AGENDA
AND
CALENDAR

Agenda – June 14 , 2023
State Attorney Addiction Recovery Task Force (SAART)

1. Introductions:

2. Updates:

    a. Overdose statistics: PBC ME and PBCFR update: Al Johnson
    b. FARR: Current State-Wide Data/Trends: Heidi Matheny:
    c. Oxford House: Lori Holtzclaw-Hunt:

3. FARR 3.0: Michael Cabot/Heidi Matheny

4. FoRCE Annual Report (NAATP): Nikki Soda

5. Behavioral Work Force Solutions: Nikki Soda

6. NADCP Overdose Prevention Project: Aaron Arnold

7. 2024 Legislative Initiatives:

    a. Chapter 419 Community Residential Homes: Jeffrey Lynne
    b. Therapeutic Housing: Level IV

8. 2023 Legislative Initiatives: Al Johnson

    a. Fentanyl Test Strip Exemption from Drug Paraphernalia §893.145(4): SB 164 & HB 165
    b. SAART Bill: SB210 & HB295:
    c. State-Wide Proviso Study on Community Housing for Persons With Disabilities:

9. SHTF Comments.-The next meeting is August 16th via zoom 1pm to 4pm

10. Public comments.

11. Closing remarks.

OFFICE OF THE STATE ATTORNEY

FIFTEENTH JUDICAL CIRCUIT
IN AND FOR PALM BEACH COUNTY

DAVE ARONBERG
STATE ATTORNEY

SOBER HOMES TASK FORCE TIP LINE-1-844-324-5463

STATE ATTORNEY ADDICTION RECOVERY TASK FORCE (SAARTF)

2023	
JANUARY –NO MEETING & HAPPY NEW YEAR	
WEDNESDAY	FEBRUARY 15, 2023
MARCH NO MEETING	
WEDNESDAY	APRIL 19, 2023
MAY NO MEETING	
WEDNESDAY	JUNE 14, 2023
JULY-NO MEETING-HAPPY 4TH TO ALL	
WEDNESDAY	AUGUST 16, 2023
SEPTEMBER NO MEETING	
WEDNESDAY	OCTOBER 18, 2023
NOVEMBER NO MEETING-HAPPY THANKSGIVING TO ALL	
WEDNESDAY	DECEMBER 13, 2023

All meetings are 1pm to 4pm

Please request a zoom link by emailing
Mary Ann Senatore-msenatore@sa15.org

Information updated Monday, June 12, 2023

ITEM 2a
Divider

2021/2022 PBCME Opiate ODs

- PBC Medical Examiner –2021 – **no pending cases**
  - Total drug overdose cases 657
    - Total opioid OD deaths 519 (79%)
    - Total Fentanyl cause or presence 477 (91%)

- PBC Medical Examiner –2022 - **no pending cases**
  - Total drug overdose cases 553
    - Total opioid OD deaths 421 (76% of total OD cases)
    - Total Fentanyl & Fentanyl analog cause or presence 391 (93%)**
    - **Decline in Opioid OD deaths - 2021/2022 (19%)**

***** Xylazine: "tranq" non-opioid animal tranquilizer – 40 OD deaths

** New Fentanyl analogues:

- N-Pyrrolidino Etonitazene (NPE) – 20x more potent than Fentanyl – 0/20
- Fleurofentanyl – similar potency to Fentanyl – 6/100

PBCFR TRANSPORTS 2017-2023
January 1 – June 1

YEAR	#CALLS	# PATIENTS	%CHANGE/CALLS
2017	1278	165	
2018	641	657	< 50%
2019	542	552	< 15 %
2020	771	786	> 30%
2021	693	709	< 10%
2022	639	654	> 10%
2023	517	525	< 19%

Net change 2017-2023 60% reduction in transports

2017

Palm Beach County Fire Rescue
Primary or Secondary Impression = Opioid

9/25/2018

2017

January	# of Calls:	162	# of Patients:	165
February	# of Calls:	135	# of Patients:	138
March	# of Calls:	329	# of Patients:	343
April	# of Calls:	238	# of Patients:	251
May	# of Calls:	414	# of Patients:	429

GRAND TOTALS	# of Calls:	**1278**	# of Patients:	**1326**

Palm Beach County Fire Rescue
Primary or Secondary Impression = Opioid

1/10/2019

2018

January	# of Calls:	144	# of Patients:	148
February	# of Calls:	128	# of Patients:	130
March	# of Calls:	116	# of Patients:	120
April	# of Calls:	129	# of Patients:	133
May	# of Calls:	124	# of Patients:	126

GRAND TOTALS	# of Calls:	**641**	# of Patients:	**657**

Palm Beach County Fire Rescue
Primary or Secondary Impression = Opioid

1/10/2020

2019

January	# of Calls:	100	# of Patients:	102
February	# of Calls:	105	# of Patients:	107
March	# of Calls:	97	# of Patients:	100
April	# of Calls:	103	# of Patients:	104
May	# of Calls:	137	# of Patients:	139

GRAND TOTALS	# of Calls:	**542**	# of Patients:	**552**

Palm Beach County Fire Rescue
Primary or Secondary Impression = Opioid

1/5/2021

2020

January	# of Calls:	183	# of Patients:	187
February	# of Calls:	147	# of Patients:	149
March	# of Calls:	147	# of Patients:	148
April	# of Calls:	143	# of Patients:	148
May	# of Calls:	151	# of Patients:	154

GRAND TOTALS	# of Calls:	**771**	# of Patients:	**786**

Palm Beach County Fire Rescue
Primary or Secondary Impression = Opioid

1/3/2022

2021

January	# of Calls:	127	# of Patients:	129
February	# of Calls:	119	# of Patients:	121
March	# of Calls:	151	# of Patients:	156
April	# of Calls:	143	# of Patients:	144
May	# of Calls:	153	# of Patients:	159

GRAND TOTALS	# of Calls:	**693**	# of Patients:	**709**

2022

Palm Beach County Fire Rescue
Primary or Secondary Impression = Opioid

1/3/2023

2022

January	# of Calls:	140	# of Patients:	144
February	# of Calls:	148	# of Patients:	150
March	# of Calls:	126	# of Patients:	130
April	# of Calls:	102	# of Patients:	103
May	# of Calls:	123	# of Patients:	127

GRAND TOTALS	# of Calls:	**639**	# of Patients:	**654**

Palm Beach County Fire Rescue
Primary or Secondary Impression = Opioid

10/1/2022 to 5/31/2023

6/5/2023

2023

January	# of Calls:	97	# of Patients:	98
February	# of Calls:	81	# of Patients:	83
March	# of Calls:	115	# of Patients:	116
April	# of Calls:	112	# of Patients:	114
May	# of Calls:	112	# of Patients:	114

*1 call with 1 Patient May 2023 - from new system; April and May have matching counts-that is not an error

2023 totals **517** **525**

ITEM 2b

Divider

FARR

FARR 3.0


Setting the Standards for Quality
Recovery Residence Services in Florida

Certification Process

FARR recognizes the importance of drafting and implementing policies and procedures that not only meet national standards but uphold resident rights through proper consents and practical protocols. Therefore, FARR has developed templates that providers may use as guidelines for drafting policies and procedures, staffing documents and resident orientation handbooks. These templates are available for Level II, III and IV providers to assist with expediting the certification process. This new service is geared towards new applicants; however, certified providers may access these templates as they have been developed to be compliant with the NARR 3.0 standards. With the NARR 3.0 rollout anticipated later this year, new policies can be found in these templates. It is FARR's hope that these templates will set a baseline for minimum standards that are compliant with the new NARR 3.0 standards and to help certified providers update their current policy and procedures to meet these new standards in an easy and efficient manner.

Assessment Policy

FARR recognizes and values the time of our providers. Going forward, FARR will ask providers to send resident orientation handbooks prior to the assessment date. This will allow FARR's field staff to review the handbook ahead of a site visit to better consult while at a site visit and to inform providers of any updates that are required. Additionally, we request logs and records be readily available at a site visit for FARR's field staff to review. A calendar invite is sent to the provider when a scheduled onsite visit date is assigned with a list of all documentation that is required.

Renewal Policy

FARR will contact providers within 90 days prior to a certificate expiration to coordinate the renewal process and site visit. This ensures that FARR staff can invoice, schedule, assess and request any corrective action well ahead of the certificate expiration dates. The result will be providers having a current, annual certificate.

Software Enhancements

FARR is working to make its certification portal a more user-friendly, pleasant experience for anyone who uses the platform. Software upgrades will include new features to ensure providers have easy access to reports, forms, policy templates and compliance tools. More details will come in the following months.

Training Videos

FARR is in the process of developing training videos that will be available on the FARR website. These videos will cover a variety of relevant topics that will be relevant to providers and residents, such as Medically Assisted Treatment, Recovery Oriented Systems of Care and information about the certification process. More details will come in the following months.

Level IV Program Fee Guidance

FARR will no longer require documentation of program fees for residents receiving services under a Department of Children and Families Day/Night with Community Housing License. It is FARR's position that Housing Program Fees are not required as separate payment by patients to stay in attached program housing. FARR will no longer require "Program Fee Logs" or "Rent Logs" for any clients that are provided services under said license.

A provider offering services under a Day/Night ("DN"), Intensive Outpatient Program ("IOP") or Outpatient Program ("OP") license will continue to be required to produce records of any financial obligations for any client receiving services under said DCF licenses. Clients who receive services under these licenses should be charged a "Fair Market" rate for housing and any services provided that is not covered under DCF licensure. FARR will not define "Fair Market" as this will be up to a provider to determine.

Meet the FARR Team

Josh Thrasher
Certification Administrator

Heidi Matheny
Operations Administrator

Christopher Nino
Field Assessor

Kayla McKinney
Office Assistant

ITEM 4
Divider
FoRSE

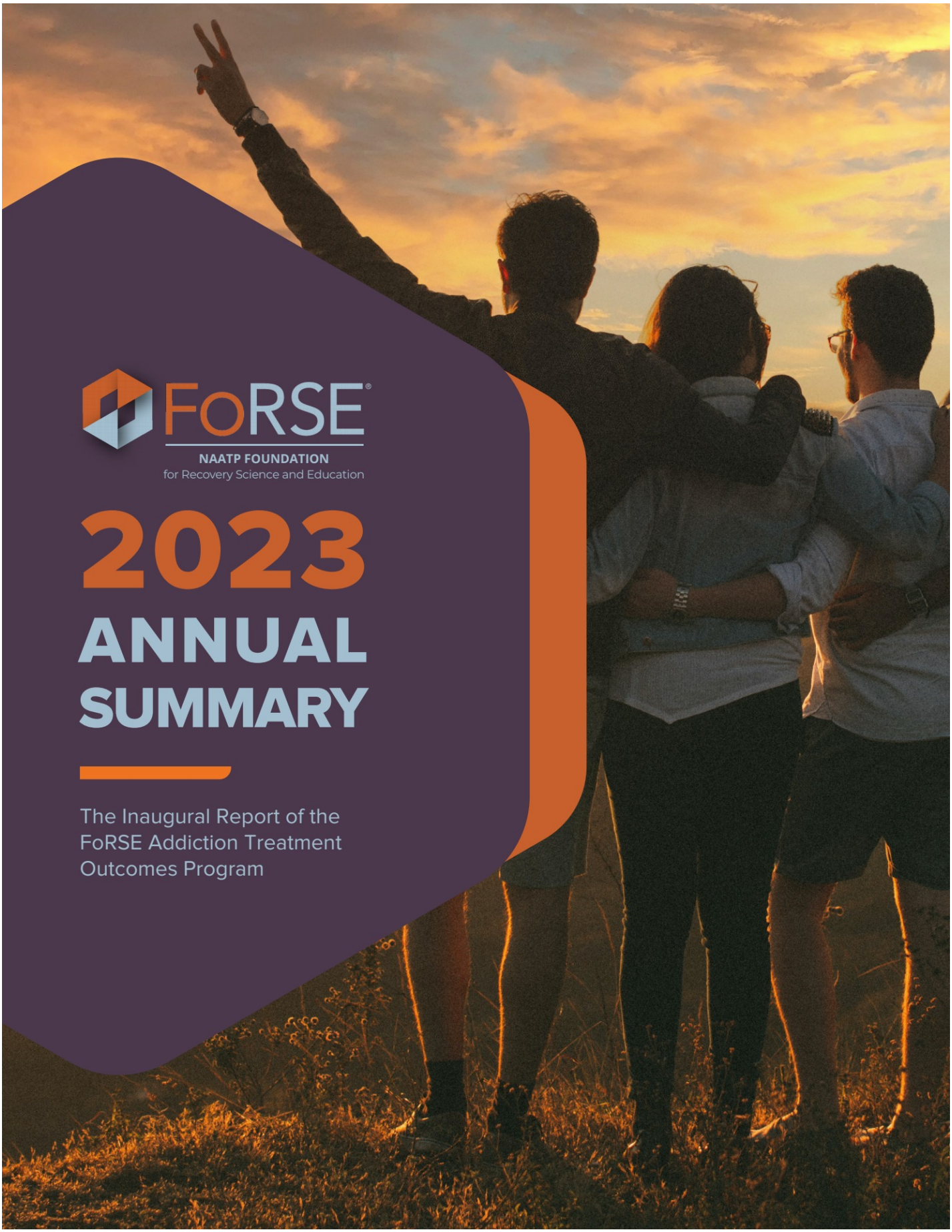
FoRSE®
NAATP FOUNDATION
for Recovery Science and Education
2023
ANNUAL
SUMMARY
The Inaugural Report of the
FoRSE Addiction Treatment
Outcomes Program

Table of Contents

Executive Summary

The NAATP Foundation for Recovery Science and Education (FoRSE) was developed in 2020 in response to the growing problem of Substance Use Disorders (SUDs) in the US, along with a recognized need to transform addiction healthcare through unprecedented collaboration. Challenges facing the industry include pervasive stigma, criminalization of the illness, lack of equity in access to care, lack of universal professional standards, lack of biomarkers of recovery, lack of integration of systems, a struggling and shrinking workforce, and lack of parity in reimbursement for addiction healthcare services (CEO Alliance for Mental Health, 2022). With millions more suffering from this chronic illness every year, a wholesale transformation is required to deliver needed services broadly in an effective and cost-effective manner.

