FLORIDA OPIOID ALLOCATION AND STATEWIDE RESPONSE AGREEMENT

BETWEEN

STATE OF FLORIDA DEPARTMENT OF LEGAL AFFAIRS,
OFFICE OF THE ATTORNEY GENERAL

And

CERTAIN LOCAL GOVERNMENTS IN THE STATE OF FLORIDA

This Florida Opioid Allocation and Statewide Response Agreement (the "Agreement") is entered into between the State of Florida ('State") and certain Local Governments ("Local Governments" and the State and Local Governments are jointly referred to as the "Parties" or individually as a "Party"). The Parties agree as follows:

Whereas, the people of the State and its communities have been harmed by misfeasance, nonfeasance and malfeasance committed by certain entities within the Pharmaceutical Supply Chain; and

Whereas, the State, through its Attorney General, and certain Local Governments, through their elected representatives and counsel, are separately engaged in litigation seeking to hold many of the same Pharmaceutical Supply Chain Participants accountable for the damage caused by their misfeasance, nonfeasance and malfeasance as the State; and

Whereas, certain of the Parties have separately sued Pharmaceutical Supply Chain participants for the harm caused to the citizens of both Parties and have collectively negotiated settlements with several Pharmaceutical Supply Chain Participants; and

Whereas, the Parties share a common desire to abate and alleviate the impacts of that misfeasance, nonfeasance and malfeasance throughout the State; and

Whereas, it is the intent of the State and its Local Governments to use the proceeds from any Settlements with Pharmaceutical Supply Chain Participants to increase the amount of funding presently spent on opioid and substance abuse education, treatment, prevention and other related programs and services, such as those identified in Exhibits "A" and "B," and to ensure that the funds are expended in compliance with evolving evidence-based "best practices;" and

Whereas, the State and its Local Governments enter into this Agreement and agree to the allocation and use of the proceeds of any settlement described herein

Wherefore, the Parties each agree to as follows:

A. Definitions

As used in this Agreement:

1. "Approved Purpose(s)" shall mean forward-looking strategies, programming and services used to expand the availability of treatment for individuals impacted by substance use disorders, to: (a) develop, promote, and provide evidence-based substance use prevention strategies; (b) provide substance use avoidance and awareness education; (c) decrease the oversupply of licit and illicit opioids; and (d) support recovery from addiction. Approved Purposes shall include, but are not limited to, the opioid abatement strategies listed in Exhibits "A" and "B" which are incorporated herein by reference.

2. "Local Governments" shall mean all counties, cities, towns and villages located within the geographic boundaries of the State.

3. "Managing Entities" shall mean the corporations selected by and under contract with the Florida Department of Children and Families or its successor ("DCF") to manage the daily operational delivery of behavioral health services through a coordinated system of care. The singular "Managing Entity" shall refer to a singular of the Managing Entities.

4. "County" shall mean a political subdivision of the state established pursuant to s. 1, Art. VIII of the State Constitution.

5. "Dependent Special District" shall mean a Special District meeting the requirements of Florida Statutes § 189.012(2).

6. "Municipalities" shall mean cities, towns, or villages located in a County within the State that either have: (a) a Population greater than 10,000 individuals; or (b) a Population equal to or less than 10,000 individuals and that has either (i) filed a lawsuit against one or more Pharmaceutical Supply Chain Participants; or (ii) executes a release in connection with a settlement with a Pharmaceutical Supply Chain participant. The singular "Municipality" shall refer to a singular city, town, or village within the definition of Municipalities.

7. "'Negotiating Committee" shall mean a three-member group comprised by representatives of the following: (1) the State; and (2) two representatives of Local Governments of which one representative will be from a Municipality and one shall be from a County (collectively, "Members") within the State. The State shall be represented by the Attorney General or her designee.

8. "Negotiation Class Metrics" shall mean those county and city settlement allocations which come from the official website of the Negotiation Class of counties and cities certified on September 11, 2019 by the U.S. District for the Northern District of Ohio in *In re National Prescription Opiate Litigation*, MDL No. 2804 (N.D. Ohio). The website is located at https://allocationmap.iclaimsonline.com.

9. "Opioid Funds" shall mean monetary amounts obtained through a Settlement.

10. "Opioid Related" shall have the same meaning and breadth as in the agreed Opioid Abatement Strategies attached hereto as Exhibits "A" or "B."

11. "Parties" shall mean the State and Local Governments that execute this Agreement. The singular word "Party" shall mean either the State or Local Governments that executed this Agreement.

12. "PEC" shall mean the Plaintiffs' Executive Committee of the National Prescription Opiate Multidistrict Litigation pending in the United States District Court for the Northern District of Ohio.

13. "Pharmaceutical Supply Chain" shall mean the entities, processes, and channels through which Controlled Substances are manufactured, marketed, promoted, distributed or dispensed.

14. "Pharmaceutical Supply Chain Participant" shall mean any entity that engages in, or has engaged in the manufacture, marketing, promotion, distribution or dispensing of an opioid analgesic.

15. "Population" shall refer to published U.S. Census Bureau population estimates as of July 1, 2019, released March 2020, and shall remain unchanged during the term of this Agreement. These estimates can currently be found at *https://www.census.gov. For purposes of Population under the definition of Qualified County, a County's population shall be the greater of its population as of the July 1, 2019, estimates or its actual population, according to the official U.S. Census Bureau count, which was released by the U.S. Census Bureau in August 2021.*

16. "Qualified County" shall mean a charter or non-chartered County that has a Population of at least 300,000 individuals and: (a) has an opioid taskforce or other similar board, commission, council, or entity (including some existing sub-unit of a County's government responsible for substance abuse prevention, treatment, and/or recovery) of which it is a member or it operates in connection with its municipalities or others on a local or regional basis; (b) has an abatement plan that has been either adopted or is being utilized to respond to the opioid epidemic; (c) is, as of December 31, 2021, either providing or is contracting with others to provide substance abuse prevention, recovery, and/or treatment services to its citizens; and (d) has or enters into an interlocal agreement with a majority of Municipalities (Majority is more than 50% of the Municipalities' total Population) related to the expenditure of Opioid Funds. The Opioid Funds to be paid to a Qualified County will only include Opioid Funds for Municipalities whose claims are released by the Municipality or Opioid Funds for Municipalities whose claims are otherwise barred. For avoidance of doubt, the word "operate" in connection with opioid task force means to do at least one of the following activities: (1) gathers data about the nature, extent, and problems being faced in communities within that County; (2) receives and reports recommendations from other government and private entities about activities that should be undertaken to abate the opioid epidemic to a County; and/or (3) makes recommendations to a County and other public and private leaders about steps, actions, or plans that should be undertaken to abate the opioid epidemic. For avoidance of doubt, the Population calculation required by subsection (d) does not include Population in unincorporated areas.

