Florida Department of Children and Families
Florida's State Opioid Response Project Narrative

A-1. The populations of focus for this project are individuals that misuse opioids, individuals that experience an opioid overdose, and individuals with opioid use disorders. The catchment area for this project is the entire state of Florida, with funding streams coordinated by the State Opioid Coordinator. This will entail development of allocation methodologies and fiscal monitoring procedures to prevent duplication and ensure that system expansion occurs. The various funding streams that will be coordinated include state General Revenue and four SAMHSA grants (the Substance Abuse Prevention and Treatment Block Grant, State Targeted Response to the Opioid Crisis Grant, Partnership for Success Grant, and the State Opioid Response Grant). The Coordinator will also coordinate funding streams through other agencies, namely the Department of Health, Agency for Health Care Administration, and the Office of State Courts Administrator.

A-2. SAMHSA recently provided Florida-specific estimates of the prevalence of past year opioid use (which includes heroin and the nonmedical use of prescription pain relievers), opioid abuse or dependence, and unmet treatment need among individuals ages 12 or older for four (4) time periods: 2003-2006, 2007-2010, 2011-2014, and 2015-2016.[1] Multiple years of data were pooled to increase the precision of the estimates. The most recent estimates in the table below indicate that 4.0% of Floridians ages 12 and older engaged in nonmedical opioid use and that 0.70% experienced an opioid use disorder (abuse or dependence). The estimated number of individuals with an opioid use disorder that did not receive treatment at a specialty facility is 94,000.

Past Year Nonmedical Opioid Use, Abuse or Dependence, and Unmet Treatment Need among Floridians Ages 12 and Older				
	2003-2006	**2007-2010**	**2011-2014**	**2015-2016**
Nonmedical Opioid Use	5.2%	4.3%	3.6%	4.0%
Opioid Abuse or Dependence	0.67%	0.77%	0.78%	0.70%
Unmet Need for Treatment	92,000	105,000	101,000	94,000

The table below presents the most recent publicly available state-level NSDUH estimates of the prevalence of past-year heroin use and pain reliever misuse in Florida, using 2015-2016 data.[2]

Past Year Prevalence of Heroin Use and Pain Reliever Misuse in Florida, by Age Group (2015-2016)					
	12 and Older	**12-17**	**18-25**	**18 and Older**	**26 and Older**
Heroin Use	0.24%	0.22%	0.58%	0.24%	0.19%
Pain Reliever Misuse	4.06%	3.42%	6.40%	4.11%	3.79%

Florida's opioid-related overdose death rate was 14.4 deaths per 100,000 in 2016, which is significantly higher than the national rate of 13.3 deaths per 100,000 persons.[3] In the first half of 2017 (January – June), 2,096 opioid-caused deaths were reported in Florida, which is a 27 percent increase compared to January – June 2016.[4] However, compared to the second half of 2016 (July – December) during which 2,271 opioid-related deaths were reported, this represents an 8 percent decrease.

A recent study compared the rate of past-year opioid abuse or dependence (using combined 2009 to 2012 restricted-use NSDUH data) among Floridians ages 12 and older (7.7 per 1,000) to the maximum number of individuals who could be treated with buprenorphine in Florida (4.2 per 1,000) and found buprenorphine is potentially available to only about half of the people who might need it.[5] According to a recent analysis of Florida pharmacy claims for buprenorphine formulations (without an FDA

indication for treatment of pain) from 2010-2013, the median monthly patient census among Florida prescribers is 11 patients. The interquartile range, which describes the range of patients treated by the middle 50% of the distribution of prescribers, is between 4 and 30 patients.[6] During this period, waivered physicians were restricted to treating up to 30 patients concurrently, or, after a year, up to 100 patients upon request (the cap was recently increased to 275). This analysis reveals that Florida prescribers, similar to their counterparts in the rest of the country, tend to treat below regulatory limits. A survey of professionals in Florida Opioid Treatment Programs found that only 57% reported that their agency had provided focused training regarding the adoption and use of buprenorphine to clinical staff. However, 88% reported a desire for additional training on the use of buprenorphine for opioid dependence.[7] Additional details regarding needs and gaps can be found in Florida's State Targeted Response (STR) Needs Assessment, available at www.myflfamilies.com/service-programs/substance-abuse/samh/treatment/opioidSTRP. According to the Funding Opportunity Announcement, the SOR-funded service array must be based on these needs.

