Provider: Ocala Fire Rescue – CORE Program
Agreement #: 718

AGREEMENT TERMS AND CONDITIONS

This Agreement (the "AGREEMENT") is between the Marion County Hospital District, a Florida special district ("MCHD"), and the undersigned Provider ("Provider").

In consideration for receiving grant funds from MCHD, Provider agrees to the following conditions, which are a material part of the fund requirement for Provider's program described on the attached Grant Proposal (the "Program") funded by the MCHD:

1. This AGREEMENT may be terminated by MCHD for a breach by Provider of any term of this AGREEMENT, including all attachments, which are incorporated herein by reference. Notice may be delivered by certified mail, return receipt requested, by personal delivery, or via email, and such termination shall be effective upon transmission. MCHD reserves the discretion to waive any breach by the Provider, but such waiver shall be in writing. Any such waiver shall not constitute a waiver of any future breaches, including breaches of the same type.

2. MCHD's obligation to disburse funds or fulfill any other obligation related to this AGREEMENT is contingent upon the availability of funds to finance the Program. In the event funds to finance the program become unavailable, MCHD may immediately terminate the AGREEMENT. Notice may be delivered by certified mail, return receipt requested, by personal delivery, or via email, and such termination shall be effective upon transmission.

3. Provider shall defend, hold harmless, and indemnify MCHD and its governing board officers, agents, and employees from and against all liabilities and claim for damage for death, sickness, or injury to any person(s) or damage to any property, including, without limitation, all consequential damages and expenses (including attorney fees), from any cause whatsoever arising from or connected with its service hereunder, including, without limiting the generality of the foregoing, the negligence, gross negligence, or intentional acts of Provider, its agents or employees. It is understood and agreed that such indemnity shall survive the termination of AGREEMENT.

4. MCHD may immediately terminate or suspend the AGREEMENT if it suspects that the welfare of children or individuals are endangered. Payment will be withheld during any periods of suspension.

5. Provider and any subcontractors shall promptly notify MCHD in writing of any circumstances or events that may reasonably be expected to jeopardize their ability to fulfill obligations under this Agreement, but in no event later than five (5) business days after becoming aware of such circumstances or events.

6. Provider shall ensure that all personnel employed by, serving as volunteers for, or providing services for Provider pursuant to this AGREEMENT are duly qualified to perform the duties required as outlined in the response to the Executed Grant Proposals received by MCHD. All such persons, shall successfully undergo a Level II background screening as described in Florida Statute 435.04, and no such person, including persons under the age of 18, shall have a criminal record that is a disqualifier under Level II background standards.

7. All teachers or educational staff who are employed by Provider shall remain subject to Code of Ethics of the Education Profession in Florida. Providers may not request that teachers or educational staff engage in any activity that is not permitted under the Code of Ethics of the Education Profession in Florida.

8. All staff members, including volunteers, of Provider shall be familiar with and adhere to elder abuse, child abuse and/or missing children reporting obligations and procedures under Florida law including but not limited to, **Florida Statute 39.201 and shall immediately report any knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-962-2873 or 180096ABUSE).** Provider shall provide training to all its employees regarding mandated reporting of child abuse and missing children. Provider agrees that staff members will abide such laws in a timely manner. If Provider, or any of its staff, becomes aware of circumstances, including but not limited to employee allegations of molestation, child abuse, elder abuse, abuse of someone disabled, or missing children under Providers supervision, in addition to contacting the aforementioned Abuse Hotline, the Provider or staff person or persons shall immediately contact the appropriate law enforcement agency, and also notify MCHD in writing via email or letter within 3 hours of incident occurring. Failure to report shall be grounds for termination of Agreement.

9. Provider must train all personnel responsible for supervising or providing care to Provider's clients in appropriate procedures for handling and reporting accidents or incidents when a child or client has suffered an injury, injured another individual or have been involved in an activity requiring notification of law enforcement or emergency personnel. The purpose of incident reporting is to ensure all providers report incidents concerning safety of employees, clients, and visitors to the MCHD and its funded programs. Providers are required to enter incident details into Provider's previously created Mindshare account while ensuring that no client information is included in the report. If there is any uncertainty about why an incident needs to be reported, providers should contact healthprojects@mchdt.org.

10. Provider agrees that no person shall, on the grounds of race, sex, handicap, national origin, sexuality, marital status, religion, or political belief be excluded, from participation in, denied the benefit(s) of, or be otherwise discriminated against as an employee, volunteer, or client of the Provider, except those services that may be designated for specific client groups as defined by the American with Disabilities Act and its subcontractors agree to maintain reasonable access for handicapped persons.

11. In the performance of this AGREEMENT, Provider will be acting in the capacity of an independent contractor, and nothing in this AGREEMENT shall be construed to create a partnership, joint venture, agency, or employment relationship between MCHD and Provider or any of Provider's employees, agents, or subcontractors. Provider has no authority to bind or obligate MCHD in any manner, and all persons employed by, contracted with, or otherwise engaged by Provider shall be under Provider's sole direction, supervision, and control. Provider shall be solely responsible for the means, methods, techniques, sequences, and procedures utilized by Provider in the full performance of this Agreement.

12. Provider shall keep all client records in a secure location preventing access to unauthorized individuals.

13. All records related to the AGREEMENT shall be maintained by the Provider for 6 years from the date this AGREEMENT expires or is terminated.

14. Provider must have personnel certified in CPR/and or on-site nurse.

15. All of Provider's facilities shall have reasonable safety features including, but not limited to, fire extinguishers, smoke detectors, fire inspections, and first aid kits.

16. Provider certifies that it is, and will remain, in compliance with all State of Florida labor and wage laws, including regulations governing wages, hours, and working conditions of employees of contractors performing services.

17. Provider shall comply with all laws applicable to entities doing business in the State of Florida and shall remain in good standing at all times. If applicable, Provider shall register with the Florida Department of State, Division of Corporations, and maintain such registration in good standing.

18. Provider shall not provide services or be entitled to any payment under this AGREEMENT until satisfactory documentation of compliance with following documentation and insurance requirements has been provided to MCHD prior to the Provider's commencement of the services required herein:

    a. **Tax Clearance:** a copy of a current valid tax-exempt certificate issued by the State of Florida, and the Internal Revenue Service (IRS), if agency is declared itself a not-for-profit agency.

    b. **Legal documentation exhibiting the ability to conduct business in Florida including:**

        i. License

        ii. Certification and/or Accreditation

        iii. Qualified and credentialed staff

    c. **Transportation and Automobile Liability**: Pursuant to Section 409.1671, F.S., staffs who transport clients in their personal automobiles to carry out their job responsibilities

    d. **Insurance Requirements**: The Provider shall maintain the following insurance throughout this AGREEMENT:

    e. **Professional Liability, and Sexual Abuse/Molestation Insurance**: Provider shall maintain professional, comprehensive general liability, and sexual abuse/molestation insurance carrier covering Provider for claims arising from acts or omissions within the scope of the services provided, with a minimum coverage limit of $1,000,0000 (per occurrence) and $2,000,000 (aggregate).

