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April 13, 2021

Chairman Jeff Gold
Marion County
601 SE 25th Ave
Ocala, FL 34471
Jeff.Gold@marioncountyfl.org

RE: Opioid Litigation

Dear Chairman Jeff Gold :

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.[1] 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), 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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[1] *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 (5th 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,

John M. Guard,
Chief Deputy Attorney General

cc: Matthew Minter
601 S.E. 25TH AVE.
Ocala, FL 34471
matthew.minter@marioncountyfl.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.

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: _____

Schedule A

Core Strategies

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

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

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

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

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

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

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

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

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

C. Pregnant & Postpartum Women

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

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

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

D. Expanding Treatment for Neonatal Abstinence Syndrome

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

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

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

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

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

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

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

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

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

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

F. Treatment for Incarcerated Population

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

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

G. Prevention Programs

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

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

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

4. Funding for community drug disposal programs; and

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

H. Expanding Syringe Service Programs

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

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

Schedule B

Approved Uses

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Create and/or support recovery high schools.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART TWO: PREVENTION

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

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

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

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

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

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

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

a. Increase the number of prescribers using PDMPs;

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

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

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

7. Increase electronic prescribing to prevent diversion or forgery.

8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Fund media campaigns to prevent opioid misuse.

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

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Public education relating to emergency responses to overdoses.

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

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

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

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

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

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

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

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

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

J. LEADERSHIP, PLANNING AND COORDINATION

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

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

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

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

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

K. TRAINING

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

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

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

L. RESEARCH

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

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

2. Research non-opioid treatment of chronic pain.

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

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

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

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

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

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

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

City/County Fund		15%
Regional Fund		35%
Scenario 1	$	130,000,000.00
City/County Fund Scenario 1	$	19,500,000.00
Regional Fund Scenario 1	$	45,500,000.00
Scenario 2	$	100,000,000.00
City/County Fund Scenario 2	$	15,000,000.00
Regional Fund Scenario 2	$	35,000,000.00
Scenario 3	$	70,000,000.00
City/County Fund Scenario 3	$	10,500,000.00
Regional Fund Scenario 3	$	24,500,000.00

County	Allocated Subdivisions	Overall Total %	Allocated % by entity	Scenario 1 City/County Fund	Scenario 1 Regional Fund	Scenario 2 City/County Fund	Scenario 2 Regional Fund	Scenario 3 City/County Fund	Scenario 3 Regional Fund
Alachua		1.241060164449%			$ 564,682.37		$ 434,371.06		$ 304,059.74
	Alachua County		0.821689546303%	$ 160,229.46		$ 123,253.43		$ 86,277.40	
	Alachua		0.013113332457%	$ 2,557.10		$ 1,967.00		$ 1,376.90	
	Archer		0.000219705515%	$ 42.84		$ 32.96		$ 23.07	
	Gainesville		0.381597611347%	$ 74,411.53		$ 57,239.64		$ 40,067.75	
	Hawthorne		0.000270546460%	$ 52.76		$ 40.58		$ 28.41	
	High Springs		0.011987568663%	$ 2,337.58		$ 1,798.14		$ 1,258.69	
	La Crosse		0.000975056706%	$ 190.14		$ 146.26		$ 102.38	
	Micanopy		0.002113530737%	$ 412.14		$ 317.03		$ 221.92	
	Newberry		0.006102729215%	$ 1,190.03		$ 915.41		$ 640.79	
	Waldo		0.002988721299%	$ 582.80		$ 448.31		$ 313.82	
Baker		0.193173804130%			$ 87,894.08		$ 67,610.83		$ 47,327.58
	Baker County		0.169449240037%	$ 33,042.60		$ 25,417.39		$ 17,792.17	
	Glen St. Mary		0.000096234647%	$ 18.77		$ 14.44		$ 10.10	
	Macclenny		0.023628329446%	$ 4,607.52		$ 3,544.25		$ 2,480.97	
Bay		0.839656373312%			$ 382,043.65		$ 293,879.73		$ 205,715.81
	Bay County		0.508772605155%	$ 99,210.66		$ 76,315.89		$ 53,421.12	
	Callaway		0.024953825527%	$ 4,866.00		$ 3,743.07		$ 2,620.15	
	Lynn Haven		0.039205632015%	$ 7,645.10		$ 5,880.84		$ 4,116.59	
	Mexico Beach		0.005614292988%	$ 1,094.79		$ 842.14		$ 589.50	
	Panama City		0.155153855596%	$ 30,255.00		$ 23,273.08		$ 16,291.15	
	Panama City Beach		0.080897023117%	$ 15,774.92		$ 12,134.55		$ 8,494.19	
	Parker		0.008704696178%	$ 1,697.42		$ 1,305.70		$ 913.99	
	Springfield		0.016354442736%	$ 3,189.12		$ 2,453.17		$ 1,717.22	
Bradford		0.189484204081%			$ 86,215.31		$ 66,319.47		$ 46,423.63
	Bradford County		0.151424309090%	$ 29,527.74		$ 22,713.65		$ 15,899.55	
	Brooker		0.000424885045%	$ 82.85		$ 63.73		$ 44.61	
	Hampton		0.002839829559%	$ 553.77		$ 425.97		$ 298.18	
	Lawtey		0.003400896108%	$ 663.17		$ 510.13		$ 357.09	
	Starke		0.031392468132%	$ 6,121.53		$ 4,708.87		$ 3,296.21	
Brevard		3.878799180444%			$ 1,764,853.63		$ 1,357,579.71		$ 950,305.80
	Brevard County		2.323022668525%	$ 452,989.42		$ 348,453.40		$ 243,917.38	
	Cape Canaveral		0.045560750209%	$ 8,884.35		$ 6,834.11		$ 4,783.88	
	Cocoa		0.149245411423%	$ 29,102.86		$ 22,386.81		$ 15,670.77	
	Cocoa Beach		0.084363286155%	$ 16,450.84		$ 12,654.49		$ 8,858.15	
	Grant-Valkaria		0.000321387406%	$ 62.67		$ 48.21		$ 33.75	
	Indialantic		0.024136738902%	$ 4,706.66		$ 3,620.51		$ 2,534.36	
	Indian Harbour Beach		0.021089913665%	$ 4,112.53		$ 3,163.49		$ 2,214.44	
	Malabar		0.002505732317%	$ 488.62		$ 375.86		$ 263.10	
	Melbourne		0.383104682233%	$ 74,705.41		$ 57,465.70		$ 40,225.99	
	Melbourne Beach		0.012091066302%	$ 2,357.76		$ 1,813.66		$ 1,269.56	
	Melbourne Village		0.003782203200%	$ 737.53		$ 567.33		$ 397.13	
	Palm Bay		0.404817397481%	$ 78,939.39		$ 60,722.61		$ 42,505.83	
	Palm Shores		0.000127102364%	$ 24.78		$ 19.07		$ 13.35	
	Rockledge		0.096603243798%	$ 18,837.63		$ 14,490.49		$ 10,143.34	
	Satellite Beach		0.035975416224%	$ 7,015.21		$ 5,396.31		$ 3,777.42	
	Titusville		0.240056418924%	$ 46,811.00		$ 36,008.46		$ 25,205.92	
	West Melbourne		0.051997577066%	$ 10,139.53		$ 7,799.64		$ 5,459.75	
Broward		9.057962672578%			$ 4,121,373.02		$ 3,170,286.94		$ 2,219,200.85
	Broward County		3.966403576878%	$ 773,448.70		$ 594,960.54		$ 416,472.38	
	Coconut Creek		0.101131719448%	$ 19,720.69		$ 15,169.76		$ 10,618.83	
	Cooper City		0.073935445073%	$ 14,417.41		$ 11,090.32		$ 7,763.22	
	Coral Springs		0.323406517664%	$ 63,064.27		$ 48,510.98		$ 33,957.68	
	Dania Beach		0.017807041180%	$ 3,472.37		$ 2,671.06		$ 1,869.74	
	Davie		0.266922227153%	$ 52,049.83		$ 40,038.33		$ 28,026.83	
	Deerfield Beach		0.202423224725%	$ 39,472.53		$ 30,363.48		$ 21,254.44	
	Fort Lauderdale		0.830581264531%	$ 161,963.35		$ 124,587.19		$ 87,211.03	
	Hallandale Beach		0.154950491614%	$ 30,215.35		$ 23,242.57		$ 16,269.80	
	Hillsboro Beach		0.012407006463%	$ 2,419.37		$ 1,861.05		$ 1,302.74	
	Hollywood		0.520164608456%	$ 101,432.10		$ 78,024.69		$ 54,617.28	
	Lauderdale-By-The-Sea		0.022807611325%	$ 4,447.48		$ 3,421.14		$ 2,394.80	
	Lauderdale Lakes		0.062625150435%	$ 12,211.90		$ 9,393.77		$ 6,575.64	
	Lauderhill		0.144382838130%	$ 28,154.65		$ 21,657.43		$ 15,160.20	
	Lazy Lake		0.000021788977%	$ 4.25		$ 3.27		$ 2.29	
	Lighthouse Point		0.029131861803%	$ 5,680.71		$ 4,369.78		$ 3,058.85	
	Margate		0.143683775129%	$ 28,018.34		$ 21,552.57		$ 15,086.80	
	Miramar		0.279280208419%	$ 54,459.64		$ 41,892.03		$ 29,324.42	
	North Lauderdale		0.066069624496%	$ 12,883.58		$ 9,910.44		$ 6,937.31	
	Oakland Park		0.100430840699%	$ 19,584.01		$ 15,064.63		$ 10,545.24	
	Ocean Breeze		0.005381877237%	$ 1,049.47		$ 807.28		$ 565.10	
	Parkland		0.045804060448%	$ 8,931.79		$ 6,870.61		$ 4,809.43	
	Pembroke Park		0.024597938908%	$ 4,796.60		$ 3,689.69		$ 2,582.78	
	Pembroke Pines		0.462832363603%	$ 90,252.31		$ 69,424.85		$ 48,597.40	
	Plantation		0.213918725664%	$ 41,714.15		$ 32,087.81		$ 22,461.47	
	Pompano Beach		0.335472163493%	$ 65,417.07		$ 50,320.82		$ 35,224.58	
	Sea Ranch Lakes		0.005024174870%	$ 979.71		$ 753.63		$ 527.54	
	Southwest Ranches		0.025979723178%	$ 5,066.05		$ 3,896.96		$ 2,727.87	
	Sunrise		0.286071106146%	$ 55,783.87		$ 42,910.67		$ 30,037.47	
	Tamarac		0.134492458472%	$ 26,226.03		$ 20,173.87		$ 14,121.71	
	Weston		0.138637811283%	$ 27,034.37		$ 20,795.67		$ 14,556.97	
	West Park		0.029553115352%	$ 5,762.86		$ 4,432.97		$ 3,103.08	
	Wilton Manors		0.031630331127%	$ 6,167.91		$ 4,744.55		$ 3,321.18	
Calhoun		0.047127740781%			$ 21,443.12		$ 16,494.71		$ 11,546.30
	Calhoun County		0.038866087128%	$ 7,578.89		$ 5,829.91		$ 4,080.94	
	Altha		0.000366781107%	$ 71.52		$ 55.02		$ 38.51	
	Blountstown		0.007896688293%	$ 1,539.85		$ 1,184.50		$ 829.15	
Charlotte		0.737346233376%			$ 335,492.54		$ 258,071.18		$ 180,649.83
	Charlotte County		0.690225755587%	$ 134,594.02		$ 103,533.86		$ 72,473.70	
	Punta Gorda		0.047120477789%	$ 9,188.49		$ 7,068.07		$ 4,947.65	
Citrus		0.969645776606%			$ 441,188.83		$ 339,376.02		$ 237,563.22
	Citrus County		0.929715661117%	$ 181,294.55		$ 139,457.35		$ 97,620.14	
	Crystal River		0.021928789266%	$ 4,276.11		$ 3,289.32		$ 2,302.52	
	Inverness		0.018001326222%	$ 3,510.26		$ 2,700.20		$ 1,890.14	
Clay		1.193429461456%			$ 543,010.40		$ 417,700.31		$ 292,390.22
	Clay County		1.055764891131%	$ 205,874.15		$ 158,364.73		$ 110,855.31	
	Green Cove Springs		0.057762577142%	$ 11,263.70		$ 8,664.39		$ 6,065.07	
	Keystone Heights		0.000753535443%	$ 146.94		$ 113.03		$ 79.12	
	Orange Park		0.078589207339%	$ 15,324.90		$ 11,788.38		$ 8,251.87	
	Penney Farms		0.000561066149%	$ 109.41		$ 84.16		$ 58.91	
Collier		1.551333376427%			$ 705,856.69		$ 542,966.68		$ 380,076.68
	Collier County		1.354673336030%	$ 264,161.30		$ 203,201.00		$ 142,240.70	
	Everglades		0.000148891341%	$ 29.03		$ 22.33		$ 15.63	
	Marco Island		0.062094952003%	$ 12,108.52		$ 9,314.24		$ 6,519.97	
	Naples		0.134416197054%	$ 26,211.16		$ 20,162.43		$ 14,113.70	
Columbia		0.446781150792%			$ 203,285.42		$ 156,373.40		$ 109,461.38

