WEST VIRGINIA FIRST
MEMORANDUM OF UNDERSTANDING

General Principles

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

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

Whereas, the State, through its Attorney General, and its Local Governments share a common desire to abate and alleviate the impacts of that misfeasance, nonfeasance, and malfeasance throughout the State of West Virginia;

Terms

The State and its Local Governments and communities, subject to the completion of formal documents effectuating the Parties' agreements, enter into this Memorandum of Understanding ("MOU") relating to the allocation and use of the proceeds of Settlements and Judgments described herein.

A. Definitions

As used in this Memorandum of Understanding:

1. "Approved Purpose(s)" shall mean evidence-based strategies, programming and/or services used to expand the availability of treatment for individuals affected by substance use disorders and/or addiction, to develop, promote and provide evidence-based substance use prevention strategies, to provide substance use avoidance and awareness education, to engage in enforcement to curtail the sale, distribution, promotion or use of opioids and other drugs, to decrease the oversupply of licit and illicit opioids and to support recovery from addiction to be performed by qualified providers as is further set forth in Exhibit A and Paragraph B(3) below.

2. "Court" is the West Virginia Mass Litigation Panel.

3. "Foundation Share" shall mean Opioid Funds allocated to the Foundation from any settlement or judgment.

4. "Judgment" shall mean a final judgment or verdict in favor of any of the Parties in a judicial proceeding pending in either state or federal court (including Bankruptcy Court) which resolves legal or equitable claims regarding opioids against a Pharmaceutical Supply Chain Participant. Judgment shall not include any judgment on the claims of Cabell County and the City of Huntington which were previously tried in the United States District Court for the Southern District of West Virginia, or any judgment on any claims asserted by the State against a Pharmaceutical Supply Chain Participant arising under federal or state antitrust laws, state criminal laws, or claims asserted pursuant to W. Va. Code § 9-7-6(c) or for Medicaid reimbursement.

5. "Local Government(s)" shall mean all counties, cities, villages, and towns located within the geographic boundaries of the State.

6. "Local Government Share" or "LG Share" shall mean Opioid Funds allocated directly to Local Governments from any settlement or judgment.

7. "Regional Share Calculation" shall mean each Region's share of Opioid Funds which shall be calculated by summing the individual percentage shares of the Local Governments set forth in Exhibit C for all of the subdivisions in the entire Region as defined in Exhibit B.

8. "Net Opioid Fund" is the Opioid Fund less the Opioid Seed Fund payment.

9. "Opioid Funds" shall mean monetary amounts obtained through a Settlement or Judgment as defined in this Memorandum of Understanding.

10. "Pharmaceutical Supply Chain" shall mean the process and channels through which opioids are manufactured, marketed, promoted, distributed, or dispensed.

11. "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, including but not limited to those persons or entities identified as Defendants in the matter captioned In re: Opioid Litigation, MDL 2804 pending in the United States District Court for the Northern District of Ohio, the proceedings before the West Virginia Mass Litigation Panel, styled In Re: Opioid Litigation, Civil Action No. 19-C-9000, and relates to conduct occurring prior to the date of this agreement. For the avoidance of doubt, the term Pharmaceutical Supply Chain Participant includes any parent or subsidiary company of any entity that engages in or has engaged in the manufacture, marketing, promotion, distribution or dispensing of an opioid analgesic, and any entity that engages in or has engaged in the manufacture, marketing, promotion, distribution or dispensing of an opioid analgesic, that seeks or has sought protection under the United States Bankruptcy Code.

12. "Settlement" shall mean the negotiated resolution by any of the Parties, of legal or equitable claims regarding opioids against a Pharmaceutical Supply Chain Participant when that resolution has been jointly entered into by the Parties. It does not include the Settlements the State and/or the West Virginia Attorney General entered into with any Pharmaceutical Supply Chain Participant prior to December 1, 2021. For the avoidance of doubt McKinsey is included. Settlement shall not include the claims of Cabell County and the City of Huntington, which were previously tried in the United States District Court for the Southern District of West Virginia or settlement of any claims asserted by the State and/or the West Virginia Attorney General against a Pharmaceutical Supply Chain Participant arising under federal or state antitrust laws, state criminal laws, or claims asserted pursuant to W. Va. Code, § 9-7-6(c) or for Medicaid reimbursement.

13. "State Share" shall mean Opioid Funds allocated to the State from any settlement or judgment.

14. "The Parties" shall mean the State and the Local Governments.

15. "Regions" shall mean the division of the Local Governments into six (6) separate areas as set forth in Exhibit B.

16. "The State" shall mean the State of West Virginia acting through its Attorney General.

