

Legislative #

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**ASHLEY MOODY  
ATTORNEY GENERAL  
STATE OF FLORIDA**

ATTORNEY OFFICE OF THE ATTORNEY GENERAL

APR 15 2021

PL-01 The Capitol  
Tallahassee, FL 32399-1050  
Phone (850) 414-3300  
Fax (850) 487-0168  
<http://www.myfloridalegal.com>

April 13, 2021

Mayor Lauren Poe  
City of Gainesville  
200 East University Avenue  
Gainesville, FL 32601  
[poelb@cityofgainesville.org](mailto:poelb@cityofgainesville.org)

OFFICE OF THE CITY ATTORNEY

APR 15 2021

**RE: Opioid Litigation**

Dear Mayor Poe:

My name is John Guard and I am the Chief Deputy Attorney General for the State of Florida (the "State"). Since she took office, Attorney General Moody has been heavily involved in leading both the State's ongoing opioid litigation and several different negotiations with defendants in that litigation. Those negotiations have included litigation counsel representing cities and counties.

As part of those negotiations to enable Florida to achieve the maximum amount recoverable for both the State and its subdivisions, the State has been negotiating for a lengthy time with outside counsel for nearly all litigating political subdivisions within the State. After multiple sessions and significant compromise by both sides, the attached memorandum of understanding ("MOU") has been reached. We have offered and the lawyers for the litigating subdivisions are recommending to their clients that the attached MOU be accepted. This proposal is the result of numerous meetings and includes feedback and comments from many local subdivisions. Based on the status of this litigation, the likely structure of any resolution, the potential litigation risks in the absence of such an agreement, the State believe that this proposal reflects a reasonable compromise between the State and its political subdivisions.

The purpose of this letter is to summarize the primary terms of the MOU and attempt to anticipate questions that you, your commission, and your internal and/or other legal counsel may have regarding this litigation and allocation proposal.

### **What cases does this MOU apply?**

This allocation agreement is intended to govern the distribution of settlement proceeds obtained through the Purdue Pharma L.P. (“Purdue”) bankruptcy, the Mallinckrodt PLC (“Mallinckrodt”) bankruptcy, the distributor (Cardinal Health, Inc., McKesson Corp., and AmerisourceBergen Corp. (collectively referred to as the “Distributors”)) and Johnson & Johnson (“J&J”) potential deal, as well as any additional settlements obtained related to the opioid litigation.

### **Why is an allocation agreement necessary and why now?**

Almost 100 political subdivisions within the State of Florida, as well as the State of Florida itself, have filed suit against numerous entities engaged in the manufacture, marketing, promotion, distribution or dispensing of opioids. Another 30 political subdivisions within the State of Florida have filed claims in the Purdue bankruptcy.

The State and the Plaintiffs’ Executive Committee for the Opioid Litigation Multi-District Litigation panel (the “PEC”) are in ongoing negotiations with Purdue, Mallinckrodt, the Distributors, and J&J with potential resolutions anticipated in the coming weeks. Under the likely settlement structure for these cases, states and their political subdivisions are strongly incentivized to reach a joint resolution of all State and political subdivision claims. Under the Distributor and J&J deal, the State and its subdivisions receive a substantially larger settlement amount the higher the number of subdivisions sign on to the deal. Therefore, it is in the best interest of all political subdivisions and the State of Florida to reach an allocation agreement which will permit the joint resolution of all claims within the state.

The deals contemplate the need for relatively quick buy in by subdivisions in order to maximize recovery. The pace of negotiations is accelerating, and Purdue has filed its plan of reorganization. Given this accelerating pace, there is a greater sense of urgency among all counsel to come to agreement and resolve how monies are going to be allocated, so that we can move Purdue, Mallinckrodt, and other potential settlements toward finality. Given the Sunshine law, the likely need for public notice and comment, and the complexity of the deals, we need to agree to an allocation plan now to ensure that Florida maximizes recovery.