	Columbia County		0.341887201373%	$ 66,668.00		$ 51,283.08		$ 35,898.16			
	Fort White		0.000236047247%	$ 46.03		$ 35.41		$ 24.78			
	Lake City		0.104659717920%	$ 20,408.64		$ 15,698.96		$ 10,989.27			
DeSoto		0.113640407802%			$ 51,706.39		$ 39,774.14			$	27,841.90
	DeSoto County		0.096884684746%	$ 18,892.51		$ 14,532.70		$ 10,172.89			
	Arcadia		0.016755723056%	$ 3,267.37		$ 2,513.36		$ 1,759.35			
Dixie		0.103744580900%			$ 47,203.78		$ 36,310.60			$	25,417.42
	Dixie County		0.098822087921%	$ 19,270.31		$ 14,823.31		$ 10,376.32			
	Cross City		0.004639236282%	$ 904.65		$ 695.89		$ 487.12			
	Horseshoe Beach		0.000281440949%	$ 54.88		$ 42.22		$ 29.55			
Duval		5.434975156935%			$ 2,472,913.70		$ 1,902,241.30			$	1,331,568.91
	Jacksonville		5.270570064997%	$ 1,027,761.16		$ 790,585.51		$ 553,409.86			
	Atlantic Beach		0.038891507601%	$ 7,583.84		$ 5,833.73		$ 4,083.61			
	Baldwin		0.002251527589%	$ 439.05		$ 337.73		$ 236.41			
	Jacksonville Beach		0.100447182431%	$ 19,587.20		$ 15,067.08		$ 10,546.95			
	Neptune Beach		0.022814874318%	$ 4,448.90		$ 3,422.23		$ 2,395.56			
Escambia		1.341634449244%			$ 610,443.67		$ 469,572.06			$	328,700.44
	Escambia County		1.005860871574%	$ 196,142.87		$ 150,879.13		$ 105,615.39			
	Century		0.005136751249%	$ 1,001.67		$ 770.51		$ 539.36			
	Pensacola		0.330636826421%	$ 64,474.18		$ 49,595.52		$ 34,716.87			
Flagler		0.389864712244%			$ 177,388.44		$ 136,452.65			$	95,516.85
	Flagler Counry		0.279755934409%	$ 54,552.41		$ 41,963.39		$ 29,374.37			
	Beverly Beach		0.000154338585%	$ 30.10		$ 23.15		$ 16.21			
	Bunnell		0.009501809575%	$ 1,852.85		$ 1,425.27		$ 997.69			
	Flagler Beach		0.015482883669%	$ 3,019.16		$ 2,322.43		$ 1,625.70			
	Marineland		0.000114392127%	$ 22.31		$ 17.16		$ 12.01			
	Palm Coast		0.084857169626%	$ 16,547.15		$ 12,728.58		$ 8,910.00			
Franklin		0.049911282550%			$ 22,709.63		$ 17,468.95			$	12,228.26
	Franklin County		0.046254365966%	$ 9,019.60		$ 6,938.15		$ 4,856.71			
	Apalachicola		0.001768538606%	$ 344.87		$ 265.28		$ 185.70			
	Carabelle		0.001888377978%	$ 368.23		$ 283.26		$ 198.28			
Gadsden		0.123656074077%			$ 56,263.51		$ 43,279.63			$	30,295.74
	Gadsden County		0.090211810642%	$ 17,591.30		$ 13,531.77		$ 9,472.24			
	Chattahoochee		0.004181667772%	$ 815.43		$ 627.25		$ 439.08			
	Greensboro		0.000492067723%	$ 95.95		$ 73.81		$ 51.67			
	Gretna		0.002240633101%	$ 436.92		$ 336.09		$ 235.27			
	Havana		0.005459954403%	$ 1,064.69		$ 818.99		$ 573.30			
	Midway		0.001202025213%	$ 234.39		$ 180.30		$ 126.21			
	Quincy		0.019867915223%	$ 3,874.24		$ 2,980.19		$ 2,086.13			
Gilchrist		0.064333769355%			$ 29,271.87		$ 22,516.82			$	15,761.77
	Gilchrist County		0.061274233881%	$ 11,948.48		$ 9,191.14		$ 6,433.79			
	Bell		0.000099866143%	$ 19.47		$ 14.98		$ 10.49			
	Fanning Springs		0.000388570084%	$ 75.77		$ 58.29		$ 40.80			
	Trenton		0.002571099247%	$ 501.36		$ 385.66		$ 269.97			
Glades		0.040612836758%			$ 18,478.84		$ 14,214.49			$	9,950.15
	Glades County		0.040420367464%	$ 7,881.97		$ 6,063.06		$ 4,244.14			
	Moore Haven		0.000192469294%	$ 37.53		$ 28.87		$ 20.21			
Gulf		0.059914238588%			$ 27,260.98		$ 20,969.98			$	14,678.99
	Gulf County		0.054715751905%	$ 10,669.57		$ 8,207.36		$ 5,745.15			
	Port St. Joe		0.004617179591%	$ 939.35		$ 722.58		$ 505.80			
	Wewahitchka		0.000381307092%	$ 74.35		$ 57.20		$ 40.04			
Hamilton		0.047941195910%			$ 21,813.24		$ 16,779.42			$	11,745.59
	Hamilton County		0.038817061931%	$ 7,569.33		$ 5,822.56		$ 4,075.79			
	Jasper		0.004869836285%	$ 949.62		$ 730.48		$ 511.33			
	Jennings		0.002623755940%	$ 511.63		$ 393.56		$ 275.49			
	White Springs		0.001630541754%	$ 317.96		$ 244.58		$ 171.21			
Hardee		0.067110048132%			$ 30,535.07		$ 23,488.52			$	16,441.96
	Hardee County		0.058100306280%	$ 11,329.56		$ 8,715.05		$ 6,100.53			
	Bowling Green		0.001797590575%	$ 350.53		$ 269.64		$ 188.75			
	Wauchula		0.006667426860%	$ 1,300.15		$ 1,000.11		$ 700.08			
	Zolfo Springs		0.000544724417%	$ 106.22		$ 81.71		$ 57.20			
Hendry		0.144460915297%			$ 65,729.72		$ 50,561.32			$	35,392.92
	Hendry County		0.122147187443%	$ 23,818.70		$ 18,322.08		$ 12,825.45			
	Clewiston		0.017589151414%	$ 3,429.88		$ 2,638.37		$ 1,846.86			
	LaBelle		0.004724576440%	$ 921.29		$ 708.69		$ 496.08			
Hernando		1.510075949110%			$ 687,084.56		$ 528,526.58			$	369,968.61
	Hernando County		1.447521612849%	$ 282,266.71		$ 217,128.24		$ 151,989.77			
	Brooksville		0.061319627583%	$ 11,957.33		$ 9,197.94		$ 6,438.56			
	Weeki Wachee		0.001234708678%	$ 240.77		$ 185.21		$ 129.64			
Highlands		0.357188510237%			$ 162,520.77		$ 125,015.98			$	87,511.19
	Highlands County		0.287621754986%	$ 56,086.24		$ 43,143.26		$ 30,200.28			
	Avon Park		0.025829016090%	$ 5,036.66		$ 3,874.35		$ 2,712.05			
	Lake Placid		0.005565267790%	$ 1,085.23		$ 834.79		$ 584.35			
	Sebring		0.038172471371%	$ 7,443.63		$ 5,725.87		$ 4,008.11			
Hillsborough		8.710984113657%			$ 3,963,497.77		$ 3,048,844.44			$	2,134,191.11
	Hillsborough County		6.523111204400%	$ 1,272,006.68		$ 978,466.68		$ 684,926.68			
	Plant City		0.104218491142%	$ 20,322.61		$ 15,632.77		$ 10,942.94			
	Tampa		1.975671881253%	$ 385,256.02		$ 296,350.78		$ 207,445.55			
	Temple Terrace		0.107980721113%	$ 21,056.24		$ 16,197.11		$ 11,337.98			
Holmes		0.081612427851%			$ 37,133.65		$ 28,564.35			$	19,995.04
	Holmes County		0.066805002459%	$ 13,026.98		$ 10,020.75		$ 7,014.53			
	Bonifay		0.006898026863%	$ 1,345.12		$ 1,034.70		$ 724.29			
	Esto		0.006269778036%	$ 1,222.61		$ 940.47		$ 658.33			
	Noma		0.001278286631%	$ 249.27		$ 191.74		$ 134.22			
	Ponce de Leon		0.000179759057%	$ 35.05		$ 26.96		$ 18.87			
	Westville		0.000179759057%	$ 35.05		$ 26.96		$ 18.87			
Indian River		0.753076058781%			$ 342,649.61		$ 263,576.62			$	184,503.63
	Indian River County		0.623571460217%	$ 121,596.43		$ 93,535.72		$ 65,475.00			
	Fellsmere		0.004917045734%	$ 958.82		$ 737.56		$ 516.29			
	Indian River shores		0.025322422382%	$ 4,937.87		$ 3,798.36		$ 2,658.85			
	Orchid		0.000306861421%	$ 59.84		$ 46.03		$ 32.22			
	Sebastian		0.038315915467%	$ 7,471.60		$ 5,747.39		$ 4,023.17			
	Vero Beach		0.060642353558%	$ 11,825.26		$ 9,096.35		$ 6,367.45			
Jackson		0.158936058795%			$ 72,315.91		$ 55,627.62			$	38,939.33
	Jackson County		0.075213731704%	$ 14,666.68		$ 11,282.06		$ 7,897.44			
	Alford		0.000303229925%	$ 59.13		$ 45.48		$ 31.84			
	Bascom		0.000061735434%	$ 12.04		$ 9.26		$ 6.48			
	Campbellton		0.001648699234%	$ 321.50		$ 247.30		$ 173.11			
	Cottondale		0.001093080329%	$ 213.15		$ 163.96		$ 114.77			
	Graceville		0.002794436257%	$ 544.92		$ 419.17		$ 293.42			
	Grandridge		0.000030867717%	$ 6.02		$ 4.63		$ 3.24			
	Greenwood		0.001292812616%	$ 252.10		$ 193.92		$ 135.75			
	Jacob City		0.000481173235%	$ 93.83		$ 72.18		$ 50.52			
	Malone		0.000092603151%	$ 18.06		$ 13.89		$ 9.72			
	Marianna		0.073519638768%	$ 14,336.33		$ 11,027.95		$ 7,719.56			
	Sneads		0.002404050426%	$ 468.79		$ 360.61		$ 252.43			
Jefferson		0.040821647784%			$ 18,573.85		$ 14,287.58			$	10,001.30
	Jefferson County		0.037584169001%	$ 7,328.91		$ 5,637.63		$ 3,946.34			
	Monticello		0.003237478783%	$ 631.31		$ 485.62		$ 339.94			
Lafayette		0.031911772076%			$ 14,519.86		$ 11,169.12			$	7,818.38
	Lafayette County		0.031555885457%	$ 6,153.40		$ 4,733.38		$ 3,313.37			
	Mayo		0.000355886619%	$ 69.40		$ 53.38		$ 37.37			
Lake		1.139211224519%			$ 518,341.11		$ 398,723.93			$	279,106.75
	Lake County		0.757453827343%	$ 147,703.50		$ 113,618.07		$ 79,532.65			
	Astatula		0.002727253579%	$ 531.81		$ 409.09		$ 286.36			
	Clermont		0.075909163209%	$ 14,802.29		$ 11,386.37		$ 7,970.46			
	Eustis		0.041929254098%	$ 8,176.20		$ 6,289.39		$ 4,402.57			
	Fruitland Park		0.008381493024%	$ 1,634.39		$ 1,257.22		$ 880.06			
	Groveland		0.026154034992%	$ 5,100.04		$ 3,923.11		$ 2,746.17			
	Howey-In-The-Hills		0.002981458307%	$ 581.38		$ 447.22		$ 313.05			
	Lady Lake		0.025048244426%	$ 4,884.41		$ 3,757.24		$ 2,630.07			

