CONTRACTOR AGREEMENT FOR USE OF OPIOID LITIGATION SETTLEMENT FUNDS

This Contractor Agreement ("Agreement") is entered into by and between the County of Weber, Utah (the "County") and the Weber-Morgan Health Department ("Contractor"), individually referred to as "Party" and jointly referred to as "Parties." The purpose of this Agreement is to provide to the Contractor with settlement funds from the opioid litigation case filed by Weber County ("Settlement Funds"), which are authorized to mitigate the impacts of opioid use disorders.

WHEREAS, the County has received and will continue to receive Settlement Funds from its lawsuit filed against various manufacturers and pharmaceutical distributors of opioids ("Defendants"); and

WHEREAS, the County, after receiving input from outside third parties, developed an Opioid Settlement Plan ("the Plan") that prescribes how the County will allocate Settlement Funds for programs, services, targeted audiences, intended outcomes and entities who will receive funding; and

WHEREAS, settlement agreements with various Defendants are governed by a Universal Memorandum of Understanding that dictate the authorized uses of Settlement Funds ("Universal Memorandum") (See Exhibit A; Opioid Universal Settlement Memorandum of Understanding); and

WHEREAS, the County is authorized to disburse all Settlement Funds to Contractor, which will carry out eligible uses on behalf of the County; and

WHEREAS, the Contractor has applied to the County for an allocation of Settlement Funds, and the County has deemed the use appropriate under the Universal Memorandum; and

WHEREAS, the County desires to allocate Contractor a portion of Settlement Funds in the amount of $178,122.59, subject to the County and the Contractor entering into this Agreement with respect to the use of said Settlement Funds.

NOW, THEREFORE, in consideration of the mutual covenants contained herein, the County and the Contractor agree as follows:

1. **SCOPE OF PROJECT; ELIGIBLE USE OF SETTLEMENT FUNDS**

   A. The County shall allocate to Contractor a portion of Settlement Funds to cover necessary expenses related to the activities specifically described in the Contractor's application (the "Project") (A copy of Contractor's application is attached as Exhibit B). County has agreed to fund the Project for one year. The County may renew the Agreement for up to two additional years. Renewal shall be in the sole discretion of the County and is contingent upon Contractor adhering to the reporting requirements listed below. If there is a conflict between the terms and provisions in the Contractor's application and this Agreement, the terms of this Agreement shall govern.

B. The Contractor shall only use the Settlement Funds to cover expenses that are necessary for the completion of the Project and are eligible under the Universal Memorandum to mitigate the impacts of opioid use disorders.

C. The Contractor may make revisions to the scope of the Project with approval from the County, where such revisions to the Project do not materially alter the Project or cause the use of Settlement Funds for the revised Project to constitute an ineligible use of Settlement Funds. In no event shall a revision to the scope of the Project entitle the Contractor to an additional allocation of Settlement Funds by the County unless Contractor makes a request to the County for additional money in writing. The Weber County Commission, in its sole discretion, may approve and authorize additional Settlement Funds for the Project. However, no additional allocation of Settlement Funds is guaranteed.

D. Once the Project is completed, all costs for the management, operation, maintenance, and repair and replacement of the Project (as applicable) shall be the sole responsibility of the Contractor. The County shall have no liability, financial or otherwise, with respect to the management, operation, maintenance, repair or replacement of the Project.

2. TERM OF AGREEMENT

The term of this Agreement begins on the date this Agreement is fully executed by the Parties and ends on the day Contractor files and the County accepts a signed notice of completion. Notwithstanding other provisions, this Agreement will remain in effect until the County determines that the Contractor has completed all applicable administrative actions, reporting requirements, and all Project work required by and set forth in this Agreement. Should Contractor require additional time for auditing of or reporting for the Project, this Agreement shall be deemed automatically extended until said audit and reporting is completed.

3. PAYMENTS

A. *Direct Payment.* The County shall pay for eligible Project costs directly on behalf of Contractor upon Contractor's presentation of all forms and documents as is required by the County.

B. *Optional Reimbursement Payment.* The County, in its discretion, may elect to pay Settlement Funds to Contractor on a reimbursement basis. If Contractor wishes to seek reimbursement for an eligible expense, Contractor shall submit a reimbursement request to the County Comptroller no later than 15 days after the end of the calendar quarter during which the Contractor incurred the expense. Such requests shall be in a form acceptable to the County and include, where applicable for construction projects, certification by the Contractor's engineer that the amounts are eligible Project costs. The Contractor may not request reimbursements under this Agreement for work that has not been completed.

