SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

ITEM: 3.2
(ID # 22599)
MEETING DATE:
Tuesday, October 03, 2023

FROM : EXECUTIVE OFFICE:

SUBJECT: EXECUTIVE OFFICE: Ratify and Approve Opioid Settlement Funding and Proposed Usage, All Districts. [$84,096,552 - 100% Settlement Funds 22860]

RECOMMENDED MOTION: That the Board of Supervisors:

1. Ratify and Approve the acceptance of the Opioid Settlement Funding; and
2. Authorize the County Executive Office, or designee, to administer all actions necessary and sign all documents related to the administration of this funding.

ACTION:Policy

Jeff Van Wagenen, County Executive Officer 9/28/2023

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Jeffries, seconded by Supervisor Spiegel and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Jeffries, Spiegel, Washington, Perez and Gutierrez
Nays:	None
Absent:	None
Date:	October 3, 2023
xc:	E.O.

Kimberly A. Rector
Clerk of the Board
By: _____ Deputy

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$ 15,533,175	$ 6,825,491	$ 84,096,552	$ 0
NET COUNTY COST	$ 0	$ 0	$ 0	$ 0
SOURCE OF FUNDS: 100% Settlement Funds 22860			Budget Adjustment: No	
			For Fiscal Year: 22/23-37/38	

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

On July 21, 2021, nationwide resolutions were achieved to settle opioid litigation initiated by states and local political subdivisions against the three largest pharmaceutical distributors: AmerisourceBergen, Cardinal Health, and McKesson, or the "big three," ("Distributors"). Similarly, a resolution was reached concerning Janssen Pharmaceuticals, Inc. and its parent company, Johnson & Johnson (referred to as J&J). This settlement is a result of investigations by state attorneys general, including California, into whether the three Distributors fulfilled their legal duty to refuse to ship opioids to pharmacies that submitted suspicious drug orders and whether Johnson & Johnson misled patients and doctors about the addictive nature of opioid drugs.

These resolutions have been finalized and the processing of payments has begun. It is estimated that California will receive approximately $2.05 billion from Janssen Pharmaceuticals and Distributors Settlement Agreements through 2038.

Each state's share of the funding has been determined by agreement among the states using a formula that considers the total impact: the number of overdose deaths, number of residents with substance use disorder, number of opioids prescribed, and population of the state.

California joined these lawsuits against manufacturers, distributors, and other entities responsible for aiding the opioid epidemic. California's portion of the Opioid Settlement funding will be allocated as follows: 70% to the California Abatement Accounts Fund which will be allocated to participating counties and cities ("participating subdivisions"), 15% to the California Subdivision Fund which will be allocated to litigating local governments, and 15% to the California State Fund. Allocations to the participating subdivisions will be administered by the 2021 National Settlements Administrator, BrownGreer PLC.

As of January 2, 2022, the State of California reached the "critical mass" (minimum threshold number of participating subdivisions) required to participate in the 2021 National Settlements. California developed a State Subdivision Agreement to govern the allocation of all funds received by the State from the 2021 National Settlements.

Per the terms of the California State Subdivision Agreement, a city that is identified as a participating subdivision will have its allocation share paid directly to the county in which the city is located, unless they opt for direct payment. A city that does not opt for direct payment, may enter into agreements with the county, to set forth the terms as to the use of the city's allocation by the county. On January 11, 2022, (MT item 18030) the Riverside County Board of Supervisors (the "Board") approved the Agreement form for use between the County of Riverside ("County") and Riverside County cities. Alternatively, a city may notify BrownGreer, the Settlement Fund Administrator, that it requests a direct payment at least 60 days prior to an annual Payment Date, as defined in the Settlement Agreements. To date, the cities of Moreno Valley, Palm Desert and Riverside have opted for direct payment. All other Riverside County cities have directed their payment to the County.