17. "West Virginia Seed Fund" shall be funded as set forth in Paragraph B(2)(a). The funds are available for use in proper creation and documentation of the West Virginia Opioid Foundation and to fund their start-up work, and subsequent operation.

B. Settlement and Judgment Proceeds

1. The Parties shall organize a private, nonstock, nonprofit corporation for the purposes of receiving and distributing West Virginia Opioid Funds as set forth in Section C. of this MOU ("Opioid Foundation").

2. The Parties shall allocate all Opioid Funds as follows:

   a. Subject to relevant approvals, the State shall pay into the West Virginia Seed Fund the $10,000,000 received from McKinsey & Company as a result of the February 3, 2021, consent judgment with the State.

   b. All other Opioid Funds covered by the agreement shall be allocated as set forth below:

i. 24.5% of the Net Opioid Funds shall be allocated as LG Shares. These LG Shares shall be allocated amongst the Local Governments using the default percentages set forth in Exhibit C. Each county and its inclusive municipalities must either: (a) ratify the default allocation; (b) reach an agreement altering the default allocation; or (c) submit to binding arbitration before Judge Christopher Wilkes (WVMLP Special Master) whose decision will be final and non-app ealabl e.

ii. The Foundation will receive 72.5% of the Net Opioid Funds ("Foundation Share").

iii. The State shall receive 3% of the Net Opioid Funds ("State Share"), by and through the Attorney General, to be held in escrow for expenses incurred related to opioid litigation. If the 3% is not spent by December 31, 2026, then 1% goes to Local Governments and 2% goes to the Opioid Foundation.

3. All Net Opioid Funds, regardless of allocation, shall be used in a manner consistent with the Approved Purposes definition. The LG Share may be used as restitution for past expenditures so long as the past expenditures were made for purposes that would have qualified or were consistent with the categories of Approved Purposes listed in Exhibit A. Prior to using any portion of the LG Share as restitution for past expenditures, a Local Government shall pass a resolution or take equivalent governmental action detailing and explaining its use of the funds for restitution. Moreover, up to one-half of the LG Share may be used to provide restitution for monies that were previously expended on opioid abatement activities, including law enforcement and regional jail fees.

4. In the event a Local Government merges, dissolves, or ceases to exist, the relevant shares for that Local Government shall be redistributed equitably based on the composition of the successor Local Government. If a Local Government for any reason is excluded from a specific Settlement or Judgment, the allocation percentage for that Local Government shall be redistributed among the participating Local Governments for that Settlement or Judgment.

5. If the LG Share is less than $500, then that amount will instead be distributed to the county in which the Local Government lies to allow practical application of the abatement remedy.

6. Funds obtained that are unrelated to any Settlement or Judgment with a Pharmaceutical Supply Chain Participant, including those received via grant, bequest, gift, or the like, may be directed to the Opioid Foundation and disbursed as set forth below.

7. The Foundation Share shall be used for the benefit of the people of West Virginia consistent with the by-laws of the Foundation documents and this MOU.

8. Nothing in this MOU alters or changes the Parties' rights to pursue their own claims in litigation, subject to Paragraph E. Rather, the intent of this MOU is to join the Parties together regarding the distribution of the proceeds of settlements with or judgements against Pharmaceutical Supply Chain Participants for the benefit of all West Virginians and ensure that settlement monies are spent consistent with the Approved Purposes set forth in Exhibit A.

9. Any settlement, judgment and/or other remedy arising out of *City of Huntington v. AmerisourceBergen Drug Corporation, et al.* (Civil Action No. 3:17-01362) and/or *Cabell County Commission v. AmerisourceBergen Drug Corporation, et al.* (Civil Action No. 3:17-01665) pending in the United States District Court for the Southern District of West Virginia (Faber, J.) ("CT2") is specifically excluded from this MOU.

C. The Opioid Foundation

1. The Parties shall create a private section 501(c)(3) Opioid Foundation ("Foundation") with a governing board ("Board"), a panel of experts ("Expert Panel"), and such other regional entities as may be necessary for the purpose of receiving and disbursing Opioid Funds and other purposes as set forth both herein and in the documents establishing the Foundation. The Foundation will allow Local Governments to take advantage of economies of scale and will partner with the State to increase revenue streams.

2. Each Region shall create their own governance structure, ensuring that all Local Governments have input and equitable representation regarding regional decisions including representation on the board and selection of projects to be funded from the Regional Share Calculation. The Expert Panel may consult with and may make recommendations to Regions on projects, services and/or expenses to be funded. Regions shall have the responsibility to make decisions that will allocate funds to projects, services and/or expenses that will equitably serve the needs of the entire Region.