### **How can funds be utilized?**

You will see as you review the MOU that the State and its subdivisions, who execute this MOU, are agreeing that almost all the funds from any settlement will go to abatement activities. In other words, funds must be utilized for strategies, programming and services used to expand the availability of treatment for individuals impacted by Opioid Use Disorder or co-occurring Substance Use Disorder and Mental Health disorders (“Approved Purposes”). A non-exclusive list of potential abatement programs and uses are included in Exhibits A and B to the agreement. The list was developed nationally consulting with public health officials in multiple states, experts for the states and subdivisions, and officials within the United States Department of Health and Human Services. These uses are intended to best serve the overall purpose and

intention of this litigation, which is to abate the continuing public health crisis of opioid addiction within our communities.

While supported by the State, this requirement was imposed the defendants for tax and other reasons. It is also necessary to militate against the United States seeking substantial amounts of settlement funds from both the State and subdivisions as recoupment.

### **How are the funds allocated amongst the States?**

While not part of the MOU, the States have been negotiating the national allocation for almost two years with an agreement reached in late 2019. Florida's interstate allocation is 7.03%. That allocation is the second largest allocation in the nation ahead of Texas, which is the second largest state. Florida is one of a handful of states whose allocation is greater and greater by a significant percentage above its population (Florida has 6.54% of the United States' population). The only states that have larger gains over their population are the opioid belt states: West Virginia, Kentucky, etc. The interstate allocation is the product of two measures. One calculated by the PEC and the other calculated by the States. The data sets chosen are slightly different (including different years and what measures were selected), but the main difference is that some states demanded that population play a more significant factor in the state allocation and it is not a factor in the PEC calculation. Given how much Florida's allocation percentage is above its population, the need in these settlements to maximize the number of states settling, and the potential litigation risks in the absence of such an agreement, it would be our recommendation that cities and counties accept the interstate allocation.

### **How much money does the State expect for it and its subdivisions?**

It depends. Each of the current or proposed settlements are for different lengths of time and each contain different variability. In Purdue, payments are paid over a ten-year period and vary with the performance of the ongoing business of the new company and payments from third parties. In Mallinckrodt, payment amounts are still being negotiated, but will be paid over seven years and will vary depending on the value of the emerging company seven years later as part of the recovery is warrants in the re-emerged company. In the Distributor and J&J proposed deal, the proposed deal is over eighteen years and the amount paid varies depending on subdivision participation and whether other subdivisions file opioid related litigation in the future. As part of the MOU, the State is willing to seek judicial or legislative action to reduce the variability of the monies, especially in connection with the Distributor and J&J deal. Our current best guess based on projections and assuming total participation is \$120-140M a year for the first few years, \$90-110M a year for the middle years, and then \$60-70M a year for the later years of the deal for the State and its subdivisions. Again, these numbers can and will vary and hopefully will increase if additional settlements are reached.

### **How are the funds allocated amongst the State and its subdivisions?**

This Proposal divides all settlement funds between three funds: (1) the City/County Fund; (2) the Regional Fund; and (3) the State Fund.

The **City/County Fund** consists of 15% of the total settlement amounts allocable to the State of Florida. These funds are distributed to all counties and qualifying municipalities in the State of Florida.

The allocation of the City/County Fund between counties and municipalities is based on a model referred to as the “Negotiation Class Metrics.” This model was developed in the National Prescription Opiate MDL by the PEC, and considers: (1) the amount of opioids shipped to the county; (2) the number of opioid deaths that occurred in that county; and (3) the number of people who suffer opioid use disorder in that county. Allocations between counties and municipalities within each county use historical federal data showing how the specific county and the cities within it have made opioids-related expenditures in the past.

We have attached a spreadsheet to this letter that provides you an estimated amount per year for an amount within each range in the previous question.

The **Regional Fund** consists of a sliding scale between 30% and 40% of the total settlement amounts allocable to the State of Florida, with the largest percentages occurring in the immediate years after settlement and decreasing over time.

These funds are allocated to counties in accordance with the “Negotiating Class Metrics” described above. In the case of counties with a population of over 300,000, and which satisfy other criteria regarding abatement infrastructure, (termed “Qualified Counties”) these funds are provided directly to the county. For the remainder of counties within the State, these funds are provided to the Managing Entity (the entity that the State has contracted with to provide substance abuse treatment) for that county, to be spent on approved purposes within the region that the county is a part.