17. "SAMHSA" shall mean the U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration.

18. "Settlement" shall mean the negotiated resolution of legal or equitable claims against a Pharmaceutical Supply Chain Participant when that resolution has been jointly entered into by the State and Local Governments or a settlement class as described in (B)(1) below.

19. "State" shall mean the State of Florida.

B. Terms

1. **Only Abatement** - Other than funds used for the Administrative Costs and Expense Fund as hereinafter described or to pay obligations to the United States arising out of Medicaid or other federal programs, all Opioid Funds shall be utilized for Approved Purposes. In order to accomplish this purpose, the State will either: (a) file a new action with Local Governments as Parties; or (b) add Local Governments to its existing action, sever any settling defendants. In either type of action, the State will seek entry of a consent judgment, consent order or other order binding judgment binding both the State and Local Governments to utilize Opioid Funds for Approved Purposes ("Order") from the Circuit Court of the Sixth Judicial Circuit in and for Pasco County, West Pasco Division New Port Richey, Florida (the "Court"), except as herein provided. The Order may be part of a class action settlement or similar device. The Order shall provide for continuing jurisdiction by the Court to address non-performance by any party under the Order.

2. **Avoid Claw Back and Recoupment** - Both the State and Local Governments wish to maximize any Settlement and Opioid Funds. In addition to committing to only using funds for the Expense Funds, Administrative Costs and Approved Purposes, both Parties will agree to utilize a percentage of funds for the Core Strategies highlighted in Exhibit A. Exhibit A contains the programs and strategies prioritized by the U.S. Department of Justice and/or the U.S. Department of Health & Human Services ("Core Strategies"). The State is trying to obtain the United States' agreement to limit or reduce the United States' ability to recover or recoup monies from the State and Local Government in exchange for prioritization of funds to certain projects. If no agreement is reached with the United States, then there will be no requirement that a percentage be utilized for Core Strategies.

3. **No Benefit Unless Fully Participating** - Any Local Government that objects to or refuses to be included under the Order or refuses or fails to execute any of documents necessary to effectuate a Settlement shall not receive, directly or indirectly, any Opioid Funds and its portion of Opioid Funds shall be distributed to, and for the benefit of, the Local Governments. Funds that were a for a Municipality that does not join a Settlement will be distributed to the County where that Municipality is located. Funds that were for a County that does not join a Settlement will be distributed pro rata to Counties that join a Settlement. For avoidance of doubt, if a Local Government initially refuses to be included in or execute the documents necessary to effectuate a Settlement and subsequently effectuates such documents necessary to join a Settlement, then that Local Government will only lose those payments made under a Settlement while that Local Government was not a part of the Settlement. If a Local Government participates in a Settlement, that Local Government is thereby releasing the claims of its Dependent Special District claims, if any.

4. **Distribution Scheme** – If a Settlement has a National Settlement Administrator or similar entity, all Opioids Funds will initially go to the Administrator to be distributed. If a Settlement does not have a National Settlement Administrator or similar entity, all Opioid Funds will initially go to the State, and then be distributed by the State as they are received from the Defendants according to the following distribution scheme. The Opioid Funds will be divided into three funds after deducting any costs of the Expense Fund detailed below. Funds due the federal government, if any, pursuant to Section B-2, will be subtracted from only the State and Regional Funds below:

(a) City/County Fund- The city/county fund will receive 15% of all Opioid Funds to directly benefit all Counties and Municipalities. The amounts to be distributed to each County and Municipality shall be determined by the Negotiation Class Metrics or other metrics agreed upon, in writing, by a County and a Municipality, which are attached to this Agreement as Exhibit "C." In the event that a Municipality has a Population less than 10,000 people and it does not execute a release or otherwise join a Settlement that Municipalities share under the Negotiation Class Metrics shall be reallocated to the County where that Municipality is located.

(b) Regional Fund- The regional fund will be subdivided into two parts.

(i) The State will annually calculate the share of each County within the State of the regional fund utilizing the sliding scale in paragraph 5 of the Agreement, and according to the Negotiation Class Metrics.

(ii) For Qualified Counties, the Qualified County's share will be paid to the Qualified County and expended on Approved Purposes, including the Core Strategies identified in Exhibit A, if applicable.

(iii) For all other Counties, the State will appropriate the regional share for each County and pay that share through DCF to the Managing Entities providing service for that County. The Managing Entities will be required to expend the monies on Approved Purposes, including the Core Strategies as directed by the Opioid Abatement Task Force or Council. The Managing Entities shall expend monies from this Regional Fund on services for the Counties within the State that are non-Qualified Counties and to ensure that there are services in every County. To the greatest extent practicable, the Managing Entities shall endeavor to expend monies in each County or for citizens of a County in the amount of the share that a County would have received if it were a Qualified County.

(c) State Fund - The remainder of Opioid Funds will be expended by the State on Approved Purposes, including the provisions related to Core Strategies, if applicable.

(d) To the extent that Opioid Funds are not appropriated and expended in a year by the State, the State shall identify the investments where settlement funds will be deposited. Any gains, profits, or interest accrued from the deposit of the Opioid Funds to the extent that any funds are not appropriated and expended within a calendar year, shall be the sole property of the Party that was entitled to the initial amount.

(e) To the extent a County or Municipality wishes to pool, comingle, or otherwise transfer its share, in whole or part, of Opioid Funds to another County or Municipality, the comingling Municipalities may do so by written agreement. The comingling Municipalities shall provide a copy of that agreement to the State and any settlement administrator to ensure that monies are directed consistent with such agreement. The County or Municipality receiving any such Opioid Funds shall assume the responsibility for reporting how such Opioid Funds were utilized under this Agreement.

5. Regional Fund Sliding Scale- The Regional Fund shall be calculated by utilizing the following sliding scale of the Opioid Funds available in any year after deduction of Expenses and any funds due the federal government:

A. Years 1-6: 40%

B. Years 7-9: 35%

C. Years 10-12: 34%

D. Years 13-15: 33%

E. Years 16-18: 30%

6. Opioid Abatement Taskforce or Council - The State will create an Opioid Abatement Taskforce or Council (sometimes hereinafter "Taskforce" or "Council") to advise the Governor, the Legislature, DCF, and Local Governments on the priorities that should be addressed by expenditure of Opioid Funds and to review how monies have been spent and the results that have been achieved with Opioid Funds.

(a) Size - The Taskforce or Council shall have ten Members equally balanced between the State and the Local Government representatives.