Addiction treatment and recovery support can save and transform lives. Although addiction is a complicated and chronic illness, people do recover and thrive through multiple pathways. However, most people who need help don't seek it, don't know how to find it, or can't afford it. Lastly, addiction and its treatment are still highly stigmatized, amidst a worsening mental health crisis.

Founded in 1978, the National Association of Addiction Treatment Providers (NAATP) is a nonprofit professional membership society of addiction treatment and recovery support providers. NAATP has a four-decade record of advocacy for the quality and ethics of services provided to people with SUDs. Recognizing the barriers that prevent many people from accessing addiction healthcare, NAATP established FoRSE, a 501(c)(3) organization, specifically to launch much-needed measurement, quality improvement, and research initiatives that will help providers measure the impact of their services, use data to provide better care, and advocate to improve access to care.

The FoRSE Addiction Treatment Outcomes Program offers a centralized data repository that allows treatment providers to easily share data from their electronic medical record or other health technology system. Even the smallest set of standardized, de-identified data that FoRSE requires – about the persons served, the services provided, and patient outcomes – collected from many providers has the power to transform the future of addiction healthcare.

At the time of this publication, seventy-three (73) providers across the country are participating in the FoRSE Outcomes Program. The database consists of fully de-identified data from over 170,000 unique patient episodes, including data from facilities that span 25 states. These facilities represent a combination of non-profit and for-profit entities that differ in payer mix (e.g., public funding, private insurance, self-pay) and treatment approach (e.g., medication, Twelve Step, recovery support). All collect outcome data from patients throughout care and/or post-discharge, examining patient-reported substance use, mental health symptoms, and quality of life. Recognizing the significance of racial, ethnic, and other disparities in healthcare, FoRSE requires measurement of demographics and social determinants of health and stratifies outcome data by these variables.

FoRSE is not just one outcomes measurement effort but rather a collective of many dozens of efforts involving treatment sites throughout the country. This report represents the first analysis of this aggregated data. Making this information available publicly demonstrates transparency, collaboration, and accountability among the treatment providers who participate in the FoRSE Program and will raise the bar in the addictions field.

Demonstrating the impact of treatment can be a powerful component of advocacy efforts to expand access to more people who need care. Data from diverse service providers across the country strengthens NAATP's advocacy for parity, health equity, and the value of SUD treatment and recovery support. NAATP and FoRSE are honored to be leading this effort, and we are grateful to our advisors, donors, and participating organizations for their support of this work.

Sincerely,

Annie Peters, PhD

Annie Peters, PhD

Disclosures (Funding + Contractors)

Funders

CHAMPIONS ($100,000+)

- First City Recovery Center
- Hubert & Richard Hanlon Trust
- High Watch Recovery Center
- Jaywalker Lodge
- Patterson Family Foundation
- The Guest House Ocala

ADVOCATES ($25,000+)

- Ashley Addiction Treatment
- Caron Treatment Centers
- Cumberland Heights Foundation
- Hanley Foundation
- Hazelden Betty Ford Foundation
- Muir Wood Trusted Teen Treatment
- Origins Behavioral HealthCare
- The Rose House
- Vinck Family Foundation

BENEFACTORS ($75,000+)

- Driftwood Center

SUSTAINERS ($50,000+)

- La Hacienda Treatment Center
- Rob & Lindsay Carter
- Turning Point of Tampa

AMBASSADORS ($10,000+)

- Alina Lodge & Haley House
- Benjamin Levenson
- Marvin Ventrell and Jessica Swan
- Rosecrance Health Network
- The Gambrell Foundation
- Tully Hill Treatment & Recovery

DONORS ($1,000+)

- Addiction Recovery Consulting
- ATP, a division of NSM Insurance Group
- Bradford Health Services
- Choice House
- Coppersmith Brockelman PLC
- Deni Carise
- designRoom
- Dilworth Center
- Dr. Annie Peters
- Fellowship Hall
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- Imagine Recovery

James F Witteck Consultant
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Patrick Kennedy Family
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Pine Grove Behavioral Health & Addiction Services
Pride Institute
Rick and Sylvia Hubbard
Schwartz, James & Darlene
Sherri and Steve Layton
Sober Escorts, Inc.
Soberlink
Sundown M Ranch

FRIENDS

< $1,000

Aashrith Reddy
Adelman Hirsch & Connors, LLP
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Faces & Voices of Recovery
George & Andrea Sollenberger
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Contractors

Altric Advisors (Accountant & Taxes)
Beazley Media Tech (Cybersecurity Insurance)
ClearData (Risk Management)
Coppersmith Brockelman (Legal)
Judy Keller (Fundraising Consultant)
Petree Consulting, Inc. (Tech)
The Research Institute at Cumberland Heights

FoRSE is a 501c3, supported by donations.

The FoRSE Analytics Partner

Research Institute
Cumberland Heights

The Research Institute at Cumberland Heights was selected to consult on the FoRSE initiative given its achievement in the successful development and implementation of a multifaceted measurement-based care and outcomes reporting system.

FoRSE data are fully de-identified by both patient information and the facilities from which they come. The researchers at the Institute have no access to keys that link confidential data to specific individuals or facilities. Although a paid contractor of FoRSE, the Institute gains no other profit from what has been created in the process, nor will it receive any additional competitive advantages.


Introduction
Strategic Vision
Technology Accelerators
Leaning into the Future
Objectives
NAATP FOUNDATION For Recovery Science and Education | www.naatp.org/foundation
8

WHY are we investing in data and research?

Strategic Vision

According to the most recent national surveys, over 46 million people, or 15% of the US population, met criteria for a Substance Use Disorder (SUD) within the past year. Among those who needed SUD treatment, only about 7% received it (SAMHSA, 2022).

A wide range of SUD treatment and recovery support services are available today, representing multiple pathways toward recovery. However, with the ongoing, rapid rise in severity of the addiction epidemic, the US healthcare system has been unable to meet the growing demand for services. Multiple barriers prevent access to these services for many people and contribute to significant racial and ethnic disparities in receiving care (USDHHS, 2016).

Much has been learned from national, longitudinal studies on treatment outcomes for SUD, including DARP, TOPS, CATOR, Project MATCH, DATOS, and the COMBINE study. The overarching output from these studies demonstrates the value of SUD treatment in reducing substance misuse, improving mental health, and saving lives. In summary, one of the most compelling predictors of sustainable recovery is the duration of treatment (Proctor & Hershman, 2014).

Partly due to the history of stigma surrounding addiction, its treatment, and lack of research training offered within clinical education programs, valid measurement practices have been adopted slowly by providers. The lack of standardized measurement practices has negatively impacted our collective ability to codify outcomes, and we are left with insufficient research evidence to make the case for reliable funding of addiction treatment for all who need it.

As addiction treatment providers, our ability to advocate for our programs has historically been associated with anecdotal alumni stories. Although these recovery stories can be powerful narratives, they are limited in their ability to effectively communicate with external stakeholders. For example, much of the larger scientific and medical communities communicate through peer-reviewed output (e.g., academic publication). Therefore, our future ability to advocate for our treatments will be grounded in data.

Extensive frameworks and proposed measures to examine the quality and outcomes of treatment have been developed by the National Institute on Drug Abuse (NIDA), the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Quality Forum (NQF), the American Society of Addiction Medicine (ASAM), the Joint Commission, Shatterproof, the International Consortium for Health Outcomes Measurement (ICHOM), both public and private health plans, and other entities. A major challenge for implementation is that, due to the fragmentation of the US behavioral healthcare system, measures and standards are not universally adopted and required (USDHHS, 2016).

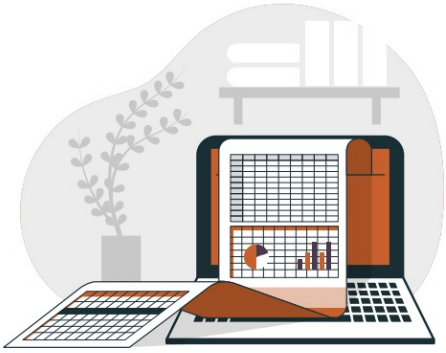
In building a future for our field, we must create datasets that are collected, analyzed, and disseminated within a standardized framework. A comprehensive system is needed to produce peer-reviewed output and expand our measurement standards. That system will increase our collective ability to better serve our patients and improve our programs. Creating that solution requires a coordinated large-scale collaborative effort among provider networks, technology partners, and community stakeholders.

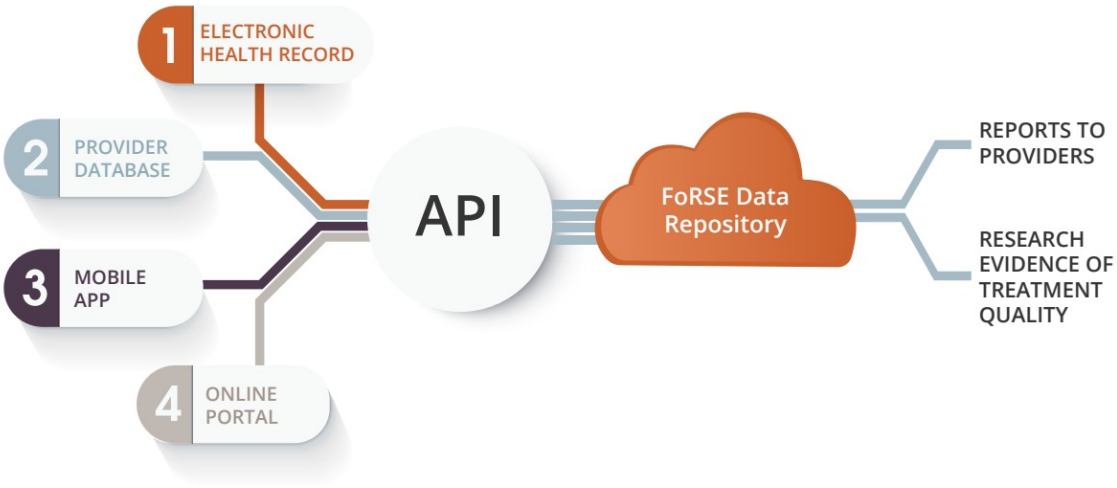
Technology Accelerators

Perhaps the most promising innovations in modern addiction healthcare are occurring in the fields of technology and data science. The breadth of digital tools available today have transformed our data ecosystems.

For example, many providers have adopted Electronic Medical Records (EMRs), sophisticated data management environments, and have partnered with third-party applications in support of patient-centered care. These accelerators help to support patients, their families, and providers by leveraging health data to inform treatment decisions.

Collecting data from patients has never been easier. Applications are available to help providers store, analyze, and report data more effectively than ever before. These resources allow the addiction healthcare field significant opportunity to improve access, effectiveness, and efficiency.





The above visualization demonstrates the pragmatic utility of how an application programming interface (API) allows our researchers to collect data across a wide range of technology platforms. These technologies significantly increase our ability to collaborate across distinct enterprises and support our future quality/research efforts.

Leaning Into the Future

Highlighted in the Surgeon General's Report, "Facing Addiction in America" (USDHHS, 2016), is a vision for the future in which widespread, equitable access to quality addiction healthcare is possible. A key component of this vision is the public availability of information about the quality of SUD treatment.

With the transition from a fee-for-service model to value-based care, SUD treatment providers have been called upon to demonstrate quality through standardized measurement of patient outcomes. Routine monitoring and feedback to patients during treatment (i.e., measurement-based care (MBC)) can improve engagement, contribute to positive outcomes, and help clinicians make care decisions (Giedzinska & Wilson, 2022, Miller et al., 2015). The Kennedy Forum (2015) suggests that all primary care and behavioral health providers treating mental health and substance use disorders should implement an MBC system using validated symptom rating scales that are completed by patients, reviewed by clinicians during treatment sessions, and used by providers to individualize treatment plans to address target symptoms. However, universally accepted benchmarks have not been established, and different stakeholders have varied perspectives on methods and tools of measurement.

As we look towards the future, it is imperative that providers demonstrate that “treatment works” not only to the public, but also to those seeking services for substance-related problems. Effective use of digital health tools, rigorous research methods, quality improvement models, and widespread training for providers are all key factors toward establishing addiction treatment as a valid and effective form of healthcare.

FoRSE was developed in response to the current challenges observed throughout the addiction healthcare system. By leveraging technology accelerators and promoting the practices of measurement-based care, data sharing, and collaborative data science, the FoRSE Program establishes the comprehensive system needed to improve the quality and availability of addiction treatment.

Objectives

The mission of FoRSE is to improve addiction treatment through science, technology, and education. FoRSE fulfills its mission by focusing on six (6) primary objectives.

Measurement Standards – Create standardized processes for measurement of treatment progress and outcomes, to include the:

- Practice of measurement-based care
- Use of standardized tools
- Disaggregation of data by demographics and social determinants of health

Quality Improvement – Build a framework for collective quality improvement by gathering and comparing site-specific and aggregated data, identifying opportunities for change, and measuring the impact of change on patient wellness.

