitating a warm handoff means actively connecting an individual to another service provider. This process goes beyond simply providing a referral name, phone number, and appointment time. Warm handoffs are a transfer of care between two provides in the presence of the individual and their family (if present). The purpose of the warm handoff is to engage the individual with the new provider.

II. Purpose

This document provides direction and guidance for administration, implementation, and management of Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care. Also included are the purpose, policies, and competencies intended to ensure that funds are used effectively to combat substance use disorder in Florida, in accordance with state and federal laws and regulations.

To ensure the implementation and administration of this project, the Managing Entity will engage in contract negotiations with Receiving Clinics, Emergency Medical Providers, Emergency Departments and Law Enforcement participating in a CORE Network and will achieve the outcomes of the service delivery and reporting requirements. Additional partners may be included to strengthen a CORE Network. Data reporting requirements include data required by opioid settlement funds in addition to some CORE specific data outcomes as defined in section IX. CORE Networks provide immediate, 24-7 easy access to evidence-based care for substance use disorders. 24-7 access points provide buprenorphine inductions when appropriate without a need for higher level of care. Patients will have a warm handoff to receiving clinic where MAT will be continued, with no lapse in care. The Managing Entity shall not make any changes or variations from fidelity to the structure, implementation, and data collection of the CORE model as stated in this document without prior written approval from the Department.

III. Program Requirements

The table below defines each of the required program elements for CORE.

CORE Element	Description
24-7 access to care.	**24-7 availability for treatment with MAT. Specifically, buprenorphine must be available 24-7 in an emergency setting with no need for admission to inpatient care to receive treatment immediately. 24-7 access to care can come from an emergency department, emergency medical services or a receiving facility/long-term medication assisted treatment provider.**
Peer support services.	Peers provide support services such as a warm handoff from the 24-7 access point (emergency department receiving facility/long term medication assisted treatment provider, emergency medical services) and continuous follow-up.
All FDA approved MAT services.	FDA approved MAT for opioid use disorders includes methadone, naltrexone, and buprenorphine products.
Maintenance of MAT according to guidelines.	The Substance Abuse and Mental Health Services Administration's TIP 43[1] recommends that patients receiving MAT should be maintained at least two years of continuous stability, or longer, without taper recommendation. Tapering is considered an optional branch.
Individual approach to dosing without limits.	Buprenorphine should not be restricted to a certain dose, because of fentanyl, as increasing doses enhances retention and decreases cocaine use. Dosing should be based on decreasing withdrawal over 24 hours.
Receiving clinic receives patients from 24-7 care and continues lifelong treatment.	**An FQHC or CBHC that can take patients during business hours for intake and serve as a substance use medical home for lifelong care providing MAT, substance use therapy, psychiatry, and primary care.**
Clinic and ER testing / Prescription Drug Monitoring Program (PDMP).	**Report through E-Force every visit and provide drug panels in receiving clinics and 24-7 access points.**
Law Enforcement	Participate in community activities that build trust, foster relationships, and educate the public about available support systems. This collaboration bridges the gap between individuals in crisis and essential treatment services