(b) Appointments Local Governments - Two Municipality representatives will be appointed by or through Florida League of Cities. Two county representatives, one from a Qualified County and one from a county within the State that is not a Qualified County, will be appointed by or through the Florida Association of Counties. The final representative will alternate every two years between being a county representative (appointed by or through Florida Association of Counties) or a Municipality representative (appointed by or through the Florida League of Cities). One Municipality representative must be from a city of less than 50,000 people. One county representative must be from a county of less than 200,000 people and the other county representative must be from a county whose population exceeds 200,000 people.

(c) Appointments State -

(i) The Governor shall appoint two Members.

(ii) The Speaker of the House shall appoint one Member.

(iii) The Senate President shall appoint one Member.

(iv) The Attorney General or her designee shall be a Member.

(d) Chair - The Attorney General or designee shall be the chair of the Taskforce or Council.

(e) Term - Members will be appointed to serve a four-year term and shall be staggered to comply with Florida Statutes § 20.052(4)(c).

(f) Support - DCF shall support the Taskforce or Council and the Taskforce or Council shall be administratively housed in DCF.

(g) Meetings - The Taskforce or Council shall meet quarterly in person or virtually using communications media technology as defined in section 120.54(5)(b)(2), Florida Statutes.

(h) Reporting - The Taskforce or Council shall provide and publish a report annually no later than November 30th or the first business day after November 30th, if November 30th falls on a weekend or is otherwise not a business day. The report shall contain information on how monies were spent the previous fiscal year by the State, each of the Qualified Counties, each of the Managing Entities, and each of the Local Governments. It shall also contain recommendations to the Governor, the Legislature, and Local Governments for priorities among the Approved Purposes or similar such uses for how monies should be spent the coming fiscal year to respond to the opioid epidemic. Prior to July 1st of each year, the State and each of the Local Governments shall provide information to DCF about how they intend to expend Opioid Funds in the upcoming fiscal year.

(i) Accountability - The State and each of the Local Governments shall report its expenditures to DCF no later than August 31st for the previous fiscal year. The Taskforce or Council will set other data sets that need to be reported to DCF to demonstrate the effectiveness of expenditures on Approved Purposes. In setting those requirements, the Taskforce or Council shall consider the Reporting Templates, Deliverables, Performance Measures, and other already utilized and existing templates and forms required by DCF from Managing Entities and suggest that similar requirements be utilized by all Parties to this Agreement.

(j) Conflict of Interest - All Members shall adhere to the rules, regulations and laws of Florida including, but not limited to, Florida Statute §112.311, concerning the disclosure of conflicts of interest and recusal from discussions or votes on conflicted matters.

7. **Administrative Costs**- The State may take no more than a 5% administrative fee from the State Fund and any Regional Fund that it administers for counties that are not Qualified Counties. Each Qualified County may take no more than a 5% administrative fee from its share of the Regional Funds. Municipalities and Counties may take no more than a 5% administrative fee from any funds that they receive or control from the City/County Fund.

8. **Negotiation of Non-Multistate Settlements** - If the State begins negotiations with a Pharmaceutical Supply Chain Participant that is separate and apart from a multi-state negotiation, the State shall include Local Governments that are a part of the Negotiating Committee in such negotiations. No Settlement shall be recommended or accepted without the affirmative votes of both the State and Local Government representatives of the Negotiating Committee.

9. **Negotiation of Multistate or Local Government Settlements** - To the extent practicable and allowed by other parties to a negotiation, both Parties agree to communicate with members of the Negotiation Committee regarding the terms of any other Pharmaceutical Supply Chain Participant Settlement.

10. **Program Requirements**- DCF and Local Governments desire to make the most efficient and effective use of the Opioid Funds. DCF and Local Governments will work to achieve that goal by ensuring the following requirements will be minimally met by any governmental entity or provider providing services pursuant to a contract or grant of Opioid Funds:

a. In either performing services under this Agreement or contracting with a provider to provide services with the Opioid Funds under this Agreement, the State and Local Governments shall be aware of and comply with all State and Federal laws, rules, Children and Families Operating Procedures (CFOPs), and similar regulations relating to the substance abuse and treatment services.

b. The State and Local Governments shall have and follow their existing policies and practices for accounting and auditing, including policies relating to whistleblowers and avoiding fraud, waste, and abuse. The State and Local Governments shall consider additional policies and practices recommended by the Opioid Abatement Taskforce or Council. c. In any award or grant to any provider, State and Local Governments shall ensure that each provider acknowledges its awareness of its obligations under law and shall audit, supervise, or review each provider's performance routinely, at least once every year.

d. In contracting with a provider, the State and Local Governments shall set performance measures in writing for a provider.

e. The State and Local Governments shall receive and report expenditures, service utilization data, demographic information, and national outcome measures in a similar fashion as required by the 42.U.S.C. s. 300x and 42 U.S.C. s. 300x-21.

f. The State and Local Governments, that implement evidenced based practice models will participate in fidelity monitoring as prescribed and completed by the originator of the model chosen..

g. The State and Local Governments shall ensure that each year, an evaluation of the procedures and activities undertaken to comply with the requirements of this Agreement are completed.

h. The State and Local Governments shall implement a monitoring process that will demonstrate oversight and corrective action in the case of non-compliance, for all providers that receive Opioid Funds. Monitoring shall include:

(i) Oversight of the any contractual or grant requirements;

(ii) Develop and utilize standardized monitoring tools;

(iii) Provide DCF and the Opioid Abatement Taskforce or Council with access to the monitoring reports; and

(iv) Develop and utilize the monitoring reports to create corrective action plans for providers, where necessary.

11. **Reporting and Records Requirements-** The State and Local Governments shall follow their existing reporting and records retention requirements along with considering any additional recommendations from the Opioid Abatement Taskforce or Council. Local Governments shall respond and provide documents to any reasonable requests from the State or Opioid Abatement Taskforce or Council for data or information about programs receiving Opioid Funds. The State and Local Governments shall ensure that any provider or sub-recipient of Opioid Funds at a minimum does the following:

(a) Any provider shall establish and maintain books, records and documents (including electronic storage media) sufficient to reflect all income and expenditures of Opioid Funds. Upon demand, at no additional cost to the State or Local Government, any provider will facilitate the duplication and transfer of any records or documents during the term that it receives any Opioid Funds and the required retention period for the State or Local Government. These records shall be made available at all reasonable times for inspection, review, copying, or audit by Federal, State, or other personnel duly authorized by the State or Local Government.