    f. **Worker's Compensation:** Provider will also maintain statutory worker's compensation insurance per Florida statutory

    g. **Transportation and Automobile Liability**:

        i. Pursuant to Section 409.1671, F.S., staffs who transport clients in their personal automobiles to carry out their job responsibilities shall obtain minimum bodily injury insurance, in the amount of $100,000 per claim, $200,000 per incident, on their personal automobiles.

        ii. In lieu of personal motor vehicle insurance, the Provider's casualty, liability, or motor vehicle insurance carrier may provide non-owned automobile liability coverage. This insurance provides liability insurance for automobiles that the Provider uses in connection with the Provider's business. The non-owned

automobile coverage for the Provider applies as excess coverage over any other collectible insurance. The personal automobile policy for the employee of the Provider shall be primary insurance, and the non-owned automobile coverage of the Provider acts as excess insurance to the primary insurance.

iii. The Provider shall provide a minimum limit of $1,000,000 in non-owned automobile coverage. Provider shall maintain automobile liability insurance coverage on all owned and leased vehicles with a minimum limit of $1,000,000 combined single limit coverage.

h. **General Insure Requirements**

i. "Marion County Hospital District" must be shown as an additional insured for General Liability, Professional Liability, Abuse and Molestation, any Umbrella coverage, and Automobile Liability Insurance.

ii. Provider shall notify MCHD of any change of such coverage within forty-eight (48) hours of such change. Each policy shall contain a provision requiring thirty (30) days' notice to MCHD and Provider of cancellation, reduction or non-renewal.

iii. In any tort action brought against Provider or its employee, net economic damages shall be limited to $1,000,000 per liability claim and $1,000,000 per automobile claim, including, but not limited to, past, and future medical expenses, wage loss, and loss of earning capacity, offset by any collateral source payment paid and payable. In and tort action brought against Provider, non-economic damages shall be limited to $200,000 per claim. A claims bill may be brought on behalf of a claimant pursuant to 768.28 F.S. for any amount exceeding the limits specified in this paragraph. Any offset collateral source payments made as of the date of the settlement or judgment shall be in accordance with 768.76 F.S.

iv. MCHD reserves the right to require additional insurance as may be deemed necessary for a particular program or service.

19. Provider shall return any unused funds to MCHD within two business days of termination of this AGREEMENT or request by MCHD, whichever is earlier.

20. Provider agrees to permit MCHD personnel, and/or persons duly authorized by MCHD to inspect any records, papers, documents, facilities, goods, and services of Provider, that are relevant to this AGREEMENT; to interview any clients and personnel of Provider to assure MCHD of the satisfactory performance of the terms and conditions of this AGREEMENT; and to cooperate fully with MCHD if it decides to require Provider to develop and implement a corrective action or performance improvement plan.

21. Provider shall have emergency preparedness plan in place and available for all employees. Provider will notify MCHD before closing or interruption of services to clients for any reason.

22. Provider shall notify MCHD of any vacancy (termination or change) or transfer of job duties in any grant funded position or individual that manages the grant or reporting thereof, within twenty-four (24) hours of change via email to Grants@mchdt.org.

23. Grant funds will be dispersed on a quarterly basis during the months of November, February, May, and August[1]. When updating the Budget Narrative or Quarterly Expense Report, the Provider must include details about the salaries of employees whose compensation is covered by MCHD. Details include position title, name of employee, percentage of salary charged to MCHD and total dollar amount charged to MCHD. Job descriptions and resumes for all staff paid for in full or part of by MCHD funding shall be maintained in Provider's Mindshare account in the Document Section.

24. MCHD will prioritize measures in a manner that will improve a consumer's health, promote high-quality cost-efficient care and hold organizations and individual providers accountable to standards of care. In addition, these measures may be used to: provide benchmark to assess effectiveness of quality improvement efforts, identify weaknesses in process and care, improve patient care and outcomes while reducing costs, evaluate progress, identify best performing clinics and/or health systems, and improve the system of care.

    a. MCHD utilizes Mindshare Technology for continuous quality improvement. This will advance a deeper commitment to data driven measures and a more collaborative process. This will also advance and guide service delivery systems of care that are encouraged by both Federal and State agencies which define best practice models.

    b. Quarterly reports are due the 12th calendar day after the close of the quarter. Reports are completed in Mindshare.

    c. Provider must agree to utilize the unique Customer Client Satisfaction Survey link provided to them at the beginning of their Grant Agreement term. The provider will make every effort to encourage clients to complete the online form with a minimum return rate of 10% of the provider's annual unique client served count.

25. Provider agrees and covenants that Provider, or any of its officer, directors, employees, or agents, will not at any time make, publish, or communicate to any person or entity or in any public forum any defamatory or disparaging remarks, comments, or statements concerning MCHD, or any of its employees, officers, board members, or existing and prospective customers, suppliers, investors, and other associated third parties.

26. Provider shall internally track and report, on at least a quarterly basis, items purchased with MCHD funds that are valued at, or have an actual cost of, $300.00[2] or more. Any computers, monitors, VOIP or mobile telephones, telecommunications equipment and audio-visual equipment (collectively "Purchased Assets"), regardless of cost, will also be tagged and tracked internally for report to MCHD quarterly. Purchased Assets shall be and remain the property of MCHD and must be inventoried on a quarterly basis. Provider shall complete and continually update a list of Purchased Assets in Mindshare. If the Purchased Assets are no longer needed by the Provider, whether due to contract termination or other reasons, they must be returned to MCHD.

27. For MATCH/LIP Providers only: In addition to reporting the unique client counts for those who received services directly through MCHD funding, Provider will also provide unique client counts for all individuals who received services through funds leveraged from the state and other sources

[1] One payment will be sent to ACHA for intergovernmental transfer for Low Income Pool Funding.
[2] Beacon Point and MATCH/LIP Providers shall track and report items valued at or having an actual cost of $1,000.00 or more.

due to the MATCH funding provided by MCHD. These client counts (both for MCHD and cumulative) should be reported electronically and automated through Mindshare.

28. The term of service delivery shall be from October 1, 2025 thru September 30, 2026.

29. The following are incorporated herein by reference:

    a. Executed Grant Proposal - Located in Mindshare

    b. Exhibit A - Funding Allocation

    c. Exhibit B - Deliverables/Performance Objectives

By signing this Agreement, Provider agrees to the terms and conditions stated herein.

