NOTICE OF EMERGENCY SHELBY COUNTY BOARD MEETING

April 18, 2023

SHELBY COUNTY EMERGENCY BOARD MEETING AGENDA

Courtroom B 12:00 PM

1. Call to Order
2. Pledge of Allegiance
3. Roll Call
4. Public Body Comment
5. Closed Session of the County Board pursuant to 5 ILCS 120/2 C 11 – Litigation
6. Discussion and vote to accept the Opioid Settlement Agreement
7. Adjournment

Please silence cell phones during the Board meeting.

EMERGENCY MEETING OF THE SHELBY COUNTY BOARD

April 18, 2023

The Shelby County Board met on Tuesday, April 18, 2023, at 12:00 P.M. in Courtroom B of the Courthouse in Shelbyville, Illinois.

Chairman Robert Orman called the meeting to order. All present recited the Pledge of Allegiance.

County Clerk Jessica Fox called the roll. Boehm, Brands, Davis, Hardy and Nelson were absent. Bennett was tardy and entered the Closed Session of meeting at 12:07 PM.

Chairman Orman called for Public Body Comment. There was no public body comment.

Kessler made motion to enter closed session pursuant to 5 ILCS 120/2-C 11 (Litigation). Tate seconded said motion, which passed by roll call vote (16 yes, 0 no). Ayes: Brown, Cole, Edwards, Firnhaber, Kessler, Martin, Mayhall, McCormick, Morse, Ogden, Orman, Ross, Shuff, Tate, Wallace, and Williams. Nay: none. Mark Bennett entered the closed session of the meeting at 12:07 PM.

CLOSED SESSION OF THE COUNTY BOARD

The doors were opened, and members of the public allowed to return to the Courtroom.

There was no action taken in Closed Session.

Williams made motion to re-enter open session. Firnhaber seconded said motion, which passed by roll call vote. (17 yes, 0 no). Ayes: Bennett, Brown, Cole, Edwards, Firnhaber, Kessler, Martin, Mayhall, McCormick, Morse, Ogden, Orman, Ross, Shuff, Tate, Wallace, and Williams. Nay: none.

Shelby County is part of a large group of governmental entities across the United States involved in a Federal lawsuit regarding Opioids. Today is the last day to accept the settlement agreement, which necessitated the emergent meeting as State's Attorney Hanlon only became aware of Shelby County's involvement in this lawsuit on Friday, April 14. Exact terms of the settlement agreement are unknown, but if Shelby County hopes to benefit in anyway, they must agree to accept the agreement today so State's Attorney Hanlon can proceed on our behalf.

Firnhaber made motion to accept the National Opioid Settlement agreement. Williams seconded said motion, which passed by voice vote (17 yes, 0 no).

No other business could come before the Shelby County Board.

McCormick made motion to adjourn the meeting. Firnhaber seconded said motion and the meeting was adjourned at 12:59 PM.

[redacted]

Jessica Fox
Shelby County Clerk and Recorder

STATE OF ILLINOIS — **ROLL CALL VOTES IN COUNTY BOARD**

SHELBY COUNTY

April 18, 2023 — **EMERGENCY MEETING**

		ROLL CALL			QUESTIONS							
			4/18/2023	/2023	Enter Closed ON MOTIONS TO Session		Re-enter ON MOTIONS TO Open Session		ON MOTIONS TO		ON MOTIONS TO	
COUNTY BOARD MEMBERS		MILEAGE	P.M.	P.M.	AYE	NAY	AYE	NAY	AYE	NAY	AYE	NAY
	BENNETT, MARK	34	A		A		✓					
	BOEHM, TERESA		A		A		A					
	BRANDS, CODY	24	A		A		A					
	BROWN, TIM	41	✓		✓		✓					
	COLE, CAROL	0	✓		✓		✓					
	DAVIS JR, CHARLES	48	A		A		A					
	EDWARDS, JULIE	0	✓		✓		✓					
	FIRNHABER, MARTHA	0	✓		✓		✓					
	HARDY, CLAY	20	A		A		A					
	KESSLER, MATT	44	✓		✓		✓					
	MARTIN, ANNETTE	44	✓		✓		✓					
	MAYHALL, TAD	14	✓		✓		✓					
	McCORMICK, HEATH		✓		✓		✓					
	MORSE, TIM	0	✓		✓		✓					
	NELSON, LORI	54	A		A		A					
	OGDEN, DAVID		✓		✓		✓					
	ORMAN, ROBERT	34	✓		✓		✓					
	ROSS, SONNY	24	✓		✓		✓					
	SHUFF, MITCHELL	10	✓		✓		✓					
	TATE, DON	40	✓		✓		✓					
	WALLACE, BRENT	50	✓		✓		✓					
	WILLIAMS, JEREMY		✓		✓		✓					