*For Counties with populations greater than 300,000:* We encourage you to review the definition of Qualified County in the MOU, so that you can understand the other requirements that you will have to meet. Importantly, the definition of Qualified County requires that you reach an agreement with at least some municipalities (at least 50% of the population) within your county as to how these funds are spent. The requirements of such agreements are subject to further discussion and negotiation.

We have attached a spreadsheet to this letter that provides you an estimated amount per year for an amount within each range in the previous question. The amount will vary for qualified counties depending on how many municipalities in that County: (1) join a settlement; and (2) enter an agreement with a County.

*For Counties with populations less than 300,000 or that do not qualify as a Qualified County:* Currently, a majority of the monies being utilized to respond to the opioid epidemic in the State flow through Managing Entities located regionally who provide service in each community. When we traveled the state before COVID and had discussions with many of you, most (outside a couple large counties) indicated that they

had a good working relationship with their Managing Entity. Indeed, several indicated that they were already involved with their Managing Entity. The actual dollar amounts annually paid to smaller counties under the contemplated settlement agreements are not substantial enough to support standalone programs. Given that reality, but wanting to maximize services locally, it made sense to have the monies flow through the existing structure to expand services in each county. If there are issues or problems with Managing Entities, we are happy to engage. We are also happy to try and help communities get involved in or engage with their Managing Entity.

We have attached a spreadsheet to this letter that demonstrates the amounts attributable to each county per year for an amount within each range in the previous question.

The **State Fund** consists of the remaining 45% to 55% of the total settlement amounts allocable to the State of Florida, depending on the amount of the Regional Fund above. As with the City/County Fund and Regional Fund, these funds must be spent on Approved Purposes

### **Why should we agree to this allocation?**

The proposed allocation in the MOU is better than the alternative that subdivisions will receive if they do not enter an agreement with the State. Two of the defendants who we have negotiated with, Purdue and Mallinckrodt are now in bankruptcy. In advance of and in connection with those bankruptcies, the states, the PEC, and city and county representatives negotiated a default intrastate allocation and agreed that it will apply unless a state and its cities and counties agree to something else. A Deputy County Attorney for Broward County, Florida, was involved in the negotiations related to Purdue. Something like the Purdue default allocation is currently in the draft connected to the Distributor and J&J deal.

The allocation above is superior for Florida's subdivisions than that default allocation. Indeed, the State offered substantial improvements over those terms from the beginning of the negotiations that led to this MOU. We have attached a copy of the Purdue abatement term sheet for your review. Under that default allocation, there is no city/county fund. Only subdivisions with populations greater than 400,000 people are eligible to receive any monies directly. Almost all the monies will flow through the Managing Entities who are regionally supplying services. The allocation percentages for the regional bucket are dollar based and decrease to half, far more quickly than in the MOU. In other words, the allocation in this MOU allows a far greater recovery directly to each Florida city and county than the alternative and greater recoveries regionally for all subdivisions.

The allocation is also better than the cities and counties would achieve if damages were proportionally allocated. In the Purdue bankruptcy, over one hundred twenty-five Florida subdivisions filed proofs of claims. When the size of those claims is compared to that of the State's claim, the State's claim was more than four, almost five times larger than all the subdivisions' claims combined. Subdivisions are getting substantially more than what their proportional share would be. The State is willing to agree to the larger because it frankly reflects the reality of how monies are currently being spent and is consistent with how the legislature has been appropriating monies to combat this crisis.

### **If individual subdivisions do not agree to a settlement, what will happen?**

If there are hold outs or subdivisions that do not respond, the MOU contemplates that the State will either file a new suit or sever its claims against settling defendants from its existing opioid lawsuit and add political subdivisions and through either a class action mechanism or declaratory relief seek to bar future subdivision claims. Such action is necessary to ensure that the State and any subdivisions that agree to a settlement maximize their recoveries. This not a novel position and there is a substantial body of Florida law that exists that the State may resolve and release public claims including subdivision claims.<sup>1</sup> That being said, the State would prefer that we reach agreement on the allocation under the proposed MOU and handle things consensually. But, if there are holdouts, the State is prepared to litigate or seek legislation from the legislature to ensure that cities and counties that agree to this MOU are protected and will receive the recovery contemplated under the allocation.

