

**INTERLOCAL AGREEMENT GOVERNING USE OF PINELLAS COUNTY  
REGIONAL OPIOID SETTLEMENT FUNDS**

THIS INTERLOCAL AGREEMENT (“Agreement”) is made and entered into as of this 22 day of December, 2021, by and between Pinellas County, a political subdivision of the State of Florida, hereinafter referred to as the “County,” and the City of St. Petersburg, the City of Pinellas Park, and the City of Clearwater, hereinafter referred to as the “Cities.”

WHEREAS, a local, state and national crisis arose as a result of the manufacture, distribution and over-prescribing of opioid analgesics (“opioids”) and resulted in opioid overdoses and addictions throughout municipalities, counties, states and the nation; and

WHEREAS, Pinellas County and the municipalities therein are not immune from this nationwide crisis; and

WHEREAS, in June 2017, a collaborative body known as the Pinellas County Opioid Task Force, hereinafter “Opioid Task Force”, was created in response to the alarming increase in opioid-related drug misuse and opioid-related deaths within the geographic boundaries of Pinellas County; and

WHEREAS, in January 2018, the Opioid Task Force implemented a comprehensive strategic plan that efficiently guides community members and resources in order to confront the crises caused by the opioid epidemic; and

WHEREAS, the Opioid Task Force meets quarterly to study and analyze data related to the opioid epidemic and abatement programming; and

WHEREAS, the crisis has caused and is causing an undue strain on local government finances to implement programming to combat the opioid epidemic, to mitigate the harmful effects

of the opioid epidemic in the community, and to increase educational campaigns to counteract misinformation about the addictive nature and harmful effects of opioids; and

WHEREAS, the opioid crisis is as pronounced within Pinellas County and within certain municipalities within Pinellas County as it was throughout most of the harder hit areas in the state of Florida and in the United States and despite the resources expended on combatting the epidemic, the opioid epidemic continues to impact the local community; and

WHEREAS, as a result of the national opioid crisis, many governmental entities throughout the country filed lawsuits against opioid manufacturers, distributors, and retailers, hereinafter referred to as the “defendants”, to hold them accountable for the damage caused by their misfeasance, nonfeasance and malfeasance, as well as to recover monetary damages for past harm and financial compensation for ongoing and future abatement efforts; and

WHEREAS, four governmental entities in Pinellas County deemed the opioid crisis significant enough to secure litigation counsel and individually elect to file suit against the defendants to wit: the City of St. Petersburg, the City of Clearwater, the City of Pinellas Park (hereinafter referred to as the “MDL Cities”) and the County; and

WHEREAS, the lawsuits filed by the MDL Cities and the County were consolidated with other lawsuits filed by state, tribal and local governmental entities into what is known as the National Prescription Opiate Litigation in the United States District Court of the Northern District of Ohio, Eastern Division, case number 1:17-MD-2804; and

WHEREAS, as a result of this litigation, multiple defendants have begun to negotiate settlements; and

WHEREAS, the Attorney General for the State of Florida (hereinafter “Attorney General”) anticipates that Settlement funds will be distributed to the State of Florida over multiple years as

part of a global settlement, and not directly to the MDL Cities and County, despite their position as party plaintiffs; and

WHEREAS, the Attorney General has proposed entering into agreements with local governments within the State of Florida to receive Settlement funds. This agreement (hereinafter referred to as the “State MOU”), as currently drafted, divides settlement funds into three portions designated as City/County, Regional and State funds; and

WHEREAS, it is anticipated that the State MOU will set forth the amount and manner of distribution of City/County and Regional Settlement funds within Florida, the requirements to receive and manage Regional funds, and the purposes for which Regional funds may be used. The current draft of the State MOU is attached hereto as Exhibit A; and

WHEREAS, the parties recognize that local control over Settlement funds is in the best interest of all persons within the geographic boundaries of Pinellas County and ensures that Settlement funds are available and used to address opioid-related impacts within Pinellas County and are, therefore, committed to the County qualifying as a “Qualified County” and thereby receiving Regional funds pursuant to the State MOU; and

WHEREAS, the State MOU requires that in order for Pinellas County to become a Qualified County eligible to receive Regional Funding, there must be an interlocal agreement among Pinellas County and Municipalities, as defined in the MOU, with combined population exceeding 50% of the total population of the Municipalities within Pinellas County, with the term “Municipalities” being defined for the purpose in this Agreement as those municipalities with a population of 10,000 or more as required by the State MOU; or with population less than 10,000 who were party plaintiffs; population for purposes of the MOU is determined by specific Census data; and

WHEREAS, historically, government-funded programming geared toward abating the opioid crisis has been data driven based upon community impacts without regard to governmental jurisdictional boundaries; and

WHEREAS, the parties recognize that it is in the best interest of the County and the Cities to enter into this interlocal agreement to ensure Pinellas County is a “Qualified County” to receive Regional Funding pursuant to the State MOU.

