STATE OF FLORIDA DEPARTMENT OF

CF OPERATING PROCEDURE CHILDREN AND FAMILIES

NO. 155 - \_\_ TALLAHASSEE (date)

Florida Statewide Response for Opioid Abatement

**Chapter 1**

**Introduction to Florida’s Behavioral Health System and Opioid Abatement Practice Model**

**1-1. Purpose.**

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

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

**1-2. Authority.**

1. Sections 394.4573 and 394.4955, Florida Statutes, promote the development and effective implementation of a coordinated system of care.
2. Section 20.195, Florida Statutes, create the State Opioid Settlement Trust Fund within the Department of Children and Families.
3. Sections 394.4573, and 394.9082, Florida Statutes, establish the duties for the Department and the Behavioral Health Managing Entities in planning, implementing, coordinating, and contracting for the delivery of community SUD services.
4. Sections 397.335, Florida Statutes, establish the Statewide Council on Opioid Abatement within the Department of Children and Families.

**1-3.** **Opioid Abatement Intent.**

This document outlines the purpose, goals, priority populations, implementation responsibilities, and the core competencies required for successful implementation of opioid abatement strategies, services, and oversight. The operating procedure aims to expand access to evidence-based treatment and recovery services for individuals with opioid use and co-occurring mental health and substance use conditions by providing requirements and guidelines for implementation.

**1-4.** **Core Competencies.**

The Department has identified a set of guiding principles and core competencies that will be considered in service design. The guiding principles stipulate that service delivery is recovery-oriented, choice and needs driven, flexible, unconditional, and data driven. The successful implementation of a program or provision of services that support the Opioid Abatement strategies require providers to possess core competencies, including:

1. Ability to provide evidence-based services, including all forms of Medication Assisted Treatment for Opioid Use Disorder (OUD) approved by the U.S. Food and Drug Administration, including but not limited to methadone, buprenorphine-based products, and naltrexone.
2. Knowledge of trauma-informed care for individuals who have experienced trauma.
3. Ability to provide culturally appropriate services and programs.
4. Knowledge of best practices for addressing the needs of criminal-justice-involved persons.
5. Knowledge of recovery management best practices and ability to integrate core concepts and related services.

The Department will review and update core competencies based on data and evolving best practices.

**1-5.** **Opioid Abatement Goals.**

Opioid abatement goals will be monitored through data collection, data reporting and performance measures. Goals are as follows:

1. Expand availability of treatment.
2. Support evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care.
3. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence-informed practices.
4. Provide comprehensive wrap-around services.
5. Support workforce development for addiction professionals.
6. Support stigma reduction efforts regarding help seeking behavior, treatment, and support.

**1-6. Definitions.**

1. **Abatement** is the prevention, reduction, or elimination of opioid use through the implementation of prevention, treatment, and recovery initiatives.
2. **Evidence-Based Practice** are skills, techniques, and strategies that have been proven to work through experimental research studies or large-scale research field studies.
3. **Evidence-Informed Practice** is an approach that shows promise, however lacks the research in controlled settings to prove effectiveness across a wide range of settings and people.
4. **Local Government** means all counties, cities, towns, and villages located within the geographic boundaries of the state.
5. **Managing Entity** as defined in 394.9082 (2)(e) Florida Statutes.
6. **Non-Qualified Counties** shall refer to the 48 counties that will be funded through the Department’s contracted Managing Entities using state opioid settlement funds.
7. **Opioid Funds** are funds received by the State of Florida as part of the opioid settlement, other than those used for Administrative Costs and Expense Fund or obligations to the United States arising out of Medicaid or other federal programs.
8. **Opioid Related** shall have the same meaning and breadth as in the agreed Opioid Abatement Strategies "A" or "B."
9. **Qualified County** shall mean a charter or non-chartered County that has a Population of at least 300,000 individuals and: (a) has an opioid taskforce or other similar board, commission, council, or entity (including some existing sub-unit of a County's government responsible for substance abuse prevention, treatment, and/or recovery) of which it is a member or it operates in connection with its municipalities or others on a local or regional basis; (b) has an abatement plan that has been either adopted or is being utilized to respond to the opioid epidemic; ( c) is, as of December 31, 2021, either providing or is contracting with others to provide substance abuse prevention, recovery, and/or treatment services to its citizens; and (d) has or enters into an interlocal agreement with a majority of Municipalities (Majority is more than 50% of the Municipalities' total Population) related to the expenditure of Opioid Funds.

