Purchase Agreement #PL316

Between

Central Florida Behavioral Health Network, Inc.

And

Polk County, A Political Subdivision of the State of Florida

THIS AGREEMENT "Agreement" is entered into by and between CENTRAL FLORIDA BEHAVIORAL HEALTH NETWORK, INC., hereinafter referred to as the "Managing Entity" and POLK COUNTY, A POLITICAL SUBDIVISION OF THE STATE OF FLORIDA, hereinafter referred to as the "Contractor", (Managing Entity and Contractor shall be jointly referred to herein as the "Parties").

FOR AND IN CONSIDERATION of the mutual undertakings and agreements hereinafter set forth, the Parties agree as follows:

1. General Description

The Department of Children and Families (DCF) requires that CFBHN enter into agreements with organizations under the Coordinated Opioid Recovery (CORE) Network of Addiction Care and in accordance with the Florida Opioid Allocation and Statewide Response Agreement, executed November 15, 2021.

Per DCF, "According to the Florida Opioid Allocation and Statewide Response Agreement between Local Governments and the Office of the Attorney General, opioid settlement funds may only be used for approved purposes, which include, but are not limited to, all of the opioid- related prevention, treatment, and recovery support services and opioid abatement strategies listed in Schedule A (Core Strategies) and Schedule B (Approved Uses) from Florida Opioid Allocation and Statewide Response Agreement. Local Governments may choose from the approved uses in Schedule B, but priority must be given to the core strategies in Schedule A."

The Florida Opioid Allocation and Statewide Response Agreement, along with the accompanying schedules, can be found on the following website: https://nationalopioidsettlement.com/states/florida/.

2. Scope of Work

The Contractor shall perform duties and activities in accordance with **Guidance 41** – Coordinated Opioid Recovery Network of Addiction Care (CORE Network).

3. Method of Payment

a. This is a Hybrid Agreement (Cost-Reimbursable + Performance Metrics) totaling **$109,375.00**, subject to the availability of funding, as outlined below.

State Fiscal Year	Base Funding	Current Fiscal Year Only (Non-Recurring)	Carry Forward	Total Value of Agreement
2025-2026	$0	$109,375.00	$0	**$109,375.00**
2026-2027	$0	$0	$0	**$0**
2027-2028	$0	$0	$0	**$0**
2028-2029	$0	$0	$0	**$0**
2029-2030	$0	$0	$0	**$0**
Total	**$0**	**$109,375.00**	$0	**$109,375.00**

b. The Managing Entity shall reduce or withhold funds pursuant to Rule 65-29.001, F.A.C., if the Contractor fails to comply with the terms of the Agreement.

c. The Contractor shall request payment through the Carisk Portal based on the due dates listed in the chart below:

Month	Due Date
July 2025	8/11/2025
August 2025	9/10/2025

Month	Due Date
September 2025	10/10/2025
October 2025	11/10/2025
November 2025	12/10/2025
December 2025	1/9/2026
January 2026	2/10/2026
February 2026	3/10/2026
March 2026	4/10/2026
April 2026	5/11/2026
May 2026	6/10/2026
June 2026	7/10/2026

d. The Managing Entity may require any other information from the Contractor that it deems necessary to verify performance and purchases made of the Contractor under the Purchase Agreement.

e. The Managing Entity reserves the right to request supporting documentation at any time after the invoice has been submitted.

f. During the fiscal year, CFBHN may request supporting documentation to complete a review of monthly expenditures. If the billed amount exceeds the actual expenditures, the Contractor will be required to repay the difference. At the close of the fiscal year, CFBHN will conduct a final reconciliation to compare the Contractor's total billed amounts with the actual expenditures reported throughout the year, and any overbilled amount must be repaid to CFBHN.

4. Contract Deliverables

a. Monthly Expenditure Report – due by the 25th of the month following services.

b. Receipt of Opioid Settlement funds is an express acknowledgement of the obligation to report data on services funded by the Settlement. Recipients shall provide data to the Department of Children and Families (Department) through the Opioid Data Management System (ODMS) as prescribed by the Department. Opioid Settlement funding is contingent upon satisfactory data reporting.

c. All deliverables and related tasks must be completed 100% as specified. Failure to satisfactorily complete or submit a deliverable in the time and manner specified may result in a corrective action plan, withholding of payment, or issuance of financial sanctions or penalties.

d. The following deliverables are required in order to support payment for the core program:

Polk County Fire Rescue, Community Paramedicine Team will support the Polk County CORE initiative in accordance with current CORE practices previously established. As this team has been working in the Community Paramedicine (CP) and Mobile Integrated Health (MIH) space for several years, they will expand by 1 team member to work full time in the support of individuals referred to CORE programing from area hospitals with established channels of communication. Recovery and medical support services will be rendered to these individuals to include substantive case management, transportation, referral, and community connections.

As such the CP Team will have the following deliverables in support of applied funding.

25-26 Deliverables:	• **Continued reporting in ODMS via MSTARs** • **Participate in CORE monthly update meeting**

5. Vendor Information

a. ANNUAL APPROPRIATIONS: Managing Entity's obligation to pay under this contract is contingent upon

annual appropriation by the legislature.

b. BACKGROUND SCREENING: The Contractor shall comply with the staffing qualifications and requirements (including background screening), required by this Agreement and as required by applicable law, rule, or regulations, including without limitation, the regulations of the Department.

The Contractor shall comply with the provisions of s. 448.095(5), F.S. The Contractor will use the E-verify system established by the U.S. Department of Homeland Security to verify the employment eligibility of its employees and the Contractor's subcontractors' employees performing under this Agreement.

Mental Health: The Contractor shall provide employment screening for all mental health personnel and all chief executive officers, directors, and chief financial officers of Contractor using the standards for Level II screening set forth in Chapter 435, and Section 408.809 Florida Statutes (F.S.), except as otherwise specified in Sections 394.4572(1)(b)-(c), F.S. For the purposes of this Agreement, "mental health personnel" includes all program directors, professional clinicians, staff members, clubhouse staff, drop-in center staff, and volunteers working in public or private mental health programs and facilities who have direct contact with individuals held for examination or admitted for mental health treatment, or who have access to client funds, personal property, or living areas. In addition, employment screening described in this paragraph may include a local criminal records check conducted through a local law enforcement agency.

Substance Abuse: The Contractor shall ensure compliance with background screening in accordance with Section 397.4073, F.S. This statute requires employment screening for:

i. Owners, directors, chief financial officers, and clinical supervisors of service providers.

ii. All service provider personnel who have direct contact with children receiving services or with adults who are developmentally disabled.

iii. All peer specialists who have direct contact with individuals receiving services are screened in accordance with Section 397.417(4), F.S.

Individuals subject to Mental Health and Substance Abuse screening in this section shall be re-screened within five (5) years from the date of their last screening results and every five (5) years thereafter.

At the time of the initial level 2 background screening, and with every 5 year re-screening, the Contractor shall require mental health and substance abuse personnel to complete the current version of DCF Affidavit of Good Moral Character. The current version of the form CF 1649 (April 2021) is incorporated by reference an available at https://www.flrules.org/Gateway/reference.asp?No=Ref-15275.

c. FEDERAL LAW:

i. The Contractor shall comply with the applicable provisions of Federal law and regulations including, but not limited to, 2 CFR, Part 200, and other applicable regulations.

ii. If this Agreement contains $10,000 or more of Federal Funds, the Contractor shall comply with Executive Order 11246, Equal Employment Opportunity, as amended by Executive Order 11375 and others, and as supplemented in Department of Labor regulation 41 CFR, Part 60 if applicable.

iii. If this Agreement contains over $150,000 of Federal Funds, the Contractor shall comply with all applicable standards, orders, or regulations issued under section 306 of the Clean Air Act, as amended (42 U.S.C. § 7401 et seq.), section 508 of the Federal Water Pollution Control Act, as amended (33 U.S.C. § 1251 et seq.), Executive Order 11738, as amended and where applicable, and Environmental Protection Agency regulations (2 CFR, Part 1500). The Contractor shall report any violations of the above to the Department. The Contractor agrees to include these requirements in this section 5.c.iii in each subcontract exceeding $150,000 financed in whole or in part with Federal assistance.

iv. No Federal Funds received in connection with this Agreement may be used by the Contractor,

or agent acting for the Contractor, or subcontractor to influence legislation or appropriations pending before the Congress or any State legislature. If this Agreement contains Federal funding in excess of $100,000, the Contractor must, prior to contract execution, complete the Certification Regarding Lobbying form. All disclosure forms as required by the Certification Regarding Lobbying form must be completed and returned to the Contract Manager, prior to payment under this Agreement.

v. If this Agreement provides services to children up to age 18, the Contractor shall comply with the Pro-Children Act of 1994 (20 U.S.C. § 6081). Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation or the imposition of an administrative compliance order on the responsible entity, or both.

vi. If the Contractor is a federal subrecipient or pass-through entity, then the Contractor and its subcontractors who are federal subrecipients or pass-through entities are subject to the following: A contract award (see 2 CFR § 180.220) must not be made to parties listed on the government-wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines in 2 CFR, Part 180 that implement Executive Orders 12549 and 12689, "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

vii. If the Contractor is a federal subrecipient or pass through entity, the Contractor and its subcontractors who are federal subrecipients or pass-through entities, must determine whether or not its Agreements are being awarded to a "contractor" or a "subrecipient," as those terms are defined in 2 CFR, Part 200. If a Contractor's subcontractor is determined to be a subrecipient, the Contractor must ensure the subcontractor adheres to all the applicable requirements in 2 CFR, Part 200.

d. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT: The Contractor shall, where applicable, comply with the Health Insurance Portability and Accountability Act (42 U.S.C. 1320d.) as well as all regulations promulgated thereunder (45 CFR Parts 160, 162, and 164).

e. INDEMNIFICATION: The Contractor shall be fully liable for the actions of its agents, employees, partners, or subcontractors and shall fully indemnify, defend, and hold harmless Managing Entity, the Department, and their officers, agents, and employees, from suits, actions, damages, and costs of every name and description, including attorneys' fees, costs, and expenses arising from or relating to an alleged act or omission by the Contractor, its agents, employees, partners, or subcontractors, provided however that the Contractor shall not indemnify for that portion of any loss or damages proximately caused by the negligent act or omission of Managing Entity or the Department.

Further, the Contractor shall, without exception, indemnify and hold harmless Managing Entity and the Department, and their employees from any liability of any nature or kind whatsoever, including attorneys' fees, costs, and expenses arising out of, relating to, or involving any claim associated with any trademark, copyrighted, patented, or unpatented invention, process, trade secret, or intellectual property right, information technology used or accessed by the Contractor, or article manufactured or used by the Contractor, its officers, agents, or Contractors in the performance of this Agreement or delivered to Managing Entity or the Department for the use of Managing Entity or the Department, its employees, agents, or contractors.

Further, the Contractor shall protect, defend, and indemnify, including attorneys' fees, costs, and expenses, Managing Entity and the Department for any and all claims and litigation (including litigation initiated by Managing Entity or the Department) arising from or relating to Contractor's claim that a document contains proprietary or trade secret information that is exempt from disclosure or the scope of the Contractor's redaction.

The Contractor's inability to evaluate liability or its evaluation of liability shall not excuse its duty to defend and indemnify after receipt of notice. Only an adjudication or judgment after the highest appeal is

exhausted finding Managing Entity or the Department negligent shall excuse the provider of performance under this provision, in which case Managing Entity or the Department shall have no obligation to reimburse the Contractor for the cost of their defense. If the Contractor is an agency or subdivision of the State, its obligation to indemnify, defend, and hold harmless the Department shall be to the extent permitted by law and without waiving the limits of sovereign immunity.

f. **INDEPENDENT CONTRACTOR:** In performing its obligations under this Agreement, the Contractor shall at all times be acting in the capacity of an independent contractor and not as an officer, employee or agent of Managing Entity or the Department. Neither the Contractor nor any of its agents, employees, Contractors or assignees shall represent to others that it is an agent of or has the authority to bind Managing Entity or the Department by virtue of this Agreement.

g. **INSURANCE:** See Attachment II.

h. **LAW AND VENUE:** This Agreement is executed and entered in the State of Florida and will be construed, performed, and enforced in all respects in accordance with Florida law, excluding Florida provisions for conflict of laws, and applicable Federal law. Venue for any action regarding this Agreement shall be in Polk County, Florida.

i. **MONITORING:** The Contractor shall permit all persons who are duly authorized by Managing Entity or the Department to inspect and copy any records, papers, documents, facilities, goods, and services of the Contractor which are relevant to this Agreement, and to interview any clients, employees, and subcontractor employees of the Contractor to assure Managing Entity of the satisfactory performance of the terms and conditions of this Agreement.

j. **PROPERTY:**

i. The following only applies to this Agreement if funded by state financial assistance.

ii. The word "property" in this section means equipment, fixtures, and other property of a non-consumable and non-expendable nature, the original acquisition cost or estimated fair market value of which is $5,000 or more and the normal expected life of which is one year or more. This definition also includes hardback-covered bound books circulated to students or the general public, the original acquisition cost or estimated fair market value of which is $25 or more, hardback-covered bound books, the cost or value of which is $250 or more, and all computers. Each item of property which it is practicable to identify by marking will be marked in the manner required by the Auditor General. Each custodian will maintain an adequate record of property in his or her custody, which record will contain such information as will be required by the Auditor General. Once each year, on July 1 or as soon thereafter as is practicable, and whenever there is a change of custodian, each custodian will take an inventory of property in his or her custody. The inventory will be compared with the property record, and all discrepancies will be traced and reconciled. All publicly supported libraries will be exempt from marking hardback-covered bound books, as required by this section. The catalog and inventory control records maintained by each publicly supported library is the property record of hardback-covered bound books with a value or cost of $25 or more included in each publicly supported library collection and is a perpetual inventory in lieu of an annual physical inventory. All books identified by these records as missing will be traced and reconciled, and the library inventory shall be adjusted accordingly.

iii. If any property is purchased by the Contractor with funds provided by this Agreement, the Contractor will inventory all non-expendable property including all computers. A copy of the inventory will be submitted to the Managing Entity along with the expenditure report for the period in which it was purchased. At least annually the Contractor will submit a complete inventory of all such property to the Managing Entity whether new purchases have been made or not.

iv. The inventory will include: the identification number; year and/or model, a description of the property, its use and condition; current location; the name of the property custodian; class code (use state standard codes for capital assets); if a group, record the number and description of the

components making up the group; name, make, or manufacturer; serial number(s), if any, and if an automobile, the Vehicle Identification Number (VIN) and certificate number; acquisition date; original acquisition cost; funding source; and, information needed to calculate the federal and/or state share of its cost.

v. The Managing Entity must provide disposition instructions to the Contractor prior to the End Date. The Contractor cannot dispose of any property reverting to the Department without the Contract Manager's approval. The Contractor will furnish a closeout inventory no later than 30 days before the completion or termination of this Agreement. The closeout inventory will include all nonexpendable property including all computers purchased by the Contractor. The closeout inventory will contain the same information required by the annual inventory.

vi. The Contractor hereby agrees all inventories required by this Agreement will be current and accurate and reflect the date of the inventory. If the original acquisition cost of a property item is not available at the time of inventory, an estimated value will be agreed upon by the Contractor, the Managing Entity, and the Department and will be used in place of the original acquisition cost.

vii. Title (ownership) to and possession of all property purchased by the Contractor pursuant to this Agreement vests in the Department upon completion or termination of this Agreement. During the term of this Agreement, the Contractor is responsible for insuring all property purchased by or transferred to the Contractor is in good working order. The Contractor hereby agrees to pay the cost of transferring title to and possession of any property for which ownership is evidenced by a certificate of title. The Contractor is responsible for repaying to the Department, the replacement cost of any property inventoried and not transferred to the Department upon completion or termination of this Agreement. When property transfers from the Contractor to the Department, the Contractor is responsible for paying for the title transfer.

viii. If the Contractor replaces or disposes of property purchased by the Contractor pursuant to this Agreement, the Contractor is required to provide accurate and complete information pertaining to replacement or disposition of the property as required on the Contractor's annual inventory.

ix. The Contractor will indemnify the Managing Entity and the Department against any claim or loss arising out of the operation of any motor vehicle purchased by or transferred to the Contractor pursuant to this Agreement.

x. An amendment is required prior to the purchase of any property item not specifically listed in the approved budget.

k. PUBLIC ENTITY CRIMES: Chapter 287.133(2)(a) states: A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a bid on a contract to provide any goods or services to a public entity, may not submit a bid on a contract with a public entity for the construction or repair of a public building or public work, may not submit bids on leases of real property to a public entity, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in s.287.017 for CATEGORY TWO for a period of 36 months from the date of being placed on the convicted vendor list.

l. PUBLIC RECORDS: The Contractor shall allow public access to all documents, papers, letters, or other public records as defined in Subsection 119.011(12), F.S. as prescribed by Subsection 119.07(1) F.S., made or received by the Contractor in conjunction with this Agreement except those public records which are made confidential by law and must be protected from disclosure. It is expressly understood that the Contractor's failure to comply with this provision shall constitute an immediate breach of this Agreement for which Managing Entity may unilaterally terminate this Agreement.

The Contractor shall retain all client records, financial records, supporting documents, statistical records and any other documents (including electronic storage media) pertinent to this Agreement for a period of six (6) years after completion of this Agreement or longer when required by law. In the event an audit is

required by this Agreement, records shall be retained for a minimum period of six (6) years after the audit report is issued or until resolution of any audit findings or litigation based on the terms of this Agreement.

m. SCRUTINIZED COMPANIES: The Contractor shall refrain from any of the prohibited business activities with the Governments of Sudan and Iran as described in Section 215.473, F.S. Pursuant to Section 287.135(5), F.S., Managing Entity will immediately terminate this Agreement for cause if the Contractor is found to have submitted a false certification or if the Contractor is placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List during the term of the Agreement. Managing Entity will terminate this Agreement at any time the Contractor is found to have been placed on the Scrutinized Companies that Boycott Israel List or is engaged in a boycott of Israel.

n. SPONSORSHIP AND PUBLICITY: The Contractor and partners shall, in publicizing, advertising or describing the sponsorship of the program, state: "Sponsored by Polk County, A Political Subdivision of the State of Florida, Central Florida Behavioral Health Network, Inc., and the State of Florida, Department of Children and Families." If the sponsorship reference is in written material, the words "State of Florida, Department of Children and Families" and "Central Florida Behavioral Health Network, Inc." shall appear in the same size letters or type as the name of the organization.

o. TERMINATION: Termination at Will. Either party may terminate this Agreement upon at least thirty (30) days prior written notice to the other party. In a termination at will by a party, the other party shall not be liable for costs of termination or damages incurred by the party giving notice of termination at will or by any of its subcontractors. In a termination at will by a party, the party giving notice of termination at will shall not be liable for costs of termination or damages incurred by the other party or by any of its subcontractors.

i. Termination for Lack of Funds. Managing Entity may terminate this Agreement upon at least twenty-four (24) hours prior written notice to Contractor if Managing Entity has not received funds from the Department for the services for which Contractor is requesting payment or for any services to be provided under this Agreement.

ii. Termination for Cause. Upon the Managing Entity's knowledge of a material breach by the Contractor, Managing Entity shall either:

1. Provide an opportunity for the Contractor to cure the breach or end the violation and terminate the Agreement or discontinue access to PHI if Contractor does not cure the breach or end the violation within the time specified by Managing Entity;

2. Immediately terminate this Agreement or discontinue access to PHI if Contractor breached a material term of this Agreement and does not end the violation; or

3. If neither termination nor cure is feasible, the Managing Entity shall report the violation to the Department of Children and Families and Secretary of the Department of Health and Human Services.

iii. Additional Breaches. Breaches by Contractor include the following items:

If Contractor is suspended or becomes disqualified from providing the services, found to be negligent or to have caused harm to a qualified individual, or otherwise is subject to disciplinary action which materially adversely affects the Contractor's ability to perform the services under this Agreement.

If Contractor (or its officers or directors) is convicted of or pleads guilty, no contest, or otherwise admits to any crime involving a morally corrupt act or practice or any felony offense.

If the Contractor makes an assignment for the benefit of creditors, files a voluntary petition in bankruptcy, is adjudicated bankrupt or insolvent or has entered against it an order for any relief in any bankruptcy or insolvency proceeding or has an involuntary petition in bankruptcy or similar proceeding filed against it which has not been dismissed within one hundred twenty

(120) days after the commencement thereof.

If Contractor commits any other material breach of this Agreement.

iv. Immediate Termination. Managing Entity shall immediately terminate this Agreement for cause, if any time during the lifetime of the Agreement, the Contractor is:

1. Found to have submitted a false certification under s. 287.135, F.S., or
2. Is placed on the Scrutinized Companies with Activities in Sudan List or
3. Is placed on the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, or
4. Is placed on the Scrutinized Companies that Boycott Israel List or is engaged in a boycott of Israel.

v. Remedies for Breach. In addition to all other remedies included in this Agreement, Contractor shall, at a minimum, be liable to Managing Entity for all foreseeable damages Managing Entity incurs as a result of Contractor's violation or breach of this Agreement. This includes without limitation any costs incurred to remediate defects in Contractor's services and/or the additional expenses to complete Contractor's services beyond the amounts agreed to in this Agreement, after Contractor has had a reasonable opportunity to remediate and/or complete its services as otherwise set for in this Agreement.

All remedies provided for in this Agreement may be exercised individually or in combination with any other remedy available hereunder or under applicable laws, rules and regulations. The exercise of any remedy shall not preclude or in any way be deemed to waive any other remedy.

On and after any event of default, Managing Entity shall have the right to exercise its legal and equitable remedies, including without limitation, the right to terminate this Agreement for cause or to seek specific performance of all or any part of this Agreement.

In addition, Managing Entity shall have the right (but no obligation) to cure (or cause to be cured) on behalf of Contractor any event of default. The Contractor shall pay to Managing Entity on demand all costs and expenses incurred by Managing Entity in effecting such cure, with interest thereon from the date of incurrence at the maximum rate then permitted by law.

Managing Entity shall have the right to offset from any amounts due to Contractor under this Agreement or any other agreement between Managing Entity and Contractor all damages, losses, costs or expenses incurred by Managing Entity as a result of such event of default and any liquidated damages, if any, due from Contractor pursuant to the terms of this Agreement or any other agreement.

Contractor shall be liable to Managing Entity for any sanctions or penalties specifically established by law and applicable to Contractor regarding the services in this Agreement.

Managing Entity shall provide such sanctions and penalties as appropriate.

vi. Lapsed Insurance. Any lapse in mandatory insurance coverage voids this Agreement until coverage is restored and proof of insurance coverage is provided to restore the ability to bill for services. Any services provided during the lapse period are invalid and cannot be invoiced to Managing Entity.

p. USE OF FUNDS FOR LOBBYING PROHIBITED: The Contractor agrees to comply with the provisions of section 216.347, Florida Statutes, which the expenditure of contract funds for the purpose of lobbying the Legislature or a state agency.

6. Incorporated Documents:

a. The following Attachments and Guidance Documents, or the latest revisions thereof, are incorporated herein and made a part of this Agreement:

i. **Attachment I** – DCF Master Contract QHME2 (posted to https://www.cfbhn.org/contracting-procurement/)

ii. **Attachment II** – Insurance

iii. **Attachment III** – Business Associate Agreement (BAA)

iv. **Attachment IV** – Florida Opioid Agreement with Schedule A and Schedule B

v. **Attachment V** – DCF Guidance 41 –Coordinated Opioid Recovery Network of Addiction Care (CORE Network)

vi. **Exhibit A** – Motor Vehicle and Equipment Form

7. Term and Termination

This Agreement shall begin on **July 1, 2025**, and will continue in effect until **June 30, 2030**, at which point it shall terminate, unless the Term is extended or terminated earlier in a written document signed by both parties.

All remedies including indemnification in **Section 5.e.** Indemnification shall survive termination of this Agreement.

THE PARTIES HERETO by and through their duly authorized representatives, whose signatures appear below, have caused this Agreement to be executed.

MANAGING ENTITY **Central Florida Behavioral Health Network, Inc.**		CONTRACTOR **Polk County, A Political Subdivision of the State of Florida**	
Signature:	_____	Signature:	_____
Print:	_____	Print:	_____
Title:	_____	Title:	_____
Date:	_____	Date:	_____
Prepared by:	Janet Higgins-Weston		

ATTACHMENT II – INSURANCE
Purchase Agreement

1. General Requirements.

1.1. The Contractor acknowledges that, as an independent contractor, the Contractor and its subcontractors at all tiers are not covered by the State of Florida Risk Management Trust Fund for liability created by § 284.30, F.S.

1.2. A governmental-entity Contractor may comply with the insurance requirements of this Purchase Agreement by participating in a self-insurance program established according to Florida law with coverage limits not less than the per occurrence and annual aggregate amounts specified for the corresponding type of insurance.

1.3. Workers' Compensation Insurance (WCI). To the extent and degree required by law, the Contractor shall self-insure or maintain WCI covering its employees connected with the services provided hereby. The Contractor shall require its subcontractors provide WCI for its employees absent coverage by the Contractor's WCI.

1.4. General Liability Insurance. The Contractor shall secure and maintain, and ensure its subcontractors secure and maintain, Commercial General Liability Insurance, including bodily injury, property damage, personal and advertising injury, and products and completed operations. This insurance will provide coverage for all claims that may arise from the services completed under this Purchase Agreement, whether such services are by the Contractor or anyone employed by it. Such insurance shall include the State and Managing Entity as an additional insured for the entire length of this Purchase Agreement.

1.5. The Contractor must cause all of its subcontractors at all tiers who the Contractor reasonably determines to present a risk of significant loss to the Contractor, the Managing Entity, or the Department to obtain and provide proof to Contractor of comprehensive general liability insurance coverage (broad form coverage), specifically including premises, fire, and legal liability covering the Contractor's subcontractors and all of their employees.

1.6. The limits of coverage for Contractor's subcontractors at all tiers must be in such amounts as the Contractor reasonably determines to be sufficient to cover the risk of loss.

1.7. Cyber/Network Security and Privacy Liability Insurance. The Contractor will, for itself if providing Cyber/Network solutions or handling confidential information, secure and maintain, and ensure any Contractor's subcontractor providing Cyber/Network solutions or handling confidential information, secure and maintain liability insurance, written on an occurrence basis, covering civil, regulatory, and statutory damages; contractual damages; data breach management exposure; and any loss of income or extra expense as a result of actual or alleged breach, violation or infringement of right to privacy, consumer data protection law, confidentiality or other legal protection for personal information.

1.8. Authorized Insurers and Documentation. All insurance policies must be with insurers authorized, and through insurance agents licensed, to transact business in the State, as required by chapter 624, F.S., or upon approval of the Managing Entity with a commercial self-insurance trust fund authorized under §624.462, F.S. The Contractor shall submit certificates of insurance coverage, or other evidence of insurance coverage acceptable to the Managing Entity, prior to this Purchase Agreement's execution.

2. Insurance Specifics.

2.1. In addition to the provisions of Section 1, the following Special Insurance Provisions shall apply to this Purchase Agreement. In the event of conflict between the requirements of Sections 2 to 5 and the requirements of Section 1, the provisions of Sections 2 to 5 shall prevail and control.

2.2. The Contractor shall notify the Contract Manager in writing within 30 calendar days if there is a modification to the terms of Contractor insurance required in this Purchase Agreement including but not limited to, nonrenewal, cancellation or modification to policy limits.

2.3. The Contractor shall obtain and provide proof to the Managing Entity of comprehensive general liability insurance coverage (broad form coverage), specifically including premises, fire and legal liability to cover the Contractor and all its employees. The limits of the Contractor's coverage shall be no less than $300,000 per occurrence with a minimal annual aggregate of no less than $1,000,000.

2.4. With the exception of any state agency or subdivision as defined by § 768.28(2), F.S., the Contractor shall cause all of its subcontractors, at all tiers, who the Contractor reasonably determines to present a risk of significant loss to the Contractor, the Managing Entity, or the Department to obtain and provide proof to the Contractor and upon written request of the Managing Entity to the Contractor, also to the Managing Entity, of comprehensive general liability insurance coverage (broad form coverage), specifically including premises, fire and legal liability covering the Contractor's subcontractors and all their employees.

2.5. The limits of coverage for the Contractor's subcontractors, at all tiers, shall be in such amounts as the Contractor reasonably determines to be sufficient to cover the risk of loss.

2.6. The Contractor shall obtain and provide proof to the Managing Entity of Cyber/Network Security and Privacy Liability Insurance as described in Section 1.7. The limits of the Contractor's coverage of Cyber/Network Security and Privacy Liability Insurance shall be no less than $1,000,000 per occurrence with a minimal annual aggregate of no less than $1,000,000.

3. Automobile Insurance.

3.1. If any officer, employee, or agent of the Contractor operates a motor vehicle in the course of the performance of its duties under this Purchase Agreement, the Contractor shall obtain and provide proof to the Managing Entity of comprehensive automobile liability insurance coverage (unless a waiver is expressly agreed to in writing by the Managing Entity). The limits of the Contractor's coverage shall be no less than $300,000 per occurrence with a minimal annual aggregate of no less than $1,000,000.

3.2. If any officer, employee, or agent of any Contractor's subcontractors, at all tiers, operates a motor vehicle in the course of the performance of the duties of the Contractor's subcontractor, the Contractor shall cause the subcontractor to obtain and provide proof to the Contractor and the Managing Entity of comprehensive automobile liability insurance coverage with the same limits as Section 3.1.

4. Professional Liability Insurance.

4.1. The Contractor shall obtain and provide proof to the Managing Entity of professional liability insurance coverage, including errors and omissions coverage, to cover the Contractor and all its employees.

4.2. If any officer, employee, or agent of the Contractor administers any prescription drug or medication or controlled substance in the course of the performance of the duties of the Contractor under this Purchase Agreement, the professional liability coverage shall include medical malpractice liability and errors and omissions coverage, to cover the Contractor and all of its employees. The limits of the coverage shall be no less than $300,000 per occurrence with a minimal annual aggregate of no less than $1,000,000.

4.3. If any officer, employee, or agent of the Contractor's subcontractors, at all tiers, provides any professional services or provides or administers any prescription drug or medication or controlled substance in the course of the performance of the duties of the Contractor's subcontractor, the Contractor shall cause the Contractor's subcontractor to obtain and provide proof to the Contractor and the Managing Entity of professional liability insurance coverage, including medical malpractice liability and errors and omissions coverage, to cover all Contractor's subcontractor's employees with the same limits as described in Section 4.2.

5. Additional Contractor Insurance Obligations.

5.1. The Managing Entity and the Department shall be exempt from, and in no way liable for, any sums of money that may represent a deductible or self-insured retention under any such insurance. The payment of any deductible on any policy shall be the sole responsibility of the Contractor, or Contractor's subcontractor purchasing the insurance.

5.2. All such insurance policies of the Contractor and Contractor's subcontractors, at all tiers, shall be provided by insurers licensed or eligible to do and that are doing business in the State of Florida. Each insurer must have a minimum rating of "A" by A. M. Best or an equivalent rating by a similar insurance rating firm and shall name the Managing Entity and the Department as an additional insured under the policy or policies.

5.3. The Contractor must use its best good faith efforts to cause the insurers issuing all such general, automobile, and professional liability insurance to use a policy form with additional insured provisions naming the Managing Entity and the Department as an additional insured or a form of additional insured endorsement that is acceptable to the Managing Entity in the reasonable exercise of its judgment. Contractor's professional liability insurance coverage, including medical malpractice liability and errors and omissions coverage, must name the Managing Entity and the Department as an additional insured.

5.4. All insurance policies of the Contractor and its subcontractors must be primary to and not contributory with any similar insurance carried by the Managing Entity.

5.5. Proof of insurance must be in the form of an Association for Cooperative Operations Research and Development (ACORD) certificate of insurance. All such current insurance certificates will be submitted to the Contract Manager, prior to expiration, as insurance policies are renewed each year.

5.6. The requirements of this Section 5 shall be in addition to, and not in replacement of, the requirements of Section 4.8 of the Department's standard contract (Attachment I) which shall be applicable to Contractor.

ATTACHMENT III – HIPAA BUSINESS ASSOCIATE AGREEMENT
INCLUDING 42 CFR Part 2
Purchase Agreement

Should this Purchase Agreement involve Contractor access to protected health information (PHI) the Contractor shall be a "Covered Entity" limited to the following permissible uses and disclosures. Reference to a section in the HIPAA Rules means the section as in effect or as amended. The Contractor shall assist the Managing Entity in amending this Contract to maintain compliance with HIPAA Rules and any other applicable law requirements. Any ambiguity in this section will be interpreted to permit compliance with the HIPAA Rules. Within the Managing Entity, Stephanie Johns has been designated the HIPAA Privacy Officer.

1.1. **Catch-all Definitions.** The following terms as used in this section have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Security Incident, Unsecured Protected Health Information, and Use.

1.2. Specific Definitions

1.2.1. "Business Associate" has the same meaning as the term "business associate" at 45 CFR §160.103 and means the Managing Entity.

1.2.2. "Covered Entity" has the same meaning as the term "covered entity" at 45 CFR §160.103 and means the Contractor.

1.2.3. "HIPAA Rules" will mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Parts 160 and 164.

1.2.4. "HIPAA Subcontractor" has the same meaning as the term "subcontractor" at 45 CFR §160.103 and includes individuals to whom a Business Associate delegates a function, activity, or service, other than as a member of the workforce of such Business Associate. This definition applies only to this **Attachment III.**

1.3. Obligations and Activities of the Contractor

The Contractor shall:

1.3.1. Not use or disclose PHI except as permitted or required in by this section or law;

1.3.2. Use the appropriate administrative safeguards in 45 CFR §164.308, physical safeguards in 45 CFR §164.310, and technical safeguards in 45 CFR §164.312; including policies and procedures regarding the protection of PHI in 45 CFR §164.316 and the provisions of training on such policies and procedures to applicable employees, independent providers, and volunteers, that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI Contractor may create, receive, maintain or transmit on the Managing Entity's behalf;

1.3.3. Acknowledge that the foregoing safeguards, policies and procedures requirements apply to the Contractor in the same manner as such requirements apply to the Department; and the Managing Entity and Contractor are directly liable under the civil and criminal enforcement provisions of §§13409 and 13410 of the HITECH Act, 45 CFR §§164.500 and 164.502(E) of the Privacy Rule (42 U.S.C. 1320d-5 and 1320d-6), as amended, for failure to comply with the safeguards, policies and procedures requirements and resulting U.S. Health and Human Services (HHS) guidance thereon;

1.3.4. Report to the Managing Entity any use or disclosure of PHI not permitted by this section, including breaches of unsecured PHI as required at 45 CFR §164.410, and any security incident;

1.3.5. Notify the Managing Entity's HIPAA Security Officer, HIPAA Privacy Officer, and Contract Manager in writing within 120 hours after finding a breach or potential breach of personal and confidential data; and

1.3.6. Notify the Managing Entity's HIPAA Privacy Officer and Contract Manager in writing within 24 hours of HHS notification of any investigations, compliance reviews, or inquiries concerning violations of HIPAA;

1.3.7. Provide additional information requested by the Managing Entity for investigation of or response to a breach;

1.3.8. Provide at no cost: Notice to affected parties within 30 days of determination of any potential breach of personal or confidential data (§501.171, F.S.); implementation of the Managing Entity's prescribed measures to avoid or mitigate potential injury to any person due to a breach or potential breach of personal and confidential data; and, immediate actions limiting or avoiding recurrence of any breach or potential breach and any actions required by applicable federal and state laws and regulations regardless of the Managing Entity's actions;

1.3.9. In accord with 45 CFR §§164.502(e)(1)(ii) and 164.308(b)(2), as applicable, ensure all entities creating, receiving, maintaining, or transmitting PHI on the Contractor's behalf are bound to the same restrictions, conditions, and requirements as the Contractor by written contract or other written agreement meeting the applicable requirements of 45 CFR §164.504(e)(2) that the entity will appropriately safeguard the PHI. For prior contracts or other arrangements, the Contractor shall provide written certification its implementation complies with 45 CFR §164.532(d);

1.3.10. Make PHI available in a designated record set to the Managing Entity as necessary to satisfy the Managing Entity's 45 CFR §164.524 obligations;

1.3.11. Make any amendment to PHI in a designated record set as directed or agreed to by the Managing Entity per 45 CFR §164.526, or take other measures as necessary to satisfy the Managing Entity's 45 CFR §164.526 obligations;

1.3.12. Maintain and make available the information required to provide an accounting of disclosures to a covered entity as needed to satisfy the Managing Entity's 45 CFR §164.528 obligations;

1.3.13. To the extent the Contractor carries any obligation under 45 CFR Subpart E, comply with the requirements of Subpart E that apply to the Managing Entity in the performance of that obligation; and

1.3.14. Make internal practices, books, and records available to HHS for determining HIPAA rule compliance.

1.4. Contractor and its HIPAA subcontractors may only use or disclose PHI as listed below:

1.4.1. To perform obligations under this section;

1.4.2. For archival purposes;

1.4.3. If necessary, for (a) proper management and administration or (b) to carry out legal responsibilities;

1.4.4. To disclose only if the disclosure is required by law; or (a) reasonable assurances are obtained from the disclosee that PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed, and (b) the disclosee agrees to notify the Contractor in writing of any instances in which the confidentiality and security of PHI has been breached;

1.4.5. To aggregate with PHI of other covered entities in its possession through its capacity as a Business Associate of such covered entities only to provide Managing Entity data analyses relating to Managing Entity health care operations (as defined in 45 C.F.R.

§164.501);

1.4.6. To conform with 45 CFR §164.514(b) in de-identifying PHI; or

1.4.7. To follow marketing, fundraising and research guidance in 45 CFR §164.501, 45 CFR §164.508 and 45 CFR §164.514.

1.5. Managing Entity Notifications Affecting Contractor Disclosure of PHI

The Managing Entity must notify the Contractor, to the extent it may affect Contractor's use or disclosure of PHI: of 45 CFR §164.520 limitations in the Notice of Privacy Practices; of changes in, or revocation of, an individual's permission to use or disclose PHI; or of any restriction on the use or disclosure of PHI information the Managing Entity has agreed to or is required to abide by under 45 CFR §164.522.

1.6. Termination Regarding PHI

1.6.1. **Termination for Cause.** Upon the Managing Entity's knowledge of a material breach of the Contractor's duties under this section, the Managing Entity may: (a) Provide the Contractor opportunity to cure the breach within the Managing Entity's specified timeframe; (b) Immediately terminate Contract or discontinue access to PHI; or (c) If termination or cure are not feasible, the Managing Entity will report the breach to the Secretary of HHS.

1.6.2. **Contractor Obligations Upon Termination.** Upon termination, the Contractor, with respect to PHI received from the Managing Entity, or created, maintained, or received on behalf of the Managing Entity, will: (a) retain only PHI necessary to continue proper management and administration or to carry out legal responsibilities; (b) return PHI not addressed in (a) to the Managing Entity, or its designee; (c) upon the Managing Entity's permission, destroy PHI the Contractor maintains in any form; (d) continue to use appropriate safeguards and comply with Subpart C of 45 CFR 164 with respect to electronic PHI to prevent use or disclosure of PHI, other than as provided for in (a) for retained PHI; (e) not use or disclose retained PHI other than for purposes for which PHI was retained and subject to the same conditions which applied prior to termination; and (f) comply with (b) and (c) when retained PHI is no longer needed under (a).

1.6.3. Obligations under **Contractor Obligations Upon Termination** section survive termination.

1.7. **42 CFR Part 2.** Managing Entity and the Contractor shall comply with the applicable provisions of 42 CFR Part 2 in the performance of this Subcontract. Pursuant to 42 CFR Part 2, the Contractor may electronically share certain information with the Managing Entity. This Section 1.7 shall be construed to satisfy the requirements of 42 C.F.R. § 2.11. The Managing Entity:

1.7.1. Acknowledges that in receiving, storing, processing, or otherwise using any information from the alcohol/drug programs about the clients of the Contractor, the Managing Entity is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2; and

1.7.2. Undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the federal confidentiality regulations, 42 C.F.R. part 2.

FLORIDA OPIOID ALLOCATION AND STATEWIDE RESPONSE AGREEMENT

BETWEEN

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

And

CERTAIN LOCAL GOVERNMENTS IN THE STATE OF FLORIDA

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

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

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

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

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

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

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

Wherefore, the Parties each agree to as follows:

A. Definitions

As used in this Agreement:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Years 1-6: 40%

B. Years 7-9: 35%

C. Years 10-12: 34%

D. Years 13-15: 33%

E. Years 16-18: 30%

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

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

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

(c) Appointments State -

(i) The Governor shall appoint two Members.

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

(iii) The Senate President shall appoint one Member.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) Develop and utilize standardized monitoring tools;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Other Terms and Conditions

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

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

a. State of Florida Agreement Manager:

Greg Slemp

PL-01, The Capitol, Tallahassee, FL 32399

850-414-3300

Greg.slemp@myfloridalegal.com

b. State of Florida Agreement Administrator

Janna Barineau

PL-01, The Capitol, Tallahassee, FL 32399

850-414-3300

Janna.barineau@myfloridalegal.com

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

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

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

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

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

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

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

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

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

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

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

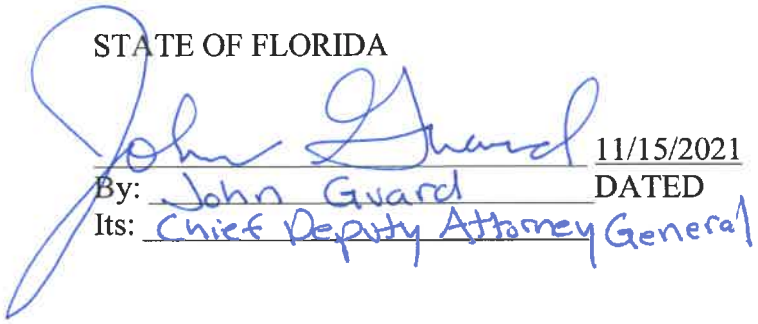
12. **Construction:** The parties hereto hereby mutually acknowledge and represent that they have been fully advised by their respective legal counsel of their rights and responsibilities under this Agreement, that they have read, know, and understand completely the contents hereof, and that they have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

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

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

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

STATE OF FLORIDA



11/15/2021
By: John Guard DATED
Its: Chief Deputy Attorney General

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.

[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.

Guidance # 41

Coordinated Opioid Recovery (CORE) Network of Addiction Care

Contract Reference: *Contract Exhibit A. Administration C-1.23*

Authority: *Section 394.9082, F.S. C-1.2.3.25*

Frequency and Due Date: Service data submissions are updated daily; all others are due monthly by the 18th.

I. Definitions

1. **24-7 Access Point**: A 24-7 access point can either be an Emergency Department (ED), Emergency Medical Services (EMS) or a Central Receiving Facility (CRF). All 24-7 access points must provide immediate buprenorphine products or other medication assisted treatment (MAT) when clinically appropriate, without a requirement for a higher level of care with a continuation plan until the patient has established care at the receiving clinic, preventing a lapse in treatment. The 24-7 access point can recommend a higher level of care but will still offer lifesaving treatment in outpatient setting if patient refuses a higher level.
2. **Receiving Clinic:** A receiving clinic is the provider in the community providing long-term MAT. A receiving clinic can be substance use only provider or a Federally Qualified Health Center (FQHC) or a Community Behavioral Health Center (CBHC) that treats all patients regardless of ability to pay and receives all patients from the 24-7 access point to continue MAT services indefinitely in an outpatient setting. Transportation should be made available to patients if this is a barrier to treatment. The receiving clinic may recommend a higher level of care for the patient but will not stop treatment if the patient refuses the recommendation. Receiving clinics serve as a substance use medical home for lifelong care providing MAT, substance use therapy, psychiatry, and primary care. If the receiving clinic does not provide primary care, including health and dental care, they must partner with a provider that offers those services to the individual.
3. **Recovery Supports:** These include peer support services, social determinants of health (supportive housing, supportive employment, transportation, drop-in centers, recovery community organizations, aftercare, and legal services). Recovery Supports must have coordinated relationships with the 24-7 access points and receiving clinics.
4. **Warm Handoff:** The patient must continue lifesaving buprenorphine or other MAT until handed off to the receiving clinic from the 24-7 access point with no lapse in care. Peer supports, case managers, care coordinators, or nurse coordinators can be utilized. Facilitating a warm handoff means actively connecting an individual to another service provider. This process goes beyond simply providing a referral name, phone number, and appointment time. Warm handoffs are a transfer of care between two providers in the presence of the individual and their family (if present). The purpose of the warm handoff is to engage the individual with the new provider.

II. Purpose

This document provides direction and guidance for administration, implementation, and management of Florida's Coordinated Opioid Recovery (CORE) Network of Addiction Care. Also included are the purpose, policies, and competencies intended to ensure that funds are used effectively to combat opioid use disorder in Florida, in accordance with state and federal laws and regulations.

To ensure the implementation and administration of this project, the Managing Entity will engage in contract negotiations with Receiving Clinics, Emergency Medical Providers, and Emergency

Departments participating in a CORE Network and will achieve the outcomes of the service delivery and reporting requirements. Additional partners may be included to strengthen a CORE Network. Data reporting requirements include data required by opioid settlement funds in addition to some CORE specific data outcomes as defined in section IX. CORE Networks provide immediate, low barrier, 24-7 access to evidence-based care for opioid use disorders. 24-7 access points provide buprenorphine inductions when appropriate without a need for higher level of care. Patients will have a warm handoff to a receiving clinic where MAT will be continued, with no lapse in care. The Managing Entity shall not make any changes or variations from fidelity to the structure, implementation, and data collection of the CORE model as stated in this document without prior written approval from the Department.

III. CORE Network Requirements

The table below defines each of the required elements for CORE.

CORE Element	Description
24-7 access to care.	**24-7 availability for treatment with MAT. Specifically, buprenorphine must be available 24-7 in an emergency setting with no need for admission to inpatient care to receive treatment immediately. 24-7 access to care can come from an ED, EMS or a CRF.**
Peer support services.	Peers provide support services such as a warm handoff from the 24-7 access point (ED, CRF, EMS) and continuous follow-up.
All FDA approved MAT services.	FDA approved MAT for opioid use disorders includes methadone, naltrexone, and buprenorphine products.
Maintenance of MAT according to guidelines.	The Substance Abuse and Mental Health Services Administration's TIP 43[1] recommends that patients receiving MAT should be maintained at least two years of continuous stability, or longer, without taper recommendation. Tapering is considered an optional branch.
Individual approach to dosing without limits.	Buprenorphine should not be restricted to a certain dose, because of fentanyl, as increasing doses enhances retention and decreases cocaine use. Dosing should be based on decreasing withdrawal over 24 hours.
Receiving clinic receives patients from 24-7 care and continues lifelong treatment.	**An FQHC or CBHC that can take patients during business hours for intake and serve as a substance use medical home for lifelong care providing MAT, substance use therapy, psychiatry, and primary care.**
Clinic and ER testing / Prescription Drug Monitoring Program (PDMP).	**Report through E-Force every visit and provide drug panels in receiving clinics and 24-7 access points.**
Established intake process.	An intake and assessment that includes a doctor's visit to start substance use disorder (SUD) treatment and a biopsychosocial completed or countersigned by a qualified professional.
Established protocol for induction on buprenorphine.	There should be a high dose and low dose induction protocol with preference given to the high dose induction protocol that can be given immediately after use or naloxone reversal.
Treating comorbid alcohol and benzodiazepine use disorder.	American Society of Addiction Medication (ASAM) report the use of benzodiazepines or other sedative-hypnotics are not a reason to withhold or suspend treatment. Follow best practices and guidelines provided in Federal Guidelines. [2, 3]
Naloxone readily available.	Naloxone quickly reverses an overdose by blocking the effects of opioids. It can restore normal breathing within 2 to 3 minutes in a person whose breath has slowed, or even stopped, as a result of an opioid overdose.
Access to higher levels of care for all.	In the county there should be a functional referral relationship with public/ private detoxification programs to assist with complex detoxification (benzodiazepines/alcohol patients with delirium tremens/DTs), access to public/

	private residential, partial hospitalization programs (PHPs), intensive outpatient programs (IOPs) and outpatient levels of care for adults and pregnant women.
Clinical expert in addiction medicine or champion.	Established Medical Doctor (MD) or Doctor of Osteopathy (DO) who is primary care or psychiatrically trained and who has addiction medicine or addiction psychiatry certification.
Therapists in outpatient setting.	Licensed Mental Health Counselors (LMHCs), psychologists, Licensed Clinical Social Workers (LCSWs) and interns who provide group and individual therapy as part of the SUD program.
Primary care access.	All patients should have access to primary care.
Infectious disease screening.	All patients enrolling in an SUD program should be tested for HIV, hepatitis panel (especially hepatitis C), syphilis, and tuberculous as needed, as part of the intake.
Access to psychiatry at the FQHC or CBHC.	Psychiatric provider should be available and all patients entering the SUD program should receive a psychiatric evaluation to assist with underlying psychiatric problems as they can be comorbid with SUD diagnosis.
Group therapy access in the clinic or with a collaborative partner.	Individuals should have access to group therapy.
Individual therapy access in clinic or with a collaborative partner.	Individuals should have access to individual therapy.
Clinic structured by phases of treatment.	Patients should start receiving MAT with methadone or buprenorphine in a phased approach to allow for flexibility based on need and clinical judgement
All levels of care to assist with pregnant women.	Evidence-based pregnancy care with buprenorphine/methadone options available while in residential, PHP, IOP or outpatient care. This should also be coordinated with the woman's OBGYN team and OB triage that is comfortable managing.
Following of outcome measures and data, specifically the Brief Addiction Monitoring (BAM) tool.	**The BAM is completed monthly by all OUD patients in the receiving clinic. Supplemental questions have been added to the BAM collection process.**

IV. Eligibility

The CORE Network prioritizes adults aged 18 or older who experience any of the following:

1. A confirmed or suspected opioid overdose requiring naloxone administration.
2. Signs and symptoms of severe opioid withdrawal.
3. Acute opioid withdrawal as a chief complaint.
4. Individuals seeking support for opioid use disorder (OUD) within a CORE Network.

V. CORE Network

The CORE Network establishes a recovery-oriented continuum of care and support for those seeking treatment and recovery support services for OUD. This comprehensive approach expands every aspect of overdose response and treats all primary and secondary impacts of substance use disorder. The CORE Network disrupts the revolving door of substance use disorder/opioid use disorders and overdose by providing an evidence based coordinated network of care linking patients to community partners in a continuum from a crisis all the way to lifelong care in a low barrier, sustainable way. It incorporates quality improvement through measure outcomes that help sustain the network locally. Department approval is required before implementing any variation of the CORE Network.

The CORE Network includes the following tiered approach with a warm handoff provided at each level:

1. Rescue response.
2. 24-7 access point for stabilization/ assessment.
3. Receiving clinics for long-term treatment.

VI. CORE Sustainability

- Sustaining CORE Networks in all counties will require blending and braiding from various funding sources at different levels. The Department will fund counties $700,000- $1,000,000 in the first year of a county onboarding a CORE Network. The funding methodology factors in:
    - Population.
    - Opioid overdose death rate.
    - Non-fatal opioid overdose hospitalizations.
    - Opioid overdose emergency department visits.
    - Opioid overdose EMS transport response.
    - Naloxone administration by EMS.
    - Historical cost of services funded by the Department.

Funding will be reduced by 50% in year two and reduced an additional 25% beginning in year 3 through the remainder of the Opioid Settlement.

VII. Managing Entity Responsibilities

To ensure consistent statewide implementation and administration of CORE, the Managing Entity shall ensure all program requirements, are met through formal partnership agreements such as subcontracts, or memorandum of understandings with Network Service Providers and system partners with implementation timelines based on community partnerships and readiness. The Managing Entity shall implement a CORE Network in accordance with the outlined programmatic standards and in accordance with Florida's Opioid Abatement requirements. The Managing Entity shall expend the funds on approved purposes only. The Statewide Council on Opioid Abatement may pass additional measures and requirements that the Department and Managing Entities must follow when evaluating compliance, performance, and implementation. CORE Networks utilize the no wrong door approach to accessing services. The CORE Network standards are as follows:

1. **Rescue Response**
    - **a.** Individual in need of services is treated by first responders (fire rescue/ Emergency Medical Services (EMS) personnel).
    - **b.** Treatment includes use of specialized EMS protocols for overdose, acute withdrawal, and can include induction to buprenorphine.
    - **c.** EMS provides a warm handoff to the ED or receiving clinic.
    - **d.** EMS may provide buprenorphine for patients while waiting for warm handoff to receiving clinic after induction performed by EMS or ED.
    - **e.** CORE EMS partners will coordinate with other EMS agencies within in their county to follow up with patients who overdosed and received care from a non-CORE Network EMS provider.

2. **Stabilization/Assessment**
    - **a.** Individual receives treatment at a 24-7 access point.
    - **b.** Treatment options include medication-assisted treatment, which entails, at a minimum, the ability to induct individuals on buprenorphine. and issue a prescription for buprenorphine that lasts until their initial appointment with a community-based provider prior to being released from the ED.
    - **c.** Specialty-trained medical staff recommend the care best suited for the individual and a peer navigator facilitates a warm handoff to the receiving clinic for long-term treatment.

3. **Receiving Clinics**

a. Individual receives long-term-care and wrap around support.
b. Individual is treated by a team of licensed and certified professionals that specialize in treating addiction.
c. Services may include long-term management of MAT, therapy, psychiatric services, individualized care coordination, and links to other health services.
d. Individuals shall receive services to address any identified social service needs.
e. Ensure implementation of the BAM along with other data requirements.

4. Warm Handoff and Recovery Supports

a. Certified Recovery Peer Specialists utilize direct lived experience with SUD and recovery to reduce stigma and increase engagement into services.
b. Certified Recovery Peer Specialists facilitate warm handoffs to treatment and recovery community organizations.

VIII. Network Service Provider and System Partner Responsibilities

Network Service Providers, Emergency Departments, and Emergency Medical Services shall identify staff to be responsible for activities required through the CORE partnership. Network Service Providers and system partners including EDs and EMS shall implement a CORE Network and shall provide eligible individuals with treatment that includes use of specialized protocols for overdose and acute withdrawal and provide MAT. CORE partners shall work together identifying a point of contact, preferably the peer specialist, to provide warm handoffs as the individual transitions to different services. Network Service Providers and system partners including EDs and EMS shall complete online CORE training available on the CORE website and any other training required by DCF.

IX. Data

1. Data Collection and Management

Opioid settlement funds will be used to implement CORE Networks. A required component of the state's opioid settlement is to use an evidence-based data collection process to analyze the effectiveness of substance use abatement. The opioid settlement states that the State and Local Governments shall receive and report expenditures, service utilization data, demographic information, and national outcome measures in a similar fashion as required by the 42.U.S.C. s. 300x and 42 U.S.C. s. 300x-21.

a. Managing Entities shall ensure that all CORE partners comply with the required data collection process. This includes collecting data on expenditures, service utilization, and demographic information of individuals receiving services within the CORE Network.
b. Data collection should be based on standardized procedures to ensure consistency and accuracy across all service providers.
c. To evaluate the effectiveness of substance use abatement, the data collection process should allow for tracking and measuring key outcome indicators related to opioid use disorder treatment, such as retention rates, reduction in overdose incidents, and improvements in overall well-being.

The Opioid Data Management System (ODMS) was developed by the Florida Department of Children and Families to store data submitted by counties, municipalities, providers, and any other entity receiving Opioid Settlement Funding. The Opioid Data Management System consists of two portals. The provider portal will receive electronic data for services rendered. The second portal will serve as a platform to enter implementation/abatement plans, financial expenditure information, financial audit documentation and other supporting documentation as necessary.

X12 837 EDI files will be submitted to the Department through the provider portal This will help to reduce administrative burdens. A recording of the Opioid Data Management System Provider Webinar is available on the Florida Opioid Settlement website. Resources - Florida Opioid Settlement

Providers must ensure secure data sharing, confidentiality, and privacy in accordance with all applicable rules and statutes. All data contained within the Opioid Data Management System is sensitive and privileged information and shall be handled accordingly. To maintain the integrity of this information, the records will be accorded proper management and security, and will only be accessed and used by authorized personnel in accordance with state and federal law. Receiving Clinics and Emergency Department staff will be required to complete the CF-112 Access Confidentiality and Nondisclosure Agreement and the DCF Security Awareness Basics Training module before being granted access to the Opioid Data Management System. Regular data audits will be conducted to ensure data integrity and identify any discrepancies or errors for timely correction.

Data submitted with an X12 837 EDI file are uploaded nightly. For any data that is not submitted with an X12 837 EDI file, data is due on the 18th of each month for services provided in the prior month. Submitted data for services will use standard industry codes such as CPT and HCPCS billing codes.

The Department will receive Emergency Medical Service data through a data sharing agreement with the Department of Health for data that has been entered into the Emergency Medical Services Tracking and Reporting System.

2. Brief Addiction Monitoring Tool

The Brief Addiction Monitoring Tool (BAM) is a 17-item, multidimensional, progress-monitoring instrument for patients in treatment for a substance use disorder (SUD). The BAM includes items that assess risk factors for substance use, protective factors that support sobriety, and drug and alcohol use. The BAM assessment tool measures patient outcomes and success of the overall project. Receiving clinics must provide the QR Code and encourage completion of the BAM on all individuals with an SUD, every 30 days. The Department created an application for individuals to complete the BAM via a QR code. In addition to the 17 questions from the BAM, the Department has included several questions related to social determinants of health.

X. Resources

The Coordinated Opioid Recovery- A Network of Addiction Care website contains training videos, protocols and best practices for all tiers within a CORE Network. For more information, visit the CORE Network - Hope for Addiction Recovery website at CORE Network - Hope for Addiction Recovery (flcorenetwork.com)

[1] Medication-Assisted Treatment For Opioid Addiction in Opioid Addiction in Opioid Treatment Programs: A Treatment Improvement Protocol TIP 43:
Bookshelf_NBK64164.pdf (nih.gov)

[2] U. S. Food and Drug Administration:
https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-urges-caution-about-withholding-opioid-addiction-medications

[3] American Society of Addiction Medicine – The ASAM National Practice Guideline For The Treatment of Opioid Use Disorder:
National Practice Guideline for the Treatment of Opioid Use Disorder

Fiscal Table

Fiscal Year	Provider Name	Contract Number	Base Recurring	Non-Recurring	Carry Forward	Total
2025-2026	Polk County, A Political Subdivision of the State of Florida	PL316	$ -	$ 109,375.00	$ -	**$ 109,375.00**
2026-2027	Polk County, A Political Subdivision of the State of Florida	PL316	$ -	$ -	$ -	**$ -**
2027-2028	Polk County, A Political Subdivision of the State of Florida	PL316	$ -	$ -	$ -	**$ -**
2028-2029	Polk County, A Political Subdivision of the State of Florida	PL316	$ -	$ -	$ -	**$ -**
2029-2030	Polk County, A Political Subdivision of the State of Florida	PL316	$ -	$ -	$ -	**$ -**
			$ -	**$ 109,375.00**	**$ -**	**$ 109,375.00**

Funding Change Report

Provider Name	Contract Number	Fiscal Year	OCA	OCA Title	Recurring NonRecurring	Amend Number	Status	Subcontract Amount	Comment
Polk County, A Political Subdivision of the State of Florida	PL316	2025-2026	MSOCR	ME Opioid TF Coord Opioid Recovery Care	Non-Recurring	Original	Pending	$109,375.00	
								$109,375.00	

Supplemental Detail Report

Fiscal Year	Provider Name	Contract Number	OCA	OCA Title	Non-Recurring
2025-2026	Polk County, A Political Subdivision of the State of Florida	PL316	MSOCR	ME Opioid TF Coord Opioid Recovery Care	$109,375.00