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September 8, 2022

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: National Prescription Opiate Litigation -- State Funding Allocation Plan -- Agenda Item II

On July 28, 2022, the Department of Health Services (DHS) submitted a plan to the Joint Committee on Finance that describes how the agency would allocate approximately $31 million in funding the administration expects to receive in calendar year 2022 under the National Prescription Opiate Litigation, Case No. MDL 2804 settlement agreements with three pharmaceutical distributors (Cardinal, McKesson, and AmerisourceBergen) and one manufacturer, Janssen Pharmaceuticals (and its parent company, Johnson and Johnson). The administration requests that the Committee approve the plan.

2021 Wisconsin Act 57 specified that 30% of Wisconsin's share of the settlement proceeds from the case is payable to the state, and 70% is payable to local governments in Wisconsin that were parties in the opiate litigation. In addition, Act 57 directed DHS to submit annual plans, by April 1 of each year, that describe how DHS intends to expend the state's share of these funds in the next state fiscal year. Each annual submission is subject to review and approval by the Committee under a passive review and approval process. The Committee objected to the Department's initial April 1, 2022 proposal, citing a lack of specific funding allocations and timing details in the submission, and objected to the Department's July 28 submission.

BACKGROUND

On November 30, 2021, the Committee approved two proposed settlement agreements involving the National Prescription Opiate Litigation. Between the two agreements, the defendants are expected to pay a total of approximately $23.9 billion over an 17-year period for opioid abatement activities. Based on this total, and the Wisconsin's share under the terms of the agreements, the state expects to receive approximately $410.7 million, of which the state would retain $129.9 million and local governments would receive $280.8 million.

In calendar year (CY) 2023, the Department of Justice estimates that the total amount of

revenues the state will receive from this case will decrease to $18.2 million, of which $8.0 million would be available to the state and $10.2 million would be available to local governments. In subsequent years, through CY 2038, the state is expected to receive between $18.1 million and $25.1 million per year, of which $5.4 million to $7.5 million will be available annually for allocation by the state.

The agreements include a broad list of over 100 approved uses of settlement funds, and a list of core strategies that recipients are encouraged to adopt. The approved uses are listed in the following categories: (a) treatment of opioid use disorder; (b) support for persons in treatment and recovery; (c) connections to care; (d) addressing the needs of criminal justice-involved persons; (e) addressing the needs of pregnant or parenting women and their families, including babies with neonatal abstinence syndrome; (f) preventing over-prescribing of opioids; (g) preventing misuse of opioids; (h) preventing overdose deaths and other harms; (i) support and training for law enforcement and first responders; (j) oversight, administration, and coordination of the distribution and expenditure of settlement funds; (k) training for government, community, and nonprofit entities for opioid abatement activities; and (l) research related to the impacts of and response to opioid use disorder.

The attachment to this memorandum is an excerpt from the distributor settlement agreement that lists permissible uses of the settlement funds. The agreement states that this list is not an exhaustive list of opioid mitigation measures.

PROPOSAL

The following table summarizes the DHS proposal to allocate $31 million in settlement funds, which includes approximately $6.0 million the state received on July 29, 2022, and $25 million that DHS still expects to receive in 2022. The administration proposes to implement the program in three phases, each corresponding to the payments DHS expects to receive in 2022. Each component of the plan is discussed below.

DHS Proposed Allocation of Opioid Settlement Funds
($ in Millions)

Purpose	Amount
Phase 1	
Increase Availability of Narcan through the Narcan Direct Program	$3.0
Establish and Fund Program to Distribute Fentanyl Test Strips	2.0
Prevention Services to Address Root Causes of Substance Abuse	1.0
Subtotal	$6.0
Phase 2	
Capital Projects	$11.0
Funding Directed