MEMORANDUM OF AGREEMENT
BETWEEN THE STATE OF HAWAI'I AND LOCAL GOVERNMENTS ON PROCEEDS RELATING TO THE SETTLEMENT OF OPIOID LITIGATION

This Memorandum of Agreement ("MOA") is made by the State of Hawai'i (hereinafter "State") and the County of Hawai'i, a municipal corporation, the County of Maui, a municipal corporation, the County of Kaua'i, a municipal corporation, the City and County of Honolulu, a municipal corporation, and the County of Kalawao (collectively, "Local Governments"). The State and Local Governments are collectively referred to as the "Parties".

Background Statement

Capitalized terms not defined below have the meanings set forth in the Definitions section of this MOA.

WHEREAS, the Parties have been harmed by misconduct committed by certain entities that engage in or have engaged in the manufacture, marketing, promotion, distribution, or dispensing of an opioid analgesic ("Pharmaceutical Supply Chain Participants"); and

WHEREAS, certain Hawai'i counties, through their counsel, and the State, through its Attorney General, are separately engaged in ongoing investigations, litigation and settlement discussions seeking to hold Pharmaceutical Supply Chain Participants accountable for the damage caused by their misconduct; and

WHEREAS, the Parties share a common desire to abate and alleviate the impacts of the misconduct described above; and

WHEREAS, the Local Governments and the State recognize the sums which may be available from the aforementioned litigation will likely be insufficient to fully abate the public health crisis caused by the opioid epidemic and therefore, they share a common interest in dedicating the most resources possible to the abatement effort; and

WHEREAS, two national settlements reached as the result of the investigations of and litigation with (1) Johnson & Johnson, and (2) AmerisourceBergen, Cardinal Health, and McKesson have taken the form of two National Settlement Agreements; and

WHEREAS, an investigation of and litigation with Purdue Pharma L.P. and its affiliates resulted in a Chapter 11 bankruptcy, filed in the United States Bankruptcy Court, Southern District of New York, and a Plan of Reorganization confirmed by the Bankruptcy Court ("Purdue Plan of Reorganization"), which is currently on appeal to the United States Court of Appeals for the Second Circuit; and

WHEREAS, the City and County of Honolulu and Counties of Hawai'i, Maui, Kaua'i and Kalawao counties and the State have voted in favor of the Purdue Plan of Reorganization, which includes, among other things, direct payments to the State and Local Governments, and establishes a separate fund from which attorneys' fees and costs are paid; and

WHEREAS, an investigation of Mallinckrodt plc and its affiliates resulted in a Chapter 11 bankruptcy, filed in the United States Bankruptcy Court, District of Delaware, and a Plan of

Reorganization confirmed by the Bankruptcy Court ("Mallinckrodt Plan of Reorganization" and together with the Purdue Plan of Reorganization, the "Plans of Reorganization"); and

WHEREAS, the City and County of Honolulu and Counties of Hawai'i, Maui, Kaua'i and Kalawao and the State have voted in favor of the Mallinckrodt Plan od Reorganization, which includes, among other things, direct payments to the State and Local Governments, and establishes a separate fund from which attorneys' fees and costs are paid; and

WHEREAS, this MOA is intended to facilitate compliance by the State and by the Local Governments with the terms of the National Settlement Agreements and the Plans of Reorganization; and

WHEREAS, the National Settlement Agreements will set a default allocation between each state and its political subdivisions unless they enter into a state-specific agreement regarding the distribution and use of settlement amounts (a "State-Subdivision Agreement"); and

WHEREAS, this MOA is intended to serve as such a State-Subdivision Agreement under the National Settlement Agreements; and

WHEREAS, this MOA is also intended to serve as a State-Subdivision Agreement under resolutions of claims concerning alleged misconduct in manufacture, marketing, promotion, distribution, or dispensing of an opioid analgesic entered in bankruptcy court that provide for payments (including payments through a trust) to both the State and the Local Governments and allow for the allocation between the State and the Local Governments to be set through a state-specific agreement ("Plans of Reorganization"); and

WHEREAS, specifically, this MOA is intended to serve under the Plans of Reorganization as a statewide abatement agreement, and under this MOA, a statewide abatement agreement is a type of State-Subdivision Agreement.

Statement of Agreement

The Parties agree as follows:

A. Definitions

As used in this MOA:

The terms "Bankruptcy Resolution," "MOA," "Pharmaceutical Supply Chain Participant," "State," and "State-Subdivision Agreement" are defined in the recitals to this MOA.