### **What are the next steps and the timeline?**

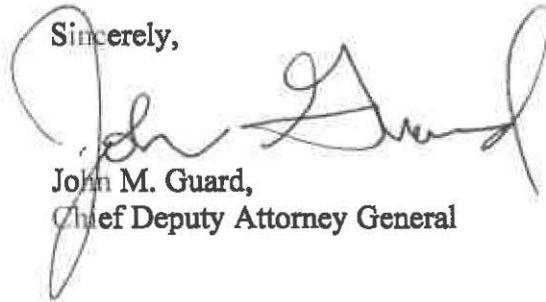
We would ask that you review the attached MOU and proposed model resolution supporting an agreement on the MOU terms. We will be scheduling calls to answer questions about the MOU. We would ask each subdivision to think about who is attending each session and ensure that any of those discussions will not violate Florida's government-in-the-sunshine law. If you will contact my administrator, Janna Barineau, by e-mail ([Janna.Barineau@myfloridalegal.com](mailto:Janna.Barineau@myfloridalegal.com)), we will include you in those discussions. After those discussions, we would then ask that you follow Florida law for approving such a resolution by your commission and in due course, pass it, and return a copy to me at the address on the first page of the letter. Potential settlements are anticipated in the coming weeks or months, but I cannot tell you exactly when a settlement will be finalized. These proposed settlements are

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<sup>1</sup> See Fla. Stat. §501.207(1)(c)(authorizing the Attorney General to bring “[a]n action on behalf of one or more consumers or government entities for actual damages...” under Florida’s Deceptive and Unfair Trade Practices Act); e.g., *Engle v. Liggett Group, Inc.*, 945 So. 2d 1246, 1258-62 (Fla. 2006); *Young v. Miami Beach Improvement Co.*, 46 So. 2d 26, 30 (Fla. 1950); *Castro v. Sun Bank of Bal Harbour*, 370 So. 2d 392, 393 (Fla. 3d DCA1979); *City of New Port Richey v. State ex rel. O’Malley*, 145 So. 903, 905 (Fla. 2d DCA 1962); also *State of Florida ex rel. Shevin v. Exxon Corp.*, 526 F.2d 266, 275 (5<sup>th</sup> Cir. 1976) (holding that the Attorney General could file suit seeking damages for injuries sustained by government entities who had not specifically authorized the Attorney General to do so); *Eggers v. City of Key West*, 2007 WL 9702450, at \*3 (S.D. Fla. Feb. 26, 2007) (concluding “[a]pplicable Florida law states that a judgment in an action brought against a public entity that adjudicates matters of general interest to the citizens of the jurisdiction is binding on all citizens of that jurisdiction.”); *Aerojet-General Corp. v. Askew*, 366 F. Supp. 901, 908-11 (N.D. Fla. 1973).

anticipated to include provisions which establish time limits on agreements between states and political subdivisions. As a result, we would request that you pass a resolution in the next 60-90 days, if possible.

Sincerely,

A handwritten signature in black ink, appearing to read "John M. Guard". The signature is fluid and cursive, with a large initial "J" and "G".

John M. Guard,  
Chief Deputy Attorney General

cc: Nicolle Shalley  
Office of the City Attorney  
Post Office Box 490 Station 46  
Gainesville, FL 32627-0490  
shalleynm@cityofgainesville.org

Enc. Proposal with Ex. A and B  
Recovery Spreadsheet  
Purdue Abatement Term Sheet



**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 (PAARD);
  - 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.

RESOLUTION NO. [INSERT]

A Resolution authorizing [City/County] (herein referred to as this "Governmental Unit") to join with the State of Florida and other local governmental units as a participant in the Florida Memorandum of Understanding and Formal Agreements implementing a Unified Plan.