C. *Optional Advance Payment.* The County, in its discretion, may elect to pay the

Contractor in advance for its allowable costs for the Project identified by this Agreement upon the presentation of all forms and documents as may be required by the County. Advance payments must be limited to the minimum amounts needed and timed to be in accordance with the Contractor's actual, immediate cash requirements in carrying out and completing the work of the Project.

D. *Withholding or Cancellation of Settlement Funds.* The County reserves the right to withhold payments until Contractor timely delivers reimbursement requests or documents as may be required under this Agreement. Upon completion of the Project, the County may cancel payment of any portion of Settlement Funds that the County determines to be surplus. The County shall be relieved of any obligation for payments if money allocated to the County cease to be available for any cause other than misfeasance of the County itself.

E. *Where Payments Are Made.* Payments shall be made by check or electronic deposit into Contractor's bank account, according to a process established by the County.

F. *Recoupment.* Settlement Funds are subject to recoupment by the County for the Contractor's failure to use the Settlement Funds for the Project in accordance with the Universal Memorandum and this Agreement.

4. REPORTING REQUIREMENTS

A. *Reporting Requirements.* The Contractor shall submit semi-annual reports and adhere to all conditions and obligations as are required by the County including, but not limited to, statutory reporting requirements attached to this Agreement as Exhibit C. Such reporting requirements shall extend beyond the term of this Agreement. The County reserves the right to inspect, at any time, the Contractor's records that are related to the Project and/or Contractor's performance of this Agreement and will provide progress reports upon request. Notwithstanding any record retention policies, Contractor shall maintain all documentation associated with the Project for the period required by State law or Federal law or seven (7) years, whichever is greater.

5. COMPLIANCE WITH FEDERAL, STATE AND LOCAL LAWS

In addition to the requirements set forth in the Universal Memorandum, Settlement Funds may be subject to various other Federal, State, and Local laws including, but not limited to, Utah Code Ann. 26B-5-211. Contractor shall comply with all applicable Federal, State, and Local laws and regulations with respect to its receipt and use of Settlement Funds pursuant to this Agreement.

6. RETURN OF SETTLEMENT FUNDS; RECOUPMENT

A. If the County determines that the Contractor's use of Settlement Funds does not comply with Universal Memorandum, the terms of this Agreement, or any other federal, state, or local law, the County shall provide the Contractor with an initial written notice of the amount subject to recoupment, along with an explanation of such amounts. Within 30 calendar days of receipt of such notice, the Contractor may

submit to the County either (1) a request for reconsideration requesting the County seek a reconsideration of any amounts subject to recoupment under the Final Rule, or (2) written consent to the notice of recoupment.

B. If the Contractor has not submitted a reconsideration request, or if the County denies the reconsideration request, the Contractor shall repay the amount subject to recoupment within 30 calendar days of the request for consideration deadline or the County's denial of the request.

7. FAILURE TO PERFORM

If Contractor fails to comply with any terms or conditions of this Agreement, or to provide in any manner the activities or other performance as agreed to herein, the County reserves the right to:

A. withhold all or any part of payment pending correction of the deficiency; or

B. suspend all or part of this Agreement.

Further, any failure to perform as required pursuant to this Agreement may subject the Contractor to recoupment of Settlement Funds. The option to withhold Settlement Funds is in addition to, and not in lieu of, the County's right to terminate as provided in Section 8 below. The County may also consider performance under this Agreement when considering future Settlement Funds.

8. TERMINATION

A. *Termination for Cause.* The County may terminate this Agreement for cause if the Contractor fails to comply with the terms and conditions of this Agreement and any of the following conditions exist:

i. The lack of compliance with the provisions of this Agreement is of such scope and nature that the County deems continuation of this Agreement to be substantially non-beneficial to the public interest;

ii. The Contractor has failed to take satisfactory corrective action as directed by the County or its authorized representative within the time specified by the same; or

iii. The Contractor has failed within the time specified by the County or its authorized representative to satisfactorily substantiate its compliance with the terms and conditions of this Agreement.