Data Accessibility – Increase access to national normative data on the impact of different types of addiction services on different populations.

Collaborative Science – Generate an atmosphere of collaboration in the production and dissemination of research and its application to clinical practice.

Advocacy – Leverage our collective output to impact public policy and improve equitable access to appropriate and effective addiction healthcare services.

These objectives are integrated into the structure of the FoRSE Addiction Treatment Outcome Program, which is described in detail throughout the next section of the Annual Report. This report represents the first publicly-available summary of aggregated data collected from nationwide treatment providers participating in the FoRSE program. The aim of this report is to provide descriptive and visual summaries of the:

- Treatment providers participating in the FoRSE program
- Patients served by these providers
- Nature and duration of services provided
- Outcomes observed during and after these services were provided

FoRSE works toward the above objectives through partnerships with providers, researchers, digital health service providers, payers, and policymakers.


Methods
The FoRSE Treatment Outcomes Program
Data Collection
Technology Partners
Privacy and Confidentiality
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14

WHAT is the FoRSE Treatment Outcomes Program?

Defined:

The FoRSE Outcomes Program was developed to address the measurement and standardization challenges through provider collaboration. To address the traditional challenges associated with large-scale data collection projects (e.g., cost, logistics, and privacy), FoRSE created a cost-free, simple, and ePHI free framework for addiction healthcare providers to share a limited set of fully de-identified patient data located in a centralized cloud-based repository. Our low-burden data sharing process broadly measures the impact of care, establishes quality benchmarks, provides opportunities to generate evidence that treatment helps people recover, and equips our programs with disaggregated business intelligence insights.

The FoRSE Outcomes Program is organized as a function of three primary domains:

The Patient

- Demographics
- Substance Use
- Mental Health
- Social Determinants

The Service

- Residential, IOP, OP
- Length of Stay
- MAT
- Recovery Support

The Outcome

- Substance Use
- Functioning
- Physical/Mental Health
- Quality of life

Data Collection

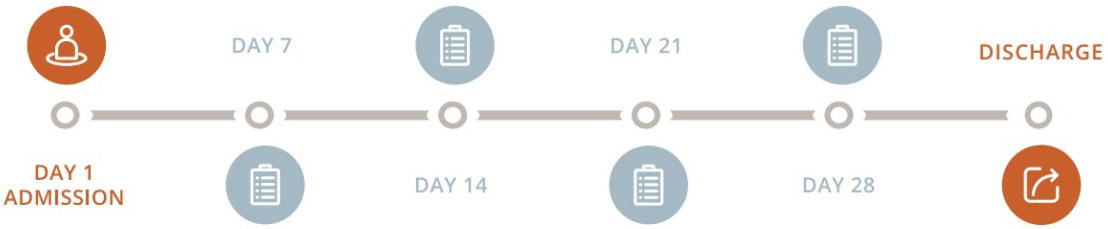
All data accepted by FoRSE are collected by providers during the process of regular healthcare operations. The Patient and Service data points mentioned above are required for FoRSE to be able to summarize the population served and the care provided.

All Patient and Service data points are arranged in survey format, populated by each provider's electronic medical record (EMR) or other software, and shared with FoRSE through an Application Programming Interface (API). The FoRSE API Documentation provides detailed guidance for providing FoRSE with all needed variables to link data within each episode of care, as well as for de-identifying, submitting, and scoring outcome measures.

Surveys are administered to patients or alumni by providers using a variety of methods. These can include: face-to-face interview, paper-and-pencil assessment, telephonic administration, tablet or kiosk, and/or collection via text/email/patient portal.

Outcome measures selected for inclusion in the FoRSE Outcomes Program are brief, public domain, cost-free, standardized tools with good validity and reliability. FoRSE also offers two additional brief surveys that can be used as adjuncts to these standardized measures. The FoRSE Progress Monitoring Survey and FoRSE Outcomes Survey were developed to address issues of importance to patients, clinicians, and payers that were not reflected in the other tools.

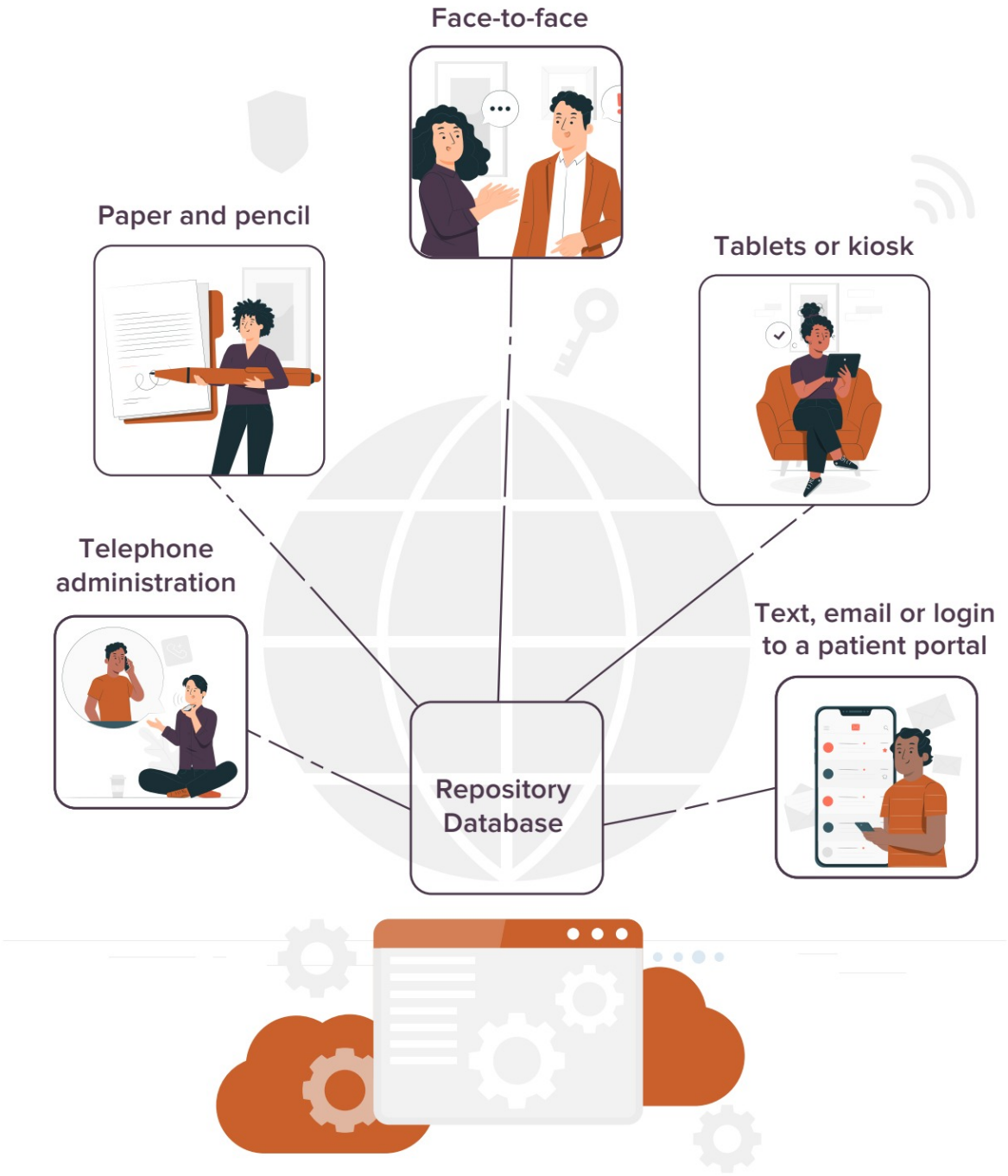
Measurement Periods: Data are collected every 7 days (at least once mid-treatment)



Post-Discharge Monitoring: 1, 2, 3, 6, 9, and 12 months post-discharge (annually thereafter)

Accepted Measures:

- Brief Addiction Monitor (BAM, BAM-R)
- Brief Assessment of Recovery Capital (BARC-10)
- FoRSE Outcomes Survey
- FoRSE Progress Monitoring Survey
- Generalized Anxiety Disorder screen (GAD-7)
- Patient Health Questionnaire (PHQ-9)
- Treatment Effectiveness Assessment (TEA)
- World Health Organization Quality of Life (WHOQOL-BREF)


Face-to-face
Paper and pencil
Tablets or kiosk
Telephone administration
Text, email or login to a patient portal
Repository Database

Technology Partners

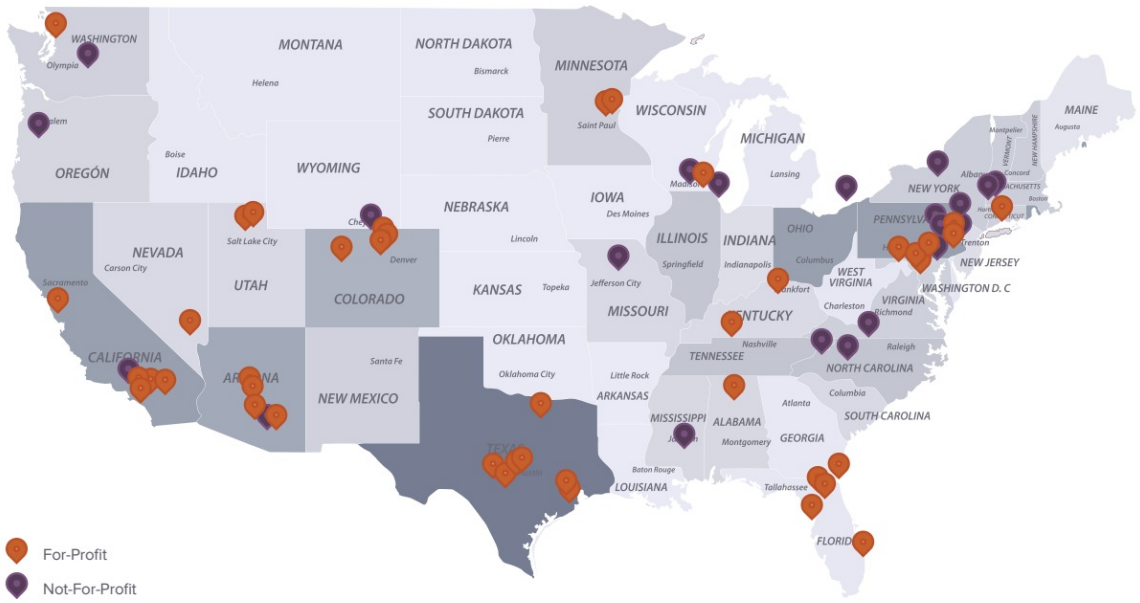
alleva · AMNet · BEHAVE HEALTH · BestNotes · blueprint · CaredFor · ERPHealth™ Engage. Research. Progress. · fiveoak · KIPU · Lightning Step · LOOSID · ONESTEP · PETREE CONSULTING INC · pretaa · SUNWAVE · Recovery Capital Index® Powered By gloo · SIGMUND SOFTWARE · Vista Research Group Improving Treatment Outcomes · TR Team Recovery Recovery Tech

Data Privacy and Confidentiality

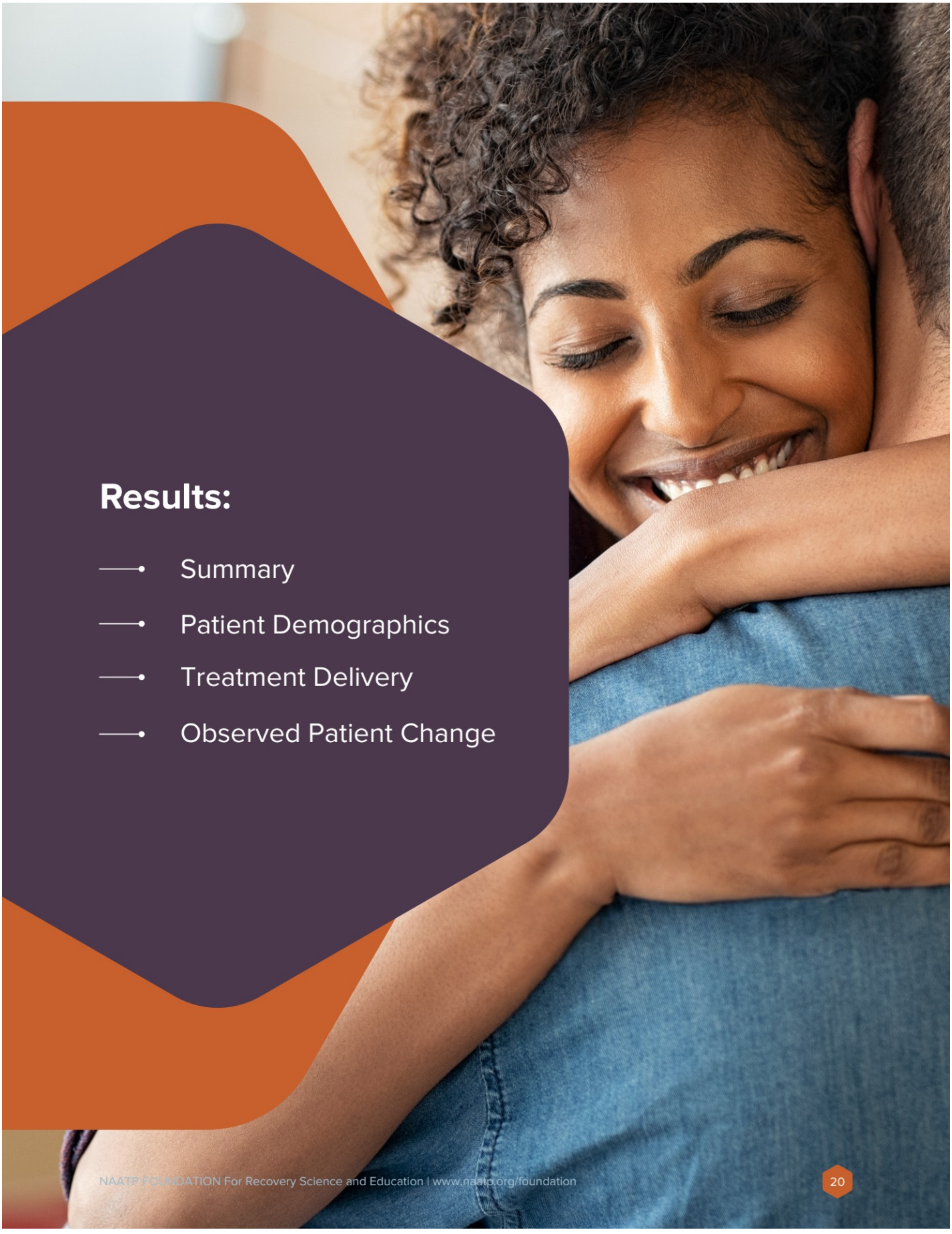
FoRSE is committed to protecting patient privacy. FoRSE only receives and uses fully de-identified data in connection with its program. Program participants strip their data sets of all direct and indirect individual identifiers before these data sets are shared with FoRSE. No one at NAATP or on the FoRSE team has access to the subject identifiers linked to the data. Because FoRSE only uses fully de-deidentified data for its program, federal human subjects research and health data privacy laws such as the Common Rule, HIPAA and 42 CFR Part 2 do not apply.