Funding Allocation and Use

The projected total amount the County will receive over 16 years is $84,096,552 which reflects future payments from Janssen and the Distributors. This amount is subject to change at any time due to the number of cities directing respective allocations to the County and future payments from the National Opioid Abatement Trust II. To date, $15,533,175 has been received by the County which includes payments from the Abatement Fund (funds allocated to participating subdivisions), Subdivision Fund (funds allocated to litigating local governments in a subdivision fund) and the National Opioid Abatement Trust II (fund established as a result of Mallinckrodt plc, pharmaceutical company, Restructuring Support Agreement).

Each fund has a specified use as defined in the California State Subdivision Agreement. The funds are specifically intended to provide the remediation of the opioid crisis and efforts should be geared toward prevention, treatment, recovery and/or harm reduction (Attachment A). The list of pre-approved uses was developed in consultation with the nation's leading public health experts. Additionally, California set its own list of High Impact Abatement Activities (Attachment B) which requires subdivisions spend no less than 50% of their funds on these specific abatement activities.

The State Department of Health Care Services (DHCS) is responsible for overseeing participating subdivisions and will monitor compliance, designating additional high-impact abatement activities, conducting stakeholder engagement, and facilitating the preparation of annual reports. The Executive Office will prepare an annual expenditure report and submit to DHCS through the dedicated portal for such submissions. An annual report is required until funds are fully expended and then one year thereafter.

Proposed Spending Plan

The Executive Office engaged with multiple County departments to discuss proposed uses of the Opioid Settlement funds. County departments then submitted proposals which were vetted to ensure the proposed programs align with allowed uses. At the time, it was anticipated that the funds would be received in large portions. When the funds arrived, they were much less than expected and thus the programs will need to be funded as funds are available.

The Executive Office has prepared a spending plan for the Board's consideration based on the current available funds as well as any future funding (Attachment C). The spending plan outlines the various departments to receive funding, which includes the Riverside University Health System, Public Safety, and the Executive Office.

Upon the Board's approval of the spending plan, recipient departments will return to the Board with a separate agenda item to designate funding for qualifying programs according to the spending plan.

During the FY 23/24 budget process some programs were identified for possible uses of Opioid Settlement funds. One such program was identified for Correctional Health Services, a division of the Riverside University Health System. The funding, if approved, will be directed towards the Medication Assisted Treatment (MAT) program which provides medications approved by the U.S. Food and Drug Administration in combination with treatment for mental health needs. The program is estimated to cost $3,307,910.

During FY 22/23, the Executive Office Communications team collaborated with Public Information Officers from multiple county departments to create the "Faces of Fentanyl" marketing campaign, which was launched in September 2022, to raise awareness of the dangers of fentanyl and prevent fentanyl deaths. This program has been identified for use of the Opioid Settlement funds. Additionally, $500,000 has been identified as an eligible use of Opioid Settlement funds to continue the marketing and education efforts during FY 23/24.

Impact on Residents and Businesses

The community at large will benefit from the programs created and/or enhanced by the provision of these funds. The funding will support programs addressing substance and opioid use disorders, prevention programs, medicated assisted treatment and medications to reverse overdoses such as Naloxone.

ATTACHMENTS:

A. Exhibit E
B. High Impact Abatement Activities List
C. Proposed Spending Plan
D. Department of Health Care Services California Opioid Settlement Funds Frequently Asked Questions

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

CALIFORNIA OPIOID SETTLEMENT FUNDS

Frequently Asked Questions (FAQs)

This document is intended to answer frequently asked questions (FAQs) from California Participating Subdivisions receiving allocations from the California Abatement Accounts Fund as part of the California Opioid Settlements. A Participating Subdivision is a city or county eligible to receive or is receiving funds from one or more California Opioid Settlements. A list of Participating Subdivisions can be found in Appendix 1 of the California State Subdivision Agreements. Questions about a Subdivision's status can be directed to the National Settlement Administrator, BrownGreer PLC.