Provider Name: _____

By: _____

Printed Name: _____

Title: _____

Date: _____

Provider: Ocala Fire Rescue – CORE Program
Agreement #: 718

Exhibit A
Funding Allocation

PROGRAM	AMOUNT
Ocala Fire Rescue – CORE Program	$199,999.00
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
TOTAL	**$199,999.00**

Exhibit B
Deliverables/Performance Objectives for Ocala Fire Rescue – CORE Program

1) **Services to be Provided.**
   a.) **See attached CORE Guidelines**
2) **Program Description and Staffing Pattern.**
   a) The Service Provider shall submit to MCHD a detailed description of each program and covered service funded in the contract, including target population and staffing pattern.
   b) **See attached CORE Guidelines**
3) **Scope of Services:**
   a) The Service Provider is responsible for the administration and delivery of Services to the target population(s) as agreed upon in the contract and in accordance with all applicable federal and state laws and regulations. In addition, the Service Provider shall comply with all policies, directives, and guidelines issues by MCHD. In the event MCHD amends policies, directives, or guidelines, after contract execution, the MCHD will provide the Service Provider with written notice.
   b) **See attached CORE Guidelines**
4) **Geographical Boundaries and Target Population**
   a) The service area for Marion County CORE Program is exclusive to Marion County. Service provided to any surrounding areas must be approved by the MCHD to ensure that its monies are utilized to serve the identified priority population.
   b) The Contract Service Provider is expressly limited to providing only those programs and services as contracted. Any delivery of services or programs outside those contracted are prohibited unless otherwise approved by MCHD.
5) **Utilization Management and Provider Monitoring.**
   a) The Service Provider acknowledges that MCHD may engage and monitor the Service Provider administratively, clinically, and fiscally to ensure the accountability of funds and services. The Service Provider acknowledges that MCHD reserves the right to monitor the Service Provider at any time during the contract period.
6) **Continuous Quality Improvement**
   a.) The Contracted Service Provider shall maintain **CQI** activities that ensure the provision of quality Health Services and consistently achieves positive outcomes.
   b.) **Performance Measures** will be developed by the MCHD and evaluated on a quarterly basis. The measures are meant to establish standards to assess Service Providers against. Performance measures are subject to ongoing review which is referred to as measure maintenance, and therefore, may change. Any changes to performance measures will be communicated in writing to the Service Provider. The Service Provider shall be solely responsible for the performance of each measure outlined in Appendix B section 7c of the contract and understands all relevant factors that may interrupt and affect service delivery. The Service Provider is responsible for meeting all performance outcomes as developed by MCHD to be within contract compliance. If the Service Provider fails to meet the standards established, MCHD may implement a corrective action plan with a prescribed time for the Service Provider to correct any performance deficiencies. If the Service Provider is unable to correct performance deficiencies, MCHD may terminate the contract.
   c.) Measures by Program:
      a. Compliance with DCF reporting requirements:
         i. Demographic info on all patients identified as CORE clients
         ii. Number of individuals served

iii. Services provided
iv. Diagnosis
v. Cost associated with Service

b. **Warm Handoff to Peer Recovery Specialist** - By June 2026, track and document all SUD-presenting individuals encountered by CORE partners and ensure that at least 80% receive a warm handoff to a Peer Recovery Specialist at SMA Healthcare within 1 hour of identification.
c. **Treatment Acceptance Post-Referral** - By June 2026, develop a tracking system to monitor the number of SUD-presenting individuals referred by hospitals, EMS, law enforcement, and other CORE partners. Set a target of at least 50% acceptance of treatment services during the initial pilot year, with ongoing adjustments as baseline data is finalized.
d. **Detox/Withdrawal Management Completion** - By June 2026, maintain or improve the current detox/withdrawal management completion rate of 83% (249 out of 299 clients) at SMA Healthcare. Performance will be reviewed quarterly, with a goal of sustaining an 83% or higher completion rate among all individuals entering detox services
e. **Enrollment and Retention in MAT (Medication-Assisted Treatment)** - By June 2026, sustain the current Medication-Assisted Treatment (MAT) program retention rate of 95% for clients remaining enrolled for 90 days or more at SMA Healthcare. Performance will be monitored quarterly to ensure continued success and to identify any emerging barriers to long-term engagement.
f. **Engagement with PEER RECOVERY Specialists** - By June 2026, maintain or improve the current rate of 64% of individuals who remain engaged in a lower level of care (including outpatient services, peer support, or community-based recovery programs) for 90 days or more following higher-intensity treatment. Ongoing efforts will focus on supporting engagement and reducing barriers to continued participation.
g. **Reduction in Repeat EMS/ER Involvement** - Using existing overdose and EMS response data as a baseline, achieve a 15% reduction in repeat EMS calls and emergency room visits involving individuals engaged in recovery services by June 2026.
h. Number of calls received to the CORE Overdose Hotline number
i. Number of field contacts made
j. Number of Emergency Department contacts made
k. Number of PEER Contacts
l. Number of patients that accept CORE services
m. Number of CORE patients that enter Detox
n. Number of CORE clients served in MAT
o. Number and percentage of repeat field encounters within 6 months and 12 months
p. Number and percentage of repeat ER visits related to substance use or overdose
q. Time from referral to MAT and engagement in MAT

r. Number of inductions made in the field/Emergency Department

7) **Compliance**. Failure to comply with any terms of the Agreement may result in suspension of funding and/or termination of the contract.
8) **Applicability and Limitations**. This Exhibit is not intended to be an exhaustive list of all program services, responsibilities, or qualifications associated with the agreed-upon services. The terms of the Agreement, along with any other Exhibits and documents incorporated therein by reference, shall also apply. Additional exhibits, appendices, supplementary material, or revisions may be added at the discretion of MCHD without requiring a formal amendment to the Agreement, and any such changes shall be communicated electronically to the Provider's point of contact.
9) **Reports**. Provider certifies that all data provided to MCHD on behalf of Provider is accurate. If multiple funding sources are used by Provider, Provider's reports will only reflect data for the programs paid for by MCHD, unless MCHD has provided MATCH/LIP funding which is used to leverage additional dollars to serve the underinsured, in which case, all affected consumers by MCHD funds and leveraged funds should be reported. Provider understands MCHD relies the data provided by Provider and that accurate reporting is required. Reports are due quarterly or as requested by MCHD staff. Should Provider report inaccurate data or submit reports late, corrective action including but not limited to, reduction of funding or termination of the Agreement may occur.

MARION COUNTY COORDINATED OPIOID RECOVERY (CORE) GUIDELINES

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The Marion County CORE Guidelines are a living document to support project fidelity and effectiveness. CORE partners will meet quarterly to review progress and barriers, updating the Guidelines as needed to ensure they remain practical and effective.

I. Purpose

The CORE Network establishes a recovery-oriented continuum of care and support for those seeking treatment and recovery support services for substance use disorder. This comprehensive approach expands every aspect of overdose response and treats all primary and secondary impacts of substance use disorder. The CORE Network disrupts the revolving door of substance use disorder, including opioid use disorder, and overdose by providing an evidence based coordinated network of care linking patients to community partners in a continuum, from a crisis all the way to lifelong care in an accessible, sustainable way.

The purpose of the CORE Process is to establish a proactive, comprehensive, and sustained response to substance use disorder, with a particular focus on treatment and long-term recovery. Traditional care models often end after emergency stabilization, resulting in individuals being discharged without support for long-term recovery. CORE addresses this gap by ensuring that each person is not only stabilized but also seamlessly connected to a wide range of recovery-supportive services.

Peer navigators are a key component of this system, providing warm hand-offs between each stage of care to ensure continuity, reduce disengagement, and foster trust throughout the recovery journey.

The CORE Process exemplifies Marion County's commitment to addressing the opioid epidemic through innovation, compassion, and interagency coordination.