Established intake process.	An intake and assessment that includes a doctor's visit to start substance use treatment and a biopsychosocial completed or countersigned by a qualified professional.
Established protocol for induction on buprenorphine.	There should be a high dose and low dose induction protocol with preference given to the high dose induction protocol that can be given immediately after use or naloxone reversal.
Treating comorbid alcohol and benzodiazepine use disorder.	American Society of Addiction Medication (ASAM) report the use of benzodiazepines or other sedative-hypnotics are not a reason to withhold or suspend treatment. Follow best practices and guidelines provided in Federal Guidelines. [2, 3]
Naloxone readily available.	Naloxone quickly reverses an overdose by blocking the effects of opioids. It can restore normal breathing within 2 to 3 minutes in a person whose breath has slowed, or even stopped, as a result of an opioid overdose.
Access to higher levels of care for all.	In the county there should be a functional referral relationship with public/ private detoxification programs to assist with complex detoxification (benzodiazepines/alcohol patients with delirium tremens), access to public/ private residential, partial hospitalization programs (PHPs), intensive outpatient programs (IOPs) and outpatient levels of care for adults and pregnant women.
Clinical expert in addiction medicine or champion.	Established Medical Doctor (MD) or Doctor of Osteopathy (DO) who is primary care or psychiatrically trained and who has addiction medicine or addiction psychiatry certification.
Therapists in outpatient setting.	Licensed Mental Health Counselors (LMHCs), psychologists, Licensed Clinical Social Workers (LCSWs) and interns who provide group and individual therapy as part of the substance use program.
Primary care access.	All patients should have access to primary care.
Infectious disease screening.	All patients enrolling in a substance use disorder program should be tested for HIV, hepatitis panel (especially hepatitis C), syphilis, and tuberculous as needed, as part of the intake.
Access to psychiatry at the FQHC or CBHC.	Psychiatric provider should be available and all patients entering the substance use disorder program should receive a psychiatric evaluation to assist with underlying psychiatric problems as they can be comorbid with substance use disorder diagnosis.
Group therapy access in the clinic or with a collaborative partner.	Individuals should have access to group therapy.
Individual therapy access in clinic or with a collaborative partner.	Individuals should have access to individual therapy.
Clinic structured by phases of treatment.	Patients should start receiving MAT with methadone or buprenorphine in a phased approach to allow for flexibility based on need and clinical judgement
All levels of care to assist with pregnant women.	Evidence-based pregnancy care with buprenorphine/methadone options available while in residential, partial hospitalization programs, intensive outpatient programs or outpatient care. This care should be coordinated

	with the woman's obstetrics and gynecological team, as well as obstetric triage services equipped to provide appropriate management.
Following of outcome measures and data, specifically the Brief Addiction Monitoring (BAM) tool.	**The Brief Addiction Monitoring tool is completed monthly by all substance use disorder patients in the receiving clinic. Supplemental questions have been added to the collection process.**

IV. Eligibility

The CORE model prioritizes adults aged 18 or older who experience any of the following:

1. A confirmed or suspected opioid overdose requiring naloxone administration.
2. Signs and symptoms of severe substance use withdrawal.
3. Acute substance use withdrawal as a chief complaint.
4. Individuals seeking support for substance use disorder within a CORE Network.

V. CORE Network

The CORE Network establishes a recovery-oriented continuum of care and support for those seeking treatment and recovery support services for substance use disorders. This comprehensive approach expands every aspect of overdose response and treats all primary and secondary impacts of substance use disorder. The CORE Network disrupts the revolving door of substance use disorder, including, opioid use disorders and overdose by providing an evidence based coordinated network of care linking patients to community partners in a continuum from a crisis all the way to lifelong care in an accessible, sustainable way. It incorporates quality improvement through measure outcomes that help sustain the network locally. Department approval is required before implementing any variation of the CORE Network.

The CORE Network includes the following tiered approach with a warm handoff provided at each level:

1. Law Enforcement.
2. Rescue Response.
3. 24-7 access point for stabilization/ assessment.
4. Receiving clinics for long-term treatment.

VI. CORE Sustainability

Sustaining CORE Networks in all counties will require blending and braiding from various funding sources at different levels. The Department will fund counties $700,000-$1,000,000 in the first year of a county onboarding a CORE Network. The funding methodology factors in:

1. Population.
2. Opioid overdose death rate.
3. Non-fatal opioid overdose hospitalizations.
4. Opioid overdose emergency department visits.
5. Opioid overdose EMS transport response.
6. Naloxone administration by EMS.
7. Historical cost of services funded by the Department.

Funding will be reduced by 50% in year two and reduced an additional 25% beginning in year 3 through the remainder of the Opioid Settlement.