Information about opioid litigation and settlement participation can be found on the California Attorney General's Opioid Settlements webpage. Questions can be directed to OpioidSettlement-LocalGovernment@doj.ca.gov.

Information about settlement payments can be found on the webpage for the National Settlement Administrator, BrownGreer PLC. Questions about the settlements, including schedule of payments, annual allocations, and recipients, can be directed to DirectingAdministrator@NationalOpioidOfficialSettlement.com.

Background Questions

» **Why is California receiving opioid settlement money?**

During the opioid epidemic, state, local, and tribal governments have brought several lawsuits against pharmaceutical and drug distribution companies that have fueled the crisis. The lawsuits allege that these companies fueled the opioid crisis by marketing opioids in misleading ways, downplaying risks, exaggerating benefits, and engaging in reckless distribution practices. The lawsuits seek to recover costs associated with the opioid epidemic and remediation.

To ensure success in addressing and preventing further crises, California has joined several lawsuits against manufacturers, distributors, and other entities responsible for aiding the opioid epidemic. In late 2022, Participating Subdivisions in California received the first round of funding from settlements to be used for future opioid abatement

activities. It is expected that Californian Subdivisions will receive additional funds as more settlements arise.

» **Why are the California Opioid Settlements paid over different time periods?**

Though often referred to in tandem, the California Opioid Settlements come from separate agreements established through nationwide lawsuits against opioid manufacturers and distributors. Funds from these settlements may be paid over different time periods depending on the terms agreed upon in the relevant settlement.

» **Are funds from the California Opioid Settlements considered State funds or federally passed through California?**

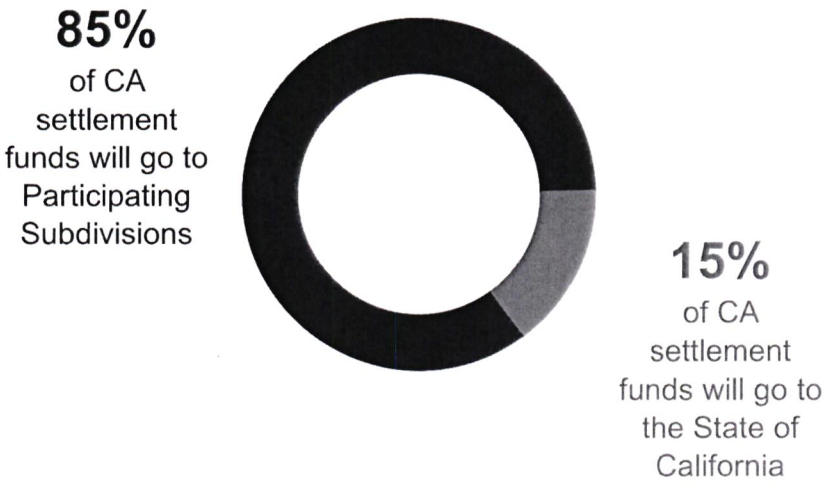
Funds from the California Opioid Settlements provided to Participating Subdivisions are not considered State or federal funds. The settlements funds originate from multistate settlements with prescription opioid manufacturers and pharmaceutical distributors to resolve their liabilities in over 3,000 opioid crisis-related lawsuits nationwide. Allocations to Participating Subdivisions will be administered by the National Settlement Administrator, BrownGreer PLC, and based on allocation percentages found in Appendix 1 of the California State Subdivision Agreements.

» **How do the California Opioid Settlements differ from other funding sources for opioid treatment and prevention?**

Funds from the California Opioid Settlements originate from multistate settlements with prescription opioid manufacturers and pharmaceutical distributors. Monies from these settlements are intended to provide states and eligible jurisdictions with financial support for **future** opioid abatement activities. California state officials, in partnership with a counsel representing Participating Subdivisions, have agreed on a proposed allocation of these resources and certain abatement activities to prioritize. These priorities can be found in the California State Subdivision Agreements.