B-1. Goals and Objectives

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

- Objective: Distribute at least 40,000 naloxone kits to community providers per year.
- Objective: Train at least 500 individuals on overdose prevention and naloxone per year.
- Objective: For individuals engaged in treatment at least 28 days, reduce overdoses by 75%

Goal 2: Prevent prescription opioid misuse among young people.

- Objective: Increase the number of evidence-based prevention programs implemented.

Goal 3: Increase access to Medication-Assisted Treatment (MAT) and associated services and supports among individuals with opioid use disorders.

- Objective: Increase the number of individuals served in certified recovery residences and Oxford Homes.
- Objective: Increase the number of DATA 2000 waived physicians in Managing Entities' provider networks.
- Objective: Increase the number of individuals with opioid use disorders treated with buprenorphine.
- Objective: Increase the number of people who receive recovery support services.
- Objective: Increase retention of individual in services by 10%
- Objective: At least 50% of individuals who completed treatment successfully (including no opioid misuse or reduced opioid misuse at discharge) will have eliminated or reduced opioid misuse 3 months and 6 months after discharge (minimum of 3 contact attempts).

Goal 4: Increase the number of individuals and organizations that are trained to provide MAT and recovery support services for opioid use disorders.

- Objective: Increase the number of treatment providers trained to provide MAT.
- Objective: Implement a minimum of 2 accredited Recovery Community Organizations.

It is estimated that between 5,000 and 6,000 new individuals could receive MAT and associated psychosocial and recovery support services each year (for a total of between 10,000 and 12,000 new individuals over the two-year period).

B-2. The needs of the Seminole Tribe and the Miccosukee Tribe will be assessed in collaboration with community-based treatment providers that have existing relationships and service arrangements with the tribes. The SOR Project Director will collaborate with the STR Project Director, the Managing Entities,

and the Florida Alcohol and Drug Abuse Association (FADAA) to assess training and technical assistance (TA) needs. SAMHSA-funded training and TA will be requested as needed. The Department also designates SOR funds for training and TA initiatives, described in more detail below, which are outside the scope of SAMHSA's existing training and TA contracts. All participating providers will be contractually required to ensure that applicable buprenorphine prescribers have obtained a DATA2000 waiver. The Department is not prescriptive about the service delivery models used by providers. According to the Agency for Healthcare Research and Quality, no trials comparing the effectiveness of one MAT model to another have been conducted yet.[8] Practical considerations and local needs, as opposed to empirical evidence regarding comparative effectiveness, will drive the selection of implementation models. Having said that, the Department encourages the use of the following models: The Emergency Department Initiation Model, the Inpatient Initiation of MAT Model, and the Hub-and-Spoke Model.

Peer recovery support services will be part of the array of services funded under this project. Services provided through certified recovery peer specialists will be reimbursable through this allocation. SOR funds will be allocated to provide recovery housing certified by the Florida Association of Recovery Residences for individuals recovering from opioid use disorders. SOR funds will also go to Oxford House, Inc. to implement new Oxford Houses throughout Florida. Additionally, SOR funds will be used to expand the 1-844-MyFLVet Support Line through the Crisis Center of Tampa Bay. This will enable veterans in need of services to speak directly to Peer Veteran Care Coordinators.

Additionally, SOR funds will be used to implement Recovery Community Organizations (RCOs) with training and technical assistance and start-up funds to help them develop into organizations that are accredited by the Association of Recovery Community Organizations and that have mission statements, strategic plans, independent governance bylaws, Department-approved standards of care, and a sustainable infrastructure. RCOs will work closely with community treatment providers and other stakeholders to provide outreach services, information and referral, wellness recovery centers, harm reduction services, and recovery support services. RCOs will use the recovery capital assessment scale as a component of the recovery planning process for individuals receiving services. SOR seed funds will be used to support the South Florida Wellness Network and Rebel Recovery Florida, two peer-operated providers, to become certified RCOs. SOR funds will also be allocated to the Peer Support Coalition of Florida to help develop 4 additional RCOs in the other regions of the state. SOR funds will be used for training to be provided by the Association of Recovery Community Organizations.