II. Definitions:

1. **Warm Handoff:** Facilitating a warm handoff means actively connecting an individual to another service provider. This process goes beyond simply providing a referral name, phone number, and appointment time. Warm handoffs are a transfer of care between two providers in the presence of the individual and their family (if present). The purpose of the warm handoff is to engage the individual with the new provider. Once initiated, the patient must continue lifesaving buprenorphine or other medication assisted treatment until handed off to the receiving clinic from the 24-7 access point with no lapse in care. Peer supports, case managers, care coordinators, or nurse coordinators can be utilized.

2. "**CORE patient"** is any individual residing in or encountered within Marion County who is diagnosed with or at risk for substance use disorder, as evidenced by substance misuse, overdose history, or clinical presentation. Eligible patients may be referred via EMS, hospital systems, law enforcement, or self-referral, and shall be offered comprehensive services including SMA Medication Assisted Treatment, behavioral health treatment, case management, peer support, and follow-up.

Priority is given to uninsured and underinsured populations unable to access coordinated care through traditional means. CORE inclusion criteria are listed below.

3. **"Overdose"** is defined as a condition, including, but not limited to, extreme physical illness, decreased level of consciousness, respiratory depression, coma, or death resulting from the consumption or use of any controlled substance that requires medical attention, assistance or treatment, and clinical suspicion for drug overdose, such as respiratory depression, unconsciousness, or altered mental status, without other conditions to explain the clinical condition.

4. **"CORE Network"** is made up of the organizations; Marion County Fire Rescue, Ocala Fire Rescue and SMA Healthcare.

5. **"Peer Recovery Specialist"** are individuals who uses their lived experience of recovery from substance use disorder combined with specialized training to support individuals in recovery. CORE Peer Recovery Specialists must be employed by SMA, a member of the CORE Network.

6. ***Marion County Fire Rescue (MCFR)*** *and* ***Ocala Fire Rescue (OFR)*** *have coordinated an "on-call schedule" to ensure CORE coverage throughout the county. On-call schedule will be attached to this document.*

III. CORE Client Criteria

1. **CORE Inclusion Criteria:**
    a. Is awake and can answers questions, expresses the desire for help with substance use disorder
    b. Has a known address, or location they can be found for 7 days
    c. Agrees to comply with administration of Medication Assisted Treatment in person until a warm hand-off to SMA can be facilitated.
    d. Age > or = to 18 years old
    e. Not currently on Methadone
    f. Will sign Medication Assisted Treatment consent form and release of information for CORE partners
    g. Individuals seeking support for substance use disorder within a CORE Network provider
2. **CORE Exclusion Criteria:**
    a. Currently prescribed/taking Methadone
    b. In custody/under arrest by Law Enforcement
    c. Under the age of 18
    d. If the patient refuses to sign a release of information covering CORE partners.
    e. If the patient has **repeatedly (greater than 4 incidents)** dropped out of the CORE program following field induction or emergency department induction.
    f. If the patient wishes to go to an alternate facility outside of the CORE Network for treatment
    g. If patient is already receiving Medication Assisted Treatment from an agency that is not SMA Healthcare, Inc.
    h. If the patient is prescribed opiates for pain management.

Note: The Receiving Facility must be integrated into the CORE network and serve as the central hub for behavioral health and Medication Assisted Treatment services, SMA Healthcare, Inc. is the designated Receiving Facility for Marion County. Continuity of care cannot be assured outside of the defined network therefore only individuals utilizing the identified CORE Network parties can be identified as CORE patients.

a. It is important to remind patients that if a patient insists on an alternative facility:
    i. They may not receive Medication Assisted Treatment immediately.
    ii. Their care will not be coordinated or funded through the CORE system.
    iii. They are responsible for follow-up and may not qualify for wraparound services.

iv. They cannot be identified as a CORE program patient
v. Patients CAN receive PEER Support services through SMA independent of their participation in CORE services.

IV. PROCESS

1. **Emergency Department Process:**
Call (352) 351-1111 to initiate a hospital OVERDOSE ALERT. A group text and an alert on the radio will be sent to all the partners (SMA PEER Recovery Specialist and identified SMA staff, Ocala Fire Rescue and Marion County Fire Rescue) This system works like the trauma alert system. Calling the number above will start all processes. PEER will arrive within 1 hour of the alert being sent.
If the SMA PEER Recovery Specialist does not answer, contact SMA Leadership (see p. 22)
    a. Emergency Department physician assessment and evaluation.
        i. The Emergency Department physician will identify that the patient has a substance abuse addiction and call in an overdose alert (352)351-1111.
        ii. The Emergency Department physician will complete a history & physical exam and document it in the patient's electronic health record.
        iii. The SMA PEER will determine if the patient is a current client with SMA Medication Assisted Treatment.
            a. If patient IS currently receiving Medication Assisted treatment with SMA Healthcare, Inc. The Peer Recovery Specialist will follow the SMA Healthcare, Inc protocol for notifying the assigned counselor and obtaining follow up care.
        iv. The SMA PEER will explain the Community Paramedicine Medication Assisted Treatment (MAT) program (CORE) to the patient.
        v. If patient expresses desire for help with addiction, the responding PEER must screen the patient for their appropriateness for the program by:
            a. Discussing the patient's desire to be transported to Detox immediately upon discharge from the Emergency Department.
            b. Reviewing the CORE inclusion/exclusion criteria
            c. Obtaining a **Release of Information** identifying all CORE partners (Marion County Fire Rescue, Ocala Fire Rescue and SMA Healthcare, Inc.)

d. The goal is to offer Detox, SMA Medication Assisted Treatment and SMA Peer support before they leave the Emergency Department.

b. If the patient is **NOT** eligible for the CORE program or if patient refuses SMA Healthcare, Inc. Detox and SMA Medication Assisted Treatment, the patient and or family/friends will still be given educational materials and be referred to other services for further follow up. Patient contact should still be documented by the responding SMA PEER Recovery Specialist.

c. If the patient **IS** eligible for the CORE Program, and the Clinical Opioid Withdrawal Scale (COWS) assessment, a Release of Information for all CORE partners and intake forms have been completed (if doctor will not do COWS, then paramedicine will):

i. If the patient IS a current client with SMA Medication Assisted Treatment clinic, the SMA PEER Recovery Specialist will follow SMA protocol for notifying the clinic.

ii. If the patient is NOT a current client with the SMA Medication Assisted Treatment clinic and an induction is needed, then:

1. Marion County Fire Rescue OR Ocala Fire Rescue will proceed with induction in the emergency department. A referral to SMA Medication Assisted Treatment Program will be made within two hours of initial induction.
2. If induction in the Emergency Department is not possible and it is Monday-Friday between 8am – 2 pm, the patient should be discharged and taken to Beacon Point Building 1 for evaluation, possible induction and Detox, if patient is agreeable.
3. When the patient is asking for help and it is after 2pm, before 8am or is a day when Beacon Point Building 1 is closed, **the on-duty Community Paramedic assigned to CORE** will perform an evaluation and Buprenorphine induction when appropriate based on the induction inclusion/exclusion criteria and SMA PEER will make a referral to SMA Medication Assisted Treatment.
4. All patients will be offered Detox prior to being discharge.

d. Prior to ED discharge, the ER physician, OFR/MCFR, and SMA Healthcare, Inc. personnel will:

i. Facilitate interaction with an OFR/MCFR Community Paramedicine Paramedic and SMA Healthcare Peer Support Specialist to schedule continuation of outpatient SMA Medication Assisted Treatment and follow up counseling or transportation to the SMA Healthcare Inc. Detox facility.

ii. Provide informational packet regarding program, meetings, Narcan, etc.

iii. When available, the discharging Emergency Department will provide the patient with all his/her labs and medical records for follow up.