» **How will funds from the California Opioid Settlements be distributed in California?**

The California Opioid Settlement Funds are allocated as follows:



Fund Type	Allocation	Allowable Uses
California Abatement Accounts Fund (70%)	Allocated to all participating cities and counties (otherwise known as Participating Subdivisions)	Funds must be used for **future** Opioid Remediation in one or more of the areas described in Exhibit E.
		No less than 50% of the funds received in each calendar year will be used for one or more High Impact Abatement Activities.[1]
California Subdivision Fund (15%)	Allocated to cities and counties that were initial plaintiffs in the California Opioid Settlements (otherwise known as Plaintiff Subdivisions)	Funds must be used towards **future** Opioid Remediation and to reimburse **past** opioid-related expenses, which may include litigation fees and expenses.
California State Fund (15%)	Allocated to the state of California	Funds must be used for **future** Opioid Remediation.

[1] DHCS may add to this list by designating additional High Impact Abatement Activities pursuant to Government Code, Title 2, Division 3, Part 2, Chapter 6, Article 2, Section 12534(e).

» **How does the California Abatements Account Fund differ from the California Subdivision Fund?**

The California Abatement Accounts Fund provides monies to all Participating Subdivisions for future opioid remediation activities. The California Subdivision Fund allocates monies to cities and counties that were initial plaintiffs in the California Opioid Settlements. These cities and counties, also known as Plaintiff Subdivisions, may use funds from the California Subdivision Fund towards future opioid remediation activities and to reimburse past opioid-related expenses, including litigation fees and expenses. Plaintiff Subdivisions will receive funds from both the California Subdivision Fund and the California Abatement Accounts Fund.

Use of Funds

» **Are there requirements for how Participating Subdivisions can spend funds received from the California Opioid Settlements?**

Yes. All funds received by Participating Subdivisions from the California Abatements Account **must** be used for future Opioid Remediation. For the purposes of this funding, Opioid Remediation is defined as the care, treatment, and other programs and expenditures designed to:

1) Address the misuse and abuse of opioid products;
2) Treat or mitigate opioid use or related disorders; or
3) Mitigate other alleged effects of, including on those injured as a result of, the opioid epidemic.

Participating Subdivisions may form joint ventures with federal, state, local, tribal, or private sector entities in pursuing Opioid Remediation activities. Participating Subdivisions can also review the California Opioid Settlement Funds: Allowable Expenditures list and the DHCS California Opioid Settlements webpage for eligible Opioid Remediation activities.

» **Can funds received from each settlement be combined to pay for one expense?**

Yes. Participating Subdivisions who receive funds from multiple settlements may combine these funds to pay for a single expense. Participating Subdivisions who combine funds for purchases should ensure financial information is delineated by each settlement during reporting periods.

» **Can funds be used for programming related to fentanyl?**

Participating Subdivisions may pursue strategies to address fentanyl as indicated in Exhibit E of the settlement agreements. Examples include purchasing naloxone for first responders or harm reduction programs, providing funding for syringe service programs

and other evidence-informed programs which include fentanyl checking, supporting screening for fentanyl in routine clinical toxicology testing, educating law enforcement or other first responders on appropriate practices when dealing with fentanyl, and researching the impacts of prevention efforts such as the provision of fentanyl test strips.

» **Can funds be used for automated external defibrillator (AEDs) and other first aid related materials?**

No. AEDs and other first aid related expenses are not considered opioid remediation and thus are not allowable expenditures pursuant to Exhibit E of the settlement agreements.

» **Can funds be encumbered or carried over to the next year?**

Yes. Participating Subdivisions may roll over funds from the previous year and/or encumber funds for future eligible purchases. Funds must be expended or encumbered within five (5) years of receipt, or seven (7) years for capital outlay projects. For example, funds received during 2022 must be spent or encumbered by 2027 (five (5) years) for non-capital outlay projects or 2029 (seven (7) years) for capital outlay projects. Funds not expended or encumbered within these timeframes must be returned to the state.