FoRSE also takes reasonable steps to protect the confidentiality of its proprietary, de-identified database sets and the confidential information of its program participants. FoRSE does not share any individual program data with third parties other than NAATP workforce members, consultants and contractors who have agreed to protect this confidential information. FoRSE only publicly releases aggregated benchmarking data and reports.

Participating Organizations



A Better Life Recovery	Gateway Foundation	Pine Grove Behavioral
A Mission for Michael	Gaudenzia	Pride Institute
ADAPT Programs	Glenbeigh	Recovery Ctrs of America
Advanced Therapeutic Svcs	The Guest House Ocala	Recovery Ways
Alpha 180	Harmony Foundation	The River Source
Alina Lodge	The Haven	Roaring Brook Recovery
American Treatment Network	High Watch Recovery Center	Rosecrance
Ashley Addiction Treatment	Jaywalker Lodge	The Rose House
Aspen Ridge	La Hacienda	Sabino Recovery
Birmingham Recovery	Lakeside-Milam	Serenity Lane
Brazos Place	Livengrin Foundation	Summit Detox
Bridging the Gaps	Maryland Addiction Recovery	Summit Estate
Caron Treatment Centers	McCall Center	Sundown M Ranch
Cumberland Heights	Mending Fences	Teen Challenge of PA
Denver Women's Recovery	New Directions for Women	Transformations
Dilworth Center	Northbound Treatment	Tully Hill
Driftwood Recovery	Northern Illinois Recovery	Turning Point of Tampa
Elam Center	NorthSight Recovery	Valley Hope
Fellowship Hall	Olympus Recovery	Vertava Health
Friendly House	Origins Behavioral Health	Wellbridge
Gallus Medical Detox	Pavillon	YourPath Health


Results:
Summary
Patient Demographics
Treatment Delivery
Observed Patient Change
NAATP FOUNDATION For Recovery Science and Education | www.naatp.org/foundation
20

Results Summary

The following results represent data submitted to FoRSE between August 2021 through December 2022. Collected from 55 distinct organizations, these data represent approximately 153,118 unique episodes of patient data. The preliminary analyses included in this report, obtained by our collective efforts, are organized within a three-part approach to expand our understanding of the patient experience.

The first approach describes the unique episodes, namely ***"Who are our patients?"*** The central focus for any large-scale data project is to identify the population through generalized observations. The second approach details ***"What treatments do we provide?"*** Pertinent to treatment science is the ability to appropriately codify both the ***type*** and ***amount*** of treatment provided. The last approach presents preliminary data on ***"What treatment outcomes do we observe?"*** Monitoring and evaluating the impact on patient outcomes is of central focus for the FoRSE Outcomes Program. The initial reporting on outcomes in this report are preliminary in nature and do not signify causality.

Highlighted Findings:

1. Participation within the FoRSE Outcomes Program has gained significant traction. As of December 31, 2022, approximately, 55 distinct provider organizations have submitted 131,180 unique episodes of patient data.

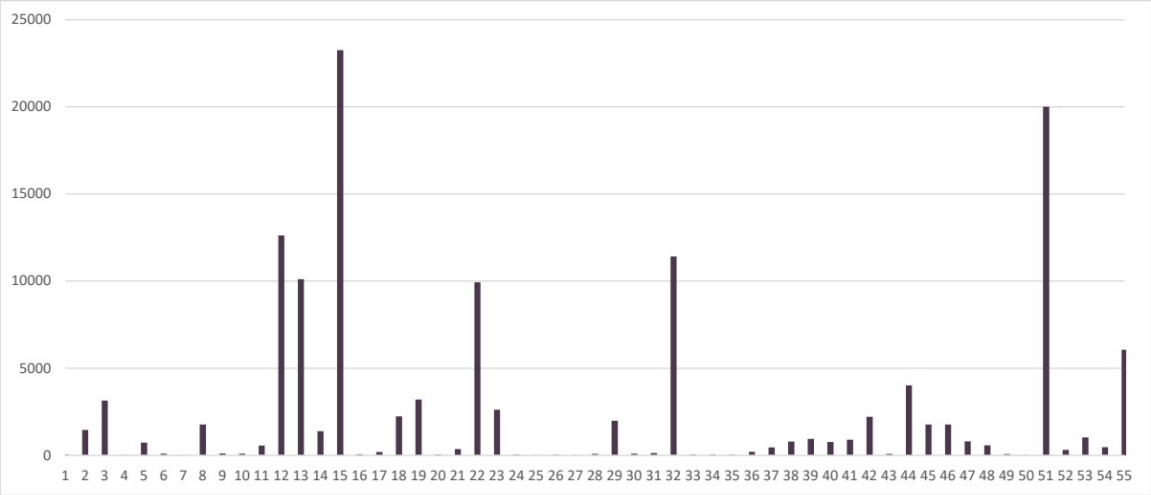
2. The reported severity of symptoms of depression (PHQ-9), anxiety (GAD-7), and addiction (BAM) were observed to decrease over the course of treatment and throughout the first year of post-discharge follow up.

3. Behaviors associated with poor recovery outcomes, such as SUD use days, emergent medical events, etc., were reported to be minimal throughout the first-year post-discharge.

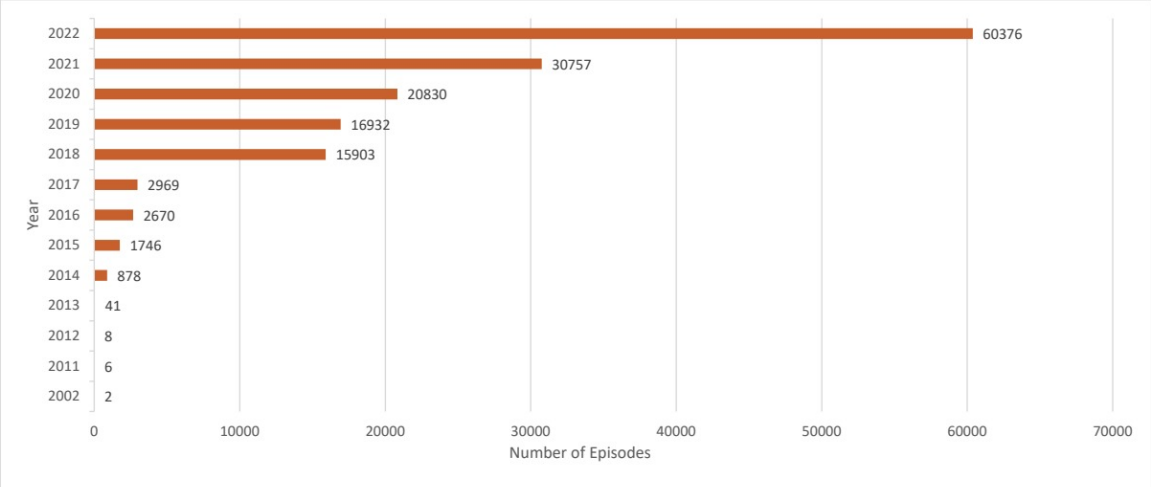
Participating Organizations (n = 55)
Unique Episodes (n = 153,118)

The number of unique patient episodes submitted to FoRSE by each of the 55 distinct organizations is shown below. Importantly, FoRSE accepts historical data, and the year of admission for submitted patient episodes ranges from 2002 through 2022.

Number of Episodes by Participating Organization



Year of Admission



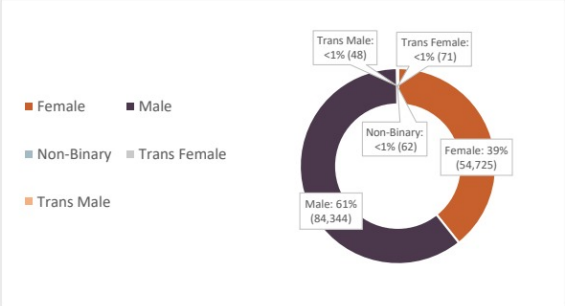
Patient Demographics

The first step in any large-scale data collection project is to provide meaningful and inclusive descriptive indicators of the population of focus. The below visualizations highlight the sample of patient episodes submitted to the FoRSE Outcomes Program.

Age Mean: 38.8 SD: 12.80

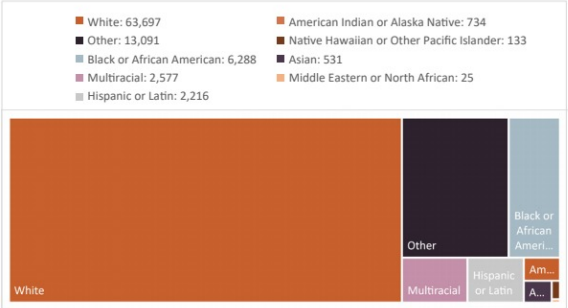
Missing Data: 2,038 episodes did not include the age indicator.

Gender



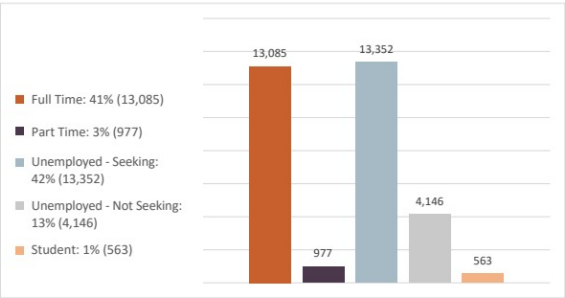
Missing Data: 13,868 episodes did not include the gender indicator.

Race and Ethnicity



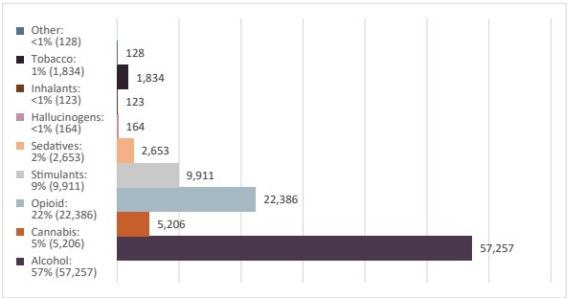
Missing Data: 63,826 episodes did not include the ethnicity indicator.
NOTE: This is a multi-select question so option totals exceed total number of episodes.

Employment Status



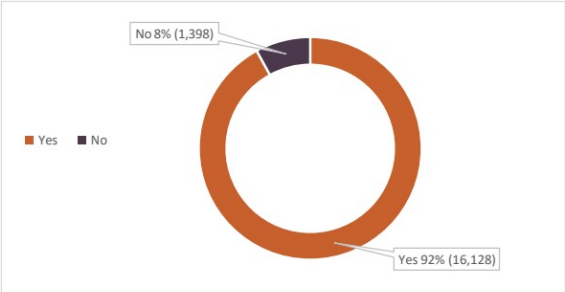
Missing Data: 120,995 episodes did not include the employment status indicator.

Primary SUD Diagnosis



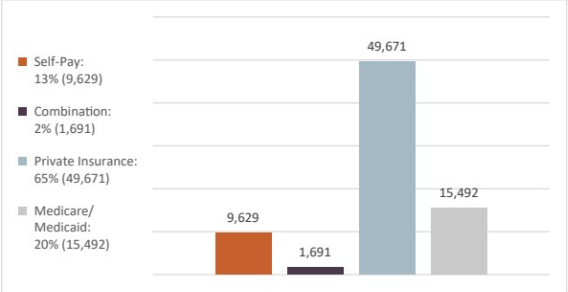
Missing Data: 53,456 episodes did not include the diagnosis indicator.

Psychiatric Comorbidity



Missing Data: 135,596 episodes did not include the comorbidity indicator.

Payor Type



Missing Data: 76,635 episodes did not include the payer indicator.