**CHAPTER 2**

**OPIOID ABATEMENT FUNDING UTILIZATION**

**2-1. Utilization Requirements.**

This Chapter applies to all Local Governments and the State of Florida.

All Opioid Funds shall be utilized for Approved Purposes, in accordance with this operating procedure and any applicable state or federal laws and regulations. Further details on Approved Purposes can be found in Chapter 7.

1. Local Governments shall report to the State of Florida on the use of Opioid Funds in accordance with this operating procedure and any policies, guidelines or procedures established by the State of Florida.
2. The State of Florida may audit Local Governments to ensure compliance with this policy and any guidelines or procedures established by the State of Florida.
3. Local Governments shall cooperate with any such audits and provide access to all records, documents, and other information related to the use of Opioid Funds.
4. Any deviation from this operating procedure and any guidelines or procedures established by the State of Florida shall be reported to the State of Florida immediately via email to: HQW.SAMH.Opioid.Settlement.Inquiry@myflfamilies.com.
5. Any funds that are not utilized for Approved Purposes shall be returned to the State of Florida.
6. State and Local Governments shall implement a monitoring process that will demonstrate oversight and corrective action in the case of non-compliance, for all providers that receive Opioid Funds. Monitoring shall include:
7. Oversight of the any contractual or grant requirements.
8. Develop and utilize standardized monitoring tools.
9. Provide DCF and the Opioid Abatement Taskforce or Council with access to the monitoring reports.
10. Develop and utilize the monitoring reports to create corrective action plans for providers, where necessary.

**2-2. Claw Back and Recoupment.**

This policy applies to both Local Governments and Managing Entities and their subcontractors.

1. Funds are available each fiscal year and may only be used for the Core Strategies in Exhibit A and the Approved Purposes in Exhibit B. Further details on Core Strategies and Approved Purposes can be found in Chapters five and six.
2. Local Governments, Managing Entities, and all subcontractors or subrecipients shall report on the use of Settlement and Opioid Funds in accordance with the data collection, recording, and reporting procedures in this operating procedure.
3. Local Governments, Managing Entities and all subcontractors or subrecipients shall cooperate with any audits conducted by the United States or any other authorized agency.
4. Local Governments, Managing Entities and all subcontractors or subrecipients shall report any deviation from this operating procedure to the Department immediately.
5. Local Governments, Managing Entities and all subcontractors or subrecipients shall return any funds that are not utilized for Approved Purposes or Core Strategies.

**2-3. Administrative Costs.**

This operating procedure intends to ensure that administrative costs for Opioid Funds are allocated in a fair and equitable manner. The Department intends to ensure that Opioid Funds are used effectively to combat opioid use disorder in Florida, in accordance with state and federal laws and regulations.

This operating procedure outlines the process for allocation of administrative costs for Opioid Funds.

**2-4. Scope:** This operating procedure applies to the State of Florida, Local Governments, and any entities that receive or control Opioid Funds.

1. Each Qualified County may take no more than a five percent administrative fee from its share of the Regional Funds.
2. Municipalities and Counties may take no more than a five percent administrative fee from any funds that they receive or control from the City/County Fund.
3. The State of Florida may audit entities that receive or control Opioid Funds to ensure compliance with this operating procedure and any guidelines or procedures established by the State of Florida.
4. Entities that receive or control Opioid Funds shall cooperate with any such audits and provide access to all records, documents, and other information related to the use of such funds.
5. Any deviation from this operating procedure and any guidelines or procedures established by the State of Florida shall be reported to the Department immediately at: HQW.SAMH.Opioid.Settlement.Inquiry@myflfamilies.com.

**CHAPTER 3**

**STATE OF FLORIDA AND DEPARTMENT RESPONSIBILITIES**

**3-1. Office of Opioid Recovery.**

The Department’s Office of Opioid Recovery shall assemble subject matter experts consisting of research analysts, epidemiologists, outreach specialists, consultants, and clinical evaluators. The Office will collaborate with community partners to identify problems, design best practice data-driven solutions, and track outcomes. In addition, the Office will focus on improving coordination and raising clinical care to national best practice standards to aid individuals receiving services, their families, and Florida communities.

**3-2. Statewide Council on Opioid Abatement.**

The Department shall establish the Statewide Council on Opioid Abatement (Council). Florida Statute 397.335 provides detailed information on membership composition and duties to be performed by the Council.