» **Can funds be transferred to another Participating Subdivisions?**

Yes. Participating Subdivisions may agree to reallocate their funds, provided that all funds will be used for Opioid Remediation activities and each entity is a Participating Subdivision. Both the providing and receiving entity must agree on the exchange and report on these transfers to DHCS during reporting periods. Participating Subdivisions wishing to transfer their funds automatically during payment periods must contact the national settlement administrator, BrownGreer PLC, at least 60 days prior to a payment date.

» **Can funds received from the California Opioid Settlements be used to supplant or replace other funds?**

Funds received from the settlements should not be used to supplant or replace funds from other sources. Participating Subdivisions may use monies received from the settlements to match or supplement funding for eligible opioid remediation activities (for example, HIAA #1 related to BHCIP).

» **What happens if Participating Subdivisions spend funds on unallowable activities?**

Participating Subdivisions suspected of spending funds allocated from the settlements on unallowable activities, whether through review of reports or information from any other sources, will be required to meet and confer with DHCS to resolve the concern. If

unable to reach a resolution, DHCS may conduct an audit of the Subdivision's use of the funds and pursue legal action.

» **Who do I contact for questions about allowable uses or reporting requirements for the California Opioid Settlements?**

Individuals seeking clarification on allowable uses or reporting requirements for the settlements can contact DHCS at OSF@dhcs.ca.gov.

California's High Impact Abatement Activities

» **What are High Impact Abatement Activities (HIAA)?**

The National Settlement Agreements allow states and their Participating Subdivisions to establish further regulations around the allocation, distribution, and/or use of funds received from the settlements. The State of California and its Participating Subdivisions have reached an agreement that includes additional opioid abatement activities to prioritize within the state, in addition to the activities listed in Exhibit E. These activities, which are referred to as High Impact Abatement Activities (HIAA), include:

No.	Activity
1	Provision of matching funds or operating costs for substance use disorder facilities with an approved project within the Behavioral Health Continuum Infrastructure Program (BHCIP)
2	Creating new or expanded substance use disorder (SUD) treatment infrastructure[2]
3	Addressing the needs of communities of color and vulnerable populations (including sheltered and unsheltered homeless populations) that are disproportionately impacted by SUD
4	Diversion of people with SUD from the justice system into treatment, including by providing training and resources to first and early responders (sworn and non-sworn) and implementing best practices for outreach, diversion and deflection, employability, restorative justice, and harm reduction
5	Interventions to prevent drug addiction in vulnerable youth
6	The purchase of naloxone for distribution and efforts to expand access to naloxone for opioid overdose reversals.

[2] May include cost overrun for BHCIP programs as needed.

» **Exhibit E contains a list of activities to prioritize (Schedule A) but does not contain the list of HIAA. Which list should my subdivision prioritize?**

Exhibit E of the settlement agreements contains the complete list of allowable expenditures for funds received from the settlements. National litigation developed a list of priority activities within this exhibit, which became Schedule A of Exhibit E. The State of California, and its Participating Subdivisions, established local priorities given the opioid remediation needs within the state, which are referred to as HIAA.

Pursuant the California State Subdivision Agreements, Participating Subdivisions must spend at least 50% of funds received within a calendar year on HIAA. Many of the activities listed in Exhibit E can qualify as HIAA, depending on their focus. DHCS encourages Participating Subdivisions to prioritize HIAA in their planning, followed by the activities listed in Schedule A of Exhibit E.

» **Does the High Impact Abatement Activity (HIAA) #4 include law enforcement activities?**

HIAA #4 is about diversion and deflection programs that decrease the number of people with substance use disorders (SUD) entering the justice system and increase their entry into treatment. Though diversion and deflection programs may involve law enforcement, not all law enforcement activities qualify as an allowable activity under the HIAA #4 or Exhibit E. For more information about law enforcement diversion efforts, review the below resources:

- National Council on Mental Wellbeing: Deflection and Pre-arrest Diversion to Prevent Opioid Overdose (Tools and Resources)
- AddictionFreeCA.org: Information about Opioid Treatment in California's Jails and Drug Courts

» **How does the established Naloxone Distribution Project differ from the new Naloxone High Impact Abatement Activity (HIAA)?**

The Naloxone Distribution Project (NDP) is a separate program through DHCS that provides naloxone to eligible organizations. The naloxone HIAA establishes the purchasing of naloxone as a priority expenditure for Participating Subdivisions in receipt of funds from the California Opioid Settlements.