"Local Governments" means the County of Hawai'i, the County of Kalawao County, the County of Kaua'i, the County of Maui, and the City and County of Honolulu.

"MDL Matter" means the matter captioned *In re: National Prescription Opiate Litigation,* MDL 2804 pending in the United States District Court for the Northern District of Ohio.

"MDL Parties" means all parties who participated in the matter captioned *In re: National Prescription Opiate Litigation,* MDL 2804 pending in the United States District Court for the

Northern District of Ohio as Plaintiffs.

"National Settlement Agreement" means a national opioid settlement agreement with the Parties and one or all of the Settling Defendants concerning alleged misconduct in manufacture, marketing, promotion, distribution, or dispensing of an opioid analgesic.

"Opioid Remediation" shall have the meaning and uses set forth in Exhibit "A" hereto.

"Opioid Settlement Funds" shall mean all funds allocated by the National Settlement Agreements and Plans of Reorganization to the State or Local Governments for purposes set forth in the National Settlement Agreements and Plans of Reorganization of opioid remediation activities or restitution, as well as any repayment of those funds and any interest or investment earnings that may accrue as those funds are temporarily held before being expended on opioid remediation strategies. Not included are funds made available in the National Settlement Agreements and Plans of Reorganization for the payment of the Parties' litigation expenses or the reimbursement of the United States Government.

"Parties" means the State of Hawai'i and the Local Governments.

"Settling Defendants" means Johnson & Johnson, AmerisourceBergen, Cardinal Health, and McKesson, as well as their subsidiaries, affiliates, officers, and directors named in the National Settlement Agreements.

B. Allocation and Use of Opioid Settlement Funds

1. Use of Opioid Settlement Funds. All Opioid Settlement Funds shall be spent to address substance abuse in the State subject to the following conditions: (i) 85% shall be spent on opioid-related remediation, consistent with Exhibit A; and (ii) 15% shall be spent on remediation regarding other substances (i.e., treatment and prevention, consistent with Exhibit A, except not limited to opioids). Paragraph B.1(i) and B.1(ii) collectively comprise the "Total Opioid Settlement Funds".

2. Allocation of Opioid Settlement Funds.

   a. State Share. Each year, 85% of the Total Opioid Settlement Funds shall be spent by the State consistent with Exhibit A, after consultation with the Advisory Committee

      i. Composition of the Advisory Committee. The composition of the Advisory Committee shall be as follows:

         - The mayor, or mayor's designee, from each of the following: the County of Hawai'i, the County of Kaua'i, the County of Maui, and the City and County of Honolulu;
         - A designee of the Director of the Department of Health;
         - The director of the Department of Public Safety, or designee;
         - The Superintendent of the Department of Education, or designee; and
         - The University of Hawai'i Medical School President, or designee.

ii. Term. Advisory Committee members shall be appointed to serve a two-year term.

iii. Experts. The Advisory Committee may seek guidance from experts in addiction, pain management, opioid remediation, and public health. The experts may be drawn from the private sector and need not be affiliated with state or local governments.

b. Local Government Share. Each year, 15% of the Total Opioid Settlement Funds shall be spent by the State at the local government level according to the following percentages:

- HI1 Hawai'i County, Hawaii 18.2671692501%
- HI2 Kalawao County, Hawaii 0.0034501514%
- HI3 Kaua'i County, Hawaii 5.7006273580%
- HI4 Maui County, Hawaii 13.9979969296%
- HI5 City and County of Honolulu, Hawaii 62.0307563109%

With respect to these funds, the County of Hawai'i, the County of Kaua'i, the County of Maui, and the City and County of Honolulu may each direct and determine how their respective share is spent, provided that the expenditures comply with Section B.1 above and, if applicable, are consistent with State law. The Local Governments' authority to direct and determine how their respective shares are spent is a material term of this Agreement and shall not be subject to severability.

c. Needs Assessment. To educate the Parties concerning Hawaii's needs with respect to Opioid Remediation, the State shall engage a private party to perform a state-wide needs assessment. The assessment shall include, but not be limited to, (i) input provided by any Local Government as to their perceived needs regarding Opioid Remediation; and (ii) the private party's independent assessment of what is needed with respect to Opioid Remediation. The expenses related to the needs assessment shall not be paid from the Local Governments' share of the Total Opioid Settlement Funds.

3. Relationship of this MOA to other agreements and resolutions. All Parties acknowledge and agree the National Settlement Agreements will require the State and the Local Governments to release all claims against the Settling Defendants to receive Opioid Settlement Funds. This MOA is not a promise from any Party that any of the National Settlement Agreements or Plans of Reorganization will be finalized or executed.
   a. This MOA may not be modified absent written consent of all Parties.
   b. This MOA does not delegate any authority to the State to negotiate terms of the National Settlement Agreements or Plans of Reorganization on behalf of the Local Governments.