1. Membership

Council members shall be composed of the following for a two-year term:

1. The Attorney General, or his or her designee, who shall serve as chair.
2. The secretary of the department, or his or her designee, who shall serve as vice chair.
3. One member appointed by the Governor.
4. One member appointed by the President of the Senate.
5. One member appointed by the Speaker of the House of Representatives.
6. Two members appointed by the Florida League of Cities who are commissioners or mayors of municipalities.
	1. One member shall be from a municipality with a population of fewer than 50,000 people.
7. Two members appointed by or through the Florida Association of Counties who are county commissioners or mayors.
8. One member shall be appointed from a county with a population of fewer than 200,00.
9. One member shall be appointed from a county with a population of more than 200,000.
10. One member who is either a county commissioner or county mayor appointed by the Florida Association of Counties or who is a commissioner or mayor of a municipality appointed by the Florida League of Cities.
11. Duties
12. Review annual plans from each county, municipality, managing entity, or state agency that receives opioid settlement funds.
13. A plan on how they intend to use those funds and how data will be collected.
14. Expenditure report outlining the results of opioid settlement expenditures.
15. Advising state and local governments on resolving or abating the opioid epidemic and reviewing how opioid settlement dollars have been spent as well as the results of those expenditures.
16. Coordinate with the Statewide Drug Policy Advisory Council and ensure that its recommendations and actions are consistent with that council’s recommendations to the extent possible.
17. Review data to advise state and local governments on the status, severity, and stage of the opioid epidemic.
18. Review annual plans submitted by each county, municipality, managing entity, or state agency that receives settlement funds from an opioid settlement providing information related to how it intends to use settlement funds and how it intends to collect data regarding its use of funds.
19. Review annual expenditure reports submitted by each county, municipality, managing entity, or state agency that receives settlement funds from an opioid settlement providing information on the results of the expenditures.
20. Develop and recommend metrics, measures, or datasets to assess the progress and success of programs funded by expenditures of opioid settlement funds.
21. Provide a system of documentation and reporting in accordance with the requirements of federal agencies and any other agencies providing funding to the state, including auditing expenditures consistent with any requirements imposed by the Legislature.
22. Provide and publish an annual report.
	1. How settlement moneys were spent the previous fiscal year by the state, each of the managing entities, and each of the counties and municipalities.
	2. Recommendations to the Governor, the Legislature, and local governments for how moneys should be prioritized and spent the coming fiscal year to respond to the opioid epidemic.

**3-3. Accountability.**

The State and each of the Local Governments shall report its expenditures to the Department no later than August 31 for the previous fiscal year. The Council will set other data sets to report to the Department demonstrating effectiveness of expenditures on Approved Purposes. In setting those requirements, the Council may consider the Reporting Templates, Deliverables, Performance Measures, and other existing templates and forms currently required by the Department from Managing Entities and direct that similar requirements be utilized by all Parties.

**CHAPTER 4**

**RESPONSIBILITIES of QUALIFIED COUNTIES, NON-QUALIFIED COUNTIES, and MANAGING ENTITIES**

**4-1. Qualified Counties.**

The Qualified County's share of Opioid Funds will be expended only on Approved Purposes, including the Core Strategies described in Chapters 5 and 6 as directed by the Opioid Abatement Council.

**4-2. Non-Qualified Counties.**

Managing Entities shall:

1. Use the regional share for each non-Qualified County on Approved Purposes, including the Core Strategies described in Chapters 5 and 6 as directed by the Opioid Abatement Council.
2. Ensure that there are services in every County.
3. To the greatest extent practicable, endeavor to expend funds in each County or for citizens of a County in the amount of the share that a County would have received if it were a Qualified County.
4. Use funds as required by the Department or Council. Managing Entities shall not adopt additional requirements.
5. Submit requests for additional operationally requirements that may be necessary for Department approval in consultation with the Council.

# **4-3. Prioritization of Funding.**

# Qualified Counties, Non-Qualified Counties and Managing Entities are required to expend the funding on approved purposes to ensure services are available within every county. Qualified Counties, Non-Qualified Counties and Managing Entities shall prioritize the following services and initiatives:

# Medication Assisted Treatment

# Coordinated Opioid Recovery (CORE)

# Hospital Bridge Programs

# Peer Supports and Recovery Community Organizations

**4-4. Medication Assisted Treatment.**

Provide medication assisted treatment (MAT) as defined in 65E-14.021, Florida Administrative Code. MAT uses medications approved by the U.S. Food and Drug Administration (FDA) and can be in combination with counseling and behavioral therapies to treat OUD involving misuse of either prescription or illicit opioids. Medications include methadone, buprenorphine-based products, and naltrexone. These medications reduce cravings and the euphoria experienced with opioids. Some medications may also reduce the risk of subsequent overdose. The primary goal is to increase opportunities for access to medications for individuals with OUD by offering integrated services designed to engage and retain individuals in treatment, recovery, and health care services.