NOW, THEREFORE, in consideration of the covenants herein contained, and other good and valuable consideration, the parties agree as follows:

**Section 1. DEFINITIONS**

- A. Unless otherwise defined herein, all defined terms in the State MOU are incorporated herein and shall have the same meanings as in the State MOU.
- B. “Pinellas County Regional Funding” shall mean the amount of the Regional Funding paid to Pinellas County in its role as a Qualified County.

**Section 2. CONDITIONS PRECEDENT**

This Agreement shall become effective on the Commencement Date set forth in Section 4, so long as the following conditions precedent have been satisfied:

- A. Execution of this Agreement by the County and the governing bodies of the municipalities as required by the State MOU to enable Pinellas County to become a Qualified County and directly receive Pinellas County Regional Funding; and
- B. Execution of all documents necessary to effectuate the State MOU in its final form; and
- C. Pinellas County being determined by the State of Florida to qualify as a “Qualified County” to receive Regional Funding under the State MOU; and

D. Filing of this Agreement with the Clerk of the Circuit Court for Pinellas County as required by Florida Statutes, Section 163.01.

**Section 3. EXECUTION**

This Agreement may be signed in counterparts by the parties hereto.

**Section 4. TERM**

The term of this Agreement and the obligations hereunder commences upon the satisfaction of all conditions precedent, runs concurrently with the State MOU, and will continue until one (1) year after the expenditure of all Pinellas County Regional Funding, unless otherwise terminated in accordance with the provisions of the State MOU. Obligations under this Agreement which by their nature should survive, including, but not limited to any and all obligations relating to record retention, audit, and indemnification will remain in effect after termination or expiration of this Agreement.

**Section 5. BOARD**

A. Pinellas County Regional Funding will be used in accordance with the requirements of the State MOU, and guidelines set forth by a board established by resolution of the Board of County Commissioners (hereinafter referred to as the “Opioid Abatement Funding Advisory Board”), which will include utilizing the Opioid Taskforce data and projections.

- i. Opioid Abatement Funding Advisory Board membership shall be comprised of the following members appointed for two-year terms:
  1. One member appointed by the City of St. Petersburg;
  2. One member appointed by the City of Pinellas Park;
  3. One member appointed by the City of Clearwater;

4. One member nominated by the County Administrator and appointed by the Board of County Commissioners;
  5. The Director of the Florida Department of Health in Pinellas County or designee or someone with subject matter expertise in public health or addiction, who is not and is not employed by a provider of opioid-related services in Pinellas County, and appointed by the four other members of the Opioid Abatement Funding Advisory Board if the Department of Health declines to participate.
- B. The Opioid Abatement Funding Advisory Board shall meet regularly and as often as needed to effectuate its responsibilities, but no less than quarterly and on a schedule which allows the Opioid Task Force to provide the data compiled for and arising out of its quarterly meeting to the Opioid Abatement Funding Advisory Board for review and consideration.
- C. The Opioid Abatement Funding Advisory Board shall establish bylaws and an annual process which must include the following:
- a. A date certain each year by which the Opioid Abatement Funding Advisory Board must meet and review the data available from previous years, tending to evidence the local status of the opioid epidemic and the effect of abatement programming.
  - b. The Opioid Abatement Funding Advisory Board must review the programs and services of the beneficiaries of Pinellas County Regional Funds to determine

the outcome of such programs and services in order to hold beneficiaries accountable.

- c. The Opioid Abatement Funding Advisory Board must annually determine funding, programs, services, and location priorities for the upcoming year(s) (“Opioid Abatement Funding Advisory Board Priority List”).
- D. The County will perform competitive solicitations for programming and services based on the Opioid Abatement Funding Advisory Board Priority List in accordance with a centralized, county-wide competitive grant process similar to that which is attached as Exhibit B, and the Pinellas Litigating Governments will be provided the opportunity to participate in the review process.
- E. Pinellas County Regional Funding may be used to enhance current programs or develop new programs. Regional funding is not intended to supplant current funding sources and general funds, and County staff will continue to seek funding for opioid related abatement at the levels opioid abatement programs were funded as of the effective date of this agreement.
- F. Final Review recommendations will be approved by the Opioid Abatement Funding Advisory Board, who shall present recommendations to the BCC for approval. The BCC shall accept/approve Opioid Abatement Funding Advisory Board recommendations unless the BCC rejects such recommendations by a vote of at least five (5) of the seven (7) commissioners.
- G. The Opioid Abatement Funding Advisory Board and the BCC shall use its best efforts to fund services and programs that are available to all residents of Pinellas County and

shall strive to allocate funding and services in a manner that equally benefits all residents of Pinellas County.