VII. Managing Entity Responsibilities

To ensure consistent statewide implementation and administration of CORE, the Managing Entity shall ensure all program requirements, are met through formal partnership agreements such as subcontracts, or memorandum of understandings with Network Service Providers and system partners with implementation timelines based on community partnerships and readiness. The Managing Entity shall implement a CORE Network in accordance with the outlined programmatic standards and in accordance with Florida's Opioid Abatement requirements. The Managing Entity shall expend the funds on approved purposes only. The Statewide Council on Opioid Abatement may pass additional measures and requirements that the Department and Managing Entities must follow when evaluating compliance, performance, and implementation. CORE Network utilizes the no wrong door approach to accessing services. The CORE Network standards are as follows:

1. **Law Enforcement**
    a. Law enforcement is often the first on scene during emergencies, where fire rescue might not typically respond, enabling them to identify individuals in crisis and connect them with appropriate support services.
    b. Their early involvement highlights their critical role within the CORE Network, fostering collaboration and timely interventions.
    c. Integrating law enforcement into the CORE Network allows them to engage in community activities that inform residents about CORE Networks, how to access services and available support systems. Integrating law enforcement encourages and connects individuals to treatment and recovery support services through CORE Networks.
    d. These activities focus on building trust, fostering relationships, and bridging the gap between individuals in crisis and essential treatment services
2. **Rescue Response**
    a. Individual in need of services is treated by first responders (fire rescue/ Emergency Medical Services (EMS) personnel).
    b. Treatment includes use of specialized EMS protocols for overdose and acute withdrawal, and can include induction to buprenorphine.
    c. EMS provides a warm handoff to the ED or receiving clinic/long-term medication assisted treatment provider.
    d. EMS may provide buprenorphine for patients while waiting for warm handoff to receiving clinic after induction performed by EMS or ED.
    e. CORE EMS partners will coordinate with other EMS agencies within in their county to follow up with patients who overdosed and received care from a non-CORE Network EMS provider.
3. **Stabilization/Assessment**
    a. Individual receives treatment at a 24-7 access point.

b. Treatment options include medication-assisted treatment, which entails, at a minimum, the ability to induct individuals on buprenorphine and issue a prescription for buprenorphine that lasts until their initial appointment with a community-based provider prior to being released from the ED.

c. Specialty-trained medical staff recommend the care best suited for the individual and a peer navigator facilitates a warm handoff to the receiving clinic for long-term treatment.

4. Receiving Clinics//Long-term treatment provider

a. Individual receives long-term-care and wrap around support.

b. Individual is treated by a team of licensed and certified professionals that specialize in treating addiction.

c. Services may include long-term management of MAT, therapy, psychiatric services, individualized care coordination, and links to other health services.

d. Individuals shall receive services to address any identified social service needs.

e. Ensure implementation of the Brief Addiction Monitor tool along with other data requirements.

5. Warm handoff and Recovery Support

a. Certified Recovery Peer Specialists utilize direct lived experience with substance use disorder and recovery to reduce stigma and increase engagement into services.

b. Certified Recovery Peer Specialists facilitate warm handoffs to treatment and recovery community organizations.

VIII. Network Service Provider and System Partner Responsibilities

Network Service Providers, Emergency Departments, and Emergency Medical Services and Law Enforcement shall identify staff to be responsible for activities required through the CORE partnership. Network Service Providers and system partners including Eds, EMS and law enforcement shall implement a CORE Network and shall provide eligible individuals with treatment that includes use of specialized protocols for overdose and acute withdrawal and provide MAT. CORE partners shall work together identifying a point of contact, preferably the peer specialist (where applicable), to provide warm handoffs as the individual transitions to different services.

Network Service Providers and system partners shall complete online CORE training available on the CORE website and any other training required by the Department.

IX. Data

1. Data Collection and Management

Opioid settlement funds will be used to implement CORE Networks. A required component of the state's opioid settlement is to use an evidence-based data collection process to analyze the effectiveness of substance use abatement. The opioid settlement states that the State and Local Governments shall receive and report expenditures, service utilization data, demographic information, and national outcome measures in a similar fashion as required by the 42.U.S.C. s. 300x and 42 U.S.C. s. 300x-21.

a. Managing Entities shall ensure that all CORE partners comply with the required data collection process. This includes collecting data on expenditures, service utilization, and demographic information of individuals receiving services within the CORE Network.

b. Data collection should be based on standardized procedures to ensure consistency and accuracy across all service providers.

c. To evaluate the effectiveness of substance use abatement, the data collection process should allow for tracking and measuring key outcome indicators related to opioid use disorder treatment, such as retention rates, reduction in overdose incidents, and improvements in overall well-being.