C. Public Statements and Communications with the Media

Upon the execution of this MOA, the Parties shall issue a joint press release and hold a joint press conference with participation from the Governor and the mayors or designees

of each Local Government

D. Miscellaneous

1. When this MOA takes effect. This MOA shall become effective at the time a sufficient number of Local Governments have joined the MOA to qualify this MOA as a State-Subdivision Agreement under the National Settlement Agreements or the Plans of Reorganization. If this MOA does not thereby qualify as a State-Subdivision Agreement, this MOA will have no effect.

2. When this MOA is no longer in effect. This MOA is effective until one year after the last date on which any Opioid Settlement Funds are being spent by Local Governments pursuant to the National Settlement Agreements and the Plans of Reorganization.

3. Applicable law. Unless otherwise required by the National Settlement Agreements or the Plans of Reorganization, this MOA shall be interpreted using Hawai'i law. Unless otherwise provided by this MOA, if any provision of this MOA is held invalid by any court of competent jurisdiction, this invalidity does not affect any other provision which can be given effect without the invalid provision.

4. Scope of this MOA. The Parties acknowledge that this MOA does not excuse any requirements placed upon them by the terms of the National Settlement Agreements or the Plans of Reorganization, except to the extent those terms allow for a State-Subdivision Agreement to do so.

5. No third-party beneficiaries. No person or entity is intended to be a third-party beneficiary of this MOA.

6. No effect on authority of parties. Nothing in this MOA shall be construed to affect or constrain the authority of the Parties under law.

7. Signing and execution of this MOA. This MOA may be signed and executed simultaneously in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same agreement. A signature transmitted by facsimile or electronic image shall be deemed an original signature for purposes of executing this MOA. Each person signing this MOA represents that he or she is fully authorized to enter into the terms and conditions of, and to execute, this MOA, and that all necessary approvals and conditions precedent to his or her execution have been satisfied.

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IN WITNESS WHEREOF, the parties have executed this Memorandum of Agreement as of the last date written below.

STATE OF HAWAI'I

DAVID Y. IGE
Governor

Date: JUL 15 2022

APPROVED AS TO FORM
AND LEGALITY

HOLLY T. SHIKADA
Attorney General

Date: 7-13-2022

CITY AND COUNTY OF HONOLULU

RICK BLANGIARDI
Mayor

Date: _____

APPROVED AS TO FORM
AND LEGALITY

DANA O. VIOLA
Corporation Counsel

Date: _____

COUNTY OF HAWAI'I

MITCH ROTH
Mayor

Date: _____

APPROVED AS TO FORM
AND LEGALITY:

ELIZABETH A. STRANCE
Corporation Counsel

Date: _____

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COUNTY OF MAUI

APPROVED AS TO FORM
AND LEGALITY:

_____

MICHAEL P. VICTORINO
Mayor

Date: _____

_____

MOANA M. LUTEY
Corporation Counsel

Date: _____

COUNTY OF KAUAI

APPROVED AS TO FORM
AND LEGALITY:

_____

DEREK S.K. KAWAKAMI
Mayor

Date: _____

_____

MATTHEW M. BRACKEN
County Attorney

Date: _____

COUNTY OF KALAWAO

_____

ELIZABETH A. CHAR
Director, Hawai'i Department of Health

Date: _____

IN WITNESS WHEREOF, the parties have executed this Memorandum of Agreement as of the last date written below.

STATE OF HAWAI'I

DAVID Y. IGE
Governor

Date: _____

APPROVED AS TO FORM
AND LEGALITY

HOLLY T. SHIKADA
Attorney General

Date: _____

CITY AND COUNTY OF HONOLULU

Rick Blangiardi

RICK BLANGIARDI
Mayor

Date: July 5, 2022

APPROVED AS TO FORM
AND LEGALITY

DANA O. VIOLA
Corporation Counsel

Date: July 5, 2022

COUNTY OF HAWAI'I

MITCH ROTH
Mayor

Date: _____

APPROVED AS TO FORM
AND LEGALITY:

ELIZABETH A. STRANCE
Corporation Counsel

Date: _____

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IN WITNESS WHEREOF, the parties have executed this Memorandum of Agreement as of the last date written below.