More information about naloxone and naloxone training options are available on the DHCS Naloxone Distribution Project webpage and the California Department of Public Health (CDPH) Naloxone webpage.

Reporting Requirements of Funds

» **How will California ensure that opioid settlement funds will be spent on strategies to address the epidemic?**

To participate in the settlements, Participating Subdivisions accepted the terms and conditions of the California State Subdivision Agreements, which certify that participating entities will use funds for eligible opioid abatement activities and prepare and file annual reports regarding the use of those funds. DHCS oversees this annual reporting and ensures compliance with the allocation agreements.

» **Why do cities and counties need to report on the use of funds if the settlements are with private companies?**

To participate in the settlements, Subdivisions accepted the terms and conditions of the California State Subdivision Agreements, which certifies that participating entities will use funds for eligible opioid abatement activities and prepare and file annual reports regarding the use of those funds. DHCS is tasked with overseeing Participating Subdivisions that receive funds from the settlements. DHCS oversight responsibilities include:

- Monitoring the California Participating Subdivisions for compliance;
- Designating additional high-impact abatement activities;
- Conducting related stakeholder engagement; and
- Preparing annual reports.

More information is available on the DHCS Opioid Settlements webpage.

» **If my city does not elect direct payment, is it still obligated to report on the use of those funds?**

Cities which have opted-out of direct payment do not need to report to DHCS during reporting periods. Cities who do not elect direct payment must notify the national settlement administrator, BrownGreer PLC, at least 60 days prior to a payment date.

Cities that received direct payment and then chose to transfer some or all their funds to another Participating Subdivision must report on the amount transferred during reporting periods.

» **If my county or city received funds from another Participating Subdivision, is it required to report the use of these funds during a reporting period?**

Yes, funds received from another Participating Subdivision will need to be reported by the Participating Subdivision that received the funds. Participating Subdivisions who transferred their funds must also indicate this transaction during reporting periods with

DHCS, unless the Subdivision opted-out of direct payment with the national settlement administrator, BrownGreer PLC.

» **Do Participating Subdivisions need to complete the reporting form if they have not spent or committed their allocations during a reporting period?**

Yes, Participating Subdivisions must indicate funds carried or rolled over year-to-year during reporting periods.

» **How do Participating Subdivisions report on their allocation expenditures?**

DHCS is currently creating an online reporting tool for Participating Subdivisions to report the use and expenditure of their funds. DHCS will alert the primary contacts of each Participating Subdivision once that form is available.

» **What documentation is needed from Participating Subdivisions during reporting periods?**

Participating Subdivisions will be able to report their use and expenditures via an online reporting tool from DHCS. Documentation required to complete this form will include, but is not limited to:

- An account of expenditures by program/activity for each settlement (e.g., Janssen Settlement or the Distributors Settlement) and the specific fund (e.g., California Subdivision Fund or the California Abatement Accounts Fund);
- An indication of how each program/activity correlates to the priorities listed in the California State Subdivision Agreements as well as Exhibit E;
- A narrative summary to provide background on the purpose of each program/activity;
- An account of interest earned on the settlement fund allocations; and
- An account of amounts transferred to, or received from, other participating entities, if applicable.

