State Opioid Response (SOR)

Requirement: The Office of Substance and Abuse and Mental Health (SAMH) Contract

Frequency: On-going

Due Date: On-going

The purpose and expectation of the SAMHSA's State Opioid Response (SOR) Grant is to provide opioid misuse prevention, treatment, and recovery support services to address the opioid crisis and provide a service array based on the needs identified in the Opioid STR Grant strategic plan.

The SOR Grant will be administered according to the Florida Department of Children and Families' (DCF) guidance document, or the latest version thereof.

System Priorities:

1. **ESTABLISH EMERGENCY DEPARTMENT BRIDGES TO COMMUNITY-BASED METHADONE OR BUPRENORPHINE PRESCRIBERS THROUGHOUT THE STATE.** Ensure that Emergency Departments (EDs) that induct patients on buprenorphine are linked to a community-based methadone or buprenorphine maintenance provider. Identify and engage community-based providers that can use State Opioid Response (SOR) grant funds to provide assessments and medication maintenance *7 days a week* for patients inducted in the ED. Managing Entities, community-based providers, and EDs must work together to overcome any obstacles to establishing or maintaining these programs. SOR funds can be used to hire prescribers and peers and establish telehealth programs. SOR funds can also be used to pay for incidentals for transporting patients from hospitals to community-based prescribers. Do not think of these as hospital "pilot" programs anymore. Think of them as standard components of your system of care going forward.

2. **ENSURE ACCESS TO BUPRENORPHINE MAINTENANCE IN ALL COUNTIES**. If existing network providers are unwilling to provide buprenorphine maintenance, then Managing Entities must identify and engage other providers who are willing to prescribe buprenorphine. State Targeted Response (STR) grant funds have supported network capacity development for a year and a half. If at this point there are still providers in your network that have only added Vivitrol to their service array, then individuals are not getting access to all options. Managing Entities will need to work quickly to bring new buprenorphine providers into their networks. SOR expenditures will be reviewed 6 months into the project to see if changes are necessary.

3. **ANALYZE AND PLAN FOR SUSTAINABILITY**. Managing Entities should monitor and analyze the "stock and flow" of individuals whose methadone and buprenorphine are paid for by STR and SOR funds. Individuals may be maintained on these medications indefinitely, but these funding streams are limited, so it is important to consider variables like the rates of admissions and discharges and the average length of care. Make sure that MAT providers are screening individuals for Medicaid eligibility. Also, go back and analyze what services for opioid use disorders were previously purchased using Block Grant dollars. The Block Grant-funded residential and detoxification services for OUDs may need to be re-allocated to support evidence-based methadone or buprenorphine maintenance. Finally, bear in mind that a portion

of the $14.6 million in recurring General Revenue funds are intended to help meet the need for methadone or buprenorphine maintenance.

4. **MONITOR AND IMPROVE RETENTION IN CARE BY CHANGING DISCHARGE PRACTICES AND POLICIES.** Retention in care is an important measure of success and it should be systematically monitored and improved as a priority. Several findings and conclusions from a landmark Consensus Study Report issued by the National Academies of Sciences, Engineering, and Medicine (*Medications for Opioid Use Disorder Save Lives* available at https://doi.org/10.17226/25310), have important implications for efforts to improve retention. The report observed that, "Behavioral interventions, in addition to medical management, do not appear to be necessary as treatment in all cases." The committee concluded that, "A lack of availability or utilization of behavioral interventions is not a sufficient justification to withhold medications to treat opioid use disorder." In other words, an individual's refusal or unwillingness to participate in counseling does not justify involuntarily discharging them out of medication-assisted treatment or withholding OUD medications.

   This mirrors the position of SAMHSA's experts within the Treatment Improvement Protocol 63, which states that, "Counseling and ancillary services should target patients' needs and shouldn't be arbitrarily required as a condition for receiving opioid use disorder medication." Buprenorphine providers are therefore discouraged from establishing arbitrary counseling requirements that can constitute a barrier to admission and retention in medication-based treatment services. Buprenorphine providers are also discouraged from involuntarily discharging individuals for not attending or participating in counseling services. **Individuals should not be denied life-saving medications just because they are not ready to engage in therapy, counseling, or AA/NA groups.**

   Another barrier to systematically improving retention in medication-based treatment is the practice of involuntarily discharging individuals for positive drug tests. According to SAMHSA's Treatment Improvement Protocol 63, "If a patient does not discontinue all illicit drugs for extended periods, it doesn't mean treatment has failed and should not result in automatic discharge. It means the treatment plan may require modification to meet the patient's needs." The expert panel issued the following directive: "Do not require discontinuation of pharmacotherapy because of incomplete treatment response. Doing so is not a rational therapeutic response to the predicted course of a chronic condition." Remember that relapses 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.