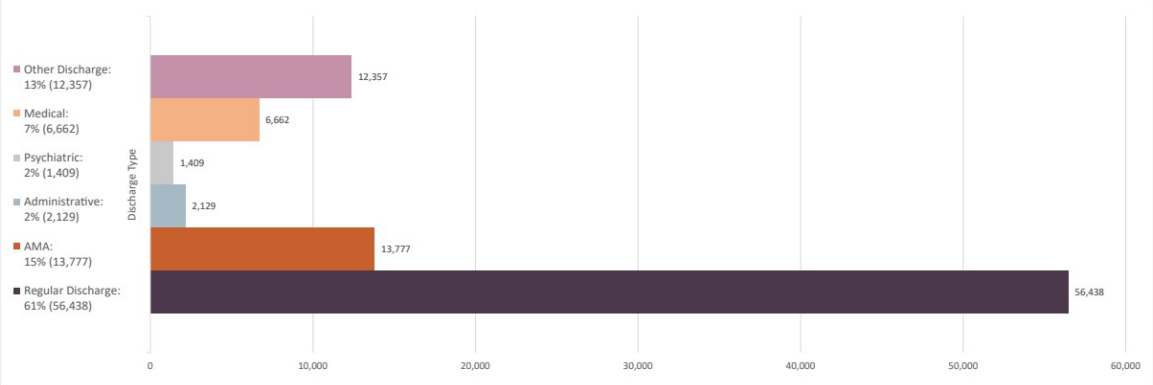
Treatment Delivery

Effectively modeling treatment delivery is fundamental to any treatment science. The FoRSE Outcomes Program has assembled a battery of standardized assessments to support our collective ability to measure and monitor treatment delivery across participating organizations. The data below highlight the aggregate of treatment engagement factors reported by the 52 organizations who used the FoRSE Discharge Survey during this submission period.

Length of Stay (in Calendar Days)

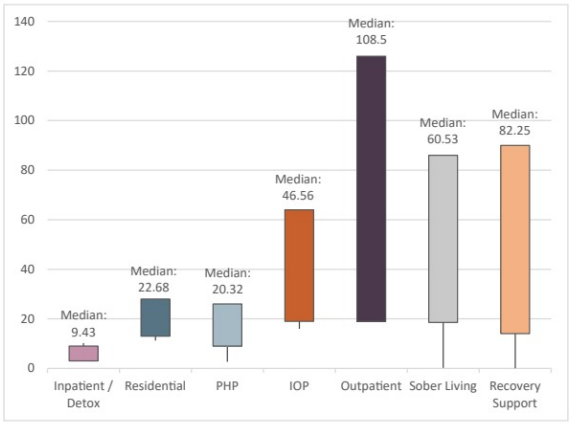
Mean: 60.21 **SD:** 111.55

Discharge Type



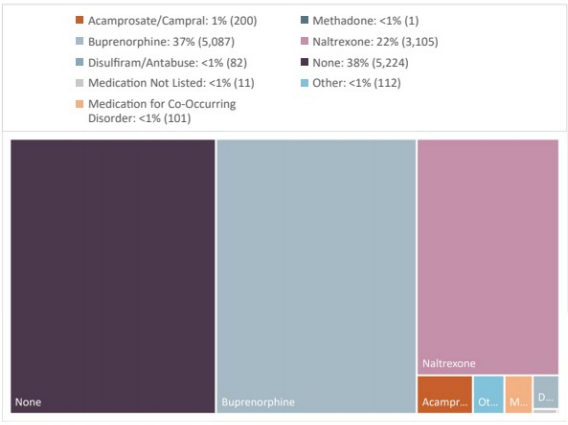
Missing Data: 60,346 episodes did not include the discharge indicator.

Length of Stay by Level of Care (in calendar days)



Missing Data: 32,516 episodes did not include the LOC indicator

MAT Use Reported at Discharge



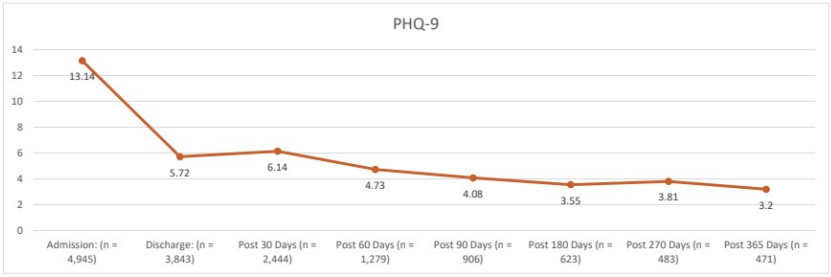
Missing Data: 139,195 episodes did not include the discharge indicator.

Observed Patient Change

The infrastructure of FoRSE was designed to be flexible to support the individualized reporting systems across all provider groups. One of the benefits of this strategic implementation was to create a collective continuity for providers to administer the standardized assessments commonly used in treatment programs. Some examples include the Patient Health Questionnaire (PHQ-9), the General Anxiety Disorder (GAD-7), and the Brief Addiction Monitor (BAM). The line-graphs below illustrate the cross-sectional aggregate of patient reported symptomatology across several indicators.

Depression Symptoms

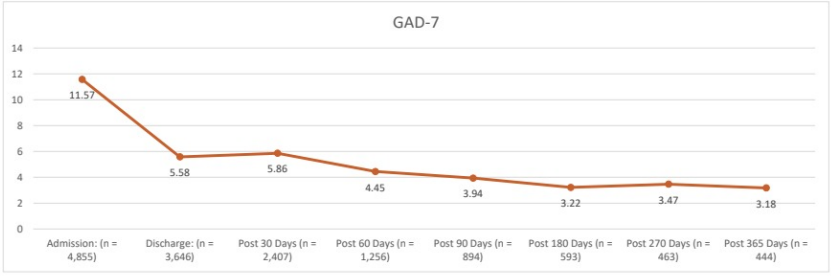
The Patient Health Questionnaire (PHQ-9) was administered by 24 providers in this submission period. Reported symptom reduction in depression severity was observed across the trajectory of treatment and post-discharge follow up.



The sample above represents (n = 13,173) patient episodes.

Anxiety Symptoms

The General Anxiety Disorder (GAD-7) was administered by 22 providers in this submission period. Reported reduction in anxiety symptoms was observed across the trajectory of treatment and post-discharge follow up.



The sample above represents (n = 12,135) patient episodes.

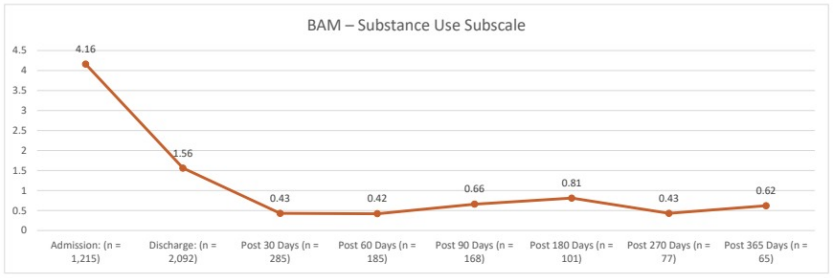
Recovery Capital

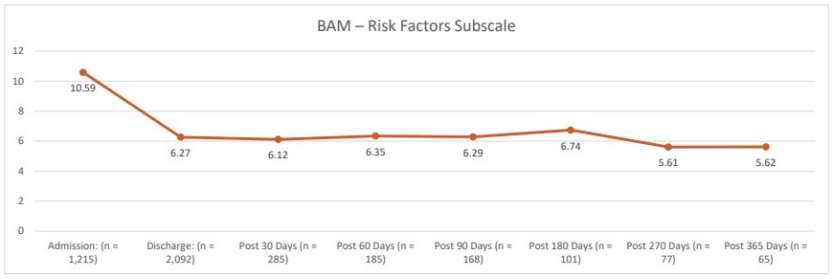
The Brief Assessment of Recovery Capital (BARC-10) was administered by 13 providers in this submission period. Patient reported increases in the positive supports associated with recovery were observed across the trajectory of treatment and post-discharge follow up.

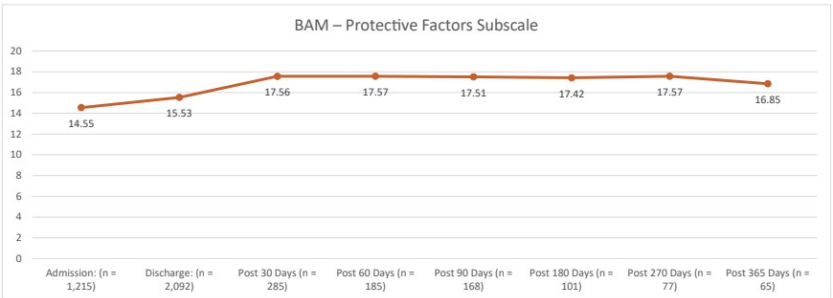
The sample above represents (n = 3,650) patient episodes.

Brief Addiction Monitor

The Brief Addiction Monitor (BAM) was administered by 6 providers in 2022. The scoring guidelines for the BAM identify three subscales: 1) substance use, 2) risk factors, and 3) protective factors. Patient reported decreases in risk factors and increases in protective factors were observed across the trajectory of treatment and post-discharge follow up. The data below were collected from (n = 6,732) unique patient episodes.





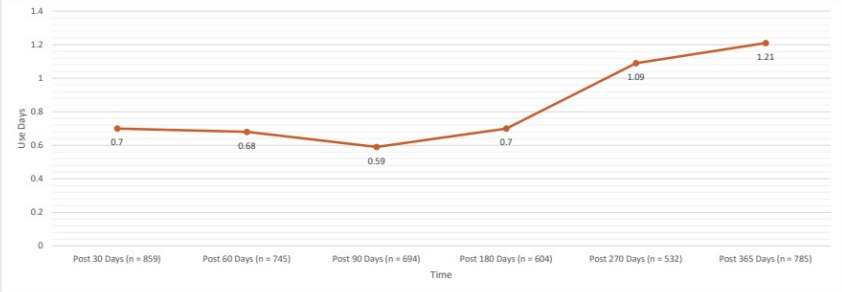


FoRSE Outcomes Survey

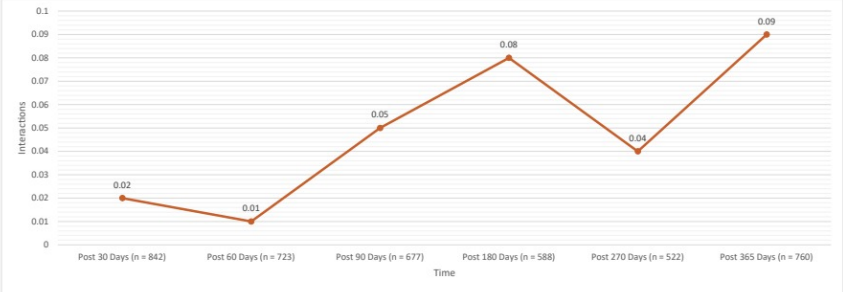
The FoRSE Outcomes Survey was created to unify examination of outcomes of importance to patients, clinicians, and payers. Such methods include longitudinal follow-up to assess both protective (e.g., meeting attendance) and risk factors (e.g., interactions with law enforcement) associated with recovery trajectories. Fifteen distinct facilities administered the FoRSE Outcomes Survey in 2022.

Meeting Attendance

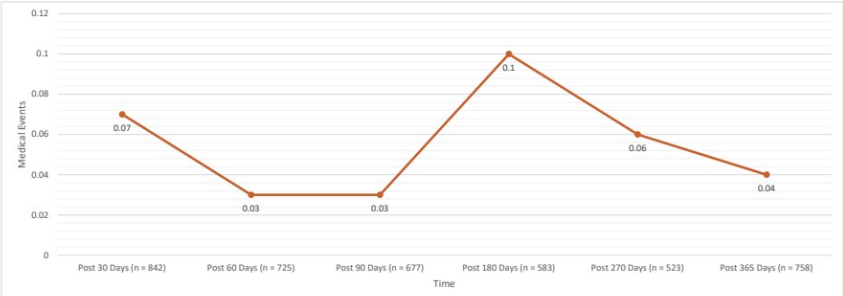
Use Days



Interactions with Law Enforcement



Emergent Medical Events




Recommendations:
Limitations
Next Steps
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28

Limitations

Launching a nationwide data collection program is not without its expected limitations. The seminal implementation of FoRSE has provided opportunities for improvement and therefore informs our next strategic steps. Improving the processes that support the FoRSE repository is dependent on broad collaboration between the many technology partners and providers currently engaged with FoRSE repository.

Missing Data

Missing data are a common issue in psychological research that can compromise the validity and reliability of study results. Missing data can occur due to a variety of reasons, such as participant non-response, attrition, or incomplete responses. It can lead to biased estimates and reduce the power of statistical analyses, potentially rendering the results of the study inconclusive. It is essential to carefully consider the implications of missing data in behavioral-health research and choose appropriate methods to handle it. It is also important to report the missing data rate and the method used to handle it. To that end, the following table outlines the specific cases of missing data observed throughout the FoRSE Outcomes Program.