In the case that DHCS has questions or needs to verify appropriate use of individual allocations, Participating Subdivisions should maintain books, records, documents, and other evidence, accounting procedures and practices to properly reflect direct and indirect costs related to their opioid abatement activities funded by the settlements. In addition, subdivisions should retain records relevant to their participation in the settlements, including correspondence with the national settlement administrator, BrownGreer, PLC. Records shall be subject at all reasonable times to inspection, audit, and reproduction. Participating Subdivisions should preserve and make available their records until all funds from the settlements are fully expended and for one year thereafter.

» **What is the reporting schedule for the California Opioid Settlements?**

Participating Subdivisions will be asked to provide a narrative summary of their activities and financial information on their expenditures from the California Opioid Settlements at least once a year until the relevant funds are fully expended, and one year thereafter.

Initial reporting periods are anticipated to occur as follows:

Month/Year	Milestone
December 2022	First payments to Subdivisions
September 30, 2023	*Expenditure reports for SFY 2022-2023 due *Planned expenditures for SFY 2023-24 due
September 30, 2024	*Expenditure reports for SFY 2023-2024 due *Planned expenditures for SFY 2023-24 due

*State Fiscal Year (SFY) runs from July 1st – June 30th every year.

**California Opioid Settlement payments are expected to be made to Subdivisions annually, starting in 2023.

***All settlement payments will be made by the national settlement administrator, BrownGreer PLC.

To ensure compliance with the settlement expenditure requirements, DHCS offers technical assistance to all Participating Subdivisions. Interested individuals can visit the California Opioid Settlements website to request assistance.

» **How do we request technical assistance?**

DHCS offers technical assistance to Participating Subdivisions interested in reviewing eligible opioid remediation activities, and expense tracking and reporting requirements under the California Opioid Settlements. Participating Subdivisions interested in receiving guidance from DHCS must follow the process listed on the California Opioid Settlements website to request assistance.

» **What happens if Participating Subdivisions do not complete their annual reporting?**

CA Participating Subdivisions receiving settlement funds must prepare and file reports annually regarding the use of those funds. It is the responsibility of the Participating Subdivision to ensure annual reports are provided to DHCS until all funds from the relevant settlement(s) are fully expended and for one year thereafter. Failure to submit a timely report may result in an audit, meet and confer with DHCS, or legal action. Participating Subdivisions who do not submit their reports by the prescribed deadlines will receive an electronic notice via email from DHCS regarding the missing report. The

electronic notice will be sent to the Participating Subdivision's primary contact. It is the responsibility of the Participating Subdivision to ensure their primary contact's information is correctly listed with DHCS.

» **How can I find out how other Participating Subdivisions are spending their funds?**

DHCS will prepare an annual report regarding the State and Participating Subdivisions' use of funds from the settlements until those funds are fully expended and for one year thereafter. These reports will be made publicly available on the California Opioid Settlements website.

OPIOID SETTLEMENT FUNDING

Spending Plan Proposal

Background: The Executive Office engaged with multiple County departments to consider proposed uses of the Opioid Settlement funds. Upon request of the Executive Office, Departments were asked to submit proposed work plans which were vetted to ensure proposed programs align with allowed funding uses.

The Executive Office recommends for the Board's consideration to allocate funding to the Riverside University Health System and the Executive Office to enhance existing programs and fund future programs that address the remediation of the opioid crisis.

According to the State Department of Health Care Services (DHCS), no less than 50% of the subdivision's funds must be spent on High Impact Abatement Activities as determined by DHCS (see Attachment B). The proposed abatement activities align with the pre-approved uses geared toward prevention, treatment, recovery and/or harm reduction.

Department Proposals:

Riverside University Health System Departments

- **Behavioral Health** –
  Treatment – Proposed programs support treatment of Opioid Use Disorder and any co-occurring Substance Use Disorder or Mental Health issue(s).