5. **BUILD PEER CAPACITY.** If providers in your network have been slow to hire peers, then Managing Entities should consider getting more involved, perhaps by developing peer-run organizations in their network, which ideally should be on-call and available to engage overdose victims in hospitals 7 days a week. ED officials are looking to the Managing Entities and their networks to have peers involved in bridge programs when needed.

6. **ENSURE ACCESS TO NALOXONE.** Ensure that providers in your network are enrolled in the Department's Overdose Prevention Program and are providing take-home naloxone kits to individuals at risk of experiencing an opioid overdose and to their loved ones that may witness

an overdose. Managing Entities should also engage hospital emergency departments, homeless service organizations, harm reduction programs, recovery support organizations, Fire/EMS departments (for naloxone leave-behind programs), and other community-based organizations that provide direct services to people who use drugs to enroll in the program and distribute naloxone to at-risk individuals. Providers do not have to contract with Managing Entities or the Department to enroll in the program and distribute naloxone.

7. **PARTNER WITH LOCAL SYRINGE EXCHANGE PROGRAMS.** The Florida legislature passed SB 366 during the 2019 session, and effective July 1, 2019, the law allows county commissions to authorize syringe exchange programs (SEPs) through local ordinances. Entities eligible to operate an SEP include hospitals licensed under chapter 365, health care clinics licensed under part X of chapter 400, accredited medical schools, licensed addictions receiving facilities as defined in s. 397.311(26)(a)1, and 501(c)(3) HIV/AIDS service organizations. While there is currently only one authorized program in Florida (the IDEA Exchange in Miami-Dade), it is expected that there will be an increase in SEPs throughout the state. Managing Entities and their providers should work closely with local SEPs as they become established to ensure that SEP participants seeking substance use treatment services are immediately linked to services, and that buprenorphine or methadone maintenance are available to participants with opioid use disorders who are seeking treatment.

Eligibility Criteria:

1. Individuals who are indigent, uninsured, or underinsured and have an opioid use disorder (or who are misusing opioids) who are receiving or will receive methadone, buprenorphine, or naltrexone maintenance treatment.
2. The following individuals who misuse opioids should be given preference in admissions in the following order:
    a. Pregnant women who are injecting opioids;
    b. Pregnant women;
    c. Caretakers involved with child welfare;
    d. Caretakers of children ages 0-5; and
    e. Individuals re-entering the community from incarceration.

FDA-Approved Medications for Opioid Use Disorders:

This includes methadone, buprenorphine products, including single-entity buprenorphine products, buprenorphine/naloxone tablets, films, buccal preparations, long-acting injectable buprenorphine products, and buprenorphine implants (Probuphine). Probuphine, which was approved by the FDA in 2016, is a six-month implant that may offer improved patient convenience from not needing to take medication daily, and it avoids the possibility of a pill or film being lost or stolen.

Oral Naltrexone

According to the National Academies of Sciences Report, “Naltrexone…can be administered by mouth daily or as depot injection once monthly, but the oral formulation has been shown to be ineffective for OUD.” The committee concluded that, “Only an extended-release formulation of naltrexone is approved by the FDA for the treatment of OUD.” Therefore, SOR funds cannot be used to purchase oral naltrexone to be used as a maintenance medication as it is not FDA-approved to treat OUD. However, SOR funds may be used to purchase oral naltrexone for the specific instances outlined below:

- For patients who opt to receive Vivitrol and are currently in an inpatient or residential treatment setting, where medication compliance can be monitored, and oral naltrexone may be a more cost-effective option. For this instance, it is expected that the patients will be transitioned to Vivitrol prior to or upon discharge from an inpatient or residential treatment setting.
- As a placeholder for patients wanting to start Vivitrol treatment until the first injection is made available
- To conduct a naltrexone challenge to ensure patients are opioid-free prior to receiving a Vivitrol injection to avoid precipitated withdrawal
- To ensure patients do not have a naltrexone allergy prior to receiving a Vivitrol injection

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.

Deductible and Co-Pays:

Funds may be used to offset deductibles and co-pays for individuals with opioid use disorders who are receiving medication-assisted treatment.