STATE OF HAWAI'I

DAVID Y. IGE
Governor

Date: _____

APPROVED AS TO FORM
AND LEGALITY

HOLLY T. SHIKADA
Attorney General

Date: _____

CITY AND COUNTY OF HONOLULU

RICK BLANGIARDI
Mayor

Date: _____

APPROVED AS TO FORM
AND LEGALITY

DANA O. VIOLA
Corporation Counsel

Date: _____

COUNTY OF HAWAI'I

MITCH ROTH
for Mayor

Date: 7/5/22

APPROVED AS TO FORM
AND LEGALITY:

ELIZABETH A. STRANCE
Corporation Counsel

Date: _____

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Approved as to Availability of Funds in the amounts and for the purposes set forth herein.

DIRECTOR OF FINANCE

JUN 2 9 2022

IN WITNESS WHEREOF, the parties have executed this Memorandum of Agreement as of the last date written below.

STATE OF HAWAI'I

DAVID Y. IGE
Governor

Date: _____

APPROVED AS TO FORM
AND LEGALITY

HOLLY T. SHIKADA
Attorney General

Date: _____

CITY AND COUNTY OF HONOLULU

RICK BLANGIARDI
Mayor

Date: _____

APPROVED AS TO FORM
AND LEGALITY

DANA O. VIOLA
Corporation Counsel

Date: _____

COUNTY OF HAWAI'I

for MITCH ROTH
Mayor

Date: _____

APPROVED AS TO FORM
AND LEGALITY:

Elizabeth A. Strance
2022.06.30 16:06:49 -10'00'

ELIZABETH A. STRANCE
Corporation Counsel

Date: _____

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Approved as to Availability of Funds in the amounts and for the purposes set forth herein.

DIRECTOR OF FINANCE

JUN 2 9 2022

COUNTY OF MAUI

Michael P Victorino

MICHAEL P. VICTORINO
Mayor

Date: JUN 24 2022

APPROVED AS TO FORM
AND LEGALITY:

MOANA M. LUTEY
Corporation Counsel

Date: JUN 24 2022

COUNTY OF KAUAI

DEREK S.K. KAWAKAMI
Mayor

Date: _____

APPROVED AS TO FORM
AND LEGALITY:

MATTHEW M. BRACKEN
County Attorney

Date: _____

COUNTY OF KALAWAO

ELIZABETH A. CHAR
Director, Hawai'i Department of Health

Date: _____

COUNTY OF MAUI

MICHAEL P. VICTORINO
Mayor

Date: _____

APPROVED AS TO FORM
AND LEGALITY:

MOANA M. LUTEY
Corporation Counsel

Date: _____

COUNTY OF KAUAI

DEREK S.K. KAWAKAMI
Mayor

Date: 7/12/22

APPROVED AS TO FORM
AND LEGALITY:

MATTHEW M. BRACKEN
County Attorney

Date: 7/12/22

COUNTY OF KALAWAO

ELIZABETH A. CHAR
Director, Hawai'i Department of Health

Date: _____

COUNTY OF MAUI

APPROVED AS TO FORM
AND LEGALITY:

MICHAEL P. VICTORINO
Mayor

Date: _____

MOANA M. LUTEY
Corporation Counsel

Date: _____

COUNTY OF KAUAI

APPROVED AS TO FORM
AND LEGALITY:

DEREK S.K. KAWAKAMI
Mayor

Date: _____

MATTHEW M. BRACKEN
County Attorney

Date: _____

COUNTY OF KALAWAO

ELIZABETH A. CHAR
Director, Hawai'i Department of Health

Date: **Elizabeth Char**
E-signed 2022-07-06 05:40PM HST
libby.char@doh.hawaii.gov
State of Hawaii
Dir of Health

EXHIBIT A TO HAWAII MOA:
Opioid Remediation Activities ("OPTION B" List

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:[1]

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

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

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

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

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

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

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

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

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

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

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

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

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

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Create and/or support recovery high schools.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART TWO: PREVENTION

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

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

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

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

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

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

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

    a. Increase the number of prescribers using PDMPs;

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

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

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

7. Increase electronic prescribing to prevent diversion or forgery.

8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Fund media campaigns to prevent opioid misuse.

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

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

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

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

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

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

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

10. Create 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 other drug misuse.

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

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

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

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

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

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

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

6. Public education relating to emergency responses to overdoses.

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

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

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

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

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

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

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

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

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

J. LEADERSHIP, PLANNING AND COORDINATION

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

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

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

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

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

K. TRAINING

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

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

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

L. RESEARCH

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

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

2. Research non-opioid treatment of chronic pain.

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

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

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

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

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

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

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