  A. Enhance Medication Assisted Treatment (MAT) Program which provides medication approved by the U.S. Food and Drug Administration in combination with treatment for mental health needs. A total of $3,307,910 is budgeted for FY 23/24.
  B. Add a Registered Nurse III and Behavioral Health Specialist IV at existing detention physical sites for MAT services and oversight of mobile Opioid Treatment Program services to the Banning Detention Facility. This effort will improve the oversight of MAT and Substance Use Disorder services in detention to assure evidence based, evidence-informed and promising practices such as delivery of MAT medications and methadone dosing. A total of $321,000 is requested from Opioid Settlement Funds for FY 23/24.
  C. Expand the Friday Night Live program to serve Mid and South County school districts. A total of $1,580,000 is requested from Opioid Settlement Funds for FY 23/24.

  Recovery Support – Proposed programs support people in treatment for and recovery from Opioid Use Disorder and any co-occurring Substance Use Disorder or Mental Health issue(s).

  D. Create and build a short-term residential Substance Use Disorder with Withdrawal Management 3.2 services and Sobering Center Program based at the Mead Valley Wellness Village. A total of $30,000,000 is requested from Opioid Settlement Funds.

- **Executive Office**
  Prevention Program – Media campaigns to prevent opioid use.

  A. Executive Office Communications team will continue media campaigns to raise awareness of the dangers of fentanyl and prevent fentanyl deaths. A total cost of $600,000 has been estimated for FY 23/24 campaign: $500,000 from Opioid Settlement Funds and $100,000 from Contingency Funds.

USE OF CALIFORNIA ABATEMENT ACCOUNTS FUNDS

HIGH IMPACT ABATEMENT ACTIVITIES

California Abatement Accounts Funds will be used for future Opioid Remediation in one or more of the areas described in the List of Opioid Remediation Uses, which is Exhibit E of the Distributor Settlement Agreement.

In addition to this requirement, no less than 50% of the Local Allocation in each calendar year will be used for one or more of the following **High Impact Abatement Activities**:

1. The provision of matching funds or operating costs for substance use disorder facilities within the Behavioral Health Continuum Infrastructure Program;
2. Creating new or expanded Substance Use Disorder ("SUD") treatment infrastructure;
3. Addressing the needs of communities of color and vulnerable populations (including sheltered and unsheltered homeless populations) that are disproportionately impacted by SUD;
4. Diversion of people with SUD from the justice system into treatment, including by providing training and resources to first and early responders (sworn and non-sworn) and implementing best practices for outreach, diversion and deflection, employability, restorative justice, and harm reduction; and/or
5. Interventions to prevent drug addiction in vulnerable youth.

The California Department of Health Care Services ("DHCS") may add to this list (but not delete from it) by designating additional High Impact Abatement Activities. DHCS will make reasonable efforts to consult with stakeholders, including the California Participating Subdivisions, before adding additional High Impact Abatement Activities to this list.

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("*Core Strategies*").[14]

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. **MEDICATION-ASSISTED TREATMENT ("*MAT*") DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT**

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

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

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment ("*SBIRT*") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("*OUD*") and other Substance Use Disorder ("*SUD*")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

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

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

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

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

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

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

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

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;

4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **TREATMENT FOR INCARCERATED POPULATION**

1. Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. **PREVENTION PROGRAMS**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

1. Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. **EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE**

Schedule B
Approved Uses

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

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder ("*OUD*") and any co-occurring Substance Use Disorder or Mental Health ("*SUD/MH*") conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:[15]

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

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

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

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

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

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

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

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

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

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

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

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

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 ("*DATA 2000*") to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.

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

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Create and/or support recovery high schools.

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

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

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

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

2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.

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

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

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

PART TWO: PREVENTION

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

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

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

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

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

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

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

1. Increase the number of prescribers using PDMPs;

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

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

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

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Funding media campaigns to prevent opioid misuse.

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

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

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

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

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

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

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

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

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

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

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

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

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

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

5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

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

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

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

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

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

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

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

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

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

J. LEADERSHIP, PLANNING AND COORDINATION

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

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

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

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

K. TRAINING

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

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

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

L. RESEARCH

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

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

2. Research non-opioid treatment of chronic pain.

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

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

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

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

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

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

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