WHEREAS, the [City/County] has suffered harm from the opioid epidemic;

WHEREAS, the [City/County] recognizes that the entire State of Florida has suffered harm as a result from the opioid epidemic;

WHEREAS, the State of Florida has filed an action pending in Pasco County, Florida, and a number of Florida Cities and Counties have also filed an action *In re: National Prescription Opiate Litigation*, MDL No. 2804 (N.D. Ohio) (the "Opioid Litigation") and [City/County] [is/is not] a litigating participant in that action;

WHEREAS, the State of Florida and lawyers representing certain various local governments involved in the Opioid Litigation have proposed a unified plan for the allocation and use of prospective settlement dollars from opioid related litigation;

WHEREAS, the Florida Memorandum of Understanding (the "Florida Plan") sets forth sets forth a framework of a unified plan for the proposed allocation and use of opioid settlement proceeds and it is anticipated that formal agreements implementing the Florida Plan will be entered into at a future date; and,

WHEREAS, participation in the Florida Plan by a large majority of Florida cities and counties will materially increase the amount of funds to Florida and should improve Florida's relative bargaining position during additional settlement negotiations;

WHEREAS, failure to participate in the Florida Plan will reduce funds available to the State, [City/County], and every other Florida city and county;

NOW, THEREFORE, BE IT RESOLVED BY THIS GOVERNMENTAL UNIT:

SECTION 1. That this Governmental Unit finds that participation in the Florida Plan would be in the best interest of the Governmental Unit and its citizens in that such a plan ensures that almost all of the settlement funds go to abate and resolve the opioid epidemic and each and every city and county receives funds for the harm that it has suffered.

SECTION 2. That this Governmental Unit hereby expresses its support of a unified plan for the allocation and use of opioid settlement proceeds as generally described in the Florida Plan, attached hereto as Exhibit "A."

SECTION 3. That [official name] is hereby expressly authorized to execute the Florida Plan in substantially the form contained in Exhibit "A."

SECTION 4. That [official name] is hereby authorized to execute the any formal agreements implementing a unified plan for the allocation and use of opioid settlement proceeds that is not substantially inconsistent with the Florida Plan and this Resolution.

**SECTION 5.** That the Clerk be and hereby is instructed to record this Resolution in the appropriate record book upon its adoption.

**SECTION 6.** The clerk of this Governmental Unit is hereby directed to furnish a certified copy of this Ordinance/Resolution to the Florida

[Florida League of Cities/Florida Association of Counties]

Attorney General Ashley Moody  
c/o John M. Guard  
The Capitol,  
PL-01  
Tallahassee, FL 32399-1050

**SECTION 7.** This Resolution shall take effect immediately upon its adoption.

Adopted this day of \_\_\_\_\_, 2021.

(Mayor/Commissioner/etc.)