(b) Any provider shall retain and maintain all client records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to the use of the Opioid Funds during the term of its receipt of Opioid Funds and retained for a period of six (6) years after its ceases to receives Opioid Funds or longer when required by law. In the event an audit is required by the State of Local Governments, records shall be retained for a minimum period of six (6) years after the audit report is issued or until resolution of any audit findings or litigation based on the terms of any award or contract.

(c) At all reasonable times for as long as records are maintained, persons duly authorized by State or Local Government auditors shall be allowed full access to and the right to examine any of the contracts and related records and documents, regardless of the form in which kept.

(d) A financial and compliance audit shall be performed annually and provided to the State.

(e) All providers shall comply and cooperate immediately with any inspections, reviews, investigations, or audits deemed necessary by The Office of the Inspector General (section 20.055, F.S.) or the State.

(f) No record may be withheld nor may any provider attempt to limit the scope of any of the foregoing inspections, reviews, copying, transfers or audits based on any claim that any record is exempt from public inspection or is confidential, proprietary or trade secret in nature; provided, however, that this provision does not limit any exemption to public inspection or copying to any such record.

12. **Expense Fund** - The Parties agree that in any negotiation every effort shall be made to cause Pharmaceutical Supply Chain Participants to pay costs of litigation, including attorneys' fees, in addition to any agreed to Opioid Funds in the Settlement. To the extent that a fund sufficient to pay the full contingent fees of Local Governments is not created as part of a Settlement by a Pharmaceutical Supply Chain Participant, the Parties agree that an additional expense fund for attorneys who represent Local Governments (herein "Expense Fund") shall be created out of the City/County fund for the purpose of paying the hard costs of a litigating Local Government and then paying attorneys' fees.

(a) The Source of Funds for the Expense Fund- Money for the Expense Fund shall be sourced exclusively from the City/County Fund.

(b) The Amount of the Expense Fund- The State recognizes the value litigating Local Governments bring to the State in connection with the Settlement because their participation increases the amount of Incentive Payments due from each Pharmaceutical Supply Chain Participant. In recognition of that value, the amount of funds that shall be deposited into the Expense Fund shall be contingent upon on the percentage of litigating Local Government participation in the Settlement, according to the following table:

Litigating Local Government Participation in the Settlement (by percentage of the population)	Amount that shall be paid into the Expense Fund from (and as a percentage of) the City/County fund
96 to 100%	10%
91 to 95%	7.5%
86 to 90%	5%
85%	2.5%
Less than 85%	0%

If fewer than 85% percent of the litigating Local Governments (by population) participate, then the Expense Fund shall not be funded, and this Section of the Agreement shall be null and void.

(c) The Timing of Payments into the Expense Fund- Although the amount of the Expense Fund shall be calculated based on the entirety of payments due to the City/County fund over a ten-to-eighteen-year period, the Expense Fund shall be funded entirely from payments made by Pharmaceutical Supply Chain Participants during the first two payments of the Settlement. Accordingly, to offset the amounts being paid from the

City/County Fund to the Expense Fund in the first two years, Counties or Municipalities may borrow from the Regional Fund during the first two years and pay the borrowed amounts back to the Regional Fund during years three, four, and five.

For the avoidance of doubt, the following provides an illustrative example regarding the calculation of payments and amounts that may be borrowed under the terms of this MOU, consistent with the provisions of this Section:

Opioid Funds due to State of Florida and Local Governments (over 10 to 18 years):	$1,000
Litigating Local Government Participation:	100%
City/County Fund (over 10 to 18 years):	$150
Expense Fund (paid over 2 years):	$15
Amount Paid to Expense Fund in 1st year:	$7.5
Amount Paid to Expense Fund in 2nd year	$7.5
Amount that may be borrowed from Regional Fund in 1st year:	$7.5
Amount that may be borrowed from Regional Fund in 2nd year:	$7.5
Amount that must be paid back to Regional Fund in 3rd year:	$5
Amount that must be paid back to Regional Fund in 4th year:	$5
Amount that must be paid back to Regional Fund in 5th year:	$5

(d) Creation of and Jurisdiction over the Expense Fund- The Expense Fund shall be established, consistent with the provisions of this Section of the Agreement, by order of the Court. The Court shall have jurisdiction over the Expense Fund, including authority to allocate and disburse amounts from the Expense Fund and to resolve any disputes concerning the Expense Fund.

(e) Allocation of Payments to Counsel from the Expense Fund- As part of the order establishing the Expense Fund, counsel for the litigating Local Governments shall seek to have the Court appoint a third-neutral to serve as a special master for purposes of allocating the Expense Fund. Within 30 days of entry of the order appointing a special master for the Expense Fund, any counsel who intend to seek an award from the Expense Fund shall provide the copies of their contingency fee contracts to the special master. The special master shall then build a mathematical model, which shall be based on each litigating Local Government's share under the Negotiation Class Metrics and the rate set forth in their contingency contracts, to calculate a proposed award for each litigating Local Government who timely provided a copy of its contingency contract.

13. **Dispute resolution-** Any one or more of the Local Governments or the State may object to an allocation or expenditure of Opioid Funds solely on the basis that the allocation or expenditure at issue (a) is inconsistent with the Approved Purposes; (b) is inconsistent with the distribution scheme as provided in paragraph,; (c) violates the limitations set forth herein with respect to administrative costs or the Expense Fund; or (d) to recover amounts advanced from the Regional Fund for the Expense Fund. There shall be no other basis for bringing an objection to the approval of an allocation or expenditure of Opioid Funds. In the event that there is a National Settlement Administrator or similar entity, the Local Governments sole action for non-payment of

amounts due from the City/County Fund shall be against the particular settling defendant and/or the National Settlement Administrator or similar entity.

C. Other Terms and Conditions

1. **Governing Law and Venue**: This Agreement will be governed by the laws of the State of Florida. Any and all litigation arising under the Agreement, unless otherwise specified in this Agreement, will be instituted in either: (a) the Court that enters the Order if the matter deals with a matter covered by the Order and the Court retains jurisdiction; or (b) the appropriate State court in Leon County, Florida.

2. **Agreement Management and Notification:** The Parties have identified the following individuals as Agreement Managers and Administrators:

a. State of Florida Agreement Manager:

Greg Slemp

PL-01, The Capitol, Tallahassee, FL 32399

850-414-3300

Greg.slemp@myfloridalegal.com

b. State of Florida Agreement Administrator

Janna Barineau

PL-01, The Capitol, Tallahassee, FL 32399

850-414-3300

Janna.barineau@myfloridalegal.com

c. Local Governments Agreement Managers and Administrators are listed on Exhibit C to this Agreement.

Changes to either the Managers or Administrators may be made by notifying the other Party in writing, without formal amendment to this Agreement.