Service Array:

The following authorized covered services described in ch. 65E-14.021, F.A.C., are allowable uses of these funds when provided to 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 can also have the following services paid for using SOR grant funds (highlighted services require additional data collection outlined below):

Code	Covered Service
29	Aftercare
01	Assessment
02	Case Management
04	Crisis Support/Emergency
05	Day Care
06	Day Treatment
28	Incidental Expenses (excluding direct payments to individuals to enter into, or continue to participate in, prevention or treatment services)
15	Outreach (to identify and link individuals with opioid use disorders to medication-assisted treatment providers)
12	Medical Services
13	Medication Assisted Treatment
14	Outpatient
08	In-Home and On-Site
46	Recovery Support
25	Supported Employment
26	Supportive Housing/Living

19-21	Residential Levels I and II only for individuals who are inducted on methadone, buprenorphine, or naltrexone, and the level of care must be reevaluated every 15 days (note this is different from the Opioid STR Grant).
32	Inpatient Detoxification and Outpatient Detoxification. Per the grant FOA, medical withdrawal (detoxification) is not the standard of care for opioid use disorders, is associated with a very high relapse rate, and significantly increases an individual's risk for opioid overdose and death if opioid use is resumed. Therefore, medical withdrawal (detoxification) when done in isolation is not an evidence-based practice for OUD. If medical withdrawal (detoxification) is performed, it must be accompanied by injectable extended-release naltrexone (Vivitrol) to protect such individuals from opioid overdose when they relapse (note this is different from the Opioid STR Grant).

When billing for incidental expenses, the Network Service Provider shall follow F.A.C. 65E-14.021(4)(k)4.b.(V).

Recovery Support:

SOR funds can be used to implement community recovery support services such as peer supports, recovery coaches, and recovery housing. Providers and Managing Entities must ensure that recovery housing supported under this grant is through houses that are certified by the Florida Association of Recovery Residences, unless the house is operated by an entity under contract with an ME or by Oxford House, Inc.

Criminal Justice:

SOR funds can be used 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.

Telehealth:

SOR funds can be used to support innovative telehealth strategies for rural and underserved areas.

Prevention:

SOR funds can be used to support evidence-based primary prevention programs. Allowable programs and strategies include media campaigns based on Use Only as Directed: Utah Prescription Pain Medication Program, Botvin LifeSkills Training, Caring School Community, Guiding Good Choices, InShape Prevention Plus Wellness, PAX Good Behavior Game, Positive Action, Project SUCCESS, Project Towards No Drug Abuse, SPORT Prevention Plus Wellness, Teen Intervene, and the Strengthening Families Program (for Parents and Youth 10-14) if done in combination with Botvin LifeSkills Training. Managing Entities may also request to implement evidence-based programs not listed, to be reviewed and approved by the Department. All prevention services must be entered into the Department's Performance Based Prevention System.

Data Collection:

FASAMS DATA: Providers must indicate what medications individuals are currently using in FASAMS with the MAT modifiers for methadone, buprenorphine mono, buprenorphine combo, and injection or

oral naltrexone for all services. All individuals receiving SOR funds must have the MAT modifier attached to service events listed in FASAMS, even if the medication itself is not being provided by the same provider of the service being entered.

GPRA: The Government Performance and Results Modernization Act of 2010 (GPRA) is a federal mandate which requires all SAMHSA grantees to collect and report performance data using approved measurement tools. Providers of treatment and recovery support services (which are in orange on the above list) will be required to collect data at **five** data collection points (**baseline, 6 months post-intake, discharge, 3-months post-discharge, and 6-months post-discharge**) using the CSAT GPRA. The target completion rate is 100%; meaning programs must attempt to follow-up with all individuals. However, SAMHSA's expects the state to achieve a minimum 6-months post-intake follow-up rate of completion of 80%. The Department is currently working with FEI Systems to provide the GPRA online; however, providers will have to utilize paper forms until the system is set up. Guidance for data collection is provided below.

- **GPRA and a GPRA Supplemental form** must be administered by program/clinic staff and questions must be asked as written with no deviation. The GPRA cannot be self-administered by the funded individual.

- **All** individuals who receive SOR-funded covered services marked in orange font above, must have completed **GPRA and a GPRA Supplemental forms** for each of the 5 collection points.
    - 6 months post-intake data should be collected on all clients, regardless of whether an individual drops out of the program prior to the 6 months. When a program cannot follow-up with an individual, the program must use the GPRA tool to report that the individual was not located.
    - 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.