SOR funds will be used to purchase NARCAN® Nasal Spray, an FDA-approved device that requires no assembly prior to use, at a cost of $75 per 2-dose kit. Florida State Hospital will purchase NARCAN® Nasal Spray in bulk with SOR funds and ship the medication to state-licensed pharmacies that are associated with organizations enrolled in the Department's Overdose Prevention Program. In order to enroll in the program, organizations must receive initial overdose recognition and response training from the Department's Overdose Prevention Coordinator, SOR Harm Reduction Coordinator, or Partnerships for Success Grant Coordinator. The primary requirement of the program is for enrolled organizations to operate under non-patient specific naloxone standing orders to distribute free take-home kits directly to individuals at risk of experiencing an opioid overdose, or to friends and family members that may witness an opioid overdose. Eligible organizations can include substance abuse and mental health treatment centers, homeless service agencies, harm reduction agencies, federally qualified health centers, county health departments, hospital emergency departments, and other community-based organizations serving individuals at-risk of overdose. Organizations participating in the program must

submit monthly reports to the Department's Overdose Prevention Coordinator documenting the number of kits distributed and the number of overdose reversals reported.

The Department will allocate SOR funds to FADAA to maintain their existing MAT Prescriber Peer Mentoring Project, which uses expert mentors to advise and guide prescribers through both formal instructional sessions and real-time consultations. Expert peer mentors will provide guidance to potential prescribers of buprenorphine, methadone, naltrexone, and naloxone and help them develop MAT programs and protocols. The peer mentors will participate in on-site trainings, quarterly technical assistance teleconferences, annual face to face meetings, and a statewide MAT stakeholder session. The peer mentors will provide expert consultation and technical assistance by phone and through web-based teleconferencing. Mentee recruitment efforts will focus on potential prescribers within federally qualified health centers, urgent care clinics, emergency departments, and primary care clinics. FADAA staff will review mentor-to-mentee calls and summarize questions asked and the answers given. These summaries will inform training plans and quality improvement initiatives. They will also provide statistics regarding the number of unique contacts, duration of contacts, mentor self-perceived effectiveness ratings, and mentee satisfaction ratings. SOR funds will also be used to provide training for treatment providers on Integrated Harm Reduction Psychotherapy through the Center for Optimal Living. The Department's six regional offices will maintain and expand the employment of Behavioral Health Consultants (BHCs) to support child protective investigative staff. The BHCs will provide clinical expertise and assist with the identification of parents with opioid disorders in the child welfare system. The BHCs will consult and collaborate with Child Protective Investigators (CPIs) and dependency case managers to build expertise with front line staff in the identification of substance use disorders, with specific focus on those with possible opioid disorders, improve engagement with families, and improve access to treatment. SOR funds will be used to provide behavioral health and MAT-related training to new state Medicaid managed care plans, Department of Corrections staff, and staff at jails throughout Florida through FADAA. SOR funds will be used to provide MAT training and TA to judges and staff from a variety of courts (including drug courts and dependency courts) throughout the state. The Office of Court Improvement (OCI) within the Office of State Courts Administrator will hire a Court Operations Consultant whose level of effort on this project will be 100%. The Court Operations Consultant will conduct needs assessments, provide training and technical assistance, coordinate outreach activities, oversee MAT contracts, develop "bench guides" and data reports, conduct site visits, and make recommendations for quality improvement initiatives and data system enhancements.

SOR funds will be used to expand the Department's contract with the Florida Alliance for Healthy Communities to develop and implement specialty training for medical professionals through Area Health Education Centers (AHECs) located within Florida medical schools or colleges. The purpose of this project is to increase the capacity of Florida's healthcare workforce to prevent and treat opioid misuse and opioid use disorders. This encompasses a wide range of disciplines, including, but not limited to, behavioral health professionals, primary care physicians, dentists, nurse practitioners, and physician assistants. AHEC staff will provide technical support to behavioral health and primary care sites throughout the state to improve their clinical practice skills. Online training courses offering CME credits will be developed and local in-person training events will be conducted.

With regard to primary prevention services, Managing Entities may work with prevention providers to implement evidence-based prevention programs listed in Section C of this Proposal. Managing Entities may also request to implement evidence-based programs not listed, to be reviewed and approved by the

Department. In year one, a one-time modification to the Department's Performance Based Prevention System will be implemented using SOR funds, to ensure that the Department can capture and report prevention service data.

