REPORT TO CITY COUNCIL

DATE: DECEMBER 8, 2021

TO: HONORABLE MAYOR AND MEMBERS OF THE CITY COUNCIL

FROM: NATHAN HAMBURGER, CITY MANAGER

SUBJECT: ADOPT RESOLUTION NO. 21-1992, A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF AGOURA HILLS, CALIFORNIA, AUTHORIZING THE CITY TO ENTER INTO THE SETTLEMENT AGREEMENTS WITH MCKESSON CORPORATION, CARDINAL HEALTH, INC., AMERISOURCEBERGEN CORPORATION, JOHNSON & JOHNSON, JANSSEN PHARMACEUTICALS, INC., ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC., AND JANSSEN PHARMACEUTICA, INC., AGREE TO THE TERMS OF THE MEMORANDUM OF UNDERSTANDING ALLOCATING SETTLEMENT PROCEEDS, AND AUTHORIZE ENTRY INTO THE MEMORANDUM OF UNDERSTANDING WITH THE ATTORNEY GENERAL AND AUTHORIZE THE CITY MANAGER TO TAKE ALL ACTIONS NECESSARY AND CONVENIENT TO IMPLEMENT THE SETTLEMENTS

Between 2017 and 2020, the State of California, 51 of 58 California counties and approximately 28 California cities filed lawsuits against opioid manufacturers and distributors seeking to abate the opioid crisis. Similar lawsuits were filed by almost all states and many cities and local governments within those states. These lawsuits were consolidated into one lawsuit in the Federal Court for the Northern District of Ohio. The Court converted the consolidated lawsuits into a class action lawsuit with the Plaintiff's Class consisting of all states and local governments in the United States. As a result, the City of Agoura Hills is a Plaintiff in these lawsuits although the City is not required to pay any attorney fees or litigation costs.

The Court appointed a group of 30 attorneys representing state, county, and city governments to serve as the Plaintiffs' Executive Committee to control the litigation on behalf of the Plaintiffs and, if possible, negotiate a settlement.

Nationwide settlements have been proposed to resolve all Opioids Litigation brought by states and local political subdivisions against the three largest pharmaceutical distributors: McKesson, Cardinal Health, and AmerisourceBergen ("Distributors"), and manufacturer Janssen Pharmaceuticals, Inc., and its parent company Johnson & Johnson (collectively, "J&J"). These settlements will provide substantial funds to states and cities for abatement of the opioid epidemic across the country and will impose transformative changes in the way the settling defendants conduct their business.

The deadline for participating in settlement agreements is January 2, 2022.

Basic Settlement Terms

- Distributors will pay a maximum of $21 billion over 18 years.

- J&J will pay a maximum of $5 billion over no more than nine years.

- Of this potential $26 Billion, approximately $22.8 billion in settlement proceeds payable to state and local subdivisions.

- Based on the allocations formula for the States, the maximum amount California will receive will be approximately $2,263,923,602 with $339,538,340 being retained by the State and $1,924,335,342 being allocated to counties and cities within the State.

- Based on the allocation formula for cities, Agoura Hills could receive up to $77,805, depending on whether there is 100% participation from cities and counties.

- The settlement proceeds to be paid to the states and local political subdivision will be in proportion to the number of states and local political subdivisions that approve the Settlements.

- Of the funds going directly to participating states and subdivisions, at least 85% must be used for abatement of the opioid epidemic.

- The settlements allow for a broad range of approved uses by state and local governments to abate the opioid epidemic. A list of approved uses is found at Exhibit E of the Master Settlement Agreements, attached as an exhibit to this Report.

- Agreements also provide for injunctive relief that requires the following important changes to the Distributors' and J&J's conduct to better protect our nation's health and welfare:

    1. Creation of a groundbreaking clearinghouse through which the Distributors will be required to account not only for their own shipments, but also the shipments of the other distributors, in order to detect, stop, and report suspicious Opioids orders.

    2. J&J (which ceased marketing Opioids in 2015 and ceased selling Opioids in 2020) will not market or sell any Opioid products in the next ten years and has agreed to cease lobbying concerning prescription opioids for ten years.

    3. J&J also has agreed to make the clinical trial data for its discontinued Opioids available for medical research.

California Allocation Terms

The National Settlements allot a certain amount of money to California to be allocated between the State and local governments. That amount is divided between State and

California local governments by agreement (the "Allocation Agreements"). The Allocation Agreements split the dollars coming into California as follows:

1. 15% to a State Fund;
2. 70% to local governments in an Abatement Accounts Fund; and
3. 15% to litigating local governments in a Subdivision Fund.