Bennett arrived at 12:07

December 12, 2022

ATTORNEY GENERAL RAOUL ANNOUNCES $10.7 BILLION SETTLEMENT WITH WALGREENS AND CVS OVER OPIOID EPIDEMIC ALLEGATIONS

Bipartisan Settlement Results from Negotiations Led by Raoul's Office

Chicago —Attorney General Kwame Raoul today announced he has reached a settlement with Walgreens and CVS to resolve allegations that the companies contributed to the opioid addiction crisis by failing to appropriately oversee the dispensing of opioids at stores.

The bipartisan settlement provides more than $10 billion nationally and requires significant improvements to how Walgreens and CVS pharmacies dispense opioids. Raoul and 17 state attorneys general on the executive committee, attorneys representing local governments, Walgreens and CVS have agreed to this settlement, which has been sent to other states for review and approval. The sign-on period for states will be until the end of 2022, followed by a 90-day sign-on period for units of local government. The $10.7 billion settlement will be divided among sign-on states, local governments and tribes, and will prioritize abatement and remediation of the opioid crises.

"The opioid epidemic has tragically affected too many Illinois families that have experienced addiction or even the death of a loved one. This $10.7 billion settlement with Walgreens and CVS builds upon the important progress we've already achieved with previous settlements, but more importantly, it holds both companies accountable," Raoul said. "I am proud of the bipartisan work we are doing across state lines to hold retail pharmacies responsible. I will continue to ensure that resources Illinois receives through settlements are distributed equitably throughout the state to help fund services needed to mitigate the ongoing opioid crisis."

Raoul said the settlement also includes broad, court-ordered requirements, such as the implementation of a robust Controlled Substance Compliance Program. The program will require independent pharmacist review of prescriptions, additional oversight of controlled substance dispensing, mandatory training and new reporting requirements.

Once the settlement goes into effect, funds to Illinois will be allocated according to the Illinois Opioid Allocation Agreement that Raoul previously reached with state's attorneys.

The settlement with Walgreens and CVS is the latest of Attorney General Raoul's ongoing efforts to combat the opioid epidemic and hold accountable companies whose deceptive practices increased opioid prescriptions at the expense of public health. It comes after Raoul's office reached a $3 billion national settlement with Walmart to resolve allegations the company contributed to the opioid addiction crisis by failing to appropriately oversee the dispensing of opioids. Raoul's office also recently announced an agreement in principle with opioid manufacturer Teva that would provide up to $4.25 billion once finalized, and an agreement in principle with former opioid maker Allergan that, once finalized, would require the company to pay up to $2.37 billion to participating states and local governments to assist in battling the opioid epidemic.

Last year, Raoul's office negotiated the Illinois Opioid Allocation Agreement. The agreement is intended to ensure the approximately $760 million Illinois will receive through the historic national $26 billion opioid settlement agreement with the nation's three major pharmaceutical distributors and Johnson & Johnson, and these additional opioid settlements, are allocated equitably, including to counties and eligible municipalities. The majority of Illinois' money will go to the Illinois Remediation Fund to be used for abatement programs throughout the state.

Attorney General Raoul led bipartisan negotiations with the attorneys general of California, Connecticut, Colorado, Delaware, Indiana, Iowa, Kentucky, Louisiana, Massachusetts, Nebraska, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Tennessee and Texas.

Attorney General I urges anyone who believes they or a loved one may be addicted to opioids to seek help by g the Illinois Helpline for Opioids and Other Substances at 833-2FINDHELP, which operates 24 hours a day, seven days a week.