2. **Field Process:**

This protocol may only be performed by OFR/MCFR Paramedics who have been approved by the Medical Director and have completed all required DOH/OFR/MCFR CORE training.

Paramedicine will initiate an ANGIE ALERT. A group text and an alert on the radio will be sent to all the partners (SMA PEER Recovery Specialist and identified SMA staff, Ocala Fire Rescue and Marion County Fire Rescue) This system works like the trauma alert system. Initiation of the ANGIE ALERT will start the process.

SMA PEER Recovery Specialist will arrive within 1 hour of the alert being sent if the SMA PEER Recovery Specialist is not already at the scene with the Community Paramedic.

If the SMA PEER Recovery Specialist does not answer, contact SMA Leadership (see p. 22)

a. The SMA PEER Recovery Specialist, Inc. will determine if the patient is a current client with SMA Medication Assisted Treatment Clinic.
    1. If patient IS currently receiving SMA Medication Assisted treatment, The Peer Recovery Specialist will follow the SMA Healthcare, Inc protocol for notifying the assigned counselor and obtaining follow up care.

b. Patient **must** sign the CORE Partner Release of Information which clearly identifies all CORE Partners (Marion County Fire Rescue, Ocala Fire Rescue and SMA Healthcare, Inc.)

c. Intake information should be obtained. Assess what services, education or referrals need to be made. Provide educational materials as needed to the patient, family members or other support system individuals if available.

d. Complete SMA Medication Assisted Therapy (MAT) Intake Information Form

e. Community Paramedic will assess patient for any induction exclusion/inclusion criteria (note: this is different from CORE program exclusion criteria any patient with substance use disorder is eligible for the CORE program):

i. **Induction Exclusion Criteria**
    1. Methadone use in last 5 days
    2. Psychosis
    3. Suicidal ideations
    4. Required use of opioids for medical condition (prescribed)
    5. Requirement for acute hospital admission
    6. Under the age of 18

7. Unwilling/Unable to provide full name AND date of birth
8. Received chest compressions/CPR prior to EMS arrival.
9. In custody/under arrest by Law Enforcement
10. Refused services by OFR/MCFR/SMA.
11. Current client at the SMA MAT Clinic

ii. **Induction inclusion Criteria (patients that do not receive an induction are still eligible for the CORE program and should be referred for follow up treatment)**:

1. Is awake and can answers questions, expresses the desire for help with substance use disorder.
2. Has a known address, or location they can be found for 7 days
3. Agrees to comply with administration of Medication Assisted Treatment in person for up to 7 days
4. No known allergy to Buprenorphine
5. If patient meets the Inclusion criteria and is willing to sign the SMA Medication Assisted Treatment Consent form giving their consent to participate in the Buprenorphine Medication Assisted Treatment Program.
6. Individuals seeking support for substance use disorder within a CORE Network provider

f. Fire Rescue will maintain all documentation for a non-transport Emergency Medical Service report.
g. Obtain signed medical records release
h. Calculate a Clinical Opiate Withdrawal Scale (COWS) score (Attachment #2)

i. **Score of less than 5:**

1. A score of less than 5 does not qualify for immediate buprenorphine induction.
2. Provide resources and coordinate a warm handoff to SMA via the Peer Recovery Specialist.
3. Discuss the option of Detox at an SMA Healthcare, Inc. facility.
4. Proceed to appointment scheduling or contacting SMA Healthcare, Inc for Detox bed availability.
5. If the patient is in mild to moderate withdrawal and it is Mon-Fri from 8:00am-2:00pm, call the ACCESS Center at 352-565-5700 and transport the patient to SMA Beacon Point at 717 SW MLK Jr. Ave, Ocala, Florida 34471. The SMA PEER recovery specialist may also provide transport.

6. Transport to local Emergency Department for further evaluation, if needed. (PEER will accompany client to Emergency Department and continue to follow Emergency Department Process above)

ii. Score of 5 or greater:

1. Counsel patient regarding Buprenorphine treatment for withdrawal
2. Assess desire to initiate treatment
3. Initiate Buprenorphine treatment
4. Discuss patient's desire to enter an SMA Healthcare, Inc. Detox facility and arrange transportation if patient is willing.

i. Patient agreeable to Buprenorphine treatment:

i. Give water to moisten mucous membranes. Mouth must be empty prior to administration. No water in the mouth. DO NOT CHEW OR SWALLOW THE SUB-LINGUAL PILL.

ii. May administer Buprenorphine sub-lingual 4 mg. (Patients report a bad taste with administration so advise your patient to expect this.)

iii. Repeat the COWS and administer buprenorphine in 8 mg increments every 15 minutes until resolution of all objective signs of withdrawal. (Gooseflesh, sweating, restlessness, yawning, joint pain/discomfort, rubbing joints, rhinorrhea, tearing.)

iv. Your goal should be to get the patient to a COWS of <5.

1. If Emergency Department has dosed the patient above 16mg, dosing maybe matched
2. If dosing is above 32 mg or if Emergency Department dose needs to be raised, contact CORE Program Medical Control at (352) 286-3166.
3. if COWs increase and precipitated withdrawal is occurring, the patient will be transferred to the medical Emergency Department.
4. Maximum dose is 32 mg. Do not exceed 40 mg.

j. When COWS is less than 5 proceed with polypharmacological management

3. **Polypharmacological Management**
    a. It is possible your patient will experience nausea or vomiting as part of their withdrawal:
        i. Administer Zofran 4 mg sublingual tablets as needed for nausea and/or vomiting.
    b. Avoiding seizure activity is another important part of withdrawal management. Frequently, illicit drugs are cut with benzodiazepines. Therefore, withdrawing a patient from the illicit substances may precipitate seizure activity as they will also be withdrawing from a benzodiazepine. Ensure the patient is not pregnant.
        i. Administer Klonopin, 1 mg PO.
4. **Follow up after program induction**
    a. OFR/MCFR Community Paramedicine and PEER Specialist will visit the subject until patient care is transferred to a long-term SMA Medication Assisted Treatment program via a warm handoff, enter SMA Detox facility or they refuse care. A referral for more intensive services will be recommended by the Community Paramedic or SMA Healthcare Staff, if necessary.
    b. After the initial induction, the established medication assisted therapy dose will be administered by the Community Paramedicine personnel daily around the same time until services begin through SMA Healthcare; the SMA PEER Specialist will accompany the Paramedicine personnel patient daily until services are established at SMA.
    c. The Community Paramedicine personnel will administer additional inductions after the initial induction only if the patient is unable to get into SMA Medication Assisted services prior to the next scheduled induction.
    d. If possible, the PEER Specialist will accompany the Paramedicine team administering the induction. At a minimum, the PEER Specialist will visit the client daily until established with SMA Medication Assisted Treatment.
    e. The Community Paramedic will make a referral to SMA Healthcare within 2 hours of initial induction and document the referral in the patient's Electronic Health Record.
    f. The Community Paramedic will document all inductions/interactions and upload scanned documents into the patient's Electronic Health Record system.