Cities and counties must be aware that the Settlement Agreements and the Allocation Agreements require that the money in the Abatement Accounts Fund must be spent on remediation with no less than 50% of each local government's allocation in each calendar year spent on one or more of the following High Impact Abatement Activities:

1. The provision of matching funds or operating costs for substance use disorder facilities within the Behavioral Health Continuum Infrastructure Program;

2. Creating new or expanded Substance Use Disorder ("SUD") treatment infrastructure;

3. Addressing the needs of communities of color and vulnerable populations (including sheltered and unsheltered homeless populations) that are disproportionately impacted by SUD;

4. Diversion of people with SUD from the justice system into treatment, including by providing training and resources to first and early responders (sworn and non-sworn) and implementing best practices for outreach, diversion and deflection, employability, restorative justice, and harm reduction; and/or

5. Interventions to prevent drug addiction in vulnerable youth.

A city that is an Eligible Local Government will be allocated its Local Allocation only when it becomes a Participating Subdivision by signing the Participation Agreements to the Settlements. The State agreements are available online at: https://oag.ca.gov/opioids.

The funds in the CA Abatement Accounts Fund will be divided according to an allocation model developed in connection with the proposed negotiating class in the National Prescription Opiate Litigation (MDL No. 2804). The percentage from the CA Abatement Accounts Fund allocated to each eligible local government (any county or city above 10,000 in population) is set forth in Appendix 1 to each Allocation Agreement. The Local Allocation for a city that is a Participating Subdivision will be paid to the county in which the city is located, rather than to the City, so long as: (a) the County is a Participating Subdivision, and (b) the City has not advised the Settlement Fund Administrator that it requests direct payment at least 60 days prior to a Payment Date as defined in the Settlement Agreements.

If the City wishes, it can elect a direct payment. It must then follow the use and reporting requirements in the Allocation Agreements and Settlement Agreements.

Why Should Our City Sign On?

- This proposal is a product of years of litigation and years of settlement negotiations.
- Negotiators have put forward this deal because they believe it is the possible best deal.
- Money is critical to addressing the opioid epidemic at this time.
- Litigation has real risk.
- Further insolvencies and bankruptcies of defendants are a real risk.
- Even if a city does not want to handle the reporting requirements or the use requirements in the settlement, by signing on, the County in which a City is located gets money to combat the opioid epidemic, thereby benefitting that City's region.

FISCAL IMPACT

There is no financial impact to the City. Assuming there is 100% participation from cities and counties, Agoura Hills is projected to receive up to $77,805 ($63,000 from the Distributors settlement and $14,805 from the J&J settlement) in Settlement Funds for the specified uses limited to the treatment of opioid abusers and prevention of opioid abuse.

RECOMMENDATION

Staff respectfully recommends that the City Council adopt Resolution No. 21-1993, A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF AGOURA HILLS, CALIFORNIA, AUTHORIZING THE CITY TO ENTER INTO THE SETTLEMENT AGREEMENTS WITH MCKESSON CORPORATION, CARDINAL HEALTH, INC., AMERISOURCEBERGEN CORPORATION, JOHNSON & JOHNSON, JANSSEN PHARMACEUTICALS, INC., ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC., AND JANSSEN PHARMACEUTICA, INC., AGREE TO THE TERMS OF THE MEMORANDUM OF UNDERSTANDING ALLOCATING SETTLEMENT PROCEEDS, AND AUTHORIZE ENTRY INTO THE MEMORANDUM OF UNDERSTANDING WITH THE ATTORNEY GENERAL AND AUTHORIZE THE CITY MANAGER TO TAKE ALL ACTIONS NECESSARY AND CONVENIENT TO IMPLEMENT THE SETTLEMENTS.

ATTACHMENTS:

1. Resolution No. 21-1992;
2. Exhibit E to the National Settlement Agreements describing the allowable uses for the Settlement Funds

RESOLUTION NO. 21-1992

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF AGOURA HILLS, CALIFORNIA, AUTHORIZING THE CITY TO ENTER INTO THE SETTLEMENT AGREEMENTS WITH MCKESSON CORPORATION, CARDINAL HEALTH, INC., AMERISOURCEBERGEN CORPORATION, JOHNSON & JOHNSON, JANSSEN PHARMACEUTICALS, INC., ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC., AND JANSSEN PHARMACEUTICA, INC., AGREE TO THE TERMS OF THE MEMORANDUM OF UNDERSTANDING ALLOCATING SETTLEMENT PROCEEDS, AND AUTHORIZE ENTRY INTO THE MEMORANDUM OF UNDERSTANDING WITH THE ATTORNEY GENERAL AND AUTHORIZE THE CITY MANAGER TO TAKE ALL ACTIONS NECESSARY AND CONVENIENT TO IMPLEMENT THE SETTLEMENTS

WHEREAS, the United States is facing an ongoing public health crisis of opioid abuse, addiction, overdose, and death. The State of California and California local governments spend billions of dollars each year to address the direct consequences of this crisis.