The MEs and their networks of service providers administer public funds, including SAMHSA grant funds, in the interest of eliminating or reducing treatment costs for indigent, uninsured, or underinsured individuals. Allocations to the each of the 7 MEs for MAT and associated psychosocial and recovery support services will be based on an estimate of need using prevalence rates from the National Survey on Drug Use and Health and opioid mortality data. In addition to paying for FDA-approved medications, these funds will also cover the following services: aftercare, assessment, case management, crisis support, day care, day treatment, incidental expenses (excluding direct payments to participants), in-home and on-site, medical services, outpatient, outreach (to identify and link individuals with opioid use disorders to MAT providers), recovery support, supported employment, supportive housing/living, detoxification, and residential. If detoxification is provided and it is not a medically necessary precursor to methadone or buprenorphine induction, perhaps due to poly-drug use (particularly alcohol or benzodiazepines), then it must be accompanied by injectable extended-release naltrexone to protect such individuals from opioid overdose, pursuant to terms of the Funding Opportunity Announcement. Similarly, residential services may only be used to stabilize and treat individuals with opioid use disorders during their transition to MAT. Level of care determinations will be reevaluated at least every 5 days for inpatient detoxification placements and every 14 days for residential placements.

DCF will contract with FEi Systems to implement the American Society of Addiction Medicine's (ASAM) CONTINUUM software statewide. CONTINUUM is a computerized structured interview and clinical decision support system for use by intake clinicians. It provides the entire treatment team with a computer-guided interview for assessing individuals with substance use disorders and co-occurring conditions. It facilitates a full biopsychosocial assessment that addresses all six dimensions of the ASAM Criteria. The decision engine uses questions and tools (such as the DSM-5, Addiction Severity Index, Clinical Institute Withdraw Assessment, and Clinical Institute Narcotic Assessment instruments) to generate a comprehensive report which includes a quantitatively-derived, ASAM-endorsed, recommended level of care determination. The CONTINUUM Triage Screener is a 21 question, computer guided, structured interview based on ASAM Criteria and the Addiction Severity Index which helps clinicians refer individuals to the correct level of care. Triage enhances efficiency and increases the likelihood that individuals go to the level of care fitting their needs. Triage can be administered in person or over the phone in 15-20 minutes and generates an output report which recommends an ASAM provisional level of care placement. The individual is then referred to a provider with that level of care who performs the CONTINUUM assessment to fully assess the individual's needs and identify the recommended level of care determination.

The Project Director will work with the Managing Entities and their provider networks to ensure that individuals reentering communities from prisons or jails are able to initiate MAT services as part of behind-the-bars reentry programming and continue MAT services by being linked to community-based MAT providers upon release. SOR funds for these reentry treatment services will be allocated to each of the 7 MEs are part of the broader allocation that is used to fund MAT induction services within emergency departments and other settings. The Project Director will coordinate with the Court Operations Consultant to engage a variety of courts in utilizing MAT services as part of diversion programs, and in lieu of adjudication, and to build more effective referral mechanisms with networks of MAT providers.

A portion of the grant funds have strategically been allocated to projects that require initial seed money that will become self-sustaining (e.g., Oxford Houses, RCOs, ASAM Continuum, etc.). To sustain the MAT services that are expanding under the STR and SOR grants, the Department will need to strategically deploy SAMHSA's Substance Abuse Prevention and Treatment Block Grant and state General Revenue funds. The Department will also take lessons learned from implementing the STR grant and propose system-wide contract revisions as needed. The Department will require the MEs to develop sustainability plans that include both client-level and system-level considerations. Provider networks will be directed to help eligible individuals connect to MAT services through Medicaid, the VA, and other forms of third party payers. SOR-funded MAT training for Medicaid managed care plans will help in this area. The provision of capacity development funds for Recovery Community Organizations will also help ensure the sustainability of peer recovery support services.

B-3.

Key Activities	Responsible Staff	First 3 Months	Year 1	Year 2
Assess the needs of tribes	Project Director	X		
Implement service delivery models that enable the full spectrum of treatment and recovery support services	Managing Entities, participating providers	X	X	X
Implement community recovery support services	Managing Entities, Project Director, participating providers	X	X	X
Implement prevention and education services	Managing Entities, participating providers		X	X
Eliminate or reduce treatment costs for uninsured or underinsured patients	Managing Entities, participating providers	X	X	X
Provide treatment transition coverage for patients reentering communities from criminal justice settings	Managing Entities, participating providers		X	X
Make use of SAMHSA-funded training and TA	Project Director, State Opioid Coordinator		X	X
Ensure all applicable practitioners obtain a DATA waiver	Managing Entities, Project Director, participating providers	X	X	X