3. **Notices**. All notices required under the Agreement will be delivered by certified mail, return receipt requested, by reputable air courier, or by personal delivery to the designee identified in paragraphs C.2., above. Either designated recipient may notify the other, in writing, if someone else is designated to receive notice.

4. **Cooperation with Inspector General:** Pursuant to section 20.055, Florida Statutes, the Parties, understand and will comply with their duty to cooperate with the Inspector General in any investigation, audit, inspection, review, or hearing.

5. **Public Records**: The Parties will keep and maintain public records pursuant to Chapter 119, Florida Statutes and will comply will all applicable provisions of that Chapter.

6. **Modification**: This Agreement may only be modified by a written amendment between the appropriate parties. No promises or agreements made subsequent to the execution of this Agreement shall be binding unless express, reduced to writing, and signed by the Parties.

7. **Execution in Counterparts**: This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

8. **Assignment:** The rights granted in this Agreement may not be assigned or transferred by any party without the prior written approval of the other party. No party shall be permitted to delegate its responsibilities or obligations under this Agreement without the prior written approval of the other parties.

9. **Additional Documents:** The Parties agree to cooperate fully and execute any and all supplementary documents and to take all additional actions which may be reasonably necessary or appropriate to give full force and effect to the basic terms and intent of this Agreement.

10. **Captions:** The captions contained in this Agreement are for convenience only and shall in no way define, limit, extend or describe the scope of this Agreement or any part of it.

11. **Entire Agreement:** This Agreement, including any attachments, embodies the entire agreement of the parties. There are no other provisions, terms, conditions, or obligations. This Agreement supersedes all previous oral or written communications, representations or agreements on this subject.

12. **Construction:** The parties hereto hereby mutually acknowledge and represent that they have been fully advised by their respective legal counsel of their rights and responsibilities under this Agreement, that they have read, know, and understand completely the contents hereof, and that they have voluntarily executed the same. The parties hereto further hereby mutually acknowledge that they have had input into the drafting of this Agreement and that, accordingly, in any construction to be made of this Agreement, it shall not be construed for or against any party, but rather shall be given a fair and reasonable interpretation, based on the plain language of the Agreement and the expressed intent of the parties.

13. **Capacity to Execute Agreement:** The parties hereto hereby represent and warrant that the individuals signing this Agreement on their behalf are duly authorized and fully competent to do so.

14. **Effectiveness:** This Agreement shall become effective on the date on which the last required signature is affixed to this Agreement.

IN WITNESS THEREOF, the parties hereto have caused the Agreement to be executed by their undersigned officials as duly authorized.

STATE OF FLORIDA

11/15/2021

By: John Guard DATED

Its: Chief Deputy Attorney General

EXHIBIT A

Schedule A

Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies (**"Core Strategies"**)[, such that a minimum of __% of the [aggregate] state-level abatement distributions shall be spent on [one or more of] them annually].[1]

A. Naloxone or other FDA-approved drug to reverse opioid overdoses

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. Medication-Assisted Treatment ("MAT") Distribution and other opioid-related treatment

1. Increase distribution of MAT to non-Medicaid eligible or uninsured individuals;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Treatment and Recovery Support Services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication with other support services.

C. Pregnant & Postpartum Women

1. Expand Screening, Brief Intervention, and Referral to Treatment ("SBIRT") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("OUD") and other Substance Use Disorder ("SUD")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with Opioid Use Disorder (OUD) including housing, transportation, job placement/training, and childcare.

D. Expanding Treatment for Neonatal Abstinence Syndrome

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

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[1] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the Term Sheet.

E. Expansion of Warm Hand-off Programs and Recovery Services

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions. ;

4. Provide comprehensive wrap-around services to individuals in recovery including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. Treatment for Incarcerated Population

1. Provide evidence-based treatment and recovery support including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. Prevention Programs

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools.;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. Expanding Syringe Service Programs

1. Provide comprehensive syringe services programs with more wrap-around services including linkage to OUD treatment, access to sterile syringes, and linkage to care and treatment of infectious diseases.

I. Evidence-based data collection and research analyzing the effectiveness of the abatement strategies within the State.

EXHIBIT B

Schedule B

Approved Uses

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:[2]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training,

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[2] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the Term Sheet.

scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. [Intentionally Blank – to be cleaned up later for numbering]

13. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

14. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.

15. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in treatment for or recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved medication with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have – or at risk of developing – OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically-appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL-JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);

b. Active outreach strategies such as the Drug Abuse Response Team (DART) model;

c. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;

e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

f. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (NAS), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

6. Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Enhanced family supports and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including but not limited to parent skills training.

10. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:

a. Increase the number of prescribers using PDMPs;

b. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increase electronic prescribing to prevent diversion or forgery.

8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Fund media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

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

6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

7. Engage non-profits and faith-based communities as systems to support prevention.

8. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create of support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address

mental health needs in young people that (when not properly addressed) increase the risk of opioid or other drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, individuals at high risk of overdose, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities provide free naloxone to anyone in the community

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Support screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in sections C, D, and H relating to first responders, support the following:

1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitation, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local, or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services; to support training and technical assistance; or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to share reports, recommendations, or plans to spend opioid settlement funds; to show how opioid settlement funds have been spent; to report program or strategy outcomes; or to track, share, or visualize key opioid-related or health-related indicators and supports as identified through collaborative statewide, regional, local, or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

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

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

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

1. Monitoring, surveillance, data collection, and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

EXHIBIT C

County	Allocated Subdivisions	Regional % by County for Abatement Fund	City/County Fund %
Alachua		1.241060164449%	
	Alachua County		0.821689546303%
	Alachua		0.013113332457%
	Archer		0.000219705515%
	Gainesville		0.381597611347%
	Hawthorne		0.000270546460%
	High Springs		0.011987568663%
	La Crosse		0.000975056706%
	Micanopy		0.002113530737%
	Newberry		0.006102729215%
	Waldo		0.002988721299%
Baker		0.193173804130%	
	Baker County		0.169449240037%
	Glen St. Mary		0.000096234647%
	Macclenny		0.023628329446%
Bay		0.839656373312%	
	Bay County		0.508772605155%
	Callaway		0.024953825527%
	Lynn Haven		0.039205632015%
	Mexico Beach		0.005614292988%
	Panama City		0.155153855596%
	Panama City Beach		0.080897023117%
	Parker		0.008704696178%
	Springfield		0.016354442736%
Bradford		0.189484204081%	
	Bradford County		0.151424309090%
	Brooker		0.000424885045%
	Hampton		0.002839829959%
	Lawtey		0.003400896108%
	Starke		0.031392468132%
Brevard		3.878799180444%	
	Brevard County		2.323022668525%
	Cape Canaveral		0.045560750209%