    EX: An individual is discharged "Left on own against staff advice with satisfactory progress" at 4 months post intake with a baseline having been completed. Individual re-enrolls 2 months later. A new baseline **MUST** be completed and continued on a new data collection timeline (for 6 months post-intake, discharge, 3-months post-discharge, and 6-months post-discharge). With the previous GPRA timeline discontinued.

- If an individual leaves SOR funding and is transferred within the same episode of care to another funding source they **MUST** complete a discharge at that time and GPRAs at subsequent data collection points. If the same individual returns (transferred back) within a certain time point to SOR funding they **do not** have to complete a new Baseline. Follow the guidance below for these situations:
    - If an individual is transferred to another funding source and is transferred back to SOR funding between 0-6 months post-intake they must continue the timeline and at 6 months post-baseline complete the 6 months post-baseline GPRA.

- If an individual is transferred to another funding source between 0-6 months post-intake and is transferred back to SOR funding after 6 months post-intake they must start a new timeline with a Baseline tool.
    - EX: Client completes baseline, transferred to other funding source at 2 months post intake, completes discharge, transferred back at 7 months post intake, client must complete new baseline and start new timeline.

WINDOWS FOR GPRA ADMINISTRATION:

- Intake/Baseline:
    - For residential facilities - GPRA intake/baseline interviews must be completed **within 3 days** after the individual enters the program.
    - For nonresidential programs - GPRA intake/baseline interviews must be completed **within 4 days** after the client enters the program.
- Follow-up (post-intake and post-discharge:
    - The window period allowed for GPRA follow-up interviews is one month before the (3 or 6 month) anniversary date and up to two months after the (3 or 6 month) anniversary date.
- Discharge:
    - Discharge interviews must be completed on the day of discharge, regardless of length of stay in the program (i.e. 1-day length of treatment still needs a discharge GPRA completed)
    - If an individual has not finished treatment, drops out, or is not present the day of discharge, the project will have 14 days after discharge to find the an 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 (Client ID, Client Type, Contract/Grant ID, Interview Type), Section J (Discharge), and Section K (Services Received) and mark that the interview was not completed.

REFUSALS: If individuals refuse to answer the GPRA questions, they cannot be denied treatment, but a GPRA still must be completed at each data collection point.

- A "REFUSED" answer option is available for all client-based questions, please use these to complete the GPRA if a client refuses to answer any questions.
- Interviewers must complete the first five items in Section A (Client ID, Client Type, Contract/Grant ID, Interview Type, Interview date), Section A: Behavioral Health Diagnosis, Section A Questions #1-3, Section A Planned Services, Section I (Follow-Up only), Section J (Discharge Only), and Section K: Services Received (Discharge only).

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 (Client ID, Client Type, Contract/Grant ID, Interview Type), follow prompts by marking "NO" in Interview Type and continue to Section I (follow-up) or J (discharge)

HOSPITAL DATA: Separate data collection will be required for Emergency Department Bridge programs. The following data elements must be sent to the SOR lead epidemiologist on the 30th of each month:

- # of individuals screened
- # of individuals induced with buprenorphine in the ED/hospital prior to discharge

- # of individuals referred to treatment providers
- # of individuals linked to treatment providers

CHILD WELFARE: Providers who are contracted for the SOR Child Welfare program must follow the program proposals as specified in provider specific attachments.

Incidentals:

Providers using incidental funds must report what they are purchasing using the following procedure codes associated with covered service 28:

- IEC00 - Housing
- IED00 - Utilities
- IEE00 - Transportation
- IEF00 - Primary Care (includes coverage of behavioral health co-pays or fees)
- IEH00 - Employment Support
- IEP00 - Fees (for legal documents such as birth certificates, IDs, driver's license, etc.)

SOR Network Service Providers

**According to the DCF State Opioid Response (SOR) Grant Guidance System Priorities, Network Service Providers must ensure access to buprenorphine maintenance in all counties. The Block Grant-funded residential and detoxification services for OUDs may need to be re-allocated to support evidence-based methadone or buprenorphine maintenance. A portion of the $14.6 million in recurring General Revenue funds are intended to help meet the need for methadone or buprenorphine maintenance.*