3. Board Composition

The Board will consist of 11 members comprising representation as follows:

a. To represent the interests of the State, five appointees of the governor, subject to confirmation by the Senate. The five appointees are intended to be limited to one from any given Region. If special circumstances are shown, this provision may be waived by a vote of four of the six Local Government members.

b. To represent the interests of the Local Governments, six members, with one member selected from each Region. The Local Governments in each Region shall make the selection of the board member to represent their region.

4. Board terms will be staggered three-year terms. Board members may be reappointed.

5. Board members shall serve as fiduciaries of the Foundation separate and distinct from any representational capacity of the entity appointing the Board Member. Members of any regional governing structure shall likewise serve as fiduciaries of their Region separate and distinct from any representational capacity of the entity appointing the member.

6. Members of the board should have expertise in a variety of disciplines, such as substance abuse treatment, mental health, law enforcement, pharmacology, finance, and healthcare policy and management. Drawing Board members from these disciplines will help to ensure that the Board will make appropriate and prudent investments in order to meet short-term and long-term goals.

7. Six members of the Board shall constitute a quorum. Members of the Board may participate in meetings by telephone or video conference or may select a designee to attend and vote if the Board member is unavailable to attend a board meeting.

8. The Foundation shall have an Executive Director appointed by the Attorney General after consultation with the Board. The Board may reject the Attorney General's selection of the Executive Director only on the affirmative vote of eight members of the board. The Executive Director shall have at least six years' experience in healthcare, finance and management and will be responsible for the management, organization, and preservation of the public/private partnership's records. The Executive Director may be removed by the Board upon the concurrence of the votes of three-fourths of the members of the Board. The Executive Director shall have the right to attend all Board meetings unless otherwise excused but shall vote only in the event of a tie.

9. The Board shall appoint the Expert Panel. The Expert Panel should include experts in the fields of substance abuse treatment, mental health, law enforcement, pharmacology, finance, and healthcare policy and management. The purpose of the Expert Panel is to assist the Board in making decisions about strategies for abating the opioid epidemic in local communities around the state. The Executive Director and any member of the Board shall have the right to attend all meetings of the Expert Panel.

10. The governance of the Board and the criteria to be established for disbursement of funds shall be guided by the recognition that expenditures should insure the efficient and effective abatement of the opioid epidemic, the enforcement of laws to curb the use of opioids, and the prevention of future addiction and substance misuse based upon an intensity and needs basis. All expenditures must be consistent with the categories of Approved Purposes as set forth in Exhibit A hereto.

11. Disbursement of Foundation Share by the Board

a. The Foundation Board shall develop and approve procedures for the disbursement of Opioid Funds of the Foundation consistent with this Memorandum of Understanding.

b. Funds for statewide programs, innovation, research, and education may also be expended by the Foundation from the Foundation Share, from the State Share (as directed by the State), or from sources other than Opioid Funds as provided below.

c. The Foundation shall spend 20% of its annual budget in the six regions during the Foundation's first seven years of funding to be divided according to each Region's fixed Regional Share Calculation. After seven years, all regional spending will be as set forth in Section 11(d), below. Regions may, after consulting with the Expert Panel, expend the sums received under this Section 11(c) for any Approved Purposes.

d. After the Regional Shares are distributed as set forth in Section 11(c), the Disbursement of Funds from the Foundation Share approved for disbursement by the Board for Approved Purposes shall be disbursed based on an evidence-based evaluation of need after consultation with the Expert Panel. The Parties do not intend to require any specific regional allocation of the Foundation Share other than those distributed pursuant to Paragraph 11(c).

e. Regions may collaborate with other Regions to submit joint proposals.

f. The proposed procedures shall set forth the role of the Expert Panel in advising the Regions and the Board concerning disbursements of Opioid Funds of the Foundation as set forth in this MOU.

g. Within 90 days of the first receipt of any Opioid Funds and annually thereafter, the Board, after receiving counsel from its investment advisors and Expert Panel, shall determine the amount and timing of Foundation funds to be distributed annually. In making this determination, the Board shall consider: (a) Pending requests for Opioid Funds from communities, entities, or regions; (b) the total Opioid Funds available; (c) the timing of anticipated receipts of future Opioid Funds; (d) non-Opioid funds received by the Foundation; (e) investment income; and (f) long-term financial viability of the Foundation. The Foundation may disburse its principal and interest with the aim towards an efficient, expeditious abatement of the Opioid crisis considering long term and short-term strategies.

12. The Foundation, Expert Panel, and any other entities under the supervision of the Foundation, including the Regions, shall operate in a transparent manner. Meetings

should be open. All operations of the Foundation and all Foundation supervised entities, including the Regions, shall be subject to audit and review by the Attorney General and/or other appropriate State officials.