	Cocoa		0.149245411423%
	Cocoa Beach		0.084363286155%
	Grant-Valkaria		0.000321387406%
	Indialantic		0.024136738902%
	Indian Harbour Beach		0.021089913665%
	Malabar		0.002505732317%
	Melbourne		0.383104682233%
	Melbourne Beach		0.012091066302%
	Melbourne Village		0.003782203200%
	Palm Bay		0.404817397481%
	Palm Shores		0.000127102364%
	Rockledge		0.096603243798%
	Satellite Beach		0.035975416224%
	Titusville		0.240056418924%
	West Melbourne		0.051997577066%
Broward		9.057962672578%	
	Broward County		3.966403576878%
	Coconut Creek		0.101131719448%
	Cooper City		0.073935445073%
	Coral Springs		0.323406517664%
	Dania Beach		0.017807041180%
	Davie		0.266922227153%
	Deerfield Beach		0.202423224725%
	Fort Lauderdale		0.830581264531%
	Hallandale Beach		0.154950491814%
	Hillsboro Beach		0.012407006463%
	Hollywood		0.520164608456%
	Lauderdale-By-The-Sea		0.022807611325%
	Lauderdale Lakes		0.062625150435%
	Lauderhill		0.144382838130%
	Lazy Lake		0.000021788977%
	Lighthouse Point		0.029131861803%
	Margate		0.143683775129%
	Miramar		0.279280208419%
	North Lauderdale		0.066069624496%

	Oakland Park		0.100430840699%
	Ocean Breeze		0.005381877237%
	Parkland		0.045804060448%
	Pembroke Park		0.024597938908%
	Pembroke Pines		0.462832363603%
	Plantation		0.213918725664%
	Pompano Beach		0.335472163493%
	Sea Ranch Lakes		0.005024174870%
	Southwest Ranches		0.025979723178%
	Sunrise		0.286071106146%
	Tamarac		0.134492458472%
	Weston		0.138637811283%
	West Park		0.029553115352%
	Wilton Manors		0.031630331127%
Calhoun		0.047127740781%	
	Calhoun County		0.038866087128%
	Altha		0.000366781107%
	Blountstown		0.007896688293%
Charlotte		0.737346233376%	
	Charlotte County		0.690225755587%
	Punta Gorda		0.047120477789%
Citrus		0.969645776606%	
	Citrus County		0.929715661117%
	Crystal River		0.021928789266%
	Inverness		0.018001326222%
Clay		1.193429461456%	
	Clay County		1.055764891131%
	Green Cove Springs		0.057762577142%
	Keystone Heights		0.000753535443%
	Orange Park		0.078589207339%
	Penney Farms		0.000561066149%
Collier		1.551333376427%	
	Collier County		1.354673336030%
	Everglades		0.000148891341%
	Marco Island		0.062094952003%

	Naples		0.134416197054%
Columbia		0.446781150792%	
	Columbia County		0.341887201373%
	Fort White		0.000236047247%
	Lake City		0.104659717920%
DeSoto		0.113640407802%	
	DeSoto County		0.096884684746%
	Arcadia		0.016755723056%
Dixie		0.103744580900%	
	Dixie County		0.098822087921%
	Cross City		0.004639236282%
	Horseshoe Beach		0.000281440949%
Duval		5.434975156935%	
	Jacksonville		5.270570064997%
	Atlantic Beach		0.038891507601%
	Baldwin		0.002251527589%
	Jacksonville Beach		0.100447182431%
	Neptune Beach		0.022814874318%
Escambia		1.341634449244%	
	Escambia County		1.005860871574%
	Century		0.005136751249%
	Pensacola		0.330636826421%
Flagler		0.389864712244%	
	Flagler Counry		0.279755934409%
	Beverly Beach		0.000154338585%
	Bunnell		0.009501809575%
	Flagler Beach		0.015482883669%
	Marineland		0.000114392127%
	Palm Coast		0.084857169626%
Franklin		0.049911282550%	
	Franklin County		0.046254365966%
	Apalachicola		0.001768538606%
	Carabelle		0.001888377978%
Gadsden		0.123656074077%	
	Gadsden County		0.090211810642%

	Chattahoochee		0.004181667772%
	Greensboro		0.000492067723%
	Gretna		0.002240633101%
	Havana		0.005459954403%
	Midway		0.001202025213%
	Quincy		0.019867915223%
Gilchrist		0.064333769355%	
	Gilchrist County		0.061274233881%
	Bell		0.000099866143%
	Fanning Springs		0.000388570084%
	Trenton		0.002571099247%
Glades		0.040612836758%	
	Glades County		0.040420367464%
	Moore Haven		0.000192469294%
Gulf		0.059914238588%	
	Gulf County		0.054715751905%
	Port St. Joe		0.004817179591%
	Wewahitchka		0.000381307092%
Hamilton		0.047941195910%	
	Hamilton County		0.038817061931%
	Jasper		0.004869836285%
	Jennings		0.002623755940%
	White Springs		0.001630541754%
Hardee		0.067110048132%	
	Hardee County		0.058100306280%
	Bowling Green		0.001797590575%
	Wauchula		0.006667426860%
	Zolfo Springs		0.000544724417%
Hendry		0.144460915297%	
	Hendry County		0.122147187443%
	Clewiston		0.017589151414%
	LaBelle		0.004724576440%
Hernando		1.510075949110%	
	Hernando County		1.447521612849%
	Brooksville		0.061319627583%

	Weeki Wachee		0.001234708678%
Highlands		0.357188510237%	
	Highlands County		0.287621754986%
	Avon Park		0.025829016090%
	Lake Placid		0.005565267790%
	Sebring		0.038172471371%
Hillsborough		8.710984113657%	
	Hillsborough County		6.523111204400%
	Plant City		0.104218491142%
	Tampa		1.975671881253%
	Temple Terrace		0.107980721113%
Holmes		0.081612427851%	
	Holmes County		0.066805002459%
	Bonifay		0.006898026863%
	Esto		0.006269778036%
	Noma		0.001278286631%
	Ponce de Leon		0.000179759057%
	Westville		0.000179759057%
Indian River		0.753076058781%	
	Indian River County		0.623571460217%
	Fellsmere		0.004917045734%
	Indian River shores		0.025322422382%
	Orchid		0.000306861421%
	Sebastian		0.038315915467%
	Vero Beach		0.060642353558%
Jackson		0.158936058795%	
	Jackson County		0.075213731704%
	Alford		0.000303229925%
	Bascom		0.000061735434%
	Campbellton		0.001648699234%
	Cottondale		0.001093080329%
	Graceville		0.002794436257%
	Grandridge		0.000030867717%
	Greenwood		0.001292812616%
	Jacob City		0.000481173235%