**Section 6. ADMINISTRATIVE COSTS**

The County is responsible for administering the “Regional Funds” remitted pursuant to the State MOU and, therefore County staff will support the Opioid Abatement Funding Advisory Board and shall provide all support services including but not limited to legal services, as well as contract management, program monitoring, and reporting required by the State MOU and is entitled to the maximum allowable administrative fee pursuant to the State MOU. The administrative fee will be deducted annually from the amount of available Pinellas County Regional Funds, and the remaining Pinellas County Regional Funds will be spent as provided in the State MOU and as provided herein.

**Section 7. LOCAL GOVERNMENT REPORTING REQUIREMENTS**

To the extent that local governmental entity receives Pinellas County Regional Funds directly from the County, any local governmental entity so receiving funds must spend such funds for Approved Purposes and must timely satisfy all reporting requirements of the MOU. Failure to comply with this provision may disqualify the local governmental entity from further direct receipt of Pinellas County Regional Funds.

**Section 8. NON-APPROPRIATION**

This Agreement is not a general obligation of the County. It is understood that neither this Agreement nor any representation by any County official, officer or employee creates any obligation to appropriate or make monies available for the purposes of the Agreement beyond the fiscal year in which this Agreement is executed. The obligations of the County as to funding required pursuant to the Agreement are limited to an obligation in any given fiscal year to budget



and appropriate from Pinellas County Regional Funds annually which are designated for regional use pursuant to the terms of the State MOU. No liability shall be incurred by the County beyond the monies budgeted and available for the purpose of the Agreement. If funds are not received by the County for any or all of this Agreement for a new fiscal period, the County is not obligated to pay or spend any sums contemplated by this Agreement beyond the portions for which funds were received and appropriated. The County agrees to promptly notify the Cities in writing of any subsequent non-appropriation, and upon such notice, this Agreement will terminate on the last day of the current fiscal year without penalty to the County and all undistributed funds will be spent for programs previously proposed by the Opioid Abatement Funding Advisory Board and adopted by the BCC.

#### **Section 9. INDEMNIFICATION**

Each City and the County shall be responsible for their respective employees' acts of negligence when such employees are acting within the scope of their employment and shall only be liable for any damages resulting from said negligence to the extent permitted by Section 768.28, Florida Statutes. Nothing herein shall be construed as a waiver of sovereign immunity, or the provisions of F.S. § 768.28, by either Party. Nothing herein shall be construed as consent by either Party to be sued by third parties for any matter arising out of this Agreement.

#### **Section 10. SEVERABILITY**

If any provision of this Agreement is held invalid, the invalidity shall not affect other provisions of the Agreement which can be given effect without the invalid provision or application, and to this end, the provisions of this Agreement are severable.

**Section 11. AMENDMENTS TO AGREEMENT**

This Agreement may be amended, in writing, upon the express written approval of the governing bodies of all the parties.

**Section 12. FILING OF AGREEMENT**

This Agreement shall be filed with the Clerk of the Circuit court as provided in Section 163.01(11), Florida Statutes.

**Section 13. GOVERNING LAW**

The laws of the State of Florida shall govern this Agreement.

IN WITNESS WHEREOF, the parties to this Agreement have caused their names to be affixed hereto by the proper officers thereof, as of the day and year first above written.

[SIGNATURE PAGES TO FOLLOW]

Countersigned:

CITY OF CLEARWATER, FLORIDA

Frank Hibbard

Frank Hibbard  
Mayor

By: William B. Horne, II

William B. Horne, II  
City Manager

Approved as to form:

Pamela K. Akin

Pamela K. Akin  
City Attorney

Attest:

Rosemarie Call

Rosemarie Call  
City Clerk



CITY OF PINELLAS PARK, FLORIDA

By: \_\_\_\_\_  
MAYOR

ATTEST:

\_\_\_\_\_  
CITY CLERK

APPROVED AS TO FORM:

BY: \_\_\_\_\_  
City Attorney

Countersigned:

CITY OF CLEARWATER, FLORIDA

\_\_\_\_\_  
Mayor-Commissioner

By: \_\_\_\_\_  
City Manager

Approved as to form and  
legal sufficiency:

Attest:

\_\_\_\_\_  
City Clerk

CITY OF PINELLAS PARK, FLORIDA

By: *Andrew Bradbury*  
MAYOR

ATTEST:

*Shirleyanna*  
CITY CLERK

APPROVED AS TO FORM:

BY:

*James W. DeLoach*  
City Attorney

ATTEST:

Collyer E. Davis  
Clerk of City Council  
Assistant City Clerk



CITY OF ST. PETERSBURG

Kanika Tomalin  
By

Approved as to form and substance

Jane Wallace  
City Attorney

PINELLAS COUNTY, a political subdivision  
of the State of Florida

Barry A. Burton  
By: Barry A. Burton, County Administrator

Date: December 21, 2021

**APPROVED AS TO FORM**

By: Christy Donovan Pemberton  
Office of the County Attorney

Exhibit A  
**PROPOSAL**  
**MEMORANDUM OF UNDERSTANDING**

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

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

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

Whereas, it is the intent of the State of Florida and its Local Governments to use the proceeds from Settlements with Pharmaceutical Supply Chain Participants to increase the amount of funding presently spent on opioid and substance abuse education, treatment 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”;

Whereas, the State of Florida and its Local Governments, subject to the completion of formal documents that will effectuate the Parties’ agreements, enter into this Memorandum of Understanding (“MOU”) relating to the allocation and use of the proceeds of Settlements described herein; and

Whereas, this MOU is a preliminary non-binding agreement between the Parties, is not legally enforceable, and only provides a basis to draft formal documents which will effectuate the Parties’ agreements.

**A. Definitions**

As used in this MOU:

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 on 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. “Municipalities” shall mean cities, towns, or villages of a County within the State with a Population greater than 10,000 individuals and shall also include cities, towns or villages within the State with a Population equal to or less than 10,000 individuals which filed a Complaint in this litigation against Pharmaceutical Supply Chain Participants. The singular “Municipality” shall refer to a singular of the Municipalities.

6. “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.

7. “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>.

8. “Opioid Funds” shall mean monetary amounts obtained through a Settlement as defined in this MOU.

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

10. “Parties” shall mean the State and Local Governments. The singular word “Party” shall mean either the State or Local Governments.

11. “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.

12. “Pharmaceutical Supply Chain” shall mean the process and channels through which Controlled Substances are manufactured, marketed, promoted, distributed or dispensed.

13. “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.

14. “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 MOU. These estimates can currently be found at <https://www.census.gov>

15. “Qualified County” shall mean a charter or non-chartered county within the State that: has a Population of at least 300,000 individuals and (a) has an opioid taskforce of which it is a member or 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 currently either providing or is contracting with others to provide substance abuse prevention, recovery, and treatment services to its citizens; and (d) has or enters into an 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.

16. “SAMHSA” shall mean the U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration.

17. “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.

18. “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 in paragraph 6 and paragraph 9, respectively), all Opioid Funds shall be utilized for Approved Purposes. To accomplish this purpose, the State will either file a new action with Local Governments as Parties or add Local Governments to its existing action, sever settling defendants, and seek entry of a consent order or other order binding both the State, Local Governments, and Pharmaceutical Supply Chain Participant(s) (“Order”). The Order may be part of a class action settlement or similar device. The Order shall provide for continuing jurisdiction of a state court to address non-performance by any party under the Order. Any Local Government that objects to or refuses to be included under the Order or entry of documents necessary to effectuate a Settlement shall not be entitled to any Opioid Funds and its portion of Opioid Funds shall be distributed to, and for the benefit of, the other Local Governments.

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. **Distribution Scheme** - All Opioid Funds will initially go to the State, and then be distributed according to the following distribution scheme. The Opioid Funds will be divided into three funds after deducting costs of the Expense Fund detailed in paragraph 9 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. For Local Governments that are not within the definition of County or Municipality, those Local Governments may receive that government's share of the City/County Fund under the Negotiation Class Metrics, if that government executes a release as part of a Settlement. Any Local Government that is not within the definition of County or Municipality and that does not execute a release as part of a Settlement shall have its share of the City/County Fund go to the County in which it 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 section 4 of the allocation contained in the Negotiation Class Metrics or other metrics that the Parties agree upon.
  - (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 regional share for each County will be paid 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. The Managing Entities shall endeavor to the greatest extent possible to expend these monies on counties within the State that are non-Qualified Counties and to ensure that there are services in every County.
- (c) State Fund - The remainder of Opioid Funds after deducting the costs of the Expense Fund detailed in paragraph 9, the City/County Fund and the Regional Fund 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 deposit.