C-1. Methadone- or buprenorphine-assisted maintenance treatment (which includes psychosocial support) is the EBP that will be used. No modifications are proposed. Compared to the use of psychosocial interventions alone, methadone or buprenorphine maintenance is more likely to retain individuals in treatment and reduce heroin use and the use of pharmaceutical opioids.[9] Methadone and buprenorphine maintenance are also the most effective ways to reduce the risk of overdose. Research shows that the risk of fatal overdoses is at least cut in half when individuals are enrolled in maintenance treatment for opioid dependence.[10] These findings are also supported by the most recently published systematic review and meta-analysis of cohort studies. Researchers analyzed all-cause and overdose mortality rates during periods in and out of treatment using 19 cohort studies involving 122,885 individuals treated with methadone and buprenorphine. Time spent in methadone treatment was associated with an average reduction of 25 deaths per 1,000 person years. Mortality risk among opioid users during methadone treatment was less than a third of that expected in the absence of treatment, with the greatest difference observed in deaths from overdose. Mortality risk while in buprenorphine maintenance treatment (about 4 deaths per 1,000 person years) is less than the mortality risk in the first four weeks after stopping treatment (32 deaths per 1,000 person years).[11] Methadone or buprenorphine treatment for opioid-dependent injecting drug users also reduces injecting use and the sharing of injecting equipment. It is also associated with reductions in the proportion of injecting drug users reporting exchanges of sex for drugs or money. The reductions in these risk behaviors translate into

reductions in cases of HIV infection.[12] While long-acting injectable naltrexone (VIVITROL) lacks comparable evidence of effectiveness at retaining clients in care and reducing opioid-related mortality,[13] it is nonetheless one of the three FDA-approved medications that states must expand access to, pursuant to the purpose of the Funding Opportunity Announcement, and it may offer advantages for highly-motivated clients who decline agonist maintenance. SOR funds will support VIVITROL-assisted treatment through FADAA.

Naloxone training and distribution will be expanded to reduce opioid overdose deaths. Research indicates that naloxone distribution can reduce community-level overdose mortality by as much as 37% to 90%.[14] It is conservatively estimated that one heroin overdose death will be prevented for every 164 naloxone kits distributed.[15] It should also be noted that there is no evidence indicating that naloxone distribution encourages or increases the use of heroin or other opioids. Rather, studies suggest that increasing health awareness through training programs that accompany naloxone distribution reduces the use of opioids and increases users' desire to seek addiction treatment.[16]

Primary prevention programs funded under this project should have evidence of effectiveness at preventing opioid misuse, opioid dependence, or opioid deaths. It should be noted that the evidence with regard to media campaigns is quite limited. SAMHSA's Center for Application of Prevention Technologies (CAPT) recently summarized evaluation findings from a selection of media campaigns designed to prevent prescription drug misuse.[17] The only study that measured one of these outcomes is an evaluation of *Use Only as Directed: Utah Prescription Pain Medication Program*. According to SAMHSA's summary, during campaign implementation the number of unintentional prescription drug-related overdose deaths decreased. Additionally, about half of participants said they were less likely to share their prescriptions than before seeing the campaign. About half also said they were less likely to use prescription drugs not prescribed to them. The only other CAPT resource on media campaigns to prevent prescription opioid misuse is a list of campaigns without any evaluation findings.[18] For these reasons, SOR prevention funds in Florida can be used for media campaigns based on the *Use Only as Directed* initiative. Looking beyond media campaigns, CAPT reviewed studies of a broad array of programs and strategies intended to reduce the nonmedical use of prescription drugs.[19] This review helped identify randomized controlled trials of Botvin LifeSkills Training documenting significant reductions in adolescent prescription opioid misuse.[20] Therefore, SOR prevention funds in Florida can also be used for Botvin LifeSkills Training. Managing Entities may also work with prevention providers to implement one of the following prevention programs that have experimental or quasi-experimental evidence of effectiveness at preventing illicit drug use: 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, or Teen Intervene.[21]

D-1. The DCF Office of Substance Abuse and Mental Health, as the Single State Agency for behavioral health, has considerable experience gained by administering the Substance Abuse Prevention and Treatment Block Grant and by implementing a variety of discretionary grants from SAMHSA, most recently including the Opioid STR grant. DCF contracts with 7 non-profit Managing Entities (MEs) for the administration and management of regional behavioral health treatment and recovery support services. These MEs work with regional provider networks that are firmly rooted in the cultures and languages of the communities that they serve. The MEs have the capability and experience needed to incorporate contract language improvements for sustainability, leverage funding multiple streams, support training and technical assistance initiatives, and procure a comprehensive array of prevention, treatment, and recovery support services on behalf of the Department.