Return to December 2022 Press Releases

TOP

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Governor Pritzker and Attorney General Raoul Announce Next Steps in Combatting Opioid Epidemic

Press Release - Friday, July 29, 2022

CHICAGO—Governor JB Pritzker and Illinois Attorney General Kwame Raoul today announced the next steps in the historic national $26 billion opioid settlement agreement with the nation's three major pharmaceutical distributors - Cardinal, McKesson, and AmerisourceBergen - and one manufacturer, Johnson & Johnson.

"As this emergency has stolen the lives of thousands of residents, the state of Illinois has been a national leader in fighting back, with our state receiving as much as $760 million over the next 18 years," **said Governor JB Pritzker**. "I'm taking executive action to ensure these new resources truly address the best interventions, prevention, and remediation for the communities hurt by these harms. Everyone's life is worth saving, and this administration will leave no stone unturned as we work to bring the opioid epidemic to an end."

"The multibillion dollar national opioid settlement is the result of countless hours I and senior attorneys in my office have worked to hold opioid manufacturers accountable for their roles in the ongoing opioid crisis. After becoming Attorney General, I committed myself to working collaboratively with my colleagues around the country to ensure that accountability includes resources to abate the crisis and its impact. I have also held bipartisan negotiations with state's attorneys across Illinois to prioritize an equitable framework for the allocation of resources coming to Illinois. As a result, Illinois will receive its full, approximately $760 million share from this settlement. I am proud to work with Gov. Pritzker's administration to make sure that funding from this settlement and any future settlement is spent equitably on abatement, even in instances where victims and survivors of addiction have transitioned from dependence on pharmaceutical opioids to street heroin," **said Illinois Attorney General Kwame Raoul.**

The Illinois Department of Human Services (IDHS) will distribute the portion of the funds coming to the State equitably, based on recommendations from an advisory board, chaired by the State's Chief Behavioral Health Officer and made up of State and local appointees. The funding is expected to support critical recovery and treatment programs throughout the state.

"There are countless communities across the state that have been touched by the opioid crisis. This funds from this settlement allow the agency's Division on Substance Use Prevention and Recovery to provide treatment for those struggling with opioid addiction," **said Illinois Department of Human Services Secretary Grace B. Hou**.

Remediation mo coming from the distributor/Johnson& Johnson settlement, the M ckrodt bankruptcy plan, and other potential future settlements or judgments, will be administered through the Executive Order for the Administration of Settlement Proceeds and the establishment of IDHS Office of Opioid Settlement Administration (OOSA). The OOSA will reside in the IDHS Division of Substance Use, Prevention and Recovery and a Statewide Opioid Settlement Administrator (SOSA) will be appointed. The SOSA will ensure (1) opioid remediation funds align with the State Overdose Action Plan (SOAP) and (2) are used equitably to fund recovery and treatment programs in the counties and municipalities with the most urgent need.

The historic $26 billion-settlement marks the culmination of three years of negotiations to resolve more than 4,000 claims of state and local governments across the country. It is the second largest multistate agreement in U.S. history, second only to the Tobacco Master Settlement Agreement. Illinois is one of 52 states and territories that have joined the settlement, along with thousands of local governments across the country. In Illinois, 94 out of 102 counties have signed onto the settlement. In addition, 104 out of 113 Illinois municipalities that are eligible to receive a direct distribution from the settlements have joined. In total, more than 290 Illinois government subdivisions have joined the settlements. Because Attorney General Raoul's office was able to produce a significant percentage of government subdivisions' participation, Illinois is eligible to receive its full share of approximately $760 million.

"The opioid epidemic has too often torn families and communities apart, and together we must take real action to help those struggling with addiction receive the proper care they deserve," **State Rep. Deborah Conroy (D-Villa Park) said**. "This settlement is a historic opportunity to invest critically-needed resources in communities that need help now. This funding will help save lives."

"The landmark settlement with the perpetrators of the opioid epidemic is a milestone in righting the wrongs this crisis has caused," **said State Rep. Camille Lilly (D-Chicago)**. "Addiction is a multifaceted issue that should be approached with compassion for it not only affects the individual or family, but our communities and society as a whole. I'm grateful for the community service providers that have stepped up to care for the families and communities hit hardest by addiction, and this settlement will help support their efforts."