ATTEST: \_\_\_\_\_











County	City/Town	Rate	Value	Amount	Rate	Value	Amount	Rate	Value	Amount	Rate	Value	Amount
Brevard	Brevard County	2.80000000000000	0.0466320415	9,093.25	0.270	294.96	6,204.61	4,296.26					
	Brevard County	1.8243153639	1.8243153639	371,241.48									
	North Port	0.2096117712	0.2096117712	41,874.30									
	Brevard	0.456470719224	0.4564707192	90,414.80									
Seminole	Seminole County	1.241491044444	1.2414910444	248,195.85	0.075	152.40	32,814.11	22,814.11					
	Winter Springs	0.00000000000000	0.0000000000	0.00									
	Winter Springs	0.00000000000000	0.0000000000	0.00									
	Winter Springs	0.00000000000000	0.0000000000	0.00									
	Winter Springs	0.00000000000000	0.0000000000	0.00									
	Winter Springs	0.00000000000000	0.0000000000	0.00									
	Winter Springs	0.00000000000000	0.0000000000	0.00									
St. Johns	St. Johns County	0.7100000000	0.7100000000	142,000.00	0.000	0.00	0.00	0.00					
	St. Johns County	0.0000000000	0.0000000000	0.00									
	St. Johns County	0.0000000000	0.0000000000	0.00									
	St. Johns County	0.0000000000	0.0000000000	0.00									
St. Lucie	St. Lucie County	0.95619858302	0.9561985830	191,237.60	0.000	0.00	0.00	0.00					
	Port St. Lucie	0.1585	0.1585	31,700.00	0.000	0.00	0.00	0.00					
	Port St. Lucie	0.0000000000	0.0000000000	0.00									
	Port St. Lucie	0.000132	0.000132	26.40	0.000	0.00	0.00	0.00					
Suwannee	Suwannee County	0.3263866	0.3263866	65,277.32	0.000	0.00	0.00	0.00					
	Bushnell	0.0055075071	0.0055075071	1,101.50	0.000	0.00	0.00	0.00					
	Leesville	0.001312	0.001312	26.24	0.000	0.00	0.00	0.00					
	Leesville	0.000748088	0.000748088	14.96	0.000	0.00	0.00	0.00					
	Leesville	0.0004335464	0.0004335464	8.67	0.000	0.00	0.00	0.00					
	Leesville	0.014039516721	0.0140395167	2,807.90	0.000	0.00	0.00	0.00					
	Leesville	0.0000000000	0.0000000000	0.00									
Taylor	Taylor County	0.090296513	0.090296513	18,059.30	0.000	0.00	0.00	0.00					
	Taylor County	0.0222120458	0.0222120458	4,442.40	0.000	0.00	0.00	0.00					
	Taylor County	0.0081989032	0.0081989032	1,639.78	0.000	0.00	0.00	0.00					
Union	Union County	0.0000000000	0.0000000000	0.00	0.000	0.00	0.00	0.00					
	Lake Butler	0.0013981	0.0013981	279.62	0.000	0.00	0.00	0.00					
	Butler	0.0000127102	0.0000127102	2.54	0.000	0.00	0.00	0.00					
	Worthington Springs	0.0001162078	0.0001162078	23.24	0.000	0.00	0.00	0.00					
	Worthington Springs	0.0000000000	0.0000000000	0.00									
Volusia	Volusia County	1.708575	1.708575	341,715.00	0.000	0.00	0.00	0.00					
	DeLand	0.4475	0.4475	89,500.00	0.000	0.00	0.00	0.00					
	DeLand	0.083388	0.083388	16,677.60	0.000	0.00	0.00	0.00					
	DeLand	0.0000000000	0.0000000000	0.00									
	DeLand	0.0000000000	0.0000000000	0.00									
	DeLand	0.058042	0.058042	11,608.40	0.000	0.00	0.00	0.00					
	DeLand	0.00022887011	0.0002288701	45.72	0.000	0.00	0.00	0.00					
	DeLand	0.09	0.09	18,168.00	0.000	0.00	0.00	0.00					
	DeLand	0.0000000000	0.0000000000	0.00									
	DeLand	0.0000000000	0.0000000000	0.00									
	DeLand	0.0000000000	0.0000000000	0.00									
	DeLand	0.0000000000	0.0000000000	0.00									
	DeLand	0.0000000000	0.0000000000	0.00									
	DeLand	0.0000000000	0.0000000000	0.00									
	DeLand	0.0000000000	0.0000000000	0.00									
	Wakulla	Wakulla County	0.115126321	0.115126321	23,025.26	0.000	0.00	0.00	0.00				
Wakulla County		0.114859	0.114859	22,971.80	0.000	0.00	0.00	0.00					
Wakulla County		0.0001071129	0.0001071129	21.42	0.000	0.00	0.00	0.00					
Wakulla County		0.0000000000	0.0000000000	0.00									
Walton	Walton County	0.26855216151	0.2685521615	53,710.30	0.000	0.00	0.00	0.00					
	Walton County	0.01705713	0.01705713	3,411.42	0.000	0.00	0.00	0.00					
	Walton County	0.0032901384	0.0032901384	658.07	0.000	0.00	0.00	0.00					
	Walton County	0.0000000000	0.0000000000	0.00									
Washington	Washington County	0.1049084	0.1049084	20,981.68	0.000	0.00	0.00	0.00					
	Washington County	0.00540175	0.00540175	1,080.35	0.000	0.00	0.00	0.00					
	Washington County	0.01	0.01	2,098.16	0.000	0.00	0.00	0.00					
	Washington County	0.0000000000	0.0000000000	0.00									
	Washington County	0.0000000000	0.0000000000	0.00									
	Washington County	0.0000000000	0.0000000000	0.00									
Total		100.00%	100.00%	19,501,000.00		45,500,000.00	15,000,000.00	35,000,000.00	10,500,000.00			24,500,000.00	