13. Each Local Government shall submit an annual financial report to the Foundation no later than April 30 of each year specifying the amounts spent on Approved Purposes within the Region during the previous fiscal year. A report for each Region shall be prepared no later than thirty days thereafter. Each Region's report shall incorporate the information disclosed in each Local Government's annual report generated pursuant to Section B(4), above. Each Region's report shall specify (i) the amount of Opioid Funds received, (ii) the amount of Opioid Funds disbursed or applied during the previous fiscal year, broken down by categories of Approved Uses (indicating the name of the recipient, the amount awarded, a description of the use of the award, and disbursement terms), and (iii) impact information measuring or describing the progress of the Approved Use strategies.

14. The Foundation shall publish a consolidated report detailing annual financial expenditures within 15 days of the last day of the state fiscal year covered by the report.

15. The Foundation shall consult with a professional investment advisor to adopt a Foundation investment policy that will seek to assure that the Foundation's investments are appropriate, prudent, and consistent with best practices for investments of public funds. The investment policy shall be designed to meet the Foundation's long and short-term goals.

16. The Foundation and any Foundation supervised entity may receive funds including stocks, bonds, real property, government grants, private-sector donations, and cash in addition to the proceeds of the Litigation. These Non-Opioid additional funds shall be subject only to the limitations, if any, contained in the individual award, grant, donation, gift, bequest, or deposit consistent with the mission of the Foundation.

D. Payment of Attorneys' Fees and Litigation Expenses

Payment of all Attorneys' Fees and Litigation Expenses shall be awarded consistent with the orders of the Court and upon recommendation of Judge Christopher Wilkes (WVMLP Special Master). Such award shall be final and non-appealable.

E. Authority to Negotiate and Announcing Resolution of Claims

1. The Court has established three case tracks.

    a. Manufacturers and Pharmacy claims are to be coordinated by the office of Attorney General Morrisey and his designated counsel. The Attorney General shall retain the authority over resolution of those claims after

consultation and coordination with Local Governments subject to Court approval.

b. The Distributor Claims are to be coordinated by Co-Lead Counsel Paul Farrell, Jr. and Robert Fitzsimmons. The Co-Leads shall retain the authority over resolution of those claims after consultation and coordination with Local Governments and their counsel and the Attorney General and his designated counsel.

2. If there is any resolution of any claim before the Court, it will be announced and presented to the Court jointly by the Attorney General and the Local Governments for Approval.

F. Amendments

The Parties agree to make such amendments as necessary to implement the general principles of this MOU.

EXHIBIT A

SCHEDULE A - CORE STRATEGIES

The Parties shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies **("Core Strategies).**[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 services.

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. 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.

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 and 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

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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 by the Opioid Abatement Foundation.

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 treatment and recovery support for NAS babies;

2. Expand services for better continuation 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 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 expansion 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. EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE.

I. LAW ENFORCEMENT

1. Funding for law enforcement efforts to curtail the sale, distribution, promotion or use of opioids and other drugs to reduce the oversupply of licit and illicit opioids, including regional jail fees.

J. RESEARCH

Research to ameliorate the opioid epidemic and to identify new tools to reduce and address opioid addiction. Holistically seek to address the problem from a supply, demand, and educational perspective. Ensure tools exist to provide law enforcement with appropriate enforcement to address needs.

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:[2]

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

1. Support treatment of Opioid Use Disorder (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 SUB/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 intervention, treatment, and recovery services, offered by qualified professionals and service providers, including but not limited to faith-based organizations or 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

[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 by the Opioid Abatement Foundation.

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.

    Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SLTD 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.

11. 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.

12. 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.

13. 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 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, 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 and support non-profits, faith-based communities, and community coalitions to support, house, and train 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 with 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.

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, 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 OLTI 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 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 and support non-profits and the faith-based 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 OLTD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, 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, 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, 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 childcare 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 the Guidelines for Prescribing Opioids for Chronic Pain

from the U.S. Centers for Disease Control and Prevention, or other recognized Best Practice guidelines, 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 and support 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 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 OPIOID-RELATED INJURIES

Support efforts to prevent or reduce overdose deaths or other opioid-related injuries 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, schools, and community 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. 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. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

10. Support mobile units that offer or provide referrals to 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.

11. Support 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. 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, 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 negative outcomes 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, law enforcement, or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of reducing the oversupply of opioids, 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, law enforcement, 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 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 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.

M. LAW ENFORCEMENT

Ensure appropriate resources for law enforcement to engage in enforcement and possess adequate equipment, tools, and manpower to address complexity of the opioid problem.