"30,000 Illinoisans use heroin every year, 74,000 have an OUD, and nearly 400,000 misuse prescription opiates," **said State Representative La Shawn Ford (D-Chicago)**. "Illinois saw over 2200 opioid-related deaths in the first three quarters of 2020, a 36 percent increase from 2019. This $26 billion opioid settlement agreement will help offset the $41 billion total economic and social cost of OUD and fatal opioid overdoses in Illinois. Responding to the opioid epidemic and treating OUD demands access to, availability, and affordability of high-quality, evidenced-based acute treatment services and a robust network of recovery supports. As a member of the Advisory Committee for the Illinois Remediation Fund, I will work with the Governor and Attorney General's team to help save lives in Illinois from preventable fatal overdoses."

Additionally, Attorney General Raoul's office negotiated the Illinois Opioid Allocation Agreement to ensure the funds Illinois received through this and any future settlements are allocated equitably to counties and municipalities. The majority of Illinois' money will go to the Illinois Remediation Fund to be used for abatement programs throughout the state. An advisory board will be established as a subcommittee of the state's Opioid Overdose Prevention and Recovery Steering Committee to make recommendations that prioritize the equitable distribution of the money in the Fund. The board will consider factors including population, opioid usage rates, overdose deaths and the amount of opioids shipped into a region.

IDHS urges any Illinois resident who believes they or a loved one may be addicted to opioids to seek help by calling the Illinois Helpline for Opioids and Other Substances at 833-2FINDHELP, which operates 24 hours a day, seven days a week.
For more information, log onto **https://helplineil.org/app/home**.

Press Releases

- **"You play a role in work zone safety. Work with us."**
  Tuesday, April 18
- **Illinois Department of Labor Recognizes National Work Zone Awareness Week**
  Monday, April 17
- **IDOC Highlights Re-Entry During Second Chance Month**
  Monday, April 17

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(735 ILCS 5/13-226)

Sec. 13-226. Opioid litigation.

(a) Definitions. In this Section:

"National multistate opioid settlement" means any agreement (i) to which the State and at least two other states are parties and (ii) in which the State agrees to release claims that it has brought or could have brought in an action against an opioid defendant or has the claims released in a final order entered by a court. "National multistate opioid settlement" includes (i) any form of resolution reached in a bankruptcy proceeding, provided that the Attorney General both agrees to the specific terms of such resolution or agreement in a bankruptcy proceeding and announces his or her agreement in the record of such bankruptcy proceeding, or (ii) a final order entered by the bankruptcy court.

"Opioid defendant" means (i) a defendant in opioid litigation brought by the Attorney General, or (ii) a person or entity engaged in the manufacturing, marketing, distribution, prescription, dispensing, or other use of opioid medications.

"Opioid litigation" means any civil litigation, demand, or settlement in lieu of litigation, alleging unlawful conduct in the manufacturing, marketing, distribution, prescription, dispensing, or other use of opioid medications.

"Unit of local government" has the meaning provided in Article VII, Section 1 of the Illinois Constitution of 1970.

(b) Release of claims.

(1) On and after the effective date of this amendatory Act of the 102nd General Assembly, no unit of local government or school district may file or become a party to opioid litigation against an opioid defendant that is subject to a national multistate opioid settlement unless approved by the Attorney General.

(2) If counties representing 60% of the population of the State, including all counties with a population of at least 250,000, have agreed to an intrastate allocation agreement with the Attorney General, then the Attorney General has the authority to appear or intervene in any opioid litigation, and release with prejudice any claims brought by a unit of local government or school district against an opioid defendant that are subject to a national multistate opioid settlement and are pending on the effective date of this amendatory Act of the 102nd General Assembly.

(c) Nothing in this Section affects the Attorney General's authority to appear, intervene, or control litigation brought in the name of the State of Illinois or on behalf of the People of the State of Illinois.

(d) When an intrastate allocation agreement between counties representing 60% of the population of the State, including all counties with a population of at least 250,000, and the Attorney General is reached, becoming a party to or filing opioid litigation against an opioid defendant that is subject to a national multistate opioid settlement are exclusive powers and functions of the State and a home rule unit may not file or become a party to opioid litigation against an opioid defendant that is subject to a national multistate opioid settlement unless approved by the Attorney General. This Section is a denial and limitation of home rule powers and functions under subsection (h) of Section 6 of Article VII of the Illinois Constitution.