	Malone		0.000092603151%
	Marianna		0.073519638768%
	Sneads		0.002404050426%
Jefferson		0.040821647784%	
	Jefferson County		0.037584169001%
	Monticello		0.003237478783%
Lafayette		0.031911772076%	
	Lafayette County		0.031555885457%
	Mayo		0.000355886619%
Lake		1.139211224519%	
	Lake County		0.757453827343%
	Astatula		0.002727253579%
	Clermont		0.075909163209%
	Eustis		0.041929254098%
	Fruitland Park		0.008381493024%
	Groveland		0.026154034992%
	Howey-In-The-Hills		0.002981458307%
	Lady Lake		0.025048244426%
	Leesburg		0.091339390185%
	Mascotte		0.011415608025%
	Minneola		0.016058475803%
	Montverde		0.001347285057%
	Mount Dora		0.041021380070%
	Tavares		0.031820984673%
	Umatilla		0.005623371728%
Lee		3.325371883359%	
	Lee County		2.115268407509%
	Bonita Springs		0.017374893143%
	Cape Coral		0.714429677167%
	Estero		0.012080171813%
	Fort Myers		0.431100350585%
	Fort Myers Beach		0.000522935440%
	Sanibel		0.034595447702%
Leon		0.897199244939%	
	Leon County		0.471201146391%

	Tallahassee		0.425998098549%
Levy		0.251192401748%	
	Levy County		0.200131750679%
	Bronson		0.005701448894%
	Cedar Key		0.005180329202%
	Chiefland		0.015326729337%
	Fanning Springs		0.000808007885%
	Inglis		0.004976965420%
	Otter Creek		0.000408543312%
	Williston		0.017774357715%
	Yankeetown		0.000884269303%
Liberty		0.019399452225%	
	Liberty County		0.019303217578%
	Bristol		0.000096234647%
Madison		0.063540287455%	
	Madison County		0.053145129837%
	Greenville		0.000110760631%
	Lee		0.000019973229%
	Madison		0.010264423758%
Manatee		2.721323346235%	
	Manatee County		2.201647174006%
	Anna Maria		0.009930326116%
	Bradenton		0.379930754632%
	Bradenton Beach		0.014012127744%
	Holmes Beach		0.028038781473%
	Longboat Key		0.034895046131%
	Palmetto		0.052869136132%
Marion		1.701176168960%	
	Marion County		1.303728892837%
	Belleview		0.009799592256%
	Dunnellon		0.018400790795%
	McIntosh		0.000145259844%
	Ocala		0.368994504094%
	Reddick		0.000107129135%
Martin		0.869487298116%	

	Martin County		0.750762795758%
	Jupiter Island		0.020873839646%
	Ocean Breeze Park		0.008270732393%
	Sewall's Point		0.008356072551%
	Stuart		0.081223857767%
Miami-Dade		5.232119784173%	
	Miami-Dade County		4.282797675552%
	Aventura		0.024619727885%
	Bal Harbour		0.010041086747%
	Bay Harbor Islands		0.004272455175%
	Biscayne Park		0.001134842535%
	Coral Gables		0.071780152131%
	Cutler Bay		0.009414653668%
	Doral		0.013977628531%
	El Portal		0.000924215760%
	Florida City		0.003929278792%
	Golden Beach		0.002847092951%
	Hialeah		0.098015895785%
	Hialeah Gardens		0.005452691411%
	Homestead		0.024935668046%
	Indian Creek		0.002543863026%
	Key Biscayne		0.013683477346%
	Medley		0.008748274131%
	Miami		0.292793005448%
	Miami Beach		0.181409572478%
	Miami Gardens		0.040683650932%
	Miami Lakes		0.007836768608%
	Miami Shores		0.006287935516%
	Miami Springs		0.006169911893%
	North Bay Village		0.005160355974%
	North Miami		0.030379280717%
	North Miami Beach		0.030391990953%
	Opa-locka		0.007847663096%
	Palmetto Bay		0.007404620570%
	Pinecrest		0.008296152866%

	South Miami		0.007833137111%
	Sunny Isles Beach		0.007693324511%
	Surfside		0.004869836285%
	Sweetwater		0.004116300842%
	Virginia Gardens		0.001172973244%
	West Miami		0.002654623657%
Monroe		0.476388738585%	
	Monroe County		0.330124785469%
	Islamorada		0.022357305808%
	Key Colony Beach		0.004751812661%
	Key West		0.088087385417%
	Layton		0.000150707089%
	Marathon		0.030916742141%
Nassau		0.476933463002%	
	Nassau County		0.392706357951%
	Callahan		0.000225152759%
	Fernandina Beach		0.083159445195%
	Hillard		0.000842507098%
Okaloosa		0.819212865955%	
	Okaloosa County		0.612059617545%
	Cinco Bayou		0.000733562214%
	Crestview		0.070440130066%
	Destin		0.014678507281%
	Fort Walton Beach		0.077837487644%
	Laurel Hill		0.000079892914%
	Mary Esther		0.009356549730%
	Niceville		0.021745398713%
	Shalimar		0.001824826796%
	Valparaiso		0.010456893052%
Okeechobee		0.353495278692%	
	Okeechobee County		0.314543851405%
	Okeechobee		0.038951427287%
Orange		4.671028214546%	
	Orange County		3.063330386979%
	Apopka		0.097215150892%

	Bay Lake		0.023566594013%
	Belle Isle		0.010798253686%
	Eatonville		0.008325204835%
	Edgewood		0.009716067845%
	Lake Buena Vista		0.010355211161%
	Maitland		0.046728276209%
	Oakland		0.005429086686%
	Ocoee		0.066599822928%
	Orlando		1.160248481490%
	Windemere		0.007548064667%
	Winter Garden		0.056264584996%
	Winter Park		0.104903028159%
Osceola		1.073452092940%	
	Osceola County		0.837248691390%
	Kissimmee		0.162366006872%
	St. Cloud		0.073837394678%
Palm Beach		8.601594372053%	
	Palm Beach County		5.552548475026%
	Atlantis		0.018751230169%
	Belle Glade		0.020828445945%
	Boca Raton		0.472069073961%
	Boynton Beach		0.306498271771%
	Briny Breezes		0.003257452012%
	Cloud Lake		0.000188837798%
	Delray Beach		0.351846579457%
	Glen Ridge		0.000052656694%
	Golf		0.004283349663%
	Greenacres		0.076424835657%
	Gulf Stream		0.010671151322%
	Haverhill		0.001084001589%
	Highland Beach		0.032510968934%
	Hypoluxo		0.005153092982%
	Juno Beach		0.016757538804%
	Jupiter Island		0.125466374888%
	Jupiter Inlet Colony		0.005276563849%