1. Providers must permit continuation in MAT for as long as the prescriber or medication-assisted treatment provider determines that the medication is clinically beneficial; and
2. While counseling and support services must be available for and offered to patients, providers shall not require mandatory counseling participation or mandatory self-help group participation as a condition of initiating or continuing medications that treat SUDs, except those established by methadone providers and applied to individuals on methadone as required in 65D-30.0142, Florida Administrative Code.

**4-5. Coordinated Opioid Recovery (CORE) Addiction Network.**

1. Standard treatment programs have had limited success in creating long term recovery for this lifelong illness. This innovative program expands a state-supported, cohesive, coordinated system of addiction care for individuals suffering from substance use disorder.
2. This comprehensive approach expands every aspect of overdose response and treats all primary and secondary impacts of substance use disorder. From care and peer navigators directly within an emergency department, to sustainable overall health care, this structure disrupts the revolving door of addiction and overdose.
3. The CORE network does not solely depend on emergency response for overdoses and substance use disorder, ensuring individuals are also stabilized and treated for coexisting medical and mental health conditions. Individuals will need dental care, primary care, psychiatric evaluation, maternal care, and social support services. Social support services can address career training, housing, or food insecurity.
4. The CORE Model includes a three-tiered model approach listed below:

a. Rescue Response

1. Individual in need of services is treated by first responders (fire rescue/ EMS personnel).
2. Treatment includes use of specialized EMS protocols for overdose and acute withdrawal.

b. Stabilization/Assessment

* + 1. Individual in need of services receives treatment in an emergency department with an addiction stabilization center.
		2. Treatment options include MAT.
		3. Individual receiving services is also assessed and treated for emergent unmet health needs.
		4. Specialty-trained medical staff recommend the care best suited for everyone receiving services and a peer navigator facilitates a warm hand off to the long-term treatment facility.

c. Long-Term Treatment

1. Individual receives long-term-care and wrap around support.
2. Individual is treated by a team of licensed professionals that specialize in treating addiction.
3. Services include long-term management of medication-assisted treatment, therapy, psychiatric services, individualized care coordination, pharmacy services, and links to other health services.
4. Individuals also receive services to address their social service needs.

**4-6. On-demand, Mobile Medication-Assisted Treatment.**

Access to care is more important than ever amid the state’s opioid crisis. Mobile assistance plays a vital role in increasing access to care by reducing barriers and bringing treatment and recovery opportunities to individuals struggling with opioid use.

1. Mobile medication-assisted treatment models provide rapid access to individuals with opioid use disorder through a mobile outreach unit capable of on-demand buprenorphine induction and telemedicine.
2. Individuals that receive this service are often homeless or in hard-to-reach areas such as rural communities.
3. The intent of this program is to develop a trusting relationship between the individual and staff and to encourage the individual to remain engaged in treatment.

**4-7. Hospital Bridge Programs.**

1. Individuals with OUD can access buprenorphine induction before discharge from hospitals that are not currently part of the CORE network, with a buprenorphine prescription and peer engagement for a warm handoff serving as the bridge to a community-based provider offering long-term, integrated, MAT.
2. The primary components of the Hospital Bridge Program include:
3. Initiation of buprenorphine before discharge.
4. Prescribing and dispensing the opioid overdose antidote (naloxone nasal spray).
5. Actively linking patients to ongoing MAT through network service providers.
6. Introduce recovery services to participants.
7. Each community has unique needs to consider when developing Hospital Bridge policies and procedures. However, there are consistent factors that should be in place across all Hospital Bridge Programs.
	* 1. Efforts between hospital emergency departments, managing entities, and medication assisted treatment providers must be consistent.
		2. Team Roles:
8. Emergency Room Physician—Screen/assess individuals for OUD, connect individual to the peer, induction of medication, dispense naloxone.
9. Peer—Provide education regarding MAT appointment process, support individual through assertive referral process, schedule an appointment with a local MAT provider.
10. MAT Provider—Provide accessible appointments, continued medication maintenance and other necessary treatment and recovery support services.
11. Managing Entity— Provide access to funds supporting treatment 4services including MAT and recovery support and ensure rapid linkage to ongoing community-based MAT services.
12. Process:
13. An individual enters the ED having overdosed or experienced medical needs due to opioid misuse.
14. The ED physician assesses if the individual is a candidate for medication assisted treatment.
15. If medication assisted treatment is an appropriate option, the ED physician will initiate a conversation to gage interest offering to start the first induction before the individual is discharged. The physician will explain the available FDA approved medication.
16. The individual is connected to a peer either onsite, via phone, or video conference to help navigate the referral process to the local MAT provider. The peer will schedule an appointment with the local MAT provider, explain the transition process, provide general support during the entire process and assist in a warm hand-off to the local MAT provider. If the individual declines MAT, the peer provides community resources and support until discharge.
17. A naloxone kit is dispensed prior to discharge from the hospital for all individuals entering an ED for opioid misuse, regardless of whether they agreed to MAT.