The County shall initiate termination for cause by providing notice to the Contractor of its intent to terminate for cause, accompanied by a written justification for the termination. After receiving the notice of termination for cause, the Contractor shall have 15 calendar days to cure the cause for termination. If the Contractor has not cured the cause for termination within 15 days of receipt of the notice, the County may pursue such remedies as are available by law,

including, but not limited to, the termination of this Agreement in whole or in part, and thereupon shall notify in writing the Contractor of the termination, the reasons for the termination, and the effective date of the termination. Upon termination, any outstanding Settlement Funds held by the Contractor are subject to recoupment by the County in accordance with this Agreement. Any costs resulting from obligations incurred by the Contractor after termination of this Agreement are not allowable and will not be reimbursed by the County unless specifically authorized in writing by the County.

B. *Termination for Convenience.* This Agreement may be terminated for convenience, in whole or in part, by written mutual agreement of the Parties.

C. *Termination for Withdrawal, Reduction, or Limitation of Funding.* In the event funding is not received from Defendants, or is withdrawn, reduced, modified or limited in any way after the effective date of this Agreement and prior to its normal completion, the County may summarily terminate this Agreement as to the Settlement Funds not received, reduced, modified, or limited, notwithstanding any other termination provision in this Agreement. If the level of funding is reduced to such an extent that the County deems that the continuation of the Project covered by this Agreement is no longer in the best interest of the public, the County may summarily terminate this Agreement in whole notwithstanding any other termination provisions in this Agreement. Termination under this Section shall be effective upon receipt of written notice by the Contractor or its representative.

9. CLOSE OUT

Upon termination of this Agreement, in whole or in part for any reason, including completion of the Project, the following provisions apply:

A. Upon written request by the Contractor, the County will make or arrange for payment to the Contractor of allowable reimbursable costs not covered by previous payments.

B. The Contractor shall submit within 30 calendar days after the date of expiration of this Agreement, all financial, performance and other reports required by this Agreement, and in addition, will cooperate in a Project audit by the County or its designee;

C. Closeout of Settlement Funds will not occur unless all requirements of this Agreement and Federal, State, and Local law are met and all outstanding issues with the Contractor have been resolved to the satisfaction of the County.

D. Any unused Settlement Funds in Contractor's possession or control shall be immediately returned to the County.

10. INDEMNIFICATION

Any Settlement Funds which are determined by the County to be ineligible under the Universal Memorandum or law shall be subject to recoupment. To the greatest extent permitted by law, the Contractor shall indemnify and hold harmless the County, its appointed and elected

officials, and employees from any liability, loss, costs (including attorney fees), damage or expense, incurred because of actions, claims or lawsuits for damages resulting from misuse of Settlement Funds by the Contractor, personal or bodily injury, including death, sustained or alleged to have been sustained by any person or persons and on account of damage to property, arising or alleged to have arisen out of the performance of this Agreement, whether or not such injuries to persons or damage to property is due to the negligence of Contractor, its subcontractors, agents, successors or assigns.

11. NOTICES

Any notices required to be given by the County or the Contractor shall be in writing and delivered to the following representatives for each party:

The County	Contractor
County of Weber Attn: County Comptroller 2380 Washington Blvd., Suite 320 Ogden, UT 84401 sparke@webercountyutah.gov	Weber-Morgan Health Department Attn: Brian Cowan 477 23rd Street Ogden, Utah 84401 bcowan@webercountyutah.gov

12. RESERVATION OF RIGHTS

Failure to insist upon strict enforcement of any terms, covenants, or conditions of this Agreement shall not be deemed a waiver of such, nor shall any waiver or relinquishment of any right or power granted through this Agreement at any time be construed as a total and permanent waiver of such right or power.

13. FURTHER ASSURANCE

Each of the Parties shall cooperate in good faith with the other to execute and deliver such further documents, to adopt any resolutions, to take any other official action and to perform such other acts as may be reasonably necessary or appropriate to consummate and carry into effect the transactions contemplated under this agreement.

Contractor shall, in good faith and to the greatest extent possible, complete the Project in accordance with the Contractor's proposed project timeline in the Contractor's application. Contractor acknowledges that time is of the essence, and Contractor shall exercise due diligence to complete the project in a timely manner.

14. ASSIGNMENT

The Contractor shall not assign any portion of Settlement Funds, nor responsibility for completion of the Project provided for by this Agreement, to any other party.

15. AMENDMENTS

This Agreement cannot be amended or modified except in writing, signed by both

Parties.