WHEREAS, since 2017, state and local governments in California and around the United States have been pursuing litigation against certain manufacturers, distributors, and retailers of opioid pharmaceuticals (the "Opioid Defendants") in an effort to hold the Opioid Defendants financially responsible for the impact on of the Opioid Epidemic on the City of Agoura Hills ("the City") and resources necessary to combat the opioid epidemic;

WHEREAS, negotiations to settle claims against several of the Opioid Defendants, specifically McKesson Corporation, Cardinal Health, Inc., AmerisourceBergen Corporation, Johnson & Johnson, Janssen Pharmaceuticals, Inc., Ortho-McNeil-Janssen Pharmaceuticals, Inc., and Janssen Pharmaceutica, Inc. (the "Settling Defendants") have been ongoing for several years;

WHEREAS, negotiations with the Settling Defendants have resulted in proposed nationwide settlements of state and local government claims to settle the Litigation;

WHEREAS, the proposed terms of those proposed nationwide settlements have been set forth in the Distributors Master Settlement Agreement and the J&J Master Settlement Agreement (collectively "Settlement Agreements") available for review on-line at: https://nationalopioidsettlement.com/;

WHEREAS, copies of the Settlement Agreements as well as summary of the main terms of the Settlement Agreements, the deadlines for submitting the Participation Agreements to the Settlement Agreements and the MDL Court's Order setting deadlines for any Plaintiff who declines to enter into the Settlement Agreements;

WHEREAS, the Settlement Agreements provide, among other things, for the payment of a certain sum to settling government entities in California including to the State of California and Participating Subdivisions upon occurrence of certain events as defined in the Settlement Agreements ("California Opioid Funds");

WHEREAS, California local governments as well as the attorneys representing those local governments have engaged in extensive discussions with the State Attorney General's Office ("AGO") as to how the California Opioid Funds will be allocated, which has resulted in the Proposed California State-Subdivision Agreement Regarding Distribution and Use of Settlement Funds- Distributor Settlement and the Proposed California State-Subdivision Agreement Regarding Distribution and Use of Settlement Funds- Janssen Settlement (collectively the "Allocation Agreements,") which are agreements between all of the entities identified in the Allocation Agreements;

WHEREAS, copies of the State Allocation Agreements are available online at https://oag.ca.gov/opioids;

WHEREAS, the Allocation Agreements propose to allocate the California Opioid Funds 15% to a State Fund; 70% to local governments in an Abatement Accounts Fund; and 15% to litigating local governments in a Subdivision Fund. For the avoidance of doubt, all funds allocated to California from the Settlements will be combined pursuant to Allocation Agreements, and 15% of that total shall be allocated to the State of California (the "State of California Allocation"), 70% to the California Abatement Accounts Fund ("CA Abatement Accounts Fund Allocation"), and 15% to the California Subdivision Fund ("CA Subdivision Fund Allocation");

WHEREAS, the funds in the CA Abatement Accounts Fund (the California Abatement Accounts Fund Allocation) will be allocated based on an allocation model developed in connection with the proposed negotiating class in the National Prescription Opiate Litigation (MDL No. 2804). The percentage from the CA Abatement Accounts Fund allocated to each eligible local government (any county or city above 10,000 in population) "Eligible Local Government") is set forth in Appendix 1 to each Allocation Agreement and provided to the Council with this Resolution. The City's share of the CA Abatement Accounts Fund is a product of the total in the CA Abatement Accounts Fund multiplied by the City's percentage set forth in Appendix 1 (the "Local Allocation").

WHEREAS, any city that is an Eligible Local Government will be allocated its Local Allocation share only when it becomes a Participating Subdivision by signing the Participation Agreements to the Settlements. The Local Allocation share for a city that is a Participating Subdivision will be paid to the county in which the city is located, rather than to the city, so long as: (a) the county is a Participating Subdivision, and (b) the city has not advised the Settlement Fund Administrator that it requests direct payment at least 60 days prior to a Payment Date as defined in the Settlement Agreements.

NOW, THEREFORE, THE CITY COUNCIL OF THE CITY OF AGOURA HILLS HEREBY RESOLVES AS FOLLOWS:

SECTION 1. The City Council hereby approves and authorizes the City Manager to settle and release the City's claims against the Settling Defendants in exchange for the consideration set forth in the Settlement Agreements, Allocation Agreements including taking the following measures:

A. The execution on behalf of the City of the Participation Agreement to the Distributors Settlement Agreement and any and all documents ancillary thereto.

B. The execution on behalf of the City of the Participation Agreement to the Janssen Settlement Agreement and any and all documents ancillary thereto.

C. The execution on behalf of the City of the Proposed California State-Subdivision Agreement Regarding Distribution and Use of Settlement Funds- Distributor Settlement.

D. The execution on behalf of the City of the Proposed California State-Subdivision Agreement Regarding Distribution and Use of Settlement Funds- Janssen Settlement Allocation Agreements.

SECTION 2. The City Manager shall have authority to, and is directed to, take all actions necessary or convenient on behalf of the City to implement and effectuate the agreements approved by this Resolution.

SECTION 3. All actions heretofore taken by the Council and other appropriate public officers and agents of the City with respect to the matters contemplated under this Resolution are hereby ratified, confirmed and approved.

SECTION 4. The City Clerk shall certify to the adoption of this Resolution.

PASSED, APPROVED, and ADOPTED this 8th day of December, 2021, by the following vote to wit:

AYES: ()
NOES: ()
ABSENT: ()
ABSTAIN: ()

_____
Deborah Klein Lopez, Mayor

ATTEST:

_____

Kimberly M. Rodrigues, City Clerk

EXHIBIT E

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.