Survey	Variable	Total Instances	Total Missing	Percent Missing
FoRSE Demographic Information Form	Gender	157,296	13,993	9%
	Race & Ethnicity	157,296	66,455	42%
	Age	157,296	2,038	1%
	Employment	104,894	72,771	69%
FoRSE Discharge Survey	Level of Care (LOC)	116,142	44,612	38%
	Discharge Type	116,142	23,370	20%
	Length of Stay (LOS)	116,142	23,841	21%
	Payor Type	116,142	39,659	34%
	Primary SUD Diagnosis	116,142	16,480	14%
	Comorbid Diagnosis	116,142	47,910	41%

Survey	Variable	Total Instances	Total Missing	Percent Missing
FoRSE Outcomes Survey	Meeting Attendance	6,799	309	5%
	Use Days	6,799	433	6%
	Medication Assisted Treatment Utilization	6,799	1,043	15%
	Emergent Medical Events	6,799	385	6%
	Interactions with Law Enforcement	6,799	429	6%
	Quality of Life	6,799	171	3%
Standardized Assessments	PHQ-9	37,305	4,544	12%
	GAD-7	35,377	4,466	13%
	BARC-10	8,548	27	<1%
	BAM	10,245	15	<1%

Data Validation

The FoRSE Outcomes Program has the potential to significantly transform our field. More specifically, our future ability to advocate for our programs will be entirely grounded in data. The FoRSE repository is a powerful mechanism to deliver the data needed to explore, investigate, and disseminate our findings. To extract accurate meaningful insights from data, it is crucial to ensure that the data have been validated through a rigorous process. Data validation, a critical step in the data science process, is necessary to ensure that collected data are accurate, complete, consistent, and relevant for its intended use. This involves checking for errors, identifying inconsistencies and addressing any missing data. These steps verify that the data meet quality standards. Data validation procedures help to ensure that any conclusions derived from data analyses are valid and reliable.

Below are a few limitations identified through data validation procedures in the current FoRSE repository. It was discovered that as a result of certain API rules to acquire data from providers to FoRSE, some coding rules may have allowed for:

- Partial submission of survey results.
- Inconsistent unique episode identifiers.
- Invalid submission of surveys with incomplete time indicators.

Additionally, it is paramount to improve survey response rates across all time points before any inferential statistical testing can be completed. These improvements should significantly impact our ability to leverage these data in support of our strategic goals.

It is paramount that we ensure the provider data are valid and reliable. Therefore the continued expansion and growth of FoRSE requires widespread collaboration among our technology partners, providers, and other external stakeholders. To improve our repository, we need widespread collaboration between our technology partners, providers, and other external stakeholders.

Our Next Steps

Data Validation

The FoRSE team is planning to implement new data validation requirements into the FoRSE API Documentation in August 2023. These process improvements will safeguard against missing data and incomplete survey submissions. Importantly, these adjustments will require broad collaboration between providers, technology partners, and other external stakeholders.

Site-Specific Reports

The provision of site-specific reports offers each participating organization the opportunity to independently examine their own patient outcomes and compare their results to the national FoRSE aggregate. These reports will include:

- **Individualized facility overview of submitted data.**
- **Aggregate summaries and visualizations illustrating:**
  - Patient characteristics (e.g., demographics, substance use history, diagnosis, mental health diagnosis, etc.)
  - Service characteristics (e.g., length of stay across each level of care, medications administered, discharge type, etc.)
  - Assessment scores (e.g., standardized assessments)
  - Tailored recommendations for improved data quality.

Research Studies

A primary objective of the FoRSE Program remains centrally focused on creating collaborative science opportunities. Using the output from the FoRSE repository, we aim to create multiple partnerships between providers and researchers to examine substantive research questions. Leveraging these data for use within retrospective study increases the utility and scale of our collective impact. A few emerging substantive areas of focus include:

- Identifying unique patient factors associated with treatment completion.
  Do patient demographics and admission acuity predict treatment success?

• Exploring how patient profiles are associated with treatment outcome and post-discharge success trajectories.
What are the treatment outcomes across patient groups?

• Evaluating treatment intensity/duration and post-discharge patient outcomes.
To what extent do various combinations of treatment duration and level of care impact recovery outcomes?

The novel collaboration between providers in support of large-scale data collection creates a unique opportunity for scientific inquiry. Simply, these data can support our collective efforts to investigate our treatment programs and communicate those findings with external stakeholders.

Recruitment

To improve the value of the FoRSE repository, we must continue recruiting providers to participate. FoRSE staff are actively engaged in outreach with hundreds of providers for inclusion into our shared repository. Importantly, the FoRSE repository should include additional providers who serve diverse populations, offer novel treatments, and have non-traditional delivery mechanisms. While providers of all types of treatment and recovery services are encouraged to join the Outcomes Program, the FoRSE outreach campaign will expand recruitment efforts to ensure inclusion of service providers who:

- Serve a patient population that is diverse in gender identity, race, ethnicity, and socioeconomic status.
- Receive Federal or State funding.
- Are operated by local, county, community, or tribal governments.
- Are Opioid Treatment Programs (OTPs).
- Offer services delivered primarily through telehealth.
- Provide recovery support services, such as recovery residences and recovery coaching.

Dashboard

Several FoRSE data sites have expressed interest in having more frequent access to the comparison of their data against the national aggregate. In response to these requests, FoRSE is currently in the process of developing a provider-centric dashboard which will allow providers to view their data "live". The dashboard offers an exciting new opportunity for providers to examine their patient outcomes in *real time* and will be offered as a yearly subscription.

The FoRSE dashboard will be accessed through a site-specific confidential online portal, and each organization will be able to see their own confidential data as well as a summary of the national aggregate. The dashboard will provide visualizations, including patient characteristics, service types, and patient outcomes collected both during and after treatment. The dashboard's user interface has been designed intuitively to promote ease of navigation for anyone to use. For example, the dashboard includes access to unique filters allowing providers to sort their data by demographics and treatment factors. We anticipate launching the FoRSE dashboard by the end of 2023 with subscription access available the first quarter of 2024.

Fundraising

Participation in the FoRSE Outcomes Program is offered free of charge to ensure that providers of all types can easily join and receive the benefits of the program. Thanks to the generosity of those who believed in the FoRSE vision, the FoRSE Founding Donors campaign successfully raised funds to cover operations through 2023. The FoRSE team is working to create a sustainable model of support which includes donations, grants, fee-for-service options, and engagement opportunities.

FoRSE is a collaborative of dedicated professionals in the addictions field who are driven to promote quality improvement and expansion of access to care with equity. The framework of the program offers great promise to the future of the field through the accomplishment of the objectives discussed throughout this report. As a collaborative effort, we encourage those who believe in our mission to donate (see https://www.naatp.org/foundation/support). Rather than focusing efforts on single large gifts, we at FoRSE understand the power of community-based work and value any gift that an individual chooses to make.

We would be honored to be part of your philanthropic efforts. Your investment, no matter the amount, will help us change the face of addiction treatment across the country. The NAATP Foundation for Recovery Science and Education (FoRSE) is a 501(c)(3) not-for-profit charitable organization governed by a Board of Directors and our Federal Tax ID is EIN 85-2067681.

Opportunities for Engagement

FoRSE is governed by a Board of Directors and further guided by an Advisory Board made up of diverse leaders from across the industry. With a deep commitment to collaboration, the FoRSE team will be announcing opportunities for engagement with our work, including advisement, consultation, and partnership regarding:

- **Future development of the FoRSE Dashboard to ensure maximum utility for participating providers.**
- **Fund development to secure the future of the FoRSE Program.**
- **Design and implementation of research studies.**
- **Public Engagement and Communications.**

We encourage those interested in these opportunities to contact us at outcomes@naatp.org

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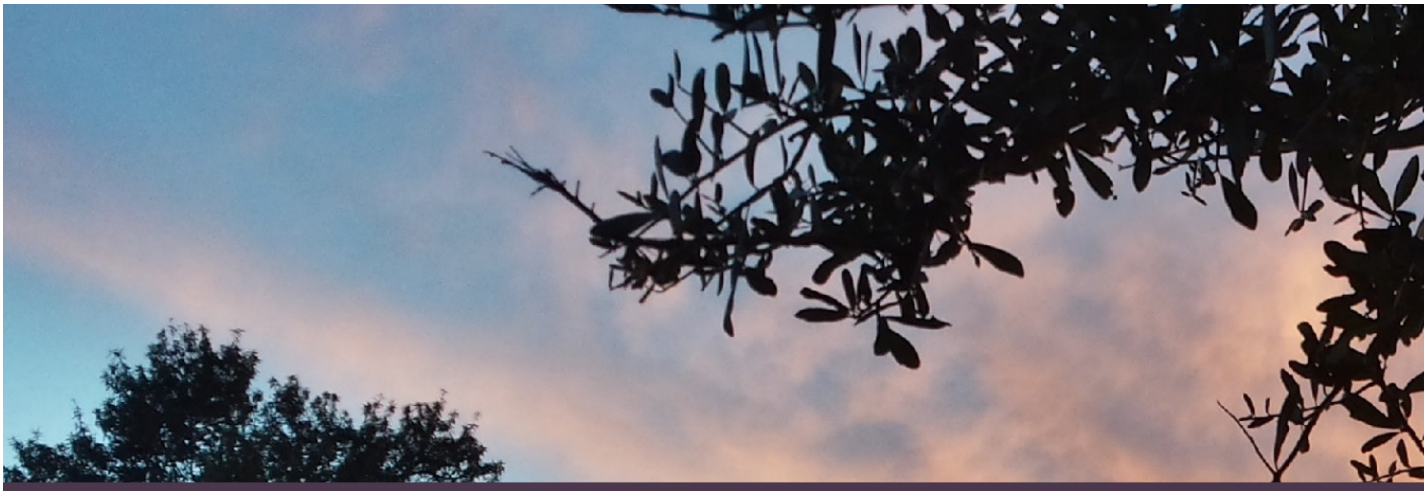

FoRSE®

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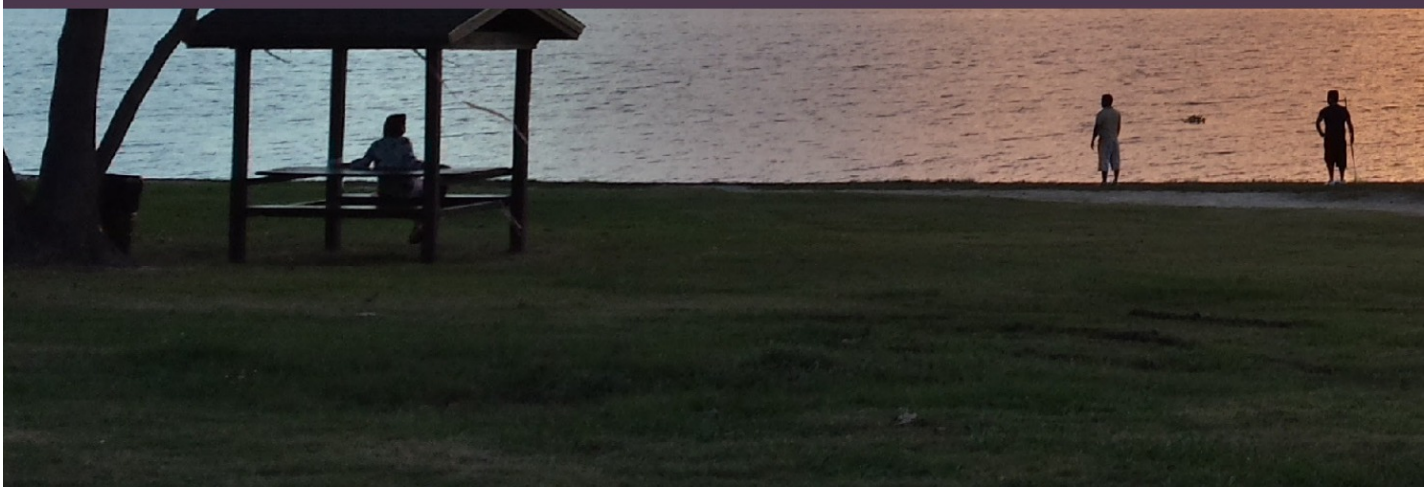

ITEM 8c
Divider
ordinance

ORDINANCE NO: 2019-025

AN ORDINANCE OF THE MAYOR AND THE CITY COUNCIL OF THE CITY OF HIALEAH, FLORIDA, REPEALING AND REPLACING ORDINANCE 2018-023 CONCERNING RESIDENTIAL CARE AND TREATMENT FACILITIES; AMENDING CHAPTER 98, ENTITLED "ZONING", ARTICLE VI, ENTITLED "SUPPLEMENTARY DISTRICT REGULATIONS", DIVISION 5 ENTITLED "USES", SUBDIVISION IX ENTITLED "RESIDENTIAL CARE AND TREATMENT FACILITIES" OF THE CODE OF ORDINANCES OF THE CITY OF HIALEAH, FLORIDA; REPEALING ALL ORDINANCES OR PARTS OF ORDINANCES IN CONFLICT HEREWITH; PROVIDING PENALTIES FOR VIOLATION HEREOF; PROVIDING FOR A SEVERABILITY CLAUSE; PROVIDING FOR INCLUSION IN THE CODE; AND PROVIDING FOR AN EFFECTIVE DATE.