	Lake Clarke Shores		0.007560774903%
	Lake Park		0.029433275980%
	Lake Worth		0.117146617298%
	Lantana		0.024507151505%
	Loxahatchee Groves		0.002531152789%
	Manalapan		0.021632822333%
	Mangonia Park		0.010696571795%
	North Palm Beach		0.044349646256%
	Ocean Ridge		0.012786497807%
	Pahokee		0.004018250447%
	Palm Beach		0.185476848123%
	Palm Beach Gardens		0.233675880257%
	Palm Beach Shores		0.014135598612%
	Palm Springs		0.038021764282%
	Riviera Beach		0.163617057282%
	Royal Palm Beach		0.049295743959%
	South Bay		0.001830274040%
	South Palm Beach		0.005866681967%
	Tequesta		0.031893614595%
	Wellington		0.050183644758%
	West Palm Beach		0.549265602541%
Pasco		4.692087260494%	
	Pasco County		4.319205239813%
	Dade City		0.055819726723%
	New Port Richey		0.149879107494%
	Port Richey		0.049529975458%
	San Antonio		0.002189792155%
	St. Leo		0.002790804761%
	Zephyrhills		0.112672614089%
Pinellas		7.934889816777%	
	Pinellas County		4.546593184553%
	Belleair		0.018095745121%
	Belleair Beach		0.004261560686%
	Belleair Bluffs		0.007502670965%
	Belleair Shore		0.000439411029%

	Clearwater		0.633863120196%
	Dunedin		0.102440873796%
	Gulfport		0.047893986460%
	Indian Rocks Beach		0.008953453662%
	Indian Shores		0.011323004874%
	Kenneth City		0.017454786058%
	Largo		0.374192990777%
	Madeira Beach		0.022616957779%
	North Reddington Beach		0.003820333909%
	Oldsmar		0.039421706033%
	Pinellas Park		0.251666311991%
	Redington Beach		0.003611522882%
	Redington Shores		0.006451352841%
	Safety Harbor		0.038061710740%
	Seminole		0.095248695748%
	South Pasadena		0.029968921656%
	St. Pete Beach		0.071791046619%
	St. Petersburg		1.456593090134%
	Tarpon Springs		0.101970595050%
	Treasure Island		0.040652783215%
Polk		2.150483025298%	
	Polk County		1.558049828484%
	Auburndale		0.028636162584%
	Bartow		0.043971970660%
	Davenport		0.005305615818%
	Dundee		0.005597951255%
	Eagle Lake		0.002580177987%
	Fort Meade		0.007702403251%
	Frostproof		0.005857603227%
	Haines City		0.047984773863%
	Highland Park		0.000063551182%
	Hillcrest Heights		0.000005447244%
	Lake Alfred		0.007489960729%
	Lake Hamilton		0.002540231530%
	Lakeland		0.294875668468%

	Lake Wales		0.036293172134%
	Mulberry		0.005414560702%
	Polk City		0.001080370093%
	Winter Haven		0.097033576087%
Putnam		0.384893194068%	
	Putnam County		0.329225990182%
	Crescent City		0.005561636294%
	Interlachen		0.001877483489%
	Palatka		0.046955244716%
	Pomona Park		0.000379491344%
	Welaka		0.000893348043%
Santa Rosa		0.701267319513%	
	Santa Rosa County		0.592523984216%
	Gulf Breeze		0.061951507906%
	Jay		0.000159785829%
	Milton		0.046632041562%
Sarasota		2.805043857579%	
	Sarasota County		1.924315263251%
	Longboat Key		0.044489458856%
	North Port		0.209611771277%
	Sarasota		0.484279979635%
	Venice		0.142347384560%
Seminole		2.141148264544%	
	Seminole County		1.508694164839%
	Altamonte Springs		0.081305566430%
	Casselberry		0.080034542791%
	Lake Mary		0.079767627827%
	Longwood		0.061710013415%
	Oviedo		0.103130858057%
	Sanford		0.164243490362%
	Winter Springs		0.062262000824%
St. Johns		0.710333349554%	
	St. Johns County		0.656334818131%
	Hastings		0.000010894488%
	Marineland		0.000000000000%

	St. Augustine		0.046510386442%
	St. Augustine Beach		0.007477250493%
St. Lucie		1.506627843552%	
	St. Lucie County		0.956156584302%
	Fort Pierce		0.159535255654%
	Port St. Lucie		0.390803453989%
	St. Lucie Village		0.000132549608%
Sumter		0.326398870459%	
	Sumter County		0.302273026046%
	Bushnell		0.006607507174%
	Center Hill		0.001312785844%
	Coleman		0.000748088199%
	Webster		0.001423546476%
	Wildwood		0.014033916721%
Suwannee		0.191014879692%	
	Suwannee County		0.161027800555%
	Branford		0.000929663004%
	Live Oak		0.029057416132%
Taylor		0.092181897282%	
	Taylor County		0.069969851319%
	Perry		0.022212045963%
Union		0.065156303224%	
	Union County		0.063629259109%
	Lake Butler		0.001398126003%
	Raiford		0.000012710236%
	Worthington Springs		0.000116207876%
Volusia		3.130329674480%	
	Volusia County		1.708575342287%
	Daytona Beach		0.447556475212%
	Daytona Beach Shores		0.039743093439%
	DeBary		0.035283616215%
	DeLand		0.098983689498%
	Deltona		0.199329190038%
	Edgewater		0.058042202343%
	Flagler Beach		0.000223337011%

	Holly Hill		0.031615805143%
	Lake Helen		0.004918861482%
	New Smyrna Beach		0.104065968306%
	Oak Hill		0.004820811087%
	Orange City		0.033562287058%
	Ormond Beach		0.114644516477%
	Pierson		0.002333236251%
	Ponce Inlet		0.023813535748%
	Port Orange		0.177596501562%
	South Daytona		0.045221205323%
Wakulla		0.115129321208%	
	Wakulla County		0.114953193647%
	Sopchoppy		0.000107129135%
	St. Marks		0.000068998426%
Walton		0.268558216151%	
	Walton County		0.224268489581%
	DeFuniak Springs		0.017057137234%
	Freeport		0.003290135477%
	Paxton		0.023942453860%
Washington		0.120124444109%	
	Washington County		0.104908475404%
	Caryville		0.001401757499%
	Chipley		0.012550450560%
	Ebro		0.000221521263%
	Vernon		0.000361333863%
	Wausau		0.000680905521%
		100.00%	100.00%