16. VENUE AND CHOICE OF LAW

If either part to this Agreement initiates any legal or equitable action to enforce the terms of this Agreement, to declare the rights of the parties under this Agreement, or which relates to this Agreement in any manner, the County and Contractor agree that the proper venue for such action is the Utah Second Judicial District. This Agreement shall be governed by the laws of the State of Utah, both as to interpretation and performance.

17. SEVERABILITY

If any part of this Agreement is held by the courts to be illegal or in conflict with any law, the validity of the remaining portions or provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if the Agreement did not contain the particular part held to be invalid.

18. INTEGRATED DOCUMENT

This Agreement, together with all exhibits and attachments, which are incorporated by reference, constitute the entire agreement between the Parties. There are no other agreements, written or oral, that have not been fully set forth in the text of this Agreement.

19. NO THIRD PARTY BENEFICIARY.

Nothing in this Agreement shall create or be interpreted to create any rights in or obligations in favor of any person or entity not a party to this agreement. Except for the Parties to this agreement, no person or entity is an intended third party beneficiary under this agreement.

20. HEADINGS

The section headings of this agreement are for the purposes of reference only and shall not limit or define the meaning thereof.

21. AUTHORITY TO SIGN

The persons executing this Agreement on behalf of the Contractor represent that one or both of them has the authority to execute this Agreement and to bind the Contractor to its terms.

[*signatures on following page*]

BOARD OF COUNTY COMMISSIONERS
OF WEBER COUNTY

By_____
Chair,

Date_____

ATTEST:

_____
Weber County Clerk/Auditor

ENTITY

By Brian Cowan Weber-Morgan Health Dept.

Date 8-18-2025

ATTEST:

By Brian Cowan

EXHIBIT A: UNIVERSAL MEMORANDUM

Exhibit: A

List of Opioid Remediation Uses

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*").[14]

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 individuals who are uninsured or whose insurance does not cover the needed service;

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. Provide 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 and with other support services.

[14] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

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 OUD, including housing, transportation, job placement/training, and childcare.

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME ("*NAS*")**

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

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

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

E. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

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

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

3. Broaden scope of recovery services to include co-occurring SUD or 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

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:

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, those that:[15]

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. Provide 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.

[15] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

8. Provide 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. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. 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.

13. Disseminate 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.

14. Develop and disseminate 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 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 programs or strategies that:

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 mediation 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. Provide 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 are 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, those that:

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 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. Provide 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, those that:

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:

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

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

    3. "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;

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

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

    6. 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 or 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, those that:

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. Provide training for obstetricians or other healthcare personnel who 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; and 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 NAS get referred to appropriate services and receive a plan of safe care.

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

7. Provide enhanced family support 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. Provide 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. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the 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. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

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

1. Increase the number of prescribers using PDMPs;

2. 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

3. 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. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating 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. Funding 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. Funding community anti-drug coalitions that engage in drug prevention efforts.

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

8. Funding 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 or 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 another 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. Increased 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, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing 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. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expanding, improving, or developing 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. Educating 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. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Supporting 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. Providing 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. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

1. Education of 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, facilitations, 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, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- 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, those that:

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

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

L. RESEARCH

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

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

2. Research non-opioid treatment of chronic pain.

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

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

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

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

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

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

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

Exhibit B to One Utah Opioid Settlement MOU
County Allocations

County	Allocation Percentage
Beaver	0.228%
Box Elder	1.464%
Cache	2.649%
Carbon	2.718%
Daggett	0.028%
Davis	8.695%
Duchesne	0.641%
Emery	0.938%
Garfield	0.147%
Grand	0.304%
Iron	1.622%
Juab	0.352%
Kane	0.439%
Millard	0.355%
Morgan	0.216%
Piute	0.022%
Rich	0.061%
Salt Lake	42.271%
San Juan	0.249%
Sanpete	1.013%
Sevier	0.661%
Summit	0.944%
Tooele	2.233%
Uintah	0.866%
Utah	15.426%
Wasatch	0.601%
Washington	4.865%
Wayne	0.109%
Weber	9.883%

EXHIBIT B: CONTRACTOR'S APPLICATION

Weber-Morgan Health Department
Weber County Opioid Settlement

Proposal

The Weber-Morgan Health Department (WMHD) will work with the Substance Use Prevention and Emergency Response (SUPER) team. WMHD has facilitated this team since 2019. The original funding in 2018 came from the Utah Department of Health and Human Services (DHHS). The WMHD has been able to use other grants and funds until Fall of 2023. DHHS's five year grant that was subawarded to WMHD and other local health departments ended. The loss of funds for the WMHD was over $76,000 a year. Since the Fall of 2023, the WMHD and SUPER team has tried to continue their opioid efforts in order to decrease opioid injuries and deaths. The WMHD is requesting $537,481.32 for three years in order to increase the opioid efforts within Weber County. See Budget section for annual details.