	Leesburg		0.0913393901850%	$ 17,811.18		$ 13,700.91		$ 9,590.64			
	Mascotte		0.0114156080250%	$ 2,226.04		$ 1,712.34		$ 1,198.64			
	Minneola		0.0160584758030%	$ 3,131.40		$ 2,408.77		$ 1,686.14			
	Montverde		0.0013472850570%	$ 262.72		$ 202.09		$ 141.46			
	Mount Dora		0.0410213800700%	$ 7,999.17		$ 6,153.21		$ 4,307.24			
	Tavares		0.0318209846730%	$ 6,205.09		$ 4,773.15		$ 3,341.20			
	Umatilla		0.0056233717280%	$ 1,096.56		$ 843.51		$ 590.45			
Lee		3.3253718833590%			$ 1,513,044.21		$ 1,163,880.16			$	814,716.11
	Lee County		2.1152684075090%	$ 412,477.34		$ 317,290.26		$ 222,103.18			
	Bonita Springs		0.0173748931430%	$ 3,388.10		$ 2,606.23		$ 1,824.36			
	Cape Coral		0.7144296771670%	$ 139,313.79		$ 107,164.45		$ 75,015.12			
	Estero		0.0120801718130%	$ 2,355.63		$ 1,812.03		$ 1,268.42			
	Fort Myers		0.4311003505850%	$ 84,064.57		$ 64,665.05		$ 45,265.54			
	Fort Myers Beach		0.0005229354400%	$ 101.97		$ 78.44		$ 54.91			
	Sanibel		0.0345954477020%	$ 6,746.11		$ 5,189.32		$ 3,632.52			
Leon		0.8971992449390%			$ 408,225.66		$ 314,019.74			$	219,813.82
	Leon County		0.4712011463910%	$ 91,884.22		$ 70,680.17		$ 49,476.12			
	Tallahassee		0.4259980985490%	$ 83,069.63		$ 63,899.71		$ 44,729.80			
Levy		0.2511924017480%			$ 114,292.54		$ 87,917.34			$	61,542.14
	Levy County		0.2001317506790%	$ 39,025.69		$ 30,019.76		$ 21,013.83			
	Bronson		0.0057014488940%	$ 1,111.78		$ 855.22		$ 598.65			
	Cedar Key		0.0051803292020%	$ 1,010.16		$ 777.05		$ 543.93			
	Chiefland		0.0153262792370%	$ 2,988.71		$ 2,299.01		$ 1,609.31			
	Fanning Springs		0.0008080078850%	$ 157.56		$ 121.20		$ 84.84			
	Inglis		0.0049769654200%	$ 970.51		$ 746.54		$ 522.58			
	Otter Creek		0.0004085433120%	$ 79.67		$ 61.28		$ 42.90			
	Williston		0.0177743577150%	$ 3,466.00		$ 2,666.15		$ 1,866.31			
	Yankeetown		0.0008842693030%	$ 172.43		$ 132.64		$ 92.85			
Liberty		0.0193994522250%			$ 8,826.75		$ 6,789.81			$	4,752.87
	Liberty County		0.0193032175780%	$ 3,764.13		$ 2,895.48		$ 2,026.84			
	Bristol		0.0000962346470%	$ 18.77		$ 14.44		$ 10.10			
Madison		0.0635402874550%			$ 28,910.83		$ 22,239.10			$	15,567.37
	Madison County		0.0531451298370%	$ 10,363.30		$ 7,971.77		$ 5,580.24			
	Greenville		0.0001107606310%	$ 21.60		$ 16.61		$ 11.63			
	Lee		0.0000199732290%	$ 3.89		$ 3.00		$ 2.10			
	Madison		0.0102644237580%	$ 2,001.56		$ 1,539.66		$ 1,077.76			
Manatee		2.7213233462350%			$ 1,238,202.12		$ 952,463.17			$	666,724.22
	Manatee County		2.2016471740060%	$ 429,321.20		$ 330,247.08		$ 231,172.95			
	Anna Maria		0.0099303261160%	$ 1,936.41		$ 1,489.55		$ 1,042.68			
	Bradenton		0.3799307546320%	$ 74,086.50		$ 56,989.61		$ 39,892.73			
	Bradenton Beach		0.0140121277440%	$ 2,732.36		$ 2,101.82		$ 1,471.27			
	Holmes Beach		0.0280387814730%	$ 5,467.56		$ 4,205.82		$ 2,944.07			
	Longboat Key		0.0348950461310%	$ 6,804.53		$ 5,234.26		$ 3,663.98			
	Palmetto		0.0528691361320%	$ 10,309.48		$ 7,930.37		$ 5,551.26			
Marion		1.7011761689600%			$ 774,035.16		$ 595,411.66			$	416,788.16
	Marion County		1.3037288928370%	$ 254,227.13		$ 195,559.33		$ 136,891.53			
	Belleview		0.0097995922560%	$ 1,910.92		$ 1,469.94		$ 1,028.96			
	Dunnellon		0.0184007907950%	$ 3,588.15		$ 2,760.12		$ 1,932.08			
	McIntosh		0.0001452598440%	$ 28.33		$ 21.79		$ 15.25			
	Ocala		0.3689945040940%	$ 71,953.93		$ 55,349.18		$ 38,744.42			
	Reddick		0.0001071291350%	$ 20.89		$ 16.07		$ 11.25			
Martin		0.8694872981160%			$ 395,616.72		$ 304,320.55			$	213,024.39
	Martin County		0.7507627957580%	$ 146,398.75		$ 112,614.42		$ 78,830.09			
	Jupiter Island		0.0208738396460%	$ 4,070.40		$ 3,131.08		$ 2,191.75			
	Ocean Breeze Park		0.0082707323930%	$ 1,612.79		$ 1,240.61		$ 868.43			
	Sewall's Point		0.0083560725510%	$ 1,629.43		$ 1,253.41		$ 877.39			
	Stuart		0.0812238577670%	$ 15,838.65		$ 12,183.58		$ 8,528.51			
Miami-Dade		5.2321197841730%			$ 2,380,614.50		$ 1,831,241.92			$	1,281,869.35
	Miami-Dade County		4.2827976755520%	$ 835,145.55		$ 642,419.65		$ 449,693.76			
	Aventura		0.0246197278850%	$ 4,800.85		$ 3,692.96		$ 2,585.07			
	Bal Harbour		0.0100410867470%	$ 1,958.01		$ 1,506.16		$ 1,054.31			
	Bay Harbor Islands		0.0042724551750%	$ 833.13		$ 640.87		$ 448.61			
	Biscayne Park		0.0011348425350%	$ 221.29		$ 170.23		$ 119.16			
	Coral Gables		0.0717801521310%	$ 13,997.13		$ 10,767.02		$ 7,536.92			
	Cutler Bay		0.0094146536680%	$ 1,835.86		$ 1,412.20		$ 988.54			
	Doral		0.0139776285310%	$ 2,725.64		$ 2,096.64		$ 1,467.65			
	El Portal		0.0009242157600%	$ 180.22		$ 138.63		$ 97.04			
	Florida City		0.0039292787920%	$ 766.21		$ 589.39		$ 412.57			
	Golden Beach		0.0028470929510%	$ 555.18		$ 427.06		$ 298.94			
	Hialeah		0.0980158957850%	$ 19,113.10		$ 14,702.38		$ 10,291.67			
	Hialeah Gardens		0.0054526914110%	$ 1,063.27		$ 817.90		$ 572.53			
	Homestead		0.0249356680460%	$ 4,862.46		$ 3,740.35		$ 2,618.25			
	Indian Creek		0.0025438630260%	$ 496.05		$ 381.58		$ 267.11			
	Key Biscayne		0.0136834773460%	$ 2,668.28		$ 2,052.52		$ 1,436.77			
	Medley		0.0087482741310%	$ 1,705.91		$ 1,312.24		$ 918.57			
	Miami		0.2927930054480%	$ 57,094.64		$ 43,918.95		$ 30,743.27			
	Miami Beach		0.1814095724780%	$ 35,374.87		$ 27,211.44		$ 19,048.01			
	Miami Gardens		0.0406836509320%	$ 7,933.31		$ 6,102.55		$ 4,271.78			
	Miami Lakes		0.0078367686080%	$ 1,528.17		$ 1,175.52		$ 822.86			
	Miami Shores		0.0062879355160%	$ 1,226.15		$ 943.19		$ 660.23			
	Miami Springs		0.0061699118930%	$ 1,203.13		$ 925.49		$ 647.84			
	North Bay Village		0.0051603559740%	$ 1,006.27		$ 774.05		$ 541.84			
	North Miami		0.0303792807170%	$ 5,923.96		$ 4,556.89		$ 3,189.82			
	North Miami Beach		0.0303919909530%	$ 5,926.44		$ 4,558.80		$ 3,191.16			
	Opa-locka		0.0078476630960%	$ 1,530.29		$ 1,177.15		$ 824.00			
	Palmetto Bay		0.0074046205700%	$ 1,443.90		$ 1,110.69		$ 777.49			
	Pinecrest		0.0082961528660%	$ 1,617.75		$ 1,244.42		$ 871.10			
	South Miami		0.0078331371110%	$ 1,527.46		$ 1,174.97		$ 822.48			
	Sunny Isles Beach		0.0076933245110%	$ 1,500.20		$ 1,154.00		$ 807.80			
	Surfside		0.0048698362850%	$ 949.62		$ 730.48		$ 511.33			
	Sweetwater		0.0041163008420%	$ 802.68		$ 617.45		$ 432.21			
	Virginia Gardens		0.0011729732440%	$ 228.73		$ 175.95		$ 123.16			
	West Miami		0.0026546236570%	$ 517.65		$ 398.19		$ 278.74			
Monroe		0.4763887385850%			$ 216,756.88		$ 166,736.06			$	116,715.24
	Monroe County		0.3301247854690%	$ 64,374.33		$ 49,518.72		$ 34,663.10			
	Islamorada		0.0223573058080%	$ 4,359.67		$ 3,353.60		$ 2,347.52			
	Key Colony Beach		0.0047518126610%	$ 926.60		$ 712.77		$ 498.94			
	Key West		0.0880873854170%	$ 17,177.04		$ 13,213.11		$ 9,249.18			
	Layton		0.0001507070890%	$ 29.39		$ 22.61		$ 15.82			
	Marathon		0.0309167421410%	$ 6,028.76		$ 4,637.51		$ 3,246.26			
Nassau		0.4769334630020%			$ 217,004.73		$ 166,926.71			$	116,848.70
	Nassau County		0.3927063579510%	$ 76,577.74		$ 58,905.95		$ 41,234.17			
	Callahan		0.0002251527590%	$ 43.90		$ 33.77		$ 23.64			
	Fernandina Beach		0.0831594451950%	$ 16,216.09		$ 12,473.92		$ 8,731.74			
	Hillard		0.0008425070980%	$ 164.29		$ 126.38		$ 88.46			
Okaloosa		0.8192128659550%			$ 372,741.85		$ 286,724.50			$	200,707.15
	Okaloosa County		0.6120596175450%	$ 119,351.63		$ 91,808.94		$ 64,266.26			
	Cinco Bayou		0.0007335622140%	$ 143.04		$ 110.03		$ 77.02			
	Crestview		0.0704401300660%	$ 13,735.83		$ 10,566.02		$ 7,396.21			
	Destin		0.0146785072810%	$ 2,862.31		$ 2,201.78		$ 1,541.24			
	Fort Walton Beach		0.0778374876440%	$ 15,178.31		$ 11,675.62		$ 8,172.94			
	Laurel Hill		0.0000798929140%	$ 15.58		$ 11.98		$ 8.39			
	Mary Esther		0.0093565497300%	$ 1,824.53		$ 1,403.48		$ 982.44			
	Niceville		0.0217453987130%	$ 4,240.35		$ 3,261.81		$ 2,283.27			
	Shalimar		0.0018248267960%	$ 355.84		$ 273.72		$ 191.61			
	Valparaiso		0.0104568930520%	$ 2,039.09		$ 1,568.53		$ 1,097.97			
Okeechobee		0.3534952786920%			$ 160,840.35		$ 123,723.35			$	86,606.34
	Okeechobee County		0.3145438514050%	$ 61,336.05		$ 47,181.58		$ 33,027.10			
	Okeechobee		0.0389514272870%	$ 7,595.53		$ 5,842.71		$ 4,089.90			
Orange		4.6710282145460%			$ 2,125,317.84		$ 1,634,859.88			$	1,144,401.91
	Orange County		3.0633303869790%	$ 597,349.43		$ 459,499.56		$ 321,649.69			

	Apopka		0.097215150892%	$ 18,956.95		$ 14,582.27		$ 10,207.59			
	Bay Lake		0.023566594013%	$ 4,595.49		$ 3,534.99		$ 2,474.49			
	Belle Isle		0.010798253686%	$ 2,105.66		$ 1,619.74		$ 1,133.82			
	Eatonville		0.008325204835%	$ 1,623.41		$ 1,248.78		$ 874.15			
	Edgewood		0.009716067845%	$ 1,894.63		$ 1,457.41		$ 1,020.19			
	Lake Buena Vista		0.010355211161%	$ 2,019.27		$ 1,553.28		$ 1,087.30			
	Maitland		0.046728276209%	$ 9,112.01		$ 7,009.24		$ 4,906.47			
	Oakland		0.005429086686%	$ 1,058.67		$ 814.36		$ 570.05			
	Ocoee		0.066599822928%	$ 12,986.97		$ 9,989.97		$ 6,992.98			
	Orlando		1.160248481490%	$ 226,248.45		$ 174,037.27		$ 121,826.09			
	Windemere		0.007548064667%	$ 1,471.87		$ 1,132.21		$ 792.55			
	Winter Garden		0.056264584996%	$ 10,971.59		$ 8,439.69		$ 5,907.78			
	Winter Park		0.104903028159%	$ 20,456.09		$ 15,735.45		$ 11,014.82			
Osceola		1.073452092940%			$ 488,420.70		$ 375,708.23			$	262,995.76
	Osceola County		0.837248691390%	$ 163,263.49		$ 125,587.30		$ 87,911.11			
	Kissimmee		0.162366006872%	$ 31,661.37		$ 24,354.90		$ 17,048.43			
	St. Cloud		0.073837394678%	$ 14,398.29		$ 11,075.61		$ 7,752.93			
Palm Beach		8.601594372053%			$ 3,913,725.44		$ 3,010,558.03			$	2,107,390.62
	Palm Beach County		5.552548475026%	$ 1,082,746.95		$ 832,882.27		$ 583,017.59			
	Atlantis		0.018751230169%	$ 3,656.49		$ 2,812.68		$ 1,968.88			
	Belle Glade		0.020828445945%	$ 4,061.55		$ 3,124.27		$ 2,186.99			
	Boca Raton		0.472069073961%	$ 92,053.47		$ 70,810.36		$ 49,567.25			
	Boynton Beach		0.306498271771%	$ 59,767.16		$ 45,974.74		$ 32,182.32			
	Briny Breezes		0.003257452012%	$ 635.20		$ 488.62		$ 342.03			
	Cloud Lake		0.000188837798%	$ 36.82		$ 28.33		$ 19.83			
	Delray Beach		0.351846579457%	$ 68,610.08		$ 52,776.99		$ 36,943.89			
	Glen Ridge		0.000052656694%	$ 10.27		$ 7.90		$ 5.53			
	Golf		0.004283349663%	$ 835.25		$ 642.50		$ 449.75			
	Greenacres		0.076424835657%	$ 14,902.84		$ 11,463.73		$ 8,024.61			
	Gulf Stream		0.010671151322%	$ 2,080.87		$ 1,600.67		$ 1,120.47			
	Haverhill		0.001084001589%	$ 211.38		$ 162.60		$ 113.82			
	Highland Beach		0.032510968934%	$ 6,339.64		$ 4,876.65		$ 3,413.65			
	Hypoluxo		0.005153092982%	$ 1,004.85		$ 772.96		$ 541.07			
	Juno Beach		0.016757538804%	$ 3,267.72		$ 2,513.63		$ 1,759.54			
	Jupiter Island		0.125466374888%	$ 24,465.94		$ 18,819.96		$ 13,173.97			
	Jupiter Inlet Colony		0.005276563849%	$ 1,028.93		$ 791.48		$ 554.04			
	Lake Clarke Shores		0.007560774903%	$ 1,474.35		$ 1,134.12		$ 793.88			
	Lake Park		0.029433275980%	$ 5,739.49		$ 4,414.99		$ 3,090.49			
	Lake Worth		0.117146617298%	$ 22,843.59		$ 17,571.99		$ 12,300.39			
	Lantana		0.024507151505%	$ 4,778.89		$ 3,676.07		$ 2,573.25			
	Loxahatchee Groves		0.002531152789%	$ 493.57		$ 379.67		$ 265.77			
	Manalapan		0.021632822333%	$ 4,218.40		$ 3,244.92		$ 2,271.45			
	Mangonia Park		0.010696571795%	$ 2,085.83		$ 1,604.49		$ 1,123.14			
	North Palm Beach		0.044349646256%	$ 8,648.18		$ 6,652.45		$ 4,656.71			
	Ocean Ridge		0.012786497807%	$ 2,493.37		$ 1,917.97		$ 1,342.58			
	Pahokee		0.004018250447%	$ 783.56		$ 602.74		$ 421.92			
	Palm Beach		0.185476848123%	$ 36,167.99		$ 27,821.53		$ 19,475.07			
	Palm Beach Gardens		0.233675880257%	$ 45,566.80		$ 35,051.38		$ 24,535.97			
	Palm Beach Shores		0.014135598612%	$ 2,756.44		$ 2,120.34		$ 1,484.24			
	Palm Springs		0.038021764282%	$ 7,414.24		$ 5,703.26		$ 3,992.29			
	Riviera Beach		0.163617057282%	$ 31,905.33		$ 24,542.56		$ 17,179.79			
	Royal Palm Beach		0.049295743959%	$ 9,612.67		$ 7,394.36		$ 5,176.05			
	South Bay		0.001830274040%	$ 356.90		$ 274.54		$ 192.18			
	South Palm Beach		0.005866681967%	$ 1,144.00		$ 880.00		$ 616.00			
	Tequesta		0.031893614595%	$ 6,219.25		$ 4,784.04		$ 3,348.83			
	Wellington		0.050183644758%	$ 9,785.81		$ 7,527.55		$ 5,269.28			
	West Palm Beach		0.549265602541%	$ 107,106.79		$ 82,389.84		$ 57,672.89			
Pasco		4.692087260494%			$ 2,134,899.70		$ 1,642,230.54			$	1,149,561.38
	Pasco County		4.319205239813%	$ 842,245.02		$ 647,880.79		$ 453,516.55			
	Dade City		0.055819726723%	$ 10,884.85		$ 8,372.96		$ 5,861.07			
	New Port Richey		0.149879107494%	$ 29,226.43		$ 22,481.87		$ 15,737.31			
	Port Richey		0.049529975458%	$ 9,658.35		$ 7,429.50		$ 5,200.65			
	San Antonio		0.002189792155%	$ 427.01		$ 328.47		$ 229.93			
	St. Leo		0.002790804761%	$ 544.21		$ 418.62		$ 293.03			
	Zephyrhills		0.112672614089%	$ 21,971.16		$ 16,900.89		$ 11,830.62			
Pinellas		7.934889816777%			$ 3,610,374.87		$ 2,777,211.44			$	1,944,048.01
	Pinellas County		4.546593184553%	$ 886,585.67		$ 681,988.98		$ 477,392.28			
	Belleair		0.018095745121%	$ 3,528.67		$ 2,714.36		$ 1,900.05			
	Belleair Beach		0.004261560686%	$ 831.00		$ 639.23		$ 447.46			
	Belleair Bluffs		0.007502670965%	$ 1,463.02		$ 1,125.40		$ 787.78			
	Belleair Shore		0.000439411029%	$ 85.69		$ 65.91		$ 46.14			
	Clearwater		0.633863120196%	$ 123,603.31		$ 95,079.47		$ 66,555.63			
	Dunedin		0.102440873796%	$ 19,975.97		$ 15,366.13		$ 10,756.29			
	Gulfport		0.047893986460%	$ 9,339.33		$ 7,184.10		$ 5,028.87			
	Indian Rocks Beach		0.008953453662%	$ 1,745.92		$ 1,343.02		$ 940.11			
	Indian Shores		0.011323004874%	$ 2,207.99		$ 1,698.45		$ 1,188.92			
	Kenneth City		0.017454786058%	$ 3,403.68		$ 2,618.22		$ 1,832.75			
	Largo		0.374192990777%	$ 72,967.63		$ 56,128.95		$ 39,290.26			
	Madeira Beach		0.022616957779%	$ 4,410.31		$ 3,392.54		$ 2,374.78			
	North Redington Beach		0.003820333909%	$ 744.97		$ 573.05		$ 401.14			
	Oldsmar		0.039421706033%	$ 7,687.23		$ 5,913.26		$ 4,139.28			
	Pinellas Park		0.251666311991%	$ 49,074.93		$ 37,749.95		$ 26,424.96			
	Redington Beach		0.003611522882%	$ 704.25		$ 541.73		$ 379.21			
	Redington Shores		0.006451352841%	$ 1,258.01		$ 967.70		$ 677.39			
	Safety Harbor		0.038061710740%	$ 7,422.03		$ 5,709.26		$ 3,996.48			
	Seminole		0.095248695748%	$ 18,573.50		$ 14,287.30		$ 10,001.11			
	South Pasadena		0.029689821656%	$ 5,843.94		$ 4,495.34		$ 3,146.74			
	St. Pete Beach		0.071791046619%	$ 13,999.25		$ 10,768.66		$ 7,538.06			
	St. Petersburg		1.456593090134%	$ 284,035.65		$ 218,488.96		$ 152,942.27			
	Tarpon Springs		0.101970595050%	$ 19,884.27		$ 15,295.59		$ 10,706.91			
	Treasure Island		0.040652783215%	$ 7,927.29		$ 6,097.92		$ 4,268.54			
Polk		2.150483025298%			$ 978,469.78		$ 752,669.06			$	526,868.34
	Polk County		1.558049828484%	$ 303,819.72		$ 233,707.47		$ 163,595.23			
	Auburndale		0.028636162584%	$ 5,584.05		$ 4,295.42		$ 3,006.80			
	Bartow		0.043971970660%	$ 8,574.53		$ 6,595.80		$ 4,617.06			
	Davenport		0.005305615818%	$ 1,034.60		$ 795.84		$ 557.09			
	Dundee		0.005597951255%	$ 1,091.60		$ 839.69		$ 587.78			
	Eagle Lake		0.002580177987%	$ 503.13		$ 387.03		$ 270.92			
	Fort Meade		0.007702403251%	$ 1,501.97		$ 1,155.36		$ 808.75			
	Frostproof		0.005857603227%	$ 1,142.23		$ 878.64		$ 615.05			
	Haines City		0.047984773863%	$ 9,357.03		$ 7,197.72		$ 5,038.40			
	Highland Park		0.000063551182%	$ 12.39		$ 9.53		$ 6.67			
	Hillcrest Heights		0.000005447244%	$ 1.06		$ 0.82		$ 0.57			
	Lake Alfred		0.007489960729%	$ 1,460.54		$ 1,123.49		$ 786.45			
	Lake Hamilton		0.002540231530%	$ 495.35		$ 381.03		$ 266.72			
	Lakeland		0.294875668468%	$ 57,500.76		$ 44,231.35		$ 30,961.95			
	Lake Wales		0.036293172134%	$ 7,077.17		$ 5,443.98		$ 3,810.78			
	Mulberry		0.005414560702%	$ 1,055.84		$ 812.18		$ 568.53			
	Polk City		0.001080370093%	$ 210.67		$ 162.06		$ 113.44			
	Winter Haven		0.097033576087%	$ 18,921.55		$ 14,555.04		$ 10,188.53			
Putnam		0.384893194068%			$ 175,126.40		$ 134,712.62			$	94,298.83
	Putnam County		0.329225990182%	$ 64,199.07		$ 49,383.90		$ 34,568.73			
	Crescent City		0.005561636294%	$ 1,084.52		$ 834.25		$ 583.97			
	Interlachen		0.001877483489%	$ 366.11		$ 281.62		$ 197.14			
	Palatka		0.046955244716%	$ 9,156.27		$ 7,043.29		$ 4,930.30			
	Pomona Park		0.000379491344%	$ 74.00		$ 56.92		$ 39.85			
	Welaka		0.000893348043%	$ 174.20		$ 134.00		$ 93.80			
Santa Rosa		0.701267319513%			$ 319,076.63		$ 245,443.56			$	171,810.49
	Santa Rosa County		0.592523984216%	$ 115,542.18		$ 88,878.60		$ 62,215.02			
	Gulf Breeze		0.061951507906%	$ 12,080.54		$ 9,292.73		$ 6,504.91			
	Jay		0.000159785829%	$ 31.16		$ 23.97		$ 16.78			

	Milton		0.046632041562%	$ 9,093.25		$ 6,994.81		$ 4,896.36			
Sarasota		2.805043857579%			$ 1,276,294.96		$ 981,765.35			$ 687,235.75	
	Sarasota County		1.924315263251%	$ 375,241.48		$ 288,647.29		$ 202,053.10			
	Longboat Key		0.044489458856%	$ 8,675.44		$ 6,673.42		$ 4,671.39			
	North Port		0.209611771277%	$ 40,874.30		$ 31,441.77		$ 22,009.24			
	Sarasota		0.484279979635%	$ 94,434.60		$ 72,642.00		$ 50,849.40			
	Venice		0.142347384560%	$ 27,757.74		$ 21,352.11		$ 14,946.48			
Seminole		2.141148264544%			$ 974,222.46		$ 749,401.89			$ 524,581.32	
	Seminole County		1.508694164839%	$ 294,195.36		$ 226,304.12		$ 158,412.89			
	Altamonte Springs		0.081305566430%	$ 15,854.59		$ 12,195.83		$ 8,537.08			
	Casselberry		0.080034542791%	$ 15,606.74		$ 12,005.18		$ 8,403.63			
	Lake Mary		0.079767627827%	$ 15,554.69		$ 11,965.14		$ 8,375.60			
	Longwood		0.061710013415%	$ 12,033.45		$ 9,256.50		$ 6,479.55			
	Oviedo		0.103130858057%	$ 20,110.52		$ 15,469.63		$ 10,828.74			
	Sanford		0.164243490362%	$ 32,027.48		$ 24,636.52		$ 17,245.57			
	Winter Springs		0.062262000824%	$ 12,141.09		$ 9,339.30		$ 6,537.51			
St. Johns		0.710333349554%			$ 323,201.67		$ 248,616.67			$ 174,031.67	
	St. Johns County		0.656334818131%	$ 127,985.29		$ 98,450.22		$ 68,915.16			
	Hastings		0.000010894488%	$ 2.12		$ 1.63		$ 1.14			
	Marineland		0.000000000000%	$ -		$ -		$ -			
	St. Augustine		0.046510386442%	$ 9,069.53		$ 6,976.56		$ 4,883.59			
	St. Augustine Beach		0.007477250493%	$ 1,458.06		$ 1,121.59		$ 785.11			
St. Lucie		1.506627843552%			$ 685,515.67		$ 527,319.75			$ 369,123.82	
	St. Lucie County		0.956156584302%	$ 186,450.53		$ 143,423.49		$ 100,396.44			
	Fort Pierce		0.159535255654%	$ 31,109.37		$ 23,930.29		$ 16,751.20			
	Port St. Lucie		0.390803453989%	$ 76,206.67		$ 58,620.52		$ 41,034.36			
	St. Lucie Village		0.000132549608%	$ 25.85		$ 19.88		$ 13.92			
Sumter		0.326398870459%			$ 148,511.49		$ 114,239.60			$ 79,967.72	
	Sumter County		0.302273026046%	$ 58,943.24		$ 45,340.95		$ 31,738.67			
	Bushnell		0.006607507174%	$ 1,288.46		$ 991.13		$ 693.79			
	Center Hill		0.001312785844%	$ 255.99		$ 196.92		$ 137.84			
	Coleman		0.000748088199%	$ 145.88		$ 112.21		$ 78.55			
	Webster		0.001423546476%	$ 277.59		$ 213.53		$ 149.47			
	Wildwood		0.014033916721%	$ 2,736.61		$ 2,105.09		$ 1,473.56			
Suwannee		0.191014879692%			$ 86,911.77		$ 66,855.21			$ 46,798.65	
	Suwannee County		0.161027800555%	$ 31,400.42		$ 24,154.17		$ 16,907.92			
	Branford		0.000929663004%	$ 181.28		$ 139.45		$ 97.61			
	Live Oak		0.029057416132%	$ 5,666.20		$ 4,358.61		$ 3,051.03			
Taylor		0.092181897282%			$ 41,942.76		$ 32,263.66			$ 22,584.56	
	Taylor County		0.069969851319%	$ 13,644.12		$ 10,495.48		$ 7,346.83			
	Perry		0.022212045963%	$ 4,331.35		$ 3,331.81		$ 2,332.26			
Union		0.065156303224%			$ 29,646.12		$ 22,804.71			$ 15,963.29	
	Union County		0.063629259109%	$ 12,407.71		$ 9,544.39		$ 6,681.07			
	Lake Butler		0.001398126003%	$ 272.63		$ 209.72		$ 146.80			
	Raiford		0.000012710236%	$ 2.48		$ 1.91		$ 1.33			
	Worthington Springs		0.000116207876%	$ 22.66		$ 17.43		$ 12.20			
Volusia		3.130329674480%			$ 1,424,300.00		$ 1,095,615.39			$ 766,930.77	
	Volusia County		1.708575342287%	$ 333,172.19		$ 256,286.30		$ 179,400.41			
	Daytona Beach		0.447556475212%	$ 87,273.51		$ 67,133.47		$ 46,993.43			
	Daytona Beach Shores		0.039743093439%	$ 7,749.90		$ 5,961.46		$ 4,173.02			
	DeBary		0.035283616215%	$ 6,880.31		$ 5,292.54		$ 3,704.78			
	DeLand		0.098983689498%	$ 19,301.82		$ 14,847.55		$ 10,393.29			
	Deltona		0.199329190038%	$ 38,869.19		$ 29,899.38		$ 20,929.56			
	Edgewater		0.058042202343%	$ 11,318.23		$ 8,706.33		$ 6,094.43			
	Flagler Beach		0.000223337011%	$ 43.55		$ 33.50		$ 23.45			
	Holly Hill		0.031615805143%	$ 6,165.08		$ 4,742.37		$ 3,319.66			
	Lake Helen		0.004918861482%	$ 959.18		$ 737.83		$ 516.48			
	New Smyrna Beach		0.104065968306%	$ 20,292.86		$ 15,609.90		$ 10,926.93			
	Oak Hill		0.004820811087%	$ 940.06		$ 723.12		$ 506.19			
	Orange City		0.033562287058%	$ 6,544.65		$ 5,034.34		$ 3,524.04			
	Ormond Beach		0.114644516477%	$ 22,355.68		$ 17,196.68		$ 12,037.67			
	Pierson		0.002333236251%	$ 454.98		$ 349.99		$ 244.99			
	Ponce Inlet		0.023813535748%	$ 4,643.64		$ 3,572.03		$ 2,500.42			
	Port Orange		0.177596501562%	$ 34,631.32		$ 26,639.48		$ 18,647.63			
	South Daytona		0.045221205323%	$ 8,818.14		$ 6,783.18		$ 4,748.23			
Wakulla		0.115129321208%			$ 52,383.84		$ 40,295.26			$ 28,206.68	
	Wakulla County		0.114953193647%	$ 22,415.87		$ 17,242.98		$ 12,070.09			
	Sopchoppy		0.000107129135%	$ 20.89		$ 16.07		$ 11.25			
	St. Marks		0.000068998426%	$ 13.45		$ 10.35		$ 7.24			
Walton		0.268558216151%			$ 122,193.99		$ 93,995.38			$ 65,796.76	
	Walton County		0.224268489581%	$ 43,732.36		$ 33,640.27		$ 23,548.19			
	DeFuniak Springs		0.017057137234%	$ 3,326.14		$ 2,558.57		$ 1,791.00			
	Freeport		0.003290135477%	$ 641.58		$ 493.52		$ 345.46			
	Paxton		0.023942453860%	$ 4,668.78		$ 3,591.37		$ 2,513.96			
Washington		0.120124444109%			$ 54,656.62		$ 42,043.56			$ 29,430.49	
	Washington County		0.104908475404%	$ 20,457.15		$ 15,736.27		$ 11,015.39			
	Caryville		0.001401757499%	$ 273.34		$ 210.26		$ 147.18			
	Chipley		0.012550450560%	$ 2,447.34		$ 1,882.57		$ 1,317.80			
	Ebro		0.000221521263%	$ 43.20		$ 33.23		$ 23.26			
	Vernon		0.000361333863%	$ 70.46		$ 54.20		$ 37.94			
	Wausau		0.000680905521%	$ 132.78		$ 102.14		$ 71.50			
		100.00%	100.00%	$ 19,500,000.00	$ 45,500,000.00	$ 15,000,000.00	$ 35,000,000.00	$ 10,500,000.00	$ 24,500,000.00		

PURDUE PHARMA L.P.

ABATEMENT PLAN TERM SHEET

SUMMARY OF TERMS AND CONDITIONS

THIS TERM SHEET DOES NOT CONSTITUTE (NOR SHALL IT BE CONSTRUED AS) AN OFFER, AGREEMENT OR COMMITMENT[1]

Issue	Description
1. APPLICABILITY OF AGREEMENT	These terms (once agreed) shall apply to the allocation of value received under, and shall be incorporated into, any plan of reorganization (the "**Chapter 11 Plan**") in the chapter 11 cases of Purdue Pharma L.P. and its affiliates (collectively, "**Purdue**") pending in the U.S. Bankruptcy Court for the Southern District of New York (the "**Bankruptcy Court**") between the states, territories and the District of Columbia (each a "**State**") on the one hand, each county, city, town, parish, village, municipality that functions as a political subdivision under State law, or a governmental entity that has the authority to bring Drug Dealer Liability Act ("**DDLA Claims**") under State law (collectively, the "**Local Governments**"), and each federally recognized Native American, Native Alaskan or American Indian Tribe (each a "**Tribe**") on the other.
2. PURPOSE	Virtually all creditors and the Court itself in the Purdue bankruptcy recognize the need and value in developing a comprehensive abatement strategy to address the opioid crisis as the most effective use of the funds that can be derived from the Purdue estate (including without limitation insurance proceeds and, if included in the Chapter 11 Plan, payments by third-parties seeking releases). Because of the unique impact the crisis has had throughout all regions of the country, and as repeatedly recognized by Judge Drain, division of a substantial portion of the bankruptcy estate should occur through an established governmental structure, with the use of such funds strictly limited to abatement purposes as provided herein.[2]

[1] As a condition to participating in this abatement structure, the settlements that the states of Kentucky and Oklahoma separately entered into with Purdue must be taken into account in any allocation to them or flowing through them. Potential adjustments may include a different Government Participation Mechanism structure for the disbursement of funds to benefit Local Governments in those states or some redirection of funds, which would still be used solely for abatement purposes.

[2] *See, e.g.,* Hrg. Tr at 149:22-150:5 (Oct. 11, 2019)(' "I would hope that those public health steps, once the difficult allocation issues that the parties have addressed here, can be largely left up to the states and municipalities so that they can use their own unique knowledge about their own citizens and how to address them. It may be that some states think it's more of a law enforcement issue, i.e. interdicting illegal opioids at this point. Others may think education is more important. Others may think treatment is more important."); *id.* At 175:24-176:6 ("I also think, and again, I didn't say this lightly, that my hope in the allocation process is that there would be an understanding between the states and the municipalities and localities throughout the whole process that[,] subject to general guidelines on how the money should be used, specific ways to use it would be left up to the states and the municipalities, with guidance from the states primarily."); Hr'g Tr. At 165:3-165:14 (Nov. 19, 2019) ("I continue to believe that the states play a major role in [the allocation] process. The role I'm envisioning for them is not one where they say we get everything.

Issue	Description
	This approach recognizes that funding abatement efforts – which would benefit most creditors and the public by reducing future effects of the crisis through treatment and other programs – is a much more efficient use of limited funds than dividing thin slices among all creditors with no obligation to use it to abate the opioid crisis. Because maximizing abatement of the opioid crisis requires coordination of efforts by all levels of government, particularly when the abatement needs far exceed the available funds, this structure requires a collaborative process between each State and its Local Governments. This Term Sheet is intended to establish the mechanisms for distribution and allocation of funds to States, Local Governments and Tribes (the "**Abatement Funds**") to be incorporated into the Chapter 11 Plan and any order approving the Chapter 11 Plan (**Abatement Funds** net of the portion thereof allocated to a Tribal Abatement Fund under Section 5 hereof are referred to herein as "**Public Funds**"). The parties agree that 100% of the Public Funds distributed under the Chapter 11 Plan shall be used to abate the opioid crisis. Specifically, (i) no less than ninety five percent (95%)of the Public Funds distributed under the Chapter 11 Plan shall be used for abatement of the opioid crisis by funding opioid or substance use disorder related projects or programs that fall within the list of uses in **Schedule B** (the "**Approved Opioid Abatement Uses**"); (ii) priority shall be given to the core abatement strategies ("**Core Strategies**") as identified on **Schedule A**; and (iii) no more than five percent (5%) of the Public Funds may be used to fund expenses incurred in administering the distributions for the Approved Opioid Abatement Uses, including the process of selecting programs to receive distributions of **Public Funds** for implementing those programs and in connection with the Government Participation Mechanism[3] (**"Allowed Administrative Expenses**," and together with the **Approved Opioid Abatement Uses**, "**Approved Uses**").[4] Notwithstanding anything in this term sheet that might imply to the contrary, projects or programs that constitute **Approved Opioid Abatement Uses** may be provided by States, State agencies, Local Governments, Local Government agencies or nongovernmental parties and funded from Public Funds.
3. GENERAL NOTES	The governmental entities maintain that the most beneficial and efficient use of limited bankruptcy funds is to dedicate as large a portion as possible to abatement programs addressing the opioid crisis. If this

I think that should be clear and I think it is clear to them. But, rather, where they act – in the best principles of federalism, for their state, the coordinator for the victims in their state."); Hr'g Tr. at 75:19-76:1 (Jan. 24, 2020) ("Even if there ultimately is an allocation here – and there's not a deal now, obviously, at this point on a plan. But if there is an allocation that leaves a substantial amount of the Debtors' value to the states and territories, one of the primary benefits of a bankruptcy case is that the plan can lock in, perhaps only in general ways, but perhaps more in specific ways, how the states use that money . . . .").

[3] Capitalized terms not defined where first used shall have the meanings later ascribed to them in this Term Sheet.

[4] Nothing in this term sheet is intended to, nor does it, limit or permit the ability of funds from the Purdue estate (other than Public Funds) to be used to pay for legal fees and expenses incurred in anticipation of or during Purdue's chapter 11 case, or once confirmed, in implementing the Chapter 11 Plan.

Issue	Description
	approach is taken, the governmental entities involved in the mediation – states, territories, tribes, counties, cities and others – would commit the Public Funds allocated to them to such future abatement, in lieu of direct payment for their claims. a. Resolution of States' and Local Governments' claims under this model presumes signoff by and support of the federal government, including an agreement that the federal government will also forego its past damages claims. Continued coordination with the federal government therefore is necessary as this model is finalized. b. This outline addresses the allocation of Abatement Funds among governmental entities to provide abatement programs to the public for the benefit of not only the governmental entities and their constituents, but also a substantial number of other creditors. The States and Local Governments welcome other, private-side creditor groups to enter discussions concerning how such creditors may participate in, contribute to and/or benefit from the government-funded abatement programs contemplated herein in lieu of direct payment on their claims for past damages. c. In addition to providing abatement services, it is understood that, if their claims are to be released in a reorganization plan, a portion of the Purdue estate will also need to be dedicated to personal injury claimants. A proposal regarding such claims is being developed separately. d. All **Public Funds** distributed from the Purdue bankruptcy estate as part of this abatement structure shall be used only for such **Approved Uses**. Compliance with these requirements shall be verified through reporting, as set out in Section 8. This outline and the terms herein are intended to apply solely to the use and allocation of Public Funds in the Purdue Chapter 11 Plan, and do not apply to the use or allocation of funds made available as the result of judgments against or settlements with any party other than those released as part of the Chapter 11 Plan.
4. DISBURSEMENT OF FUNDS	**Disbursement of Abatement Funds** The Bankruptcy Court shall appoint [a third-party administrator ("**Administrator**")] [Trustee(s)] who will perform the ministerial task of overseeing distribution of all Abatement Funds, which will consist of all assets transferred to such fund by way of the confirmed Chapter 11 Plan, and any, growth, earnings, or revenues from such assets, as well as proceeds from any future sale of such assets. The [Administrator] [Trustees] shall distribute the Abatement Fund consistent with the Chapter 11 Plan and shall provide to the Bankruptcy Court an annual report on such distributions. [Points to be addressed regarding disbursements:

Issue	Description
	• Trigger and timing for disbursements. • Insert details to show how these funds shall be distributed for abatement uses and that the funds will not flow into the state general revenue accounts (unless constitutionally required and, in that event, the funds shall still be disbursed for abatement uses as required by the terms of the document), including possible distribution to state points of contact and block grant recipients. • Possible creation of template document for Abatement Funds distribution requests. • If trust mechanism is employed, trust location and governing law.]
5. ATTORNEYS' FEES AND COSTS FUND	A separate fund will be established for attorneys' fees and litigation costs in the final bankruptcy plan. Agreement by the parties to this Abatement Plan Term Sheet is contingent upon the establishment of this fund and the details of the fund, which are subject to further negotiation, including without limitation the participants, amount, jurisdiction, oversight, and administration. Participation in an abatement program, receipt of abatement services or benefits will not affect, and specific percentages in the abatement structure received by various parties will not determine, the amount of fees and costs that may be recovered.
6. TRIBAL ABATEMENT FUNDING	a. [X%] of the **Abatement Funds** will be allocated to a Tribal Abatement Fund and these funds will not be a part of the structure involving abatement programs funded by state and local governments. b. The Tribes are working on their proposal for allocation among Tribes, which would be included as part of the overall abatement plan. c. The Tribes will use the tribal allocation of Abatement Funds for programs on the approved list of abatement strategies (see **Schedule B**) and also for culturally appropriate activities, practices, teachings or ceremonies that are, in the judgment of a tribe or tribal health organization, aimed at or supportive of remediation and abatement of the opioid crisis within a tribal community.[5] The Tribes will have a list of representative examples of such culturally appropriate abatement strategies, practices and programs which is attached as **Schedule [ ]**. The separate allocation of abatement funding and illustrative list of culturally appropriate abatement strategies recognizes that American Indian and Alaska Native Tribes and the communities they serve possess unique cultural histories, practices, wisdom, and needs that are highly relevant to the health and well-being of American Indian and Alaska Native

[5] [NTD: Discuss how private claimants will be treated under Tribal Allocation, if at all.]

Issue	Description
	people and that may play an important role in both individual and public health efforts and responses in Native communities.
7. DIVISION OF PUBLIC FUNDS	**Public Funds** are allocated among the States, the District of Columbia and Territories in the percentages set forth on **Schedule C**. Except as set forth below in section 7(C) for the District of Columbia and Territories, each State's Schedule C share shall then be allocated within the State in accordance with the following: 1. **Statewide Agreement**. Each State and its Local Governments will have until [the later of 60 days from entry of an order confirming the Chapter 11 Plan or the Effective Date of the Chapter 11 Plan][6] (the "**Agreement Date**") to file with the Bankruptcy Court an agreed-upon allocation or method for allocating the Public Funds for that State dedicated only to Approved Uses (each a "**Statewide Abatement Agreement**" or "**SAA**"). Any State and its Local Governments that have reached agreement before the Effective Date of the Chapter 11 Plan that satisfies the metric for approval as described in the immediately following paragraph shall file a notice with the Bankruptcy Court that it has adopted a binding SAA and either include the SAA with its filing or indicate where the SAA is publicly available for the SAA to be effective for the Purdue Bankruptcy. Any dispute regarding allocation within a State will be resolved as provided by the Statewide Abatement Agreement. A **Statewide Abatement Agreement** shall be agreed when it has been approved by the State and either (a) representatives[7] of its Local Governments whose aggregate Population Percentages, determined as set forth below, total more than Sixty Percent (60%), or (b) representatives of its Local Governments whose aggregate Population Percentages total more than fifty percent (50%) provided that these Local Governments also represent 15% or more of the State's counties or parishes (or, in the case of States whose counties and parishes that do not function as Local Governments, 15% of or more of the State's incorporated cities or towns), by number.[8]

[6] Should there be provision for extension of the date for filing Statewide Abatement Agreement?

[7] An authorized "representative" of local, or even State, government can differ in this Term Sheet depending on the context.

[8] All references to population in this Term Sheet shall refer to published U. S. Census Bureau population estimates as of July 1, 2019, released March 2020, and shall remain unchanged during the term of this agreement. These estimates can currently be found at https://www.census.gov/data/datasets/time-series/demo/popest/2010s-counties-total.html

Issue	Description
	Population Percentages shall be determined as follows: For States with counties or parishes that function as Local Governments,[9] the Population Percentage of each county or parish shall be deemed to be equal to (a) (1) 200% of the population of such county or parish, minus (2) the aggregate population of all Primary Incorporated Municipalities located in such county or parish,[10] divided by (b) 200% of the State's population. A "**Primary Incorporated Municipality**" means a city, town, village or other municipality incorporated under applicable state law with a population of at least 25,000 that is not located within another incorporated municipality The Population Percentage of each primary incorporated municipality shall be equal to its population (including the population of any incorporated or unincorporated municipality located therein) divided by 200% of the State's population; provided that the Population Percentage of a primary incorporated municipality that is not located within a county shall be equal to 200% of its population (including the population of any incorporated or unincorporated municipality located therein) divided by 200% of the State's population. For all States that do not have counties or parishes that function as Local Governments, the Population Percentage of each incorporated municipality (including any incorporated or unincorporated municipality located therein), shall be equal to its population divided by the State's population. The Statewide Abatement Agreement will become effective within fourteen (14) days of filing, unless otherwise ordered by the Bankruptcy Court. A State and its Local Governments may revise, supplement, or refine a Statewide Abatement Agreement by filing an amended Statewide Abatement Agreement that has been approved by the State and sufficient Local Governments to satisfy the approval standards set forth above with the Bankruptcy Court, which shall become effective within fourteen (14) days of filing, unless otherwise ordered by the Bankruptcy Court. 2. **Default Allocation Mechanism (excluding Territories and DC addressed below).** The **Public Funds** allocable to a State that is not party to a **Statewide Abatement Agreement** as defined in 7(1) above (each a "**Non-SAA State**") shall be allocated as between the State and its Local Governments to be

[9] The following states do not have counties or parishes that function as Local Governments: Alaska, Connecticut, Massachusetts, Rhode Island, and Vermont [INSERT OTHERS]. All other States have counties or parishes that function as Local Governments.

[10] Discuss how to deal with cities and towns that straddle counties.

Issue	Description
	used only for **Approved Uses**, in accordance with this Section (B) (the "**Default Allocation Mechanism**"). a. **Regions.** Except as provided in the final sentence of this paragraph, each **Non-SAA State** shall be divided into "**Regions**" as follows: (a) each **Qualifying Block Grantee** (as defined below) shall constitute a **Region**; and (b) the balance of the State shall be divided into **Regions** (such **Regions** to be designated by the State agency with primary responsibility for substance abuse disorder services employing to the maximum extent practical, existing regions established in that State for opioid abuse treatment or similar public health purposes); such non-**Qualifying Block Grantee Regions** are referred to herein as "**Standard Regions**"). The **Non-SAA States** which have populations under 4 million and do not have existing regions described in the foregoing clause (b) shall not be required to establish **Regions**;[11] such a State that does not establish **Regions** but which does contain one or more **Qualifying Block Grantees** shall be deemed to consist of one **Region** for each **Qualifying Block Grantee** and one **Standard Region** for the balance of the State. b. **Regional Apportionment**. **Public Funds** shall be allocated to each **Non-SAA State, as defined in 7(1) above,** as (a) a **Regional Apportionment** or (b) a **Non-Regional Apportionment** based on the amount of Public Funds dispersed under a confirmed Chapter 11 Plan as follows: i. **First $1 billion** – 70% Regional Apportionment/30% Non-Regional Apportionment ii. **$1-$2.5 billion** – 64% Regional Apportionment /36% Non-Regional Apportionment iii. **$2.5-$3.5 billion** – 60% Regional Apportionment /40% Non-Regional Apportionment iv. **Above $3.5 billion** – 50% Regional Apportionment /50% Non-Regional Apportionment

[11] To the extent they are not parties to a Statewide Abatement Agreement, the following States will qualify as a Non-SAA State that does not have to establish Regions: Connecticut, Delaware, Hawai'i, Iowa, Maine, Nevada, New Hampshire, New Mexico, Rhode Island, Vermont [INSERT OTHERS].

Issue	Description
	c. **Qualifying Block Grantee.** A "**Qualifying Local Government**" means a county or parish (or in the cases of States that do not have counties or parishes that function as political subdivision, a city), that (a) either (i) has a population of 400,000 or more or (ii) in the case of California has a population of 750,000 or more and (b) has funded or otherwise manages an established, health care and/or treatment infrastructure (*e.g.*, health department or similar agency) to evaluate, award, manage and administer a Local Government Block Grant.[12] A **Qualifying Local Government** that elects to receive **Public Funds** through Local Government Block Grants is referred to herein as a **Qualifying Block Grantee.**[13] d. **Proportionate Shares of Regional Apportionment.** As used herein, the "**Proportionate Share**" of each **Region** in each **Non-SAA State** shall be (a) for States in which counties or parishes function as Local Governments, the aggregate shares of the counties or parishes located in such **Region** under the allocation model employed in connection with the Purdue Bankruptcy (the "**Allocation Model**"),[14] divided by the aggregate shares for all counties or parishes in the State under the **Allocation Model**; and (b) for all other States, the aggregate shares of the cities and towns in that **Region** under the **Allocation Model's** intra-county allocation formula, divided by the aggregate shares for all cities and towns[15] in the State under the **Allocation Model.** e. **Expenditure or Disbursement of Regional Apportionment.** Subject to 7(2)(i) below regarding **Allowed Administrative Expenses**, all **Regional Apportionments** shall be disbursed or expended in the form of **Local Government Block Grants** or otherwise for **Approved Opioids Abatement Uses** in the **Standard Regions** of each **Non-SAA State.**

[12] As noted in footnote 8, the population for each State shall refer to published U. S. Census Bureau population estimates as of July 1, 2019, released March 2020, and shall remain unchanged during the term of this agreement. These estimates can currently be found at https://www.census.gov/data/datasets/time-series/demo/popest/2010s-counties-total.html

[13] [NTD: Perhaps provide for a Qualifying Political Subdivision to expand to include neighboring areas that are part of its metro area?]

[14] Need to address whether to use the Negotiation Class Allocation Model or other metric to determine Proportionate Share.

[15] Should this be all cities and towns or only primary incorporated municipalities?

Issue	Description
	f. **Qualifying Block Grantees.** Each **Qualifying Block Grantee** shall receive its **Regional Apportionment** as a block grant (a "**Local Government Block Grant**"). **Local Government Block Grants** shall be used only for **Approved Opioid Abatement Uses** by the **Qualifying Block Grantee** or for grants to organizations within its jurisdiction for **Approved Opioid Abatement Uses** and for **Allowed Administrative Expenses** in accordance with 7(2)(i) below. Where a municipality located wholly within a **Qualifying Block Grantee** would independently qualify as a block grant recipient ("**Independently Qualifying Municipality**"), the **Qualifying Block Grantee** and **Independently Qualifying Municipality** must make a substantial and good faith effort to reach agreement on use of Abatement Funds as between the qualifying jurisdictions. If the **Independently Qualifying Municipality** and the **Qualifying Block Grantee** cannot reach such an agreement on or before the **Agreement Date [or some later specified date]**, the **Qualifying Block Grantee** will receive the **Local Government Block Grant** for its full **Proportionate Share** and commit programming expenditures to the benefit of the **Independently Qualifying Municipality** in general proportion to **Proportionate Shares** (determined as provided in 7(2)(d) above) of the municipalities within the **Qualifying Block Grantee**. Notwithstanding the allocation of the Proportionate Share of each Regional Apportionment to the Qualifying Block Grantee, a Qualifying Block Grantee may choose to contribute a portion of its Proportionate Share towards a Statewide program. g. **Standard Regions.** The portions of each **Regional Apportionment** not disbursed in the form of **Local Government Block Grants** shall be expended throughout the **Standard Regions** of each **Non-SAA State** in accordance with 95%-105% of the respective **Proportionate Shares** of such **Standard Regions**. Such expenditures will be in a manner that will best address Opioid abatement within the State as determined by the State with the input, advice and recommendations of the **Government Participation Mechanism** described in Section 8 below. This regional spending requirement may be met by delivering **Approved Opioid Abatement Use** services or programs to a **Standard Region** or its residents. Delivery of such services or programs can be

Issue	Description
	accomplished directly or indirectly through many different infrastructures and approaches, including without limitation the following: i. State agencies, including local offices; ii. Local governments, including local government health departments; iii. State public hospital or health systems; iv. Health care delivery districts; v. Contracting with abatement service providers, including nonprofit and commercial entities; or vi. Awarding grants to local programs. h. **Expenditure or Disbursement of Public Funds Other Than Regional Apportionment.** All **Public Funds** allocable to a **Non-SAA State** that are not included in the State's **Regional Apportionment** shall be expended only on **Approved Uses**. The expenditure of such funds shall be at the direction of the State's lead agency (or other point of contact designated by the State) and may be expended on a statewide and/or localized manner, including in the manners described in herein. **Qualifying Block Grantees** will be eligible to participate in or receive the benefits of any such expenditures on the same basis as other **Regions.** i. **Allowed Administrative Expenses. Qualifying Block Grantees** States may use up to 5% of their Non-Regional Apportionments plus 5% of the Regional Apportionment not used to fund **Local Government Block Grants,** for **Allowed Administrative Expenses. Qualifying Block Grantees** may use up to 5% of their **Local Government Block Grants** to fund their **Allowed Administrative Expenses.** 3. **Records.** The State shall maintain records of abatement expenditures and its required reporting will include data on regional expenditures so it can be verified that the Regional Distribution mechanism guarantees are being met.[16] **Qualifying Block Grantees** shall maintain records of abatement expenditures and shall provide those records periodically to their State for inclusion in the State's required periodic reporting, and shall be subject to audit consistent with State law applicable to the granting of State funds.

[16] Additional records and reporting requirements?

Issue	Description
	(C) Allocation for Territories and the District of Columbia Only The allocation of Public Funds within a Territory or the District of Columbia will be determined by its local legislative body [within one year of the Agreement Date], unless that legislative body is not in session, in which case, the allocation of Public Funds shall be distributed pursuant to the direction of the Territory's or District of Columbia's executive, in consultation – to the extent applicable – with its Government Participation Mechanism [within ninety (90) days of the Agreement Date].[17]
8. GOVERNMENT PARTICIPATION MECHANISM	In each **Non-SAA State**, as defined in 7(1) above, there shall be a process, preferably pre-existing, whereby the State shall allocate funds under the Regional Distribution mechanism only after meaningfully consulting with its respective Local Governments. Each such State shall identify its mechanism (whether be it a council, board, committee, commission, taskforce, or other efficient and transparent structure) for consulting with its respective Local Governments (the "**Government Participation Mechanism**" or "**GPM**") in a notice filed with the Bankruptcy Court identifying what GPM has been formed and describing the participation of its Local Governments in connection therewith. States may combine these notices into one or more notices for filing with the Bankruptcy Court. These notices are reviewable by the Bankruptcy Court upon the motion of any Local Government in that State asserting that no GPM has been formed. Government Participation Mechanisms shall conform to the following: (A) ***Composition***. For each State, a. the State, on the one hand, and State's Local Governments, on the other hand, shall have equal representation on a GPM; b. Local Government representation on a GPM shall be weighted in favor of the Standard Regions but can include representation from the State's Qualifying Block Grantees; c. the GPM will be chaired by a non-voting Chairperson appointed by the State; d. Groups formed by the States' executive or legislature may be used as a GPM, provided that the group has equal representation by the State and the State's Local Governments.[18] Appointees should possess experience, expertise and education with respect to public health, substance abuse, and other related

[17] Territory and DC provisions to be discussed

[18] Additional potential terms: mechanism for state and local appointment; duration of term, reimbursement of expenses.

Issue	Description
	topics as is necessary to assure the effective functioning of the GPM. (B) ***Consensus***. Members of the GPMs should attempt to reach consensus with respect to **GPM Recommendations** and other actions of the GPM. Consensus is defined in this process as a general agreement achieved by the members that reflects, from as many members as possible, their active support, support with reservations, or willingness to abide by the decision of the other members. Consensus does not require unanimity or other set threshold and may include objectors. In all events, however, actions of a GPM shall be effective if supported by at least a majority of its Members. **GPM Recommendations** and other action shall note the existence and summarize the substance of objections where requested by the objector(s). (C) ***Proceedings***. Each GPM shall hold no fewer than four public meetings annually, to be publicized and located in a manner reasonably designed to facilitate attendance by residents throughout the State. Each GPM shall function in a manner consistent with its State's open meeting, open government or similar laws, and with the Americans with Disabilities Act. GPM members shall be subject to State conflict of interest and similar ethics in government laws. (D) ***Consultation and Discretion***. The GPM shall be a mechanism by which the State consults with community stakeholders, including Local Governments (including those not a part of the GPM), state and local public health officials and public health advocates, in connection with opioid abatement priorities and expenditure decisions for the use of Public Funds on Approved Opioid Abatement Uses.[19] (E) ***Recommendations***. A GPM shall make recommendations regarding specific opioid abatement priorities and expenditures for the use of Public Funds on Approved Opioid Abatement Uses to the State or the agency designated by a State for this purpose (**"GPM Recommendations"**). In carrying out its obligations to provide **GPM Recommendations,** a GPM may consider local, state and federal initiatives and activities related to education, prevention, treatment and services for individuals and families experiencing and affected by opioid use disorder; recommend priorities to address the State's opioid epidemic, which recommendations may be Statewide or specific to **Regions**; recommend Statewide or **Regional** funding with respect to specific programs or initiatives; recommend measurable outcomes to determine the effectiveness of funds expended for

[19] Address form of consultation with non-GPM members, public hearings, etc.

Issue	Description
	Approved Opioid Abatement Uses; monitor the level of **Allowed Administrative Expenses** expended from **Public Funds**. The goal is for a process that produces **GPM Recommendations** that are recognized as being an efficient, evidence-based approach to abatement that addresses the State's greatest needs while also including programs reflecting particularized needs in local communities. It is anticipated that such a process, particularly given the active participation of state representatives, will inform and assist the state in making decisions about the spending of the **Public Funds**. To the extent a State chooses not to follow a **GPM Recommendation**, it will make publicly available within 14 days after the decision is made a written explanation of the reasons for its decision, and allow 7 days for the GPM to respond. (F) ***Review***. Local Governments and States may object to an allocation or expenditure of **Public Funds** (whether a **Regional Apportionment** or **Non-Regional** Apportionment) solely on the basis that the allocation or expenditure at issue (i) is inconsistent with the provisions of Section 7(B)2 hereof with respect to the levels of **Regional Apportionments** and **Non-Regional** Apportionments; (ii) is inconsistent with the provisions of Section 7(B)(5) hereof with respect to the amounts of **Local Government Block Grants** or **Regional Apportionment** expenditures; (iii) is not for an **Approved Use,** or (iv) violates the limitations set forth herein with respect to **Allowed Administrative Fees**. The objector shall have the right to bring that objection to either (a) a court with jurisdiction within the applicable State ("**State Court**") or (b) the Bankruptcy Court if the Purdue chapter 11 case has not been closed; provided that nothing herein is intended to expand the scope of the Bankruptcy Court's post-confirmation jurisdiction or be deemed to be a consent to any expanded post-confirmation jurisdiction by the Bankruptcy Court (each an "**Objection**"). If an Objection is filed within fourteen (14) days of approval of an Allocation, then no funds shall be distributed on account of the aspect of the Allocation that is the subject of the Objection until the Objection is resolved or decided by the Bankruptcy Court or State Court, as applicable. There shall be no other basis for bringing an Objection to the approval of an Allocation.
8. COMPLIANCE, REPORTING, AUDIT AND ACCOUNTABILITY	At least annually, each State shall publish on the lead State Agency's website or on its Attorney General's website a report detailing for the preceding time period, respectively (i) the amount of Public Funds received, (ii) the allocation awards approved (indicating the recipient, the

Issue	Description
	amount of the allocation, the program to be funded and disbursement terms), and (iii) the amounts disbursed on approved allocations, to Qualifying Local Governments for Local Government Block Grants and Allowed Administrative Fees. At least annually, each **Qualifying Block Grantee** which has elected to take a Local Government Block Grant shall publish on its lead Agency's or Local Government's website a report detailing for the preceding time period, respectively (i) the amount of **Local Government Block Grants** received, (ii) the allocation awards approved (indicating the recipient, the amount of the grant, the program to be funded and disbursement terms), and (iii) the amounts disbursed on approved allocations. As applicable, each State or Local Government shall impose reporting requirements on each recipient to ensure that **Public Funds** are only being used for **Approved Uses**, in accordance with the terms of the allocation, and that the efficacy of the expenditure of such **Public Funds** with respect to opioids abatement can be publicly monitored and evaluated. The expenditure and disbursement of **Public Funds** shall be subject to audit by States as follows: [details of audit scope, process, output, etc.] (a) A court with jurisdiction within the applicable State ("**State Court**") or (b) the Bankruptcy Court if the Purdue chapter 11 case has not been closed shall have jurisdiction to enforce the terms of this agreement, and as applicable, a Statewide Abatement Agreement or Default Mechanism; provided that nothing herein is intended to expand the scope of the Bankruptcy Court's post-confirmation jurisdiction.

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].

A. Naloxone/Narcan

1. Expand training for first responders, EMTs, law enforcement, schools, community support groups and families; and
2. Increase distribution to non-Medicaid eligible or uninsured individuals.

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 MAT services to youth and 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. Non-MAT treatment, including addition and expansion of services for managing withdrawal and related systems such as detox, residential, hospitalization, intensive outpatient, outpatient, recovery housing, and treatment facilities.

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 from 60 days postpartum to 12 months (post-Medicaid coverage); and
3. Provide comprehensive wrap-around services to individuals in recovery 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.

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 other polysubstance abuse problems;
4. Provide comprehensive wrap-around services to individuals in recovery including housing, transportation, job placement/training, and childcare; and
5. Hire additional social 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 that currently have or had detox units to treat 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 school-based prevention programs, beyond education about MAT mentioned above, including evidence-based school-wide programs;
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 for additional city police officers/county sheriffs to specifically address OUD and opioid-related ODs.

H. Expanding Syringe Service Programs

1. Provide comprehensive syringe exchange services programs with more wrap-around services including treatment information.

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

Schedule B
Approved Uses[20]

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

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, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

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 services that include the full American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions, including but not limited to:
    a. Medication-Assisted Treatment (MAT);
    b. Abstinence-based treatment;
    c. Treatment, recovery, or other services provided by states, subdivisions, community health centers; non-for-profit providers; or for-profit providers;
    d. Treatment by providers that focus on OUD treatment as well as treatment by providers that offer OUD treatment along with treatment for other SUD/MH conditions; or
    e. Evidence-informed residential services programs, as noted below.

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, evidence-informed, or promising 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

[20] [NTD: Discuss expanded list of Approved Uses to be included. Discuss "self-executing" function based on additional information received from NCSG.]

OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Treatment of mental health trauma resulting from the traumatic experiences of the opioid user (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 detoxification (detox) and withdrawal management services for persons with OUD and any co-occurring SUD/MH conditions, including medical detox, referral to treatment, or connections to other services or supports.

8. Training on MAT for health care providers, 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 certified addiction counselors and other mental and behavioral health providers involved in addressing OUD any co-occurring SUD/MH conditions, including but not limited to training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Scholarships for persons to become certified addiction counselors, licensed alcohol and drug counselors, licensed clinical social workers, and licensed mental health counselors practicing in the SUD field, and scholarships for certified addiction counselors, licensed alcohol and drug counselors, licensed clinical social workers, and licensed mental health counselors practicing in the SUD field for continuing education and licensing fees.

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

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

2. 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.

3. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, or training for housing providers.

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

5. 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.

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

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

8. 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.

9. 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 manage the opioid user in the family.

10. Training and development of procedures for government staff to appropriately interact and provide social and other services to current and recovering opioid users, including reducing stigma.

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

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

13. Create and/or support recovery high schools.

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, evidence-informed, or promising 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.

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

6. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into community treatment or recovery services through a bridge clinic or similar approach.

7. 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.

8. 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.

9. 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.

10. Provide funding for peer navigators, recovery coaches, care coordinators, or care managers that offer assistance to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced on opioid overdose.

11. 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.

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

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

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

15. 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.

16. Create or support intake and call centers to facilitate education and access to treatment, prevention, and recovery services for persons with OUD and any co-occurring SUD/MH conditions.

17. Develop or support a National Treatment Availability Clearinghouse – a multistate/nationally accessible database whereby health care providers can list locations for currently available in-patient and out-patient OUD treatment services that are accessible on a real-time basis by persons who seek treatment.

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 – or are at risk of becoming involved – in the criminal justice system through evidence-based, evidence-informed, or promising 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 and to reduce perceived barriers associated with law enforcement 911 responses.

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 for persons with OUD and any co-occurring SUD/MH conditions, but only if these courts provide referrals to evidence-informed treatment, including MAT.

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, through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

1. Support evidence-based, evidence-informed, or promising 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 educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. 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.

3. 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.

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

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

6. 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.

7. 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.

8. 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, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

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

2. Academic counter-detailing to educate prescribers on appropriate opioid prescribing.

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.

6. Development and implementation of a national PDMP – Fund development of a multistate/national PDMP that permits information sharing while providing appropriate safeguards on sharing of private health information, including but not limited to:
    a. Integration of PDMP data with electronic health records, overdose episodes, and decision support tools for health care providers relating to OUD.
    b. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database.

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, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

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

2. Public education relating to drug disposal.

3. Drug take-back disposal or destruction programs.

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

5. 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).

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

7. Support evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

8. 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.

9. 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.

10. 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.

11. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses 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, evidence-informed, or promising 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, opioid users, families and friends of opioid users, schools, community navigators and outreach workers, drug offenders upon release from jail/prison, or other members of the general public.

2. Public health entities provide free naloxone to anyone in the community, including but not limited to provision of intra-nasal naloxone in settings where other options are not available or allowed.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, 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 C8, D1 through D7, H1, H3, and H8, support the following:

1. Law enforcement expenditures relating to the opioid epidemic.

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

3. 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, and coordination to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Community regional planning to identify goals for reducing harms related to the opioid epidemic, to identify areas and populations with the greatest needs for treatment

intervention services, or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A government dashboard to track key opioid-related indicators and supports as identified through collaborative 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 in items A7, A8, A9, A12, A13, A14, A15, B7, B10, C3, C5, D7, E2, E4, F1, F3, F8, G5, H3, H12, and I-2, 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:

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

b. Research non-opioid treatment of chronic pain.

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

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

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

f. 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).

g. Research on expanded modalities such as prescription methadone that can expand access to MAT.

h. 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.

i. 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.

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

Schedule C
State Allocation Percentages

[TO BE INSERTED]

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