5. Medication Security

a. The supply of Buprenorphine will be purchased in doses approved by the Medical Director and will be housed in a safe at OFR/MCFR Logistics. Buprenorphine will be dispensed to the Paramedicine program in amounts as needed to meet the demand of the program.
b. Buprenorphine doses will be individually packaged and numbered when received by logistics in the presence of a second paramedic.
c. Buprenorphine doses will be secured in a safe in the medication vault and signed out to Paramedics based on the days scheduling of MAT patient meetings.
d. Medication will be kept in a secured box inside of CORE Community Paramedicine vehicle.
e. All doses of Buprenorphine will be logged manually as well as in the identified Electronic Health Record.

6. Accountability and Program Misuse Prevention Guidelines

a. Patients may opt in to the CORE Program at the time of Emergency Department or Field Induction but will not continue with the program following induction if the following occur (to include but not limited to):
    i. Patient's failure to follow up with SMA Medication Assisted Treatment Program or SMA DETOX at Beacon Point.
    ii. Patient's failure to engage with or accept Peer Recovery Support.
b. Should a patient drop out of the CORE program repeatedly (greater than four times), this may result in their exclusion from the CORE program in the future.
c. Exclusion from the CORE program does not constitute refusal to provide services. Instead, they will be offered treatment through alternative programs.

V: Data

1. Opioid settlement funds will be used to implement CORE Networks. A required component of the state's opioid settlement is to use an evidence-based data collection process to analyze the effectiveness of substance use abatement. The opioid settlement states that the State and local governments shall receive and report expenditures, service utilization data, demographic information, and national outcome measures. In addition to the Performance Objectives listed below the state will require the following from all recipients of Opioid Abatement Funds:
    a. Demographic info on all patients identified as CORE clients
    b. Number of individuals served
    c. Services provided
    d. Diagnosis
    e. Cost associated with Service

2. **Performance Objectives:** Performance Objectives for the CORE Network can be found in Appendix B to the Grant Agreement. The Performance Objectives are as follows and may vary slightly from these guidelines due to currently available data streams. The measures below are the goal:
    a. **Warm Handoff to Peer Recovery Specialist**
    By June 2026, track and document all Substance Use Disorder – presenting individuals encountered by CORE partners and ensure that at least **80% receive a warm handoff** to a Peer Recovery Specialist at SMA Healthcare within **1 hour of identification**.
    b. **Treatment Acceptance Post-Referral**
    By June 2026, develop a tracking system to monitor the number of SUD-presenting individuals referred by hospitals, EMS, law enforcement, and other CORE partners. Set a target of at least 50% acceptance of treatment services during the initial pilot year, with ongoing adjustments as baseline data is finalized.
    c. **Detox/Withdrawal Management Completion**
    By June 2026, maintain or improve the current detox/withdrawal management completion rate of 83% (249 out of 299 clients) at SMA Healthcare. Performance will be reviewed quarterly, with a goal of sustaining an 83% or higher completion rate among all individuals entering detox services.
    d. **Enrollment and Retention in Medication-Assisted Treatment**
        i. By June 2026, sustain the current SMA Medication Assisted Treatment (MAT) program retention rate of 95% for clients remaining enrolled for 90 days or more at SMA Healthcare. Performance will be monitored quarterly to ensure continued success and to identify any emerging barriers to long-term engagement.

e. **Engagement with PEER RECOVERY Specialists**
By June 2026, maintain or improve the current rate of **64%** of individuals who remain engaged in a lower level of care (including outpatient services, peer support, or community-based recovery programs) for **90 days or more** following higher-intensity treatment. Ongoing efforts will focus on supporting engagement and reducing barriers to continued participation.

f. **Reduction in Repeat Emergency Medical Services and Emergency Department Involvement**
Using existing overdose and Emergency Medical Services response data as a baseline, achieve a 15% reduction in repeat Emergency Medical Services calls and emergency room visits involving individuals engaged in recovery services by June 2026.

g. Number of calls received to the CORE Overdose Hotline number
h. Number of field contacts made
i. Number of Emergency Department contacts made
j. Number of PEER Contacts
k. Number of patients that accept CORE services
l. Number of CORE patients that enter Detox
m. Number of CORE clients served in SMA Medication Assisted Treatment
n. Number and percentage of repeat field encounters within 6 months and 12 months
o. Number and percentage of repeat Emergency Department visits related to substance use or overdose
p. Time from referral to SMA Medication Assisted Treatment and engagement in SMA Medication Assisted Treatment
q. Number of inductions made in the field/Emergency Department

3. MONITORING

a. MCHD utilizes Mindshare Technology for continuous quality improvement. This will advance a deeper commitment to data driven measures and a more collaborative process. This will also advance and guide service delivery systems of care that are encouraged by both Federal and State agencies which define best practice models.
b. All data from the CORE Network will be reconciled in Mindshare and any other databases that DCF may require for the administration of the Opioid Abatement funds.
c. Quarterly reports are due the 12th calendar day after the close of the quarter. Reports are completed in Mindshare and include quarterly budget reconciliation for payment as well as any other documents agreed upon.
d. Provider must agree to utilize the unique Customer Client Satisfaction Survey link provided to them at the beginning of their Grant Agreement term. The provider will make every effort to encourage clients to complete

the online form with a minimum return rate of 10% of the provider's annual unique client served count.