Scope of work

The WMHD and SUPER use the Strategic Prevention Framework (SPF) as a basis for their local efforts. The basic components of this model are assessment, capacity building, planning, implementation, evaluation.

Strategic Prevention Model

preventimpaireddriving.org

By using this model to plan the next three years of activities will help to accomplish the following goals:

1. Addressing the local needs by working with the local community members and agencies
2. Ensuring that all efforts are driven by data. The WMHD and SUPER team is always looking at the existing data and collecting local data. These data help to inform the current and future activities.
3. Activities will be science-based. Where possible, best practices will be followed. For the few occurrences where a best practice hasn't been established, following the guidance for promising practices will be followed.

The work plan that has been created to address each of the components of the SPF model to make sure that at the end of the three years there will be data and outcomes tracked to show the impact. The overall mission for the SUPER team is to decrease opioid overdose injuries and deaths.

Strategy 1: Increase community partner knowledge and participation through conferences annually (Rx Summit, Fall Conference, Bryce Canyon)

SPF	Activity	Who's Responsible	By When?
Planning	Discuss potential participants (5 per conference) with SUPER team 6 months prior to conference	SUPER team	Quarter 3-annually
Planning	Send invite and conference agreement to participants	WMHD	Quarter 3-annually
Planning	Make reservations for Rx Summit before December in order to get early bird rates	WMHD	December-annually
Planning	Coordinate reservations for Bryce Canyon with LSAA	WMHD	Quarter 2
Planning	Make reservations for Fall conference before August	WMHD	Quarter 2
capacity	Attend annual summit and conferences	SUPER team/selected participants	Annually
	Present at Fall Conference with SUPER Coalition		
Implementation	Present at local Ogden Community Crime Conference		
	Complete post-travel paper work	WMHD	2 weeks post-summit
Evaluation	Complete summit reports for coalition	SUPER team/selected participants	2 weeks post-summit
	Evaluation: Signed conference agreements Number of participants Post-travel reports and summary Summit reports for each participant Number of people invited Newly SUPER participants		

Strategy 2: Conduct listening sessions to increase provider participation and agency utilization of ODMAP

SPF	Activity	Who's Responsible	By When?
capacity	Identify potential ODMAP users	WMHD	Quarter 1, 2025
Implementation	Provide ODMAP training for new agencies		
Implementation	Provide TA training for agencies using ODMAP		
Planning	Create a list of providers, prescribers, and pain management clinics	WMHD	Quarter 1, 2025
capacity	Invite Weber State University class to participate in facilitation	WMHD	Quarter 2, 2025
capacity	Develop listening session script/questions	WMHD, SUPER team, Weber State, evaluator	Quarter 3, 2025
Planning	Create a survey based on opioid practices (prescribing, managing, available trainings)		Planning
Planning	Analyze survey results and provide recommendations		
capacity	Create IRB application with Weber State University	WMHD and Weber State	Quarter 3, 2025
capacity	Identify and procure incentives for participants	WMHD	Quarter 3, 2025
capacity	Invite participants for listening sessions	WMHD	Quarter 4, 2025
capacity	Create a listening session packet (instructions, permissions, etc.)		
capacity	Conduct up to six listening sessions	WMHD and Weber State	Quarter 1, 2026
capacity	Create listening session report with recommendations	WMHD, evaluator, and Weber State	Quarter 2, 2026
capacity	Create plan based on report	SUPER team	Quarter 2, 2026
Implementation	Present at medical conference based on results from survey and listening sessions	Implementation	Present at medical conference based on results from survey and listening sessions
	Evaluation: List of community agencies that can use ODMAP Listening session script and questionnaire Listening session packet IRB application List of participants receiving incentive Number of participants Post-listening session survey Final report with recommendations Plan based on report		