**4-8. Peer Supports and Recovery Community Organizations.**

1. Florida’s system of care has expanded its focus from acute care to sustained recovery and wellness. Recovery support services provided by certified recovery peer specialists play a vital role in this shift. The credential is for people who use their lived experience and skills learned in training to help others achieve and maintain recovery and wellness from mental health and/or substance use.
2. Recovery Peer Specialists provide recovery-support services, promote continued engagement in treatment and inclusion in local communities and normalize recovery language.
3. Recovery Community Organizations (RCOs) work to support individuals in long-term recovery from drug and alcohol use disorders, as well as their family members, friends, and allies in a variety of ways. An RCO is an independent, non-profit organization led and governed by representatives of local communities of recovery. These organizations facilitate recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, and/or provide peer-based recovery support services.
4. RCOs work closely with community treatment providers and other stakeholders to provide outreach services, information and referrals, wellness recovery centers, and other recovery support services.
5. Peers and RCOs will work closely with hospitals and long-term community-based providers participating in the Coordinated Opioid Recovery Effort and Hospital Bridge programs. Both programs utilize the peer workforce to provide care coordination and engage the individual in on-going treatment and recovery support.

**CHAPTER 5**

**CORE STRATEGIES**

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

**5-1. Priority Populations.**

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

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

**5-2. Core Strategies.**

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

1. Naloxone or other FDA-approved medication to reverse opioid overdoses.
2. Expand training for first responders, schools, community support groups and families.
3. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.
4. Medication-assisted treatment and other opioid-related treatment.
5. Increase the provision of MAT to non-Medicaid eligible or uninsured individuals.
6. Provide education to school-based and youth-focused programs that discourage or prevent misuse.
7. Provide MAT education and awareness training to healthcare providers, Emergency Medical Technicians (EMT), law enforcement, and other first responders.
8. Treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication with other support services.
9. Pregnant & Postpartum Women.
10. Expand screening, brief intervention, and referral to treatment (SBIRT) services to non-­ Medicaid eligible or uninsured pregnant women.
11. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring OUD and other substance use disorder SUD/MH disorders for uninsured individuals; and
12. Provide comprehensive wrap-around services to individuals with OUD including housing, transportation, job placement/training, and childcare.
13. Expanding Treatment for Neonatal Abstinence Syndrome.
14. Expand comprehensive evidence-based care for NAS babies.
15. Expand services for better continuum of care with infant-need dyad.
16. Expand long-term treatment and services for medical monitoring of NAS babies and their families.
17. Expansion of Warm Hand-off to Treatment and Recovery Services.
18. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.
19. Increase warm hand-offs to transition to treatment and recovery services. Incorporate the role of peer specialists in transition services to provide peer support to individuals prior to, during, and after clinical services to facilitate access to a continuum of care and array of community-based treatment and recovery supports.
20. Broaden scope of recovery services to include co-occurring SUD or mental health conditions.
21. Provide comprehensive wrap-around services to individuals in recovery including housing, transportation, job placement/training, and childcare.
22. Hire additional social workers or other behavioral health workers to facilitate expansions above.
23. Treatment for Incarcerated Population.
24. Provide evidence-based treatment and recovery support including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system.
25. Increase funding for jails to provide treatment to inmates with OUD.
26. Prevention Programs.
27. Prevention programs shall be implemented in accordance with 65D-30.013, Florida Administrative Code.
28. Funding for media campaigns to prevent opioid use. For example, “The Facts. Your Future.” or the Food and Drug Administration’s “Real Cost” campaign to prevent youth from misusing tobacco.
29. Funding for evidence-based prevention programs in schools.
30. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing).
31. Funding for community drug disposal programs.
32. Funding and training for first responders to participate in pre-arrest diversion programs, post­ overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.
33. Supporting Syringe Service Programs.
34. Provide comprehensive syringe services programs (SSPs) with more wrap-around services including linkage to OUD treatment, access to sterile syringes, and linkage to care and treatment of infectious diseases.
35. Naloxone or other FDA-approved drugs to reverse opioid overdoses.