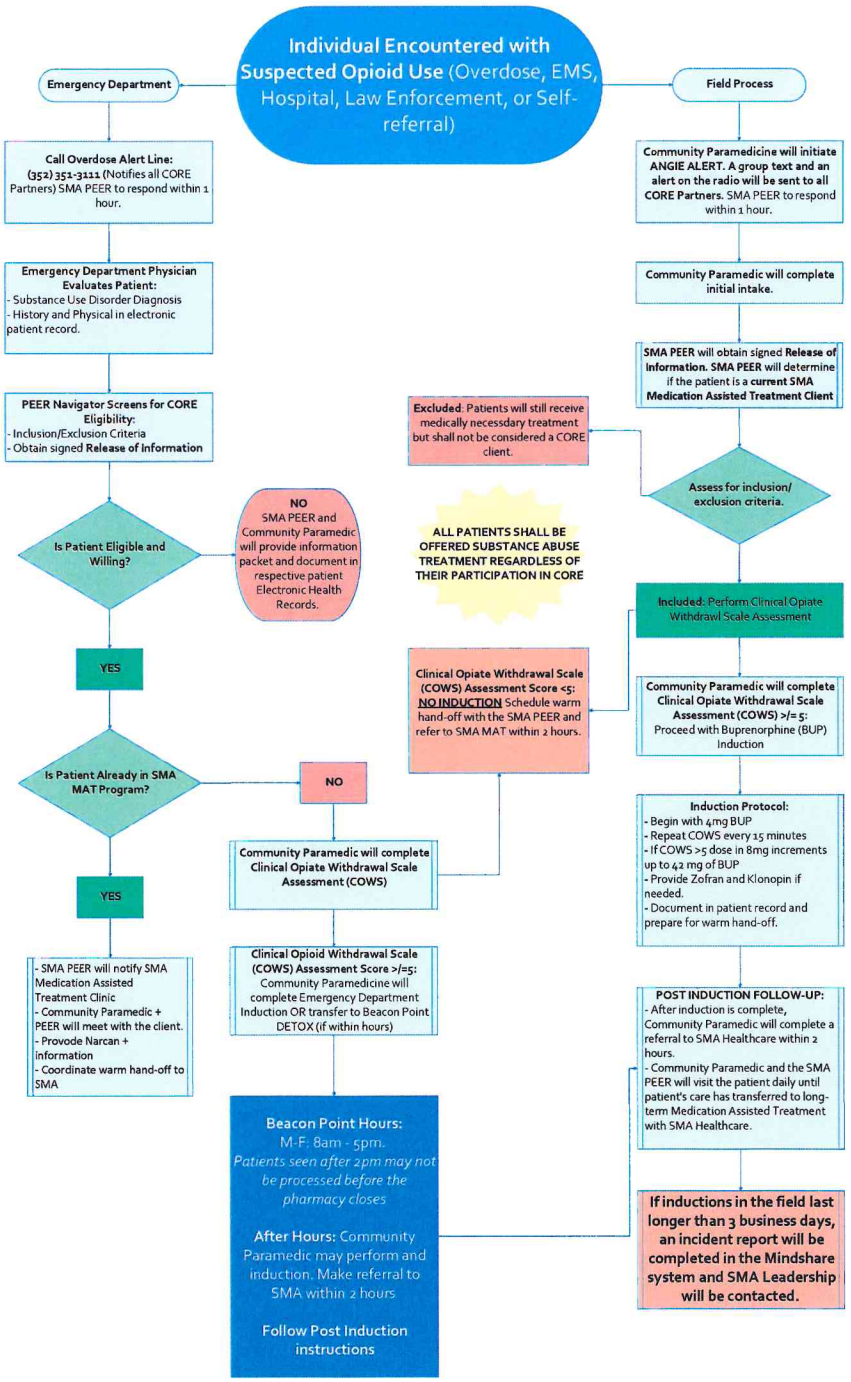
e. Incident reports shall be completed in Mindshare anytime more than two inductions are done my Community Paramedics (OFR/MCFR) within 2 days of the initial induction.
f. Incident Report should be completed on any additional incidents as outline in the Grant Agreement.
g. MCHD will review data with providers on at least continuous basis to ensure validity in the reporting across all CORE Network providers.
h. Reconciliation of data requests from the agency should be completed within 1 business day.

IMPORTANT CLINICAL GUIDANCE:

- The dose of Buprenorphine provided must meet the patient's tolerance level. Underdosing will cause the patient to seek satiation via opiates causing them to get very sick.
- It must be explained that if the patient uses any opiate substances once Buprenorphine is on board they may become violently ill and require hospitalization.
- Each patient must be counseled on keeping their daily dose of Buprenorphine out of the reach of children. Every dose of buprenorphine left to a patient will be locked in a Safe Rx bottle. Under no circumstances will medication be provided to a patient that does not have a Safe Rx bottle for the provided medications.
- Each daily dose of Buprenorphine must be kept in the blue lockable prescription bottles. The 4-digit code must be the last 4 digits of the patients verified social security number.
- Each patient must be warned that exceeding the daily prescribed dose or one-time prescribed dose of Buprenorphine will make them sick.

1. Appendix A

MARION COUNTY COORDINATED OPIOID RECOVERY (CORE) PROCESS AND INDUCTION DECISION TREE



2. Appendix B - Induction Workflow

This is the workflow if it has already been identified through the Marion County CORE Guidelines that an induction is necessary:

1. Clinical Overdose Withdrawal Scale > 5: If the patient is in mild to moderate withdrawal and it is Mon-Fri from 0800-1400, call the ACCESS Center at 352-565-5700 and transport the patient to SMA Beacon Point at 717 SW MLK Jr. Ave, Ocala, Florida 34471. The peer recovery specialist may also provide transport.
2. Clinical Overdose Withdrawal Scale <5: If the patient is in severe withdrawal, perform immediate induction. Complete consent paperwork. Get all signatures done before you leave. VERY important.
    a. Medical Information Release – So we can share with SMA Medication Assisted Treatment Clinic
    b. Methods of Release – Select paper, fax and electronic disclosure so we can share in each of those methods.
    c. Revocation statement and signature – They can verbally tell us not to share their info with the SMA Medication Assisted Treatment clinic and we will not share it.
    d. Residence Safety Assessment Waiver – Only sign if they want us to do an assessment. Otherwise, have them put an X in the signature box.
    e. Consent for CORE Program Participation Agreement
        i. Read each separate statement to the pt and mark "YES", have them sign if they understood each statement and then witness it with a signature.
    f. SMA Medication Assisted Therapy (MAT) Intake Information
        i. You do not need labs (LFT, BUN/Creatinine).
    g. Authorization to disclose confidential information
        i. Person/facility will always be SMA Healthcare
        ii. Methods of disclosure will always be all three options
        iii. Email address is helpful but not required.
        iv. Information to be disclosed is chosen by the pt and recorded by you by clicking the appropriate boxes.
        v. Diagnostic test reports can be left blank if current info is not available.
        vi. Purpose of disclosure is community care
        vii. Expiration date is today's date 7 years from now.
        viii. Type patient initials in both the Conditioning box and Revocation box
        ix. Patient signature in the large signature box and typed full name below and mark date and time.
3. Perform your physical exam and document with time stamp
4. Perform a medication reconciliation. If the patient is currently taking any prescribed opiate drugs, or methadone, they are not a candidate for buprenorphine.
5. Perform the Clinical Overdose Withdrawal Scale assessment again. Look for objective signs of withdrawal, things you can see. Patients can over-report symptoms so be objective.
6. Obtain vitals