WHEREAS, the adoption of zoning and land use planning is a fundamental function of local government; and

WHEREAS, the purpose of this Ordinance is to promote the public health, safety, and welfare; and

WHEREAS, the Fair Housing Act as amended (42 U.S.C § 3601) provides protections for person with disabilities; and

WHEREAS, the legislative history of the Fair Housing Act of 1988 cautions that local zoning regulations are prohibited that result "from false or over-protective assumptions about the needs of handicapped people, as well as unfounded fear of difficulties about the problem that their tendencies may pose." H.R. Rep. No. 711, 100th Cong. 2D Session, Reprinted in 1988 U.S.C.C.A.N 2173, 2192 (1988); and

WHEREAS, the Fair Housing Act does not preempt local zoning laws or preclude the adoption, amendment or enforcement of zoning regulations as long as the zoning regulations are consistent with the state and federal laws, including the Fair Housing Act as amended; and

WHEREAS, clustering of community residences for people with disabilities on a block or in a neighborhood undermines the ability of community residences to achieve normalization and community integration for their residents, which is one of the essential purposes of a community residence for people with disabilities; and

WHEREAS, a reasonable accommodation may be necessary under the Fair Housing Act by allowing the relatively permanent living arrangement of a family community residence for

people with disabilities as a permitted use in residential districts, subject to a rationally based spacing distance requirement, and a licensing or certification requirement for the operator or the home itself; and

WHEREAS, § 419.001, Florida Statutes, allows for community residences for people with disabilities in residential districts; and

WHEREAS, to ensure that a proposed community residence will not interfere with normalization or community integration of the occupants of any nearby existing community residences nor contribute to creating a de facto social service district that thwarts the purposes and successful functioning of community residences, and results in segregation of people with disabilities; and

WHEREAS, to ensure care and treatment facilities are sited in the most compatible zoning districts; and

WHEREAS, Ordinance No. 2018-023 passed on second reading without the changes from first to second reading; and

WHEREAS, to ensure the public health, safety, and welfare; and

WHEREAS, the Planning and Zoning Board at its meeting of February 13, 2019 recommended approval of this ordinance.

NOW, THEREFORE, BE IT ORDAINED BY THE MAYOR AND THE CITY COUNCIL OF THE CITY OF HIALEAH, FLORIDA, THAT:

Section 1.: Ordinance No. 2018-023 of the code of ordinances is hereby repealed and replaced, and Chapter 98, entitled "Zoning", Article VI, entitled "Supplementary District Regulations", Division 5 entitled "Uses", Subdivision IX entitled "Residential Care and Treatment Facilities", is amended as follows:

Chapter 98

ZONING

* * *

ARTICLE VI. SUPPLEMENTARY DISTRICT REGULATIONS

* * *

DIVISION 5. - USES

* * *

SUBDIVISION IX. RESIDENTIAL CARE AND TREATMENT FACILITIES

Sec. 98-1986. - Definitions.

The following words, terms and phrases, when used in this division, shall have the meanings ascribed to them in this section, except where the context clearly indicates a different meaning:

Applicant. The sponsor, which through ownership or management, applies in the City for a *Residential Care and Treatment Facility, or facilities/facility.*

Disability means a physical or mental impairment that substantially limits one or more of an individual's major life activities, impairs an individual's ability to live independently, having a record of such an impairment, or being regarded as having such an impairment. People with disabilities do not include individuals who are currently using alcohol, illegal drugs, or using legal drugs to which they are addicted or individuals who constitute a direct threat to the health and safety of others.

*Distance requirements. D*istance requirements as measured from the nearest point of the proposed location to the nearest point of an existing facility, and identified on an accompanying radius map prepared by a State of Florida Registered Land Surveyor shading the proposed location and tracing a radius to the applicable distances identifying existing facilities within the jurisdictional limits of the city using the most recently published data compiled from licensing entities, as applicable, indicating the distances.

Inpatient Treatment. Supervision and care by supportive staff as may be necessary to meet the physical, emotional, and social needs of the residents in a facility, such as medical professionals, mental health counselors, therapists or other professionals on a recurring basis, including nursing and dental services beyond the provision of mere personal services.

Residential Care and Treatment Facility means any institution, building, dwelling, residence, private home, or other place, whether operated for profit or not, which undertakes through its ownership or management to provide housing and personal services, for a period exceeding 24 hours, to three or more people not related to the owner or administrator by blood or marriage, who require such services, which may or may not be licensed by the State to include the Florida Agency for Persons with Disabilities, the Florida Department of Elderly Affairs, the Florida Agency for Health Care Administration, or the Florida Department of Children and Families. Personal services shall not be construed to mean the provision of inpatient treatment.

The definition of residential care and treatment facility shall not include a community residential home, as provided by state law, F.S. § 419.001, namely, a dwelling unit licensed as defined in F.S. § 419.001 that serves residents as defined therein who are clients of these agencies, which provides a living environment for 7 to 14 unrelated residents who operate as the functional equivalent of a family, including such supervision and care by supportive staff as may be necessary to meet the physical, emotional, and social needs of the residents, licensed by the aforementioned agencies, as well as, the clients of the Florida Department of Juvenile Justice. A community residential home of six or less residents that otherwise meets the definition of a community residential home as provided in F.S. § 419.001, shall also be excluded from the definition of residential care and treatment facilities or facility.

Facilities that make sober living arrangements also known as recovery residences, shall be certified by the state's designated credentialing entity established under Section 397.487 of the Florida Statutes, and shall be regulated as a residential care and treatment facility as provided in §§ 98-1987 through 98-1988, and §§ 98-1990 through 1992. If the required license or credentialing has been denied to a proposed facility, it is ineligible for a permit.

Facilities offering the services described in this definition for fewer than three people is within the meaning of this definition if it formally or informally advertises or solicits the public for residents or referrals and holds itself out to the public as an establishment, which regularly provides such services.

This definition does not include any other group living arrangement for unrelated individuals who are not disabled nor residential facilities for prison pre–parolees or sex offenders.

Supervisory residential care and treatment facilities A residential care and treatment facility that combines inpatient treatment with housing.

Sec. 98-1987. – Residential care and treatment facilities.

(a) *Of six residents or less.* Residential care and treatment facilities that are comprised of six residents or less, shall be permitted in low density residential districts (R-1, R-2, R-4 and RZ) or medium and high density residential districts (R-3, R-3-1, R-3-2, R-3-3, R-3-4 and R-3-5).

The applicant shall provide a current survey of the property, and copies of any previously approved plans (microfilms) obtained from the building department, and request a building and zoning inspection by completing an application and paying the corresponding fee. The purpose of the inspection is to verify that the property complies with this subdivision, and has not undergone modifications or improvements that were built without permits. The inspection fee is $500 and a re-inspection fee is $150, for each re-inspection.

(b) *Of more than six residents.* Residential care and treatment facilities, having more than six residents, shall be prohibited in areas zoned RO, R-1, R-2, R-4, R-Z and RDD and are allowed in R-3, R-3-1, R-3-2, R-3-3, R-3-4 and R-3-5.

The applicant shall provide a current survey of the property, and copies of any previously approved plans (microfilms) obtained from the building department, and request a building and zoning inspection by completing an application and paying the corresponding fee. The purpose of the inspection is to verify that the property complies with this subdivision, and has not undergone modifications or improvements that were built without permits. The inspection fee is $500 and a re-inspection fee is $150, for each re-inspection.

Sec. 98-1988. - Supervisory residential care and treatment facilities.

Supervisory residential care and treatment facilities are permitted as follows:

(a) *Of six residents or less.* Supervisory residential care and treatment facilities shall be permitted in low density residential districts (R-1, R-2, R-4 and RZ) or medium and high density residential districts (R-3, R-3-1, R-3-2, R-3-3, R-3-4 and R-3-5) by conditional use permit granted in accordance with division 6 of article II of this chapter, and shall provide in the application:

i. The name of the sponsoring agency, if any;

ii. The name of the operator of the facility;

iii. The street address of the facility;

iv. A description of programs to be provided or offered by the facility;

v. The maximum number of persons or clients who will reside at the facility;

vi. Status of all applicable federal, state and county licenses and authorization or certification;

vii. Specifications as to how the proposed facility meets applicable licensing criteria for the safe care and supervision of the clients in the facility;

viii. A description of the inpatient treatment and housing to be provided in the same premises;

ix. The number of employees, shifts, and duties of each;

x. The license issued by the Florida Agency for Persons with Disabilities, the Florida Department of Elderly Affairs, the Florida Agency for Health Care Administration, or the Florida Department of Children and Families or the certification from the state's designated credentialing entity established under Section 397.487 of the Florida Statutes.

xi. Applicants shall be subject to these distance requirements: 1,000 feet of another existing such home with six or fewer residents or within a radius of 1,200 feet of another existing supervisory

residential care and treatment facility of 7 or more.

(b) *Of more than six residents.* Supervisory residential care and treatment facilities shall be permitted in districts or areas zoned (R-3, R-3-1, R-3-2, R-3-3, R-3-4 and R-3-5, and in C-1, C-2, CBD and CR, only by conditional use permit granted in accordance with division 6 of article II of this chapter and shall provide in the application the same information required under subsection (a)(i)-(x).

(c) Prior to the advertised public hearing before the planning and zoning board, the planning and zoning official shall consult with the water and sewer department, police department, fire department, and streets department, and shall submit a written report and recommendation evaluating the relevant zoning regulations and the following factors:

i. Compatibility with surrounding community, to include: 1) a consistent maintenance schedule of the home inside and out, 2) the upkeep and grooming of the contiguous yards, 3) off-street parking, 4) the proper handling of trash;

ii. Prevention of overconcentration by requiring a distance separation of 1,200 feet of another existing supervisory residential home of 7 or more residents, and a radius of 500 feet of a single-family home.

iii. Strain on public safety services;

iv. Proximity to a network of supportive public and private services; and

v. The specifications as to how the facility meets the applicable licensing or certification criteria for the safe care and supervision of the clients and residents in the facility.

Sec. 98-1989. – Community Residential Homes.

(a) *Six or fewer occupants.* For a community residential home of six or less persons as defined in F.S. § 419.001 in a residential district, the applicant is subject to:

(i) The zoning letter for the applicant to pursue it licensing

with the State.

(b) Prior to occupancy, the applicant shall provide the zoning official, in writing:

(1) Verification of the distance requirements as provided in § 419.001(2) are satisfied;

(2) the applicant must also provide the home's location, the residential district, the number of residents, and include a statement indicating the need for, and the licensing status of the proposed home and specifying how the home intends to function; and

(3) its license and status as issued by the state of Florida or from the appropriate licensing agency.

(c) *Seven to fourteen occupants.* A community residential home as defined in F.S. § 419.001(a) of seven to fourteen persons shall be permitted to site in a multifamily zoning district, with the exception of the Residential Development District, provided the applicant establishes the following:

(1) the applicable licensing criteria established and determined by the appropriate licensing entity are met;

(2) it shall house no more than fourteen residents, and conforms to existing zoning regulations applicable to other multifamily uses in the area;

(3) provide the specific address of the proposed site, and a written statement that explains how the home shall assure the safe care and supervision of its clients in the home; and

(4) provide the zoning official with verification of the distance requirements as provided in F.S. § 419.001(3)(c)(3) in order to show that a concentration of community residential homes in the area in proximity to the site selected would not result in a combination of such homes with other residences in the community, such that the nature and character of the area would be substantially altered.

(5) Once the applicant satisfies the foregoing subsections,

the city shall review the application, and deemed permitted, if the city fails to review and respond to an application within 60 days of submission.

Sec. 98-1990 - Reasonable Accommodation.

(a) A conditional use permit otherwise required may be issued based on a reasonable accommodation only if a proposed facility cannot be located within the distance requirements of an existing facility, and:

1. The applicant demonstrates that the proposed facility will not interfere with the normalization and community integration of the residents of any existing facility, and that the presence of other facilities will not interfere with the normalization and community integration of the residents of the proposed facility;

2. The applicant demonstrates that the proposed facility in combination with any existing facility will not alter the residential character of the surrounding neighborhood by creating an institutional atmosphere or by creating or intensifying a de facto social service district by concentrating facilities on a block or in neighborhood;

3. The applicant demonstrates that the proposed facility will be compatible with the residential uses allowed as of right on the zoning district;

4. When the proposed facility would be located in a single-family zoning district, the applicant demonstrates that the proposed facility will not alter the residential stability of the single-family zoning district;

5. The applicant demonstrates that the applicant or the proposed facility has been granted certification by the State of Florida or license required by the State of Florida;

6. When the State of Florida does not offer certification or require a license for the proposed facility and the population it would serve, the application must demonstrate that the proposed facility will be operated in a manner effectively similar to that of a license or certified facility, that staff will be

adequately trained, that the facility will emulate a biological family and be operated to achieve normalization and community integration, and that the rules and practices governing how the facility is run will actually protect residents from abuse, exploitation, fraud, theft, insufficient support, use of illegal drugs or alcohol, and misuse of prescription medication;

7. The primary function of the proposed facility is residential as any treatment is merely incidental to the residential use of the property;

8. The applicant demonstrates that it will ensure that the proposed facility emulates a biological family and operated as a functional family, rather than as an institution, roominghouses, boardinghouses and lodginghouses, dormitories, fraternity houses, sorority houses, hospitals, apartment hotels, nursing homes, sanitariums, convalescent homes, nursing home, short term vacation rentals, continuing care facility, motels, hotels, inpatient treatment centers that are not residential care and treatment facilities, rehabilitation centers, and other similar facilities, or a nonresidential use; and

9. The applicant demonstrates that the requested number of residents in the proposed facility will not interfere with the normalization and community integration of the occupants of any existing facility.

(b) Reasonable accommodation shall be decided by either the City Council or a Special Magistrate appointed by the City, subject to the approval of the City Council.

(c) The application fee of $300.00 is paid.

Sec. 98-1991- Emergency Power

Supervisory Residential Care and Treatment Facilities, and community residential homes of seven persons or more shall provide an adequate fully operational emergency power source, and a supply of fuel sufficient to sustain the emergency power source for at least 5 days during a power outage, to power the facility to:

1. Power life safety equipment used or needed by the residents;

2. Consistently maintain an ambient air temperature of 81° F. or less within one or more areas of the facility having enough space to safely hold all of the facility's residents; and

3. Allow for the refrigeration and heating for preparation of food and beverages that are served by the facility to its residents, and for the storage of ice.

Sec. 98-1992 – No Use Variances.