**CHAPTER 6**

**APPROVED USES**

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

**6-1. Treatment of Opioid Use Disorder.**

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

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

**6-2. Support people in treatment and recovery.**

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

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

**6-3. Connect people who need help to the help they need (connections to care).**

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

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

**6-4. Address the needs of criminal-justice-involved persons.**

Many individuals who come in contact with the criminal or juvenile justice system have a mental or substance use disorder. Upon release from incarceration, individuals with behavioral health conditions face many barriers to successful re-entry into the community. They may lack health care, job skills, education, and stable housing—such gaps may jeopardize their recovery and increase their probability of relapse and rearrest. Addressing persons involved in, at risk of becoming involved in, or transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

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

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

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

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

**6-6. Prevention.**

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

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

* 1. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by Substance Abuse Mental Health Services Administration.
	2. Engage non-profits and faith-based communities as systems to support prevention.
	3. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.
	4. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.
	5. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.
	6. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.
	7. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or other drug misuse.
1. Prevent overdose deaths and other harms (harm reduction). Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence­ based or evidence-informed programs or strategies that may include, but are not limited to, the following:
2. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, individuals at high risk of overdose, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the public.
3. provide free naloxone to anyone in the community.
4. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the public.
5. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.
6. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.
7. Public education relating to emergency responses to overdoses.
8. Public education relating to immunity and Good Samaritan laws.
9. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.
10. SSP and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.
11. Expand access to testing and treatment for infectious diseases such as Human Immunodeficiency Virus (HIV) and Hepatitis C resulting from intravenous opioid use.
12. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.
13. Provide training in harm reduction strategies to health care providers, students, peer recovery specialists, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.
14. Support screening for fentanyl in routine clinical toxicology testing.

**6-7. Other Approved Strategies.**

1. First responders. In addition to items in sections 7-4, 7-5, and 7-10 relating to first responders, support the following:
	1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.
	2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.
2. Leadership, strategic planning and coordination. Support efforts to provide leadership, planning, coordination, facilitation, training, and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:
	1. Statewide, regional, local, or community planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services; to support training and technical assistance; or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
	2. A dashboard to share reports, recommendations, or plans to spend opioid settlement funds; to show how opioid settlement funds have been spent; to report program or strategy outcomes; or to track, share, or visualize key opioid-related or health-related indicators and supports as identified through collaborative statewide, regional, local, or community processes.
	3. Monitoring, surveillance, and evaluation of opioid abatement programs and strategies.
	4. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.
	5. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.
	6. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.
	7. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.
	8. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.
	9. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
	10. Provide resources to staff government oversight and management of opioid abatement programs.

**6-8. Training.**

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

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

**6-9. Research.**

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

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

**CHAPTER 7**

**REPORTING AND RECORDING REQUIREMENTS**

**7-1. State and Local Government.**

The State and Local Governments shall follow their existing reporting and records retention requirements along with considering any additional recommendations from the Opioid Abatement Council. Local Governments shall respond and provide documents to any reasonable requests from the State or Opioid Abatement Council for data or information about programs receiving Opioid Funds.

**7-2. Providers and Sub-Recipients.**

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

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

**CHAPTER 8**

**DATA COLLECTION AND REPORTING**

**8-1. Data Reporting Frequency.**

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. Questions related to reporting should be emailed to HQW.SAMH.Opioid.Settlement.Inquiry@myflfamilies.com.

1. Qualified Counties, Non-Qualified Counties and Managing Entities shall submit data on the 18th of each month for services provided in the prior month, using industry standard codes such as CPT and HCPCS billing codes.
2. Data on opioid settlement funded services are required to be reported to the Department in a file format determined by the Department.

**8-2 Data Security.**

Qualified Counties, Non-Qualified Counties and Managing Entities will ensure secure data sharing, confidentiality, and privacy in accordance with HIPAA regulations and Section 397.501, Florida Statutes. Qualified Counties, Non-Qualified Counties and Managing Entities will require completion of HIPAA and Department security training modules before being granted access to any direct or subcontracted staff.

1. All data collected should be stored in a secure and centralized database, accessible only to authorized personnel, to facilitate accurate reporting and analysis.
2. Regular data audits should be conducted to ensure data integrity and identify any discrepancies or errors for timely correction.