D-2. The Department will hire a qualified Project Director whose level of effort on this project will be 100%. Qualifications will include having a bachelor's degree in human services or a related field, and at least five years of relevant experience, including project management experience. The Project Director's role entails overall project oversight and management to ensure that goals and objectives are met, strategic planning, tracking measurable objectives, implementing quality improvement initiatives, conducting site visits with participating providers, and ensuring compliance with all aspects of the terms and conditions of the award. The Project Director will also coordinate and collaborate with all other SOR-funded positions and compile annual reports documenting progress, barriers, and efforts to overcome these barriers. The Department will hire a qualified State Opioid Coordinator whose level of effort on this project will be 100%. Qualifications will include having a bachelor's degree in human services or a related field, and at least three years of relevant experience with project management, interagency coordination, and budgeting. The State Opioid Coordinator's role will be to ensure that all funding streams that address the opioid epidemic, both state and federal, are coordinated to prevent duplication and ensure sustainable expansion of services. The Department will hire a Harm Reduction Coordinator whose level of effort on this project will be 100%. Qualifications will include having a bachelor's degree in public health or a related field and two years of experience directly providing harm reduction services. The Harm Reduction Coordinator's role will be to assist with overdose prevention and naloxone trainings and other aspects of the Department's overdose prevention program, including enrolling providers, providing technical assistance, and tracking data. The Harm Reduction Coordinator will develop and implement processes and procedures that facilitate access to treatment, such as warm hand-offs and expedited enrollment in MAT programs, and collaborate with the regions and MEs to ensure that providers are implementing harm reduction strategies and adhering to principles of recovery-oriented systems of care. This position will also track and analyze proposed harm reduction legislation and initiatives and opportunities for local, state, and national collaboration (including conferences, conference calls, and workgroups that address opioids, MAT, and public health initiatives). The Department will hire a fulltime Epidemiologist Assistant whose level of effort on this project will be 100%. The Epidemiologist Assistant will assist the Department's Lead Epidemiologist with grant deliverables, database management, ad-hoc analyses, literature reviews, reports, resource allocation methodologies, and other projects as assigned. The Department will hire a Pharmacy Tech whose level of effort on this project will be 50%. The individual hired for this position must be registered as a pharmacy technician with Florida. This role entails processing purchase requisitions for naloxone, maintaining records of purchase orders, inputting all purchase orders and receiving orders into the State Inventory Management System, maintaining appropriate inventory by reviewing naloxone supplies and placing orders as needed, compiling reports and inventory data as needed, ensuring proper naloxone storage, maintaining records of pharmacy licenses receiving medications and signature authorizations for medication orders from each provider, among other duties. The Office of Court Improvement (OCI) within the Office of State Courts Administrator will hire a Court Operations Consultant whose level of effort on this project will be 100%. The Court Operations Consultant will conduct needs assessments, provide training and technical assistance, coordinate outreach activities, oversee MAT contracts, develop "bench guides" and data reports, conduct site visits, and make recommendations for quality improvement initiatives and data system enhancements. Qualifications will include having a bachelor's degree in economics, statistics, information technology, public administration, social science, or a closely related field.

E-1. The Department has the ability to collect and report all of the required data. The Managing Entities will ensure that the service contracts contain all necessary data collection and reporting requirements. All participating providers will be required to report client-level data on elements including diagnosis,

demographic characteristics, substances used, services received (including specific medications used), length of stay in treatment, employment status, criminal justice involvement, overdoses, and housing. Additional data elements that are identified upon award will also be contractually required from participating providers. All participating providers will be contractually required to collect GPRA data via a face-to-face interview at intake to services, three months post intake, six months post-intake, and at discharge. Participating providers will also be contractually required to achieve a three-month follow-up rate of 80% and a six-month follow-up rate of 80%. Providers have the option of providing a $30 non-cash incentive to individuals to participate in the follow-up interviews. This amount may be provided for participation in each required follow-up interview. The Project Director and the Epidemiologist Assistant will be responsible for tracking the measurable objectives. The Project Director will review and analyze the performance data on a quarterly basis and work with the providers, MEs, and other SOR staff on quality improvement initiatives based on the findings.

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