The Opioid Data Management System (ODMS) was developed by the Florida Department of Children and Families to store data submitted by counties, municipalities, providers, and any other entity receiving Opioid Settlement Funding. The Opioid Data Management System consists of two portals. The provider portal will receive electronic data for services rendered. The second portal will serve as a platform to enter implementation/abatement plans, financial expenditure information, financial audit documentation and other supporting documentation as necessary.

X12 837 EDI files will be submitted to the Department through the provider portal. This will help to reduce administrative burdens. A recording of the Opioid Data Management System Provider Webinar is available on the Florida Opioid Settlement website: Resources - Florida Opioid Settlement

Providers must ensure secure data sharing, confidentiality, and privacy in accordance with all applicable rules and statutes. All data contained within the Opioid Data Management System is sensitive and privileged information and shall be handled accordingly. To maintain the integrity of this information, the records will be accorded proper management and security, and will only be accessed and used by authorized personnel in accordance with state and federal law. Receiving Clinics and Emergency Department staff will be required to complete the CF-112 Access Confidentiality and Nondisclosure Agreement and the DCF Security Awareness Basics Training module before being granted access to the Opioid Data Management System. Regular data audits will be conducted to ensure data integrity and discrepancies or errors for timely correction.

Data submitted with an X12 837 EDI file are uploaded nightly. For any data that is not submitted with an X12 837 EDI file, data is due on the 18th of each month for services provided in the prior month. Submitted data for services will use standard industry codes such as CPT and HCPCS billing codes.

The department will receive Emergency Medical Service data through a data sharing agreement with the Department of Health for data that has been entered into the Emergency Medical Services Tracking and Reporting System.

2. Coordinated Opioid Recovery (CORE) Quarterly Reports- Templates 37 and 38

The Department will collect data on a quarterly basis from receiving clinics within the CORE Network. If the peer support services are not provided by the receiving clinic, then the Managing Entity will be responsible for collecting it from the peer service provider. The Coordinated Opioid Recovery Network Quarterly Narrative Report (Template 37) and the Quarterly Data Report (Template 38) are due by the 8th day of the month following the reporting quarter. These reports track the progress and performance of the Coordinated Opioid Recovery Networks statewide.

3. Brief Addiction Monitoring Tool

The Brief Addiction Monitoring Tool (BAM) is a 17-item, multidimensional, progress-monitoring instrument for patients in treatment for a substance use disorder (SUD). The BAM includes items that assess risk factors for substance use, protective factors that support sobriety, and drug and alcohol use, The BAM assessment tool measures patient outcomes and success of the overall project. Receiving clinics must provide the QR Code and encourage completion of the BAM on all individuals with a substance use disorder, every 30 days. The Department created an application for individuals to complete the BAM via QR code. In addition to the 17 questions from the BAM, the department has included several questions related to social determinants of health. It is important to note that these supplementary questions, while valuable and providing deeper insights into patient circumstances, are distinct from the brief addiction monitoring assessment itself, and do not influence the brief addiction monitoring score.

X. Resources

The Coordinated Opioid Recovery- A Network of Addiction Care website contains training videos, protocols and best practices for all tiers within a CORE Network. For more information, visit the CORE Network – Hope for Addiction Recovery website at CORE Network - Hope for Addiction Recovery (flcorenetwork.com)

Medication-Assisted Treatment for Opioid Addiction in Opioid Addiction in Opioid Treatment Programs: A Treatment Improvement Protocol TIP 43: Bookshelf NBK64164.pdf (nih.gov)

U.S. Food and Drug Administration https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medications

American Society of Addiction Medicine – The ASAM National Practice Guideline For The Treatment of Opioid Use Disorder: National Practice Guideline for the Treatment of Opioid Use Disorder

Coordinated Opioid Recovery (CORE) Network of Addiction Care will be administered according to DCF Guidance 41, which can be found at following link using the applicable fiscal year: https://www.myflfamilies.com/services/samh/samh-providers/managing-entities