(Source: P.A. 102-85, eff. 7-9-21.)

EXHIBIT A-2

State of Illinois
Counties Only Percentages

Qualifying Subdivision	Counties Only Percentage
Adams County	0.5325627744%
Alexander County	0.0431846002%
Bond County	0.1313618076%
Boone County	0.3993006496%
Brown County	0.0455436631%
Bureau County	0.2675493675%
Calhoun County	0.0374496996%
Carroll County	0.1059047501%
Cass County	0.0902574340%
Champaign County	1.5953670185%
Christian County	0.2717469407%
Clark County	0.1346384837%
Clay County	0.1009205688%
Clinton County	0.2710071787%
Coles County	0.3899340741%
Cook County	39.7070170529%
Crawford County	0.1502157232%
Cumberland County	0.0765804365%
De Witt County	0.1343763530%
Dekalb County	0.7648068692%
Douglas County	0.1396209979%
Dupage County	6.9961301825%
Edgar County	0.1369536821%
Edwards County	0.0557876634%
Effingham County	0.2745921107%
Fayette County	0.1730292191%
Ford County	0.1050766592%
Franklin County	0.3753293914%
Fulton County	0.2857420449%
Gallatin County	0.0461748227%
Greene County	0.1120932638%
Grundy County	0.4447604831%
Hamilton County	0.0586888564%
Hancock County	0.1237654700%
Hardin County	0.0525232340%
Henderson County	0.0468231560%

EXHIBIT A-2

State of Illinois
Counties Only Percentages

Henry County	0.3631064984%
Iroquois County	0.2340046386%
Jackson County	0.4766842676%
Jasper County	0.0729264789%
Jefferson County	0.3076865268%
Jersey County	0.2029662011%
Jo Daviess County	0.1594100240%
Johnson County	0.0934835787%
Kane County	3.7592516293%
Kankakee County	0.8907176656%
Kendall County	0.9152447008%
Knox County	0.4095413266%
Lake County	5.4323006331%
Lasalle County	1.0382633595%
Lawrence County	0.1362169504%
Lee County	0.2713491451%
Livingston County	0.3277646387%
Logan County	0.2230314720%
Macon County	0.8339920017%
Macoupin County	0.3637461000%
Madison County	2.5601663484%
Marion County	0.3444624326%
Marshall County	0.0878603767%
Mason County	0.1123492816%
Massac County	0.1236043365%
McDonough County	0.2216295193%
McHenry County	2.3995936239%
McLean County	1.3208345544%
Menard County	0.0917783576%
Mercer County	0.1144419910%
Monroe County	0.2714501969%
Montgomery County	0.2342865810%
Morgan County	0.2708645052%
Moultrie County	0.1003140855%
Ogle County	0.3811415242%
Peoria County	1.5640744904%
Perry County	0.1751336763%
Piatt County	0.1214359333%
Pike County	0.1155220743%
Pope County	0.0347091515%
Pulaski County	0.0404416607%

EXHIBIT A-2

State of Illinois
Counties Only Percentages

Putnam County	0.0452090528%
Randolph County	0.2879823727%
Richland County	0.1208518975%
Rock Island County	1.0782047657%
Saline County	0.2659477915%
Sangamon County	1.5850818631%
Schuyler County	0.0485294910%
Scott County	0.0349810216%
Shelby County	0.1586806535%
St Clair County	2.1366773448%
Stark County	0.0381570939%
Stephenson County	0.3550412743%
Tazewell County	1.1033013785%
Union County	0.1447352927%
Vermilion County	0.6907560341%
Wabash County	0.0923901750%
Warren County	0.1239679440%
Washington County	0.1076671021%
Wayne County	0.1225391595%
White County	0.1115911540%
Whiteside County	0.4275606484%
Will County	5.3461509816%
Williamson County	0.6715468751%
Winnebago County	2.7201669312%
Woodford County	0.3076824807%

EXHIBIT B

APPROVED ABATEMENT PROGRAMS

List of Opioid Remediation Uses

Schedule A
Core Strategies

Priority shall be given to the following core abatement strategies ("*Core Strategies*").

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.

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:

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.

As used in this Schedule, 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.