Network Service Provider - MAT	**County Coverage**	**Circuit**
Clay Behavioral Health Center, Inc.	Clay	4
EPIC Community Services, Inc.	St. Johns	7
Gateway Community Services, Inc.	Duval	4
LifeStream Behavioral Center, Inc.	Lake, Sumter, Citrus	5
Meridian Behavioral Healthcare, Inc.	Hamilton, Suwannee, Columbia, Lafayette, Dixie, Union, Bradford, Gilchrist, Alachua, Levy, Baker, Putnam	3/8
Metro Treatment of Florida, LP, d/b/a Jacksonville Metro Treatment Center, d/b/a Quad County Treatment Center, d/b/a St. Augustine Metro Treatment Center	Duval, Marion, St. Johns	4, 5, 7
Operation PAR, Inc.	Hernando	5
SMA Healthcare, Inc.	Volusia, Flagler, Putnam	7
Nassau County Mental Health, Alcoholism & Drug Council, Inc. d/b/a Starting Point Behavioral Healthcare	Nassau	4
The Centers, Inc.	Marion	5
Network Service Provider - Prevention	**County Coverage**	**Circuit**
BayCare Behavioral Health, Inc.	Hernando	5

Hanley Center Foundation, Inc.	Baker, Clay, Bradford, Levy, Gilchrist, Alachua	4, 8
Meridian Behavioral Healthcare, Inc.	Hamilton, Dixie, Bradford, Gilchrist, Baker	3/8

Prohibited Uses of SOR Grant Funds:

1. **Denial of Care:** Funds may not be used by any provider that denies any eligible individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders, namely methadone and buprenorphine. In all cases, MAT must be permitted to be continued for as long as the prescriber determines that the medication is clinically beneficial. Providers must assure that individuals will not be compelled to no longer use MAT as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.

2. **Direct Payments to Persons Served:** Funds may not be used to make direct payments to individuals to induce them to enter prevention or treatment services. However, SAMHSA grant funds may be used for nonclinical support services (e.g., bus tokens, child care) designed to improve access to and retention in prevention and treatment programs.

3. **Limits on Detoxification Services:** Funds may not be used to provide detoxification services unless it is part of the transition to extended release naltrexone (Vivitrol). As previously noted, SAMHSA has declared that, "Medical withdrawal (detoxification) is not the standard of care for opioid use disorders, is associated with a very high relapse rate, and significantly increases an individual's risk for opioid overdose and death if opioid use is resumed. Therefore, medical withdrawal (detoxification) when done in isolation is not an evidence-based practice for OUD. If medical withdrawal (detoxification) is performed, it must be accompanied by injectable extended-release naltrexone to protect such individuals from opioid overdose in relapse and improve treatment outcomes."

4. **Construction:** Funds may not be used to pay for the purchase or construction of any building or structure to house any part of the program..

5. **Executive Salary Limits:** Funds may not be used to pay the salary of an individual at a rate in excess of $189,600.

Medication Assisted Treatment (MAT) Guidelines:

1. FDA-approved medications for opioid use disorders prescribed under MAT will be reimbursed through the MAT covered service rate.
2. Each dosage of the medication for the consumer, whether issued daily, weekly, or monthly should be entered into the Managing Entity's data system daily for the duration of the prescription.
    a. Example – If Jane Doe has a prescription for 14 days, you must enter it daily for 14 days to receive payment.
3. To ensure that the medication is being administered and monitored, the substantiating documentation for MAT, in lieu of a Medication Assisted Record (MAR), the following is required:
    a. The consumer's chart note for the date the prescription was written and
    b. Copies of all prescriptions.

The role of the Network Service Provider is to:

1. Administer the project as outlined in the initial proposal which is subject to change based on the need identified through referrals, waitlist, special populations, and observation of outcomes.
2. Ensure any eligible client, patient or individual receive access to their program regardless of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine). In all cases, MAT must be permitted to be continued for as long as the prescriber or treatment provider determines that the medication is clinically beneficial.
3. Ensure that clients will not be compelled to no longer use MAT as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.
4. Offer all FDA-approved medications for opioid use disorders as part of the MAT program. If the provider does not offer the specific FDA-approved medication requested by the consumer, the provider must refer them to the nearest facility that does. Proof of this process must be documented in the consumer chart and include the consumer's consent.
5. Enroll in the Department's Overdose Prevention Program and provide take-home naloxone kits to individuals at risk of experiencing an opioid overdose and to their loved ones that may witness an overdose.
6. Work closely with local syringe exchange programs (SEP) as they become established to ensure that SEP participants seeking substance use treatment services are immediately linked to services, and that buprenorphine or methadone maintenance are available to participants with opioid use disorders who are seeking treatment.
7. Ensure monthly reporting of SOR reports, as outlined in this incorporated document, are provided to Managing Entity (LSFHS) by the 10th of each month.