4. Regional Fund Sliding Scale- The Regional Fund shall be calculated by utilizing the following sliding scale of the Opioid Funds available in any year:

- 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%

5. 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, Florida's Department of Children and Families ("DCF"), and Local Governments on the priorities that should be addressed as part of the opioid epidemic 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 Governments.
- (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 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 two-year term.

- (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 for how monies should be spent the coming fiscal year to respond to the opioid epidemic.
- (i) Accountability - 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. The State and each of the Local Government 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 Approved Purposes. All programs and expenditures shall be audited annually in a similar fashion to SAMHSA programs. Local Governments shall respond and provide documents to any reasonable requests from the State for data or information about programs receiving Opioid Funds.
- (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.

6. **Administrative Costs**- The State may take no more than a 5% administrative fee from the State Fund (“Administrative Costs”) 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.

7. **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.

8. **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.

9. **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 entirety of all contingency fee contracts for Local Governments in the State of Florida 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 of Florida in connection with the Settlement because their participation increases the amount 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 MOU 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 years of the Settlement. Accordingly, to offset the amounts being paid from the City/County 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 MOU, by order of the Circuit Court of the Sixth Judicial Circuit in and for Pasco County, West Pasco Division New Port Richey, Florida, in the matter of *The State of Florida, Office of the Attorney General, Department of Legal Affairs v. Purdue Pharma L.P., et al.*, Case No. 2018-CA-001438 (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.

10. **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 3, or (c) violates the limitations set forth herein

with respect to administrative costs or the Expense Fund. There shall be no other basis for bringing an objection to the approval of an allocation or expenditure of Opioid Funds.

## 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.<sup>1</sup>

#### 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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<sup>1</sup> 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.



**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:<sup>2</sup>

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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<sup>2</sup> 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 B

### **Centralized, County-wide Competitive Grant Process (following Social Action Model)**

- **Fiscal Oversight:**
  - Regional Funding is provided to Pinellas County for direct fiscal oversight, accountability, and coordination across litigation partners (i.e.: St. Petersburg, Clearwater, and Pinellas Park)
- **Unified, Competitive Process for Fund Allocation:**
  - Pinellas County would leverage the County's infrastructure, including but not limited to Social Action Funding infrastructure, to perform competitive solicitation in single or multiple rounds
  - Leverage Online Neighborly Granting Software, or other similar software, for application submission, documentation, and review
  - Agencies/service providers can have multiple submissions under different priority areas
  - Awards can be designed as one-year or multi-year efforts depending on the structure of the opioid funding
- **Review Team Under Unified Process:**
  - Reviewers would represent County, St. Petersburg, Clearwater, Pinellas Park, and may also include local Department of Health
  - Final Review recommendations approved by the BCC for funding pursuant to the terms of the Interlocal Agreement Governing Use of Pinellas County Regional Opioid Settlement Funds
- **Oversight and Reporting:**
  - Contracts would be issued by Pinellas County
  - Quarterly Governance Meetings by the Pinellas Opioid Abatement Funding Advisory Board (OAFAB)
  - Quarterly reporting by awarded agencies/service providers
  - Annual, or as required, Reporting by County (report to BCC for approval and forwarded to State) pursuant to the agreement with the Florida Plan
- **Priority Areas for Awards:**
  - As determined by OAFAB pursuant to the Approved Uses under the Florida Plan which may include:
    - Opioid and substance misuse prevention and education
    - Opioid and substance misuse treatment and supportive services
    - Opioid and substance misuse education and caregiver support
    - Opioid and substance misuse mitigation and enforcement
    - System-Level Investments and Innovations to abate the opioid epidemic
- **Competitive Award Amounts:**
  - Award amounts may vary depending on available resource levels and priorities of OAFAB and data-reflected needs of the community.
- **Basic Eligibility Examples for Competitive Awards:**
  - The proposed programs/services must serve residents of Pinellas County.
  - The applicant organization must not discriminate against any person on the basis of age, sex, race, ethnicity, color, religion, national origin, disability, marital status or sexual orientation in admission, treatment, or participation in its programs, services, activities and/or employment.

- The mission of the applicant organization must be consistent with the goal of addressing the health, economic, and social well-being of Pinellas County residents in need of opioid and substance misuse assistance.
- The applicant organization must be incorporated in the State of Florida for at least one (1) year prior to date of application.
- The applicant organization must agree to all terms and conditions contained in the Pinellas County Funding Agreement.
- Programs proposed by faith organizations must have a secular purpose, neither advance nor inhibit religion, and must not require worship or religious instruction activities as a condition of participation per Federal guidelines. Services provided by faith organizations must be available to Pinellas County residents, not solely for congregation members.

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