No use variances shall be permitted for residential care and treatment facilities, nor for community residential homes in F.S. § 419.001 or that otherwise meets the definition of a community residential home as provided therein.

* * *

Section 2: Repeal of Ordinances in Conflict.

Ordinance No. 2018-023, and all ordinances or parts of ordinances in conflict herewith are hereby repealed to the extent of such conflict.

Section 3: Penalties.

Every person violating any provision of the Code or any ordinance, rule or regulation adopted or issued in pursuance thereof shall be assessed a civil penalty not to exceed $500.00 within the discretion of the court or administrative tribunal having jurisdiction. Each act of violation and each day upon which any such violation shall occur shall constitute a separate offense. In addition to the penalty prescribed above, the city may pursue other remedies such as abatement of nuisance, injunctive relief, administrative adjudication and revocation of licenses or permits.

Section 4: Severability Clause.

If any phrase, clause, sentence, paragraph or section of this ordinance shall be declared invalid or unconstitutional by the judgment or decree of a court of competent jurisdiction, such invalidity or unconstitutionality shall not affect any of the remaining phrases, clauses, sentences, paragraphs or sections of this ordinance.

Section 5: Inclusion in Code.

The provisions of this Ordinance shall be included and incorporated in the Code of Ordinances of the City of Hialeah, as an addition or amendment thereto, and the sections of this ordinance shall be renumbered to conform to the uniform numbering system of the Code.

Section 6: **Effective Date.** This ordinance shall become effective when passed by the City Council and signed by the Mayor or at the next regularly scheduled City Council meeting, if the Mayor's signature is withheld or if the City Council overrides the Mayor's veto.

PASSED and ADOPTED this 26 day of March, 2019.

THE FOREGOING ORDINANCE OF THE CITY OF HIALEAH WAS PUBLISHED IN ACCORDANCE WITH THE PROVISIONS OF FLORIDA STATUTE 166.041 PRIOR TO FINAL READING.

Vivian Casáls-Muñoz
Council President

Attest:

Approved on this 3 day of April, 2019.

Marbelys Fatjo, City Clerk

Carlos Hernandez, Mayor

Approved as to form and legal sufficiency:

Lorena E. Bravo, City Attorney

Ordinance was adopted by a 7-0 vote with Councilmembers, Caragol, Zogby, Lozano, Casáls-Munoz, Hernandez, Garcia-Martinez and Cue-Fuente voting "Yes".

~~Strikethrough indicates deletion~~. Underline indicates addition.

S:\DJ\ORDINANCES\Amended Care and Treatment Facilities and repealing existing v2.docx

ITEM 10
Divider
ARTICLES

FDA NEWS RELEASE

FDA Approves New Buprenorphine Treatment Option for Opioid Use Disorder

For Immediate Release:

May 23, 2023

Español (https://www.fda.gov/news-events/press-announcements/la-fda-aprueba-una-nueva-opcion-de-tratamiento-con-buprenorfina-para-el-trastorno-por-consumo-de)

Today, the U.S. Food and Drug Administration approved Brixadi (buprenorphine) extended-release injection for subcutaneous use (under the skin) to treat moderate to severe opioid use disorder (OUD). Brixadi is available in two formulations, a weekly injection that can be used in patients who have started treatment with a single dose of a transmucosal buprenorphine product or who are already being treated with buprenorphine, and a monthly version for patients already being treated with buprenorphine.

"Buprenorphine is an important treatment option for opioid use disorder. Today's approval expands dosing options and provides people with opioid use disorder a greater opportunity to sustain long-term recovery," said FDA Commissioner Robert M. Califf, M.D. "The FDA will continue to take the critical steps necessary to pursue efforts that advance evidence-based treatments for substance use disorders, which is a strategic priority under the FDA's Overdose Prevention Framework (https://www.fda.gov/drugs/drug-safety-and-availability/food-and-drug-administration-overdose-prevention-framework)."

Buprenorphine is a safe and effective medication for the treatment of OUD. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), patients receiving medication for their OUD cut their risk of death from all causes in half.

The FDA continues to implement a comprehensive approach to increase options to treat OUD. Earlier this month, the agency issued a joint letter with SAMHSA (https://www.fda.gov/media/168027/download) to clarify the importance of counseling and other services as part of a comprehensive treatment plan for OUD, and to also reiterate that supplying buprenorphine should not be made contingent upon participation in such services. The agency also held a virtual public workshop that highlighted the need for additional strengths and dosing regimens for extended-release formulations.

Brixadi is approved in both weekly and monthly subcutaneous injectable formulations at varying doses, including lower doses that may be appropriate for those who do not tolerate higher doses of extended-release buprenorphine that are currently available. The weekly doses are 8 milligrams (mg), 16 mg, 24 mg, 32 mg; and the monthly doses are 64 mg, 96 mg, 128 mg. The approved weekly formulation in various lower strengths offers a new option for people in recovery who may benefit from a weekly injection to maintain treatment adherence. Brixadi will be available through a Risk Evaluation and Mitigation Strategy (REMS) program and administered only by health care providers in a health care setting.

The most common adverse reactions (occurring in ≥5% of patients) with Brixadi include injection-site pain, headache, constipation, nausea, injection-site erythema, itchy skin at the injection site (injection-site pruritus), insomnia and urinary tract infections.

The safety and efficacy of Brixadi were evaluated in a behavioral pharmacology study assessing the ability of two weekly doses of Brixadi to block the subjective effects of opioids, and one randomized, double-blind, active-controlled clinical trial in 428 adults with a diagnosis of moderate-to-severe OUD. After an initial test dose of transmucosal buprenorphine, patients were randomized to treatment with Brixadi plus a sublingual placebo, or active sublingual buprenorphine plus placebo injections. After titration over the first week, patients were treated with weekly injections over 12 weeks and then transitioned to monthly injections for an additional 12 weeks. A response to treatment was measured by urine drug screening and self-reporting of illicit opioid use during the treatment period. Patients were considered responders if they had negative opioid assessments at the end of each of the two treatment phases. The proportion of patients meeting the responder definition was 16.9% in the Brixadi group and 14.0% in the sublingual buprenorphine group.

The FDA granted approval of Brixadi to Braeburn Inc.

The agency remains focused on responding to all facets of substance use, misuse, substance use disorders, overdose and death in the U.S. through its FDA Overdose Prevention Framework (https://www.fda.gov/drugs/drug-safety-and-availability/food-and-drug-administration-overdose-prevention-framework). The framework's priorities include: supporting primary prevention by eliminating unnecessary initial prescription drug exposure and inappropriate prolonged prescribing; encouraging harm reduction through innovation and education; advancing development of evidence-based treatments for substance use disorders; and protecting the public from unapproved, diverted or counterfeit drugs presenting overdose risks.

Related Information

- FDA Overdose Prevention Framework (https://www.fda.gov/drugs/drug-safety-and-availability/food-and-drug-administration-overdose-prevention-framework)
- Information About Medicated Assisted Treatment (MAT) (https://www.fda.gov/drugs/information-drug-class/information-about-medication-assisted-treatment-mat)
- Removal of DATA Waiver (X-Waiver) Requirement (SAMHSA) (https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement)
- Timeline of Selected FDA Activities and Significant Events Addressing Opioid Misuse and Abuse (https://www.fda.gov/drugs/information-drug-class/timeline-selected-fda-activities-and-significant-events-addressing-opioid-misuse-and-abuse)

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The FDA, an agency within the U.S. Department of Health and Human Services, protects the public health by assuring the safety, effectiveness, and security of human and veterinary drugs, vaccines and other biological products for human use, and medical devices. The agency also is responsible for the safety and security of our nation's food supply, cosmetics, dietary supplements, products that give off electronic radiation, and for regulating tobacco products.

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USA TODAY

HEALTH Opioids Add Topic

This opioid addiction drug is rarely misused. So why is there so much regulation?

A watchdog report concludes that less than 1% of Medicare recipients misuse buprenorphine. Experts say it's an important tool to address the nation's opioid crisis.

Ken Alltucker
USA TODAY

Published 4:01 a.m. ET May 18, 2023 | **Updated 8:27 p.m. ET May 18, 2023**

Buprenorphine, an important drug in fighting the opioid crisis, has long been closely monitored over concerns it would be abused. But a first-of-its-kind government oversight report released Thursday finds Medicare recipients rarely misuse the drug, which is considered an underused tool to treat opioid addiction and stem overdose deaths.

Less than 1% of Medicare recipients potentially misused or diverted the opioid-substitute medication in 2021, according to the report from U.S. Department of Health and Human Services inspector general investigators.

The report concluded buprenorphine is “critical to addressing the nation’s opioid crisis" but likely isn't prescribed enough. Fewer than 1 in 6 Medicare enrollees who are addicted to opioids take the medication even as drug overdose deaths soar.

Earlier this year, the U.S. Drug Enforcement Administration sought to require people to visit a doctor or clinic within 30 days of getting a telehealth prescription for controlled substances such as buprenorphine. However, the DEA announced last week it would postpone the proposal and extend a COVID-19 pandemic policy allowing remote prescribing through Nov. 11.

HHS inspector general analysts declined to comment on the DEA proposal but said Thursday's report provides evidence that Medicare recipients rarely misused the drug in 2021 while the pandemic's remote prescribing was in effect. Furthermore, analysts say HHS

should take steps to make buprenorphine available to people with opioid-use disorder, particularly as more than 100,000 people died last year from drug overdoses.

“Access to buprenorphine is extremely important,” said Miriam Anderson, a social science research analyst at HHS inspector general. “It can save lives and now can be widely prescribed by many health care providers.”

What is buprenorphine?

The National Institute on Drug Abuse says people use buprenorphine mainly to reduce cravings and ease withdrawal symptoms from opioids, whether prescription painkillers or illegal substances such as heroin or illicit fentanyl. People can overdose on buprenorphine, but the risk is much lower than those who are on opioids, according to NIDA. Drugs such as buprenorphine are classified as controlled substances based on the potential for abuse or misuse.

How federal policies on opioid substitute drugs are changing

Federal policies are evolving on how to balance the risk of diversion – when drugs are used or resold inappropriately – while ensuring people with opioid-use disorder can get the medication.

Federal legislation passed in 2000 required doctors to register with the Substance Abuse and Mental Health Services Administration and undergo training to prescribe the medication. Doctors and advocacy organizations said the so-called "X waiver" limited the number of prescribers. One report found just 5% of doctors prescribed the drug.

But the Mainstreaming Addiction Treatment Act of 2023, signed by President Joe Biden last December, eliminated the waiver requirement for doctors and other clinicians who prescribe the drug. In other words, doctors who register with the DEA are free to prescribe the medication if they choose to do so.

The inspector general said its findings, including the low rate of buprenorphine misuse, "support the recent repeal of the waiver." With opioid overdose deaths near all-time highs, the inspector general urged HHS and the Centers for Medicare & Medicaid Services "use all tools at their disposal to address the crisis."

How often is buprenorphine misused?

Inspector general investigators focused on finding fraud, waste and abuse in buprenorphine prescribing. Despite concerns the drug is prone to diversion, investigators found little evidence that is occurring.

Of the 1.1 million Medicare recipients with opioid-use disorder, 170,408 were prescribed buprenorphine in 2021, of which just 1,245 – or 0.7% – potentially misused the drug due to high dosages or being prescribed opioids while on the substitute drug, the report found, including:

- 323 were prescribed more than 36 mg per day of buprenorphine – more than 50% higher than the maximum recommended daily dose.
- 927 received buprenorphine while they were prescribed opioid painkillers. Getting both medications at the same time could mean buprenorphine was misused or patients had doctors who did not coordinate care.
- 35 doctors or other clinicians had abnormal prescribing patterns. Of those, two doctors ordered high dosages while 33 doctors prescribed buprenorphine for patients on opioids.

What do government oversight investigators want to see?

The inspector general recommended Medicare monitor buprenorphine use and share information with other agencies and partners. This would give health officials and a government committee monitoring overdoses early information about buprenorphine use, prescribing, barriers that prevent people from getting the drug and any signs of misuse.

In a response to the oversight recommendations, the Centers for Medicare & Medicaid Services said such additional monitoring wasn't necessary. The agency said it already tracked

drug spending and prescribing patterns that can detect potential problems. The agency added that the inspector general's report showed buprenorphine misuse is low and doesn't raise an investigative concern.

The inspector general also recommended Medicare:

- Inform doctors about the low risk of buprenorphine misuse and encourage them to treat more people with opioid-use disorder.
- Share information about versions – such as Suboxone – that combined buprenorphine with naloxone, the overdose reversal drug. These combination drugs are less likely to be misused.
- Review and take action on the small number of prescribers with concerning patterns.

This study looked at Medicare. How does that translate to younger adults?

Medicare is a federal health program for adults over 65, but it also covers younger adults with disabilities. In fact, about half of Medicare recipients with opioid-use disorder are younger than 65.

The study looked at buprenorphine use among 50 million people with Part D prescription drug coverage. An estimated 2.1 million Americans have opioid-use disorder.

What does other research say about buprenorphine?

Buprenorphine overdose deaths have not increased even as the drug has become more widely available during the nation's addiction crisis, said Kevin Roy, chief policy officer with Shatterproof, a nonprofit that addresses addiction treatment.■

He said the inspector general report echoes research that showed buprenorphine misuse is low.

"There's a growing body of evidence that the risks of buprenorphine diversion are fairly limited and offset by the benefits of access to this treatment," Roy said. "Policy should be geared toward access to treatment whenever possible."

Ken Alltucker is on Twitter at @kalltucker, or can be emailed at alltuck@usatoday.com