7. Have patient wet mouth with water and administer initial buprenorphine dose of 4 mg if Clinical Overdose Withdrawal Scale score is over 5. **Let tabs dissolve under tongue. The patient will think the medication is not working if swallowed or chewed.**
8. Obtain post administration vitals
9. Wait 10 minutes.
10. Perform Clinical Overdose Withdrawal Scale assessment
11. If Clinical Overdose Withdrawal Scale score is over 5, administer appropriate dose of buprenorphine. Dosing at 4 mg each time is usually safe. If Clinical Overdose Withdrawal Scale score is still more than 5 but less than 10, 2 mg may be appropriate.
12. Obtain post administration vitals
13. Wait 10 minutes
14. Perform Clinical Overdose Withdrawal Scale assessment again
15. Repeat Clinical Overdose Withdrawal Scale, medication, and vitals sequence until the pt's objective signs are 5 or less on the Clinical Overdose Withdrawal Scale score. If the patient is falling asleep, their Clinical Overdose Withdrawal Scale score is 5 or less.
16. If the patient is still reporting serious or severe anxiety after 16 mg of buprenorphine, you may administer 1 mg Klonopin PO with water. They swallow this like an ibuprofen. Do not chew and it's not sub-lingual.
17. If you administer 16 mg and the pt has not made much progress, you may administer 0.1 mg Clonidine with water, like an ibuprofen. Do not chew and it's not sub-lingual.
18. If the patient requires more than 32 mg of buprenorphine, please consult Dr. Fraunfelter at (352) 286-3166.
19. Do not leave any medication with the patient on their initial visit. They must take all the medication in your presence.
20. Email tabrown@smahealthcare.org with a screenshot or cut and paste of your narrative ASAP after you complete the report.
21. Questions?
    a. (352) 239-5585 (Jesse Blaire)
    b. (352) 844-3795 (Robert Kruger)
    c. (352) 425-8787 (Robin Lanier)
    d. (352) 266-4769, (352) 286-3166 (Dr. Fraunfelter)

Essential Elements in your report

If it's the first time the patient is receiving buprenorphine since their most recent Overdose, and Community Paramedicine is giving it to them: under Procedures, select **Medication Assisted Treatment Induction.** If Community Paramedice is administering buprenorphine on a follow-up visit: under procedures, select **Medication Assisted Treatment Maintenance**
Simplified order of treatment:

- Sign paperwork-**Only on the induction visit, follow-up visits do not require signatures or consents.
- Perform physical exam
- Get initial Clinical Overdose Withdrawal Scale
- Obtain vitals
- Administer initial dose of buprenorphine

- Wait 5 minutes and repeat vitals
- Obtain new Clinical Overdose Withdrawal Scale
- Fifteen to twenty minutes after initial dose and if clinically appropriate, administer a subsequent dose of buprenorphine.
- Repeat the order Clinical Overdose Withdrawal Scale, vitals, buprenorphine waiting 15-20 minutes between doses until Clinical Overdose Withdrawal Scale is 5 or less. Times are very important.

3. Appendix C - CORE NETWORK REQUIREMENTS

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

CORE Element	Description
24-7 access to care.	**24-7 availability for treatment with medication assisted treatment. Specifically, buprenorphine must be available 24-7 in an emergency setting with no need for admission to inpatient care to receive treatment immediately. 24-7 access to care can come from an, emergency department emergency medical services or a receiving facility/long-term medication assisted treatment provider.**
Peer support services.	Peers provide support services such as a warm handoff from the 24-7 access point (emergency department receiving facility/long term medication assisted treatment provider, emergency medical services) and continuous follow-up.
All FDA approved medication assisted treatment services.	FDA approved medication assisted treatment for opioid use disorders includes methadone, naltrexone, and buprenorphine products.
Maintenance of medication assisted treatment according to guidelines.	The Substance Abuse and Mental Health Services Administration's TIP 43[1] recommends that patients receiving medication assisted treatment should be maintained at least two years of continuous stability, or longer, without taper recommendation. Tapering is considered an optional branch.
Individual approach to dosing without limits.	Buprenorphine should not be restricted to a certain dose, because of fentanyl, as increasing doses enhances retention and decreases cocaine use. Dosing should be based on decreasing withdrawal over 24 hours.
Receiving clinic receives patients from 24-7 care and continues lifelong treatment.	**A federally qualified health center or community behavioral health center that can take patients during business hours for intake and serve as a substance use medical home for lifelong care providing medication assisted treatment, substance use therapy, psychiatry, and primary care.**
Clinic and ER testing / Prescription Drug Monitoring Program.	**Report through E-Force every visit and provide drug panels in receiving clinics and 24-7 access points.**
Law Enforcement	Participate in community activities that build trust, foster relationships, and educate the public about available support systems. This collaboration bridges the gap between individuals in crisis and essential treatment services.
Established intake process.	An intake and assessment that includes a doctor's visit to start substance use treatment and a biopsychosocial completed or countersigned by a qualified professional.
Established protocol for induction on buprenorphine.	There should be a high dose and low dose induction protocol with preference given to the high dose induction protocol that can be given immediately after use or naloxone reversal.
Treating comorbid alcohol and benzodiazepine use disorder.	American Society of Addiction Medication reports the use of benzodiazepines or other sedative-hypnotics are not a reason to withhold or suspend treatment. Follow best practices and guidelines provided in Federal Guidelines. [2, 3]
Naloxone readily available.	Naloxone quickly reverses an overdose by blocking the effects of opioids. It can restore normal breathing within 2 to 3 minutes in a person whose breath has slowed, or even stopped, because of an opioid overdose.
Access to higher levels of care for all.	In the county there should be a functional referral relationship with public/private detoxification programs to assist with complex detoxification

	(benzodiazepines/alcohol patients with delirium tremens), access to public/private residential, partial hospitalization programs, intensive outpatient programs and outpatient levels of care for adults and pregnant women.
Clinical expert in addiction medicine or champion.	Established Medical Doctor or Doctor of Osteopathy who is primary care or psychiatrically trained and who has addiction medicine or addiction psychiatry certification.
Therapists in outpatient setting.	Licensed Mental Health Counselors, psychologists, Licensed Clinical Social Workers and interns who provide group and individual therapy as part of the substance use program.
Primary care access.	All patients should have access to primary care.
Infectious disease screening.	All patients enrolling in a substance use disorder program should be tested for HIV, hepatitis panel (especially hepatitis C), syphilis, and tuberculous as needed, as part of the intake.
Access to psychiatry at the federally qualified health center or community behavioral health center	Psychiatric provider should be available and all patients entering the substance use disorder program should receive a psychiatric evaluation to assist with underlying psychiatric problems as they can be comorbid with substance use disorder diagnosis.
Group therapy access in the clinic or with a collaborative partner.	Individuals should have access to group therapy.
Individual therapy access in clinic or with a collaborative partner.	Individuals should have access to individual therapy.
Clinic structured by phases of treatment.	Patients should start receiving medication assisted treatment with methadone or buprenorphine in a phased approach to allow for flexibility based on need and clinical judgement.
All levels of care to assist with pregnant women.	Evidence-based pregnancy care with buprenorphine/methadone options available while in residential, partial hospitalization programs, intensive outpatient programs or outpatient care. This care should be coordinated with the woman's obstetrics and gynecological team, as well as obstetric triage services equipped to provide appropriate management.
Following of outcome measures and data, specifically the Brief Addiction Monitoring (BAM) tool.	**The Brief Addiction Monitoring tool is completed monthly by all substance use disorder patients in the receiving clinic. Supplemental questions have been added to the collection process.**

Contact Index			
Name	**Title**	**Number**	**Email**
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