Strategy 3:Increase partnerships in the community to address opioid concerns in local/small areas

SPF	Activity	Who's Responsible	By When?
capacity	Provide situational awareness training on opioids for all CTC's	WMHD, WHS	
capacity	Create application proposal for CTC's	WMHD	
capacity	Create work plan(s) for proposal(s)	WMHD	
capacity	Create reporting and evaluation plan(s)	WMHD	
capacity	Complete report(s)	CTCs	
capacity	Send out request for applications	WMHD	
capacity	Award applications	WMHD	
capacity	Provide orientation meeting with requirements and agreements	WMHD	
capacity	Create annual report for all applicants	WMHD	
Implementation	Provide naloxone training for local businesses		
Implementation	Provide JIT naloxone training for Code Blue participants		
	Evaluation: Finalized opioid training Number of participants Application packet Number of applicants Approved work plans Report for each applicant Final annual report		

Strategy 4: Develop community messaging around opioid safety and prevention

SPF	Activity	Who's Responsible	By When?
Planning	Partner with Weber State University students to create a local social media campaign		
Planning	Create a list of potential media campaign agencies for future partnership		
Planning	Select an agency for media campaign		
Planning	Create a media campaign		
Implementation	Create opioid educational materials for Code Blue events		
Implementation	Create harm reduction materials		
Implementation	Create educational materials for providers, prescribers, and pain management clinics		
Implementation	Create educational materials for ODMAP users		
Implementation	Create coalition educational materials used for outreach		
	Evaluation: Number of survey responses Survey analysis and recommendations List of community providers, prescribers, and pain management clinics Listening session script and questionnaire Listening session packet IRB application List of participants receiving incentive Number of participants Post-listening session survey Final report with recommendations Plan based on report		

County Opioid Settlement Fund Proposal

				Year 1	Year 2	Year 3
I. Personnel						
A. Salaries/Wages	Rate/hour	Hours/week	Hours/year			
Director (Bryce Sherwood)	[redacted]	5	260	$12,188.80	$12,432.58	$12,681.23
Community Health Educator (Mcki Rohde)		20	1040	$29,068.00	$29,649.36	$30,242.35
Epidemiologist (Liz Jones)		2	104	$3,568.24	$3,639.60	$3,712.40
Position/Name:				$0.00	$0.00	$0.00
Subtotal				$44,825.04	$45,721.54	$46,635.97
B. Benefits	**Rate**	**Salary**				
Director (Bryce Sherwood)	47%	$12,188.80		$5,728.74	$5,728.74	$5,728.74
Community Health Educator (Mcki Rohde)	47%	$29,068.00		$13,661.96	$13,661.96	$13,661.96
Epidemiologist (Liz Jones)	43%	$3,568.24		$1,534.34	$1,534.34	$1,534.34
Position/Name:		$0.00		$0.00	$0.00	$0.00
Subtotal				$20,925.04	$20,925.04	$20,925.04
TOTAL PERSONNEL				$65,750.08	$66,646.58	$67,561.01
II. Non-Personnel						
A. Travel	**Miles/month**	**Miles/year**	**Rate/Mile**			
Mileage		1000	$0.61	$610.00	$610.00	$610.00
	# of people	Amount/person				
Rx Summit (National conference)	5	$ 2,826.00		$ 14,130.00	$ 14,130.00	$ 14,130.00
Bryce Canyon (coalition building/substance use)	5	$ 1,100.00		$ 5,500.00	$ 5,500.00	$ 5,500.00
Fall Conference (treatment, recovery, prevention)	5	$ 1,400.00		$ 7,000.00	$ 7,000.00	$ 7,000.00
Subtotal				$27,240.00	$27,240.00	$27,240.00
B. Supplies (list items)						
Provider listening session				$5,000	$5,000	$5,000
Medical conference				$1,000	$1,000	$1,000
ODMAP listening sessions				$5,000	$5,000	$5,000
Gang conference presentation				$1,200	$1,200	$1,200
Code Blue (participation, educational mats)				$2,500	$2,500	$2,500
Naloxone for Code Blue and business trianings				$2,500	$2,500	$2,500
CTCs ($5k per CTC)				$30,000	$30,000	$30,000
Educational materials				$9,070.00	$9,070.00	$9,070.00
Subtotal				$56,270.00	$56,270.00	$56,270.00
C. Equipment (itemize)	Staff	Cost				
Subtotal				$0.00	$0.00	$0.00
D. Subcontractors						
Evaluator (10%) (not selected yet)				$17,000.00	$17,000.00	$17,000.00
Subtotal				$17,000.00	$17,000.00	$17,000.00
E. Telephone	**Rate/Month**	**Rate/Year**	**Staff**			
		$0.00		$0.00	$0.00	$0.00
Subtotal				$0.00	$0.00	$0.00
F. Postage						
Subtotal				$0.00	$0.00	$0.00
G. Printing & Copying						
Media materials (naloxone, FTS, taskforce) and flyers				$2,000.00	$2,000.00	$2,000.00
Subtotal				$2,000.00	$2,000.00	$2,000.00
H. Other						
Admin costs	15%			$9,862.51	$9,996.99	$10,134.15
Subtotal				$9,862.51	$9,996.99	$10,134.15
TOTAL NON-PERSONNEL				$112,372.51	$112,506.99	$112,644.15
TOTAL EXPENSES				$178,122.59	$179,153.57	$180,205.16

EXHIBIT C: REPORTING REQUIREMENTS

Effective 5/1/2024

26B-5-211 Administration of opioid litigation proceeds -- Requirements for governmental entities receiving opioid funds -- Reporting.

(1) As used in this section:

(a) "Office" means the Office of Substance Use and Mental Health within the department.

(b) "Opioid funds" means money received by the state or a political subdivision of the state as a result of any judgment, settlement, or compromise of claims pertaining to alleged violations of law related to the manufacture, marketing, distribution, or sale of opioids.

(c) "Restricted account" means the Opioid Litigation Proceeds Restricted Account created in Section 51-9-801.

(2) Opioid funds may not be used to:

(a) reimburse expenditures that were incurred before the opioid funds were received by the governmental entity; or

(b) supplant or take the place of any funds that would otherwise have been expended for that purpose.

(3) The office shall serve as the reporting entity to receive, compile, and submit any reports related to opioid funds that are required by law, contract, or other agreement.

(4) The requirement described in Subsection (5) applies to:

(a) a recipient of opioid funds from the restricted account, in any year that opioid funds are received; and

(b) a political subdivision that received opioid funds.

(5) A person described in Subsection (4) shall provide an annual report to the office, in a form and by a date established by the office, that includes:

(a) an accounting of all opioid funds that were received by the person in the year;

(b) the number of individuals served through programs funded by the opioid funds, including the individuals' age, gender, and other demographic factors reported in a de-identified manner;

(c) the measures that were used to determine whether the program funded by the opioid funds achieved the intended outcomes;

(d) if applicable, any information required to be submitted to the reporting entity under applicable law, contract, or other agreement; and

(e) the percentage of total funds received by the person in the year that the person used to promote the items under Subsections (6)(d)(i) through (vi).

(6) On or before October 1 of each year, the office shall provide a written report that includes:

(a) the opening and closing balance of the restricted account for the previous fiscal year;

(b) the name of and amount received by each recipient of funds from the restricted account;

(c) a description of the intended use of each award, including the specific program, service, or resource funded, population served, and measures that the recipient used or will use to assess the impact of the award;

(d) the amount of funds expended to address each of the following items and the degree to which the department administered the program or subcontracted with a private entity:

(i) treatment services;

(ii) recovery support services;

(iii) prevention;

(iv) criminal justice;

(v) harm reduction; and

(vi) expanding any of the following services:

(A) housing;

(B) legal support;

(C) education; and
(D) job training;
(e) a description of any finding or concern as to whether all opioid funds disbursed from the restricted account violated the prohibitions in Subsection (2) and, if applicable, complied with the requirements of a settlement agreement;
(f) the performance indicators and progress toward improving outcomes and reducing mortality and other harms related to substance use disorders; and
(g) administrative costs including indirect rates and direct service costs.
(7) The office shall provide the information that is received, compiled, and submitted under this section:
(a) to the Health and Human Services Interim Committee;
(b) to the Social Services Appropriations Subcommittee;
(c) if required under the terms of a settlement agreement under which opioid funds are received, to the administrator of the settlement agreement in accordance with the terms of the settlement agreement; and
(d) in a publicly accessible location on the department's website.
(8) The office may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this section.

Amended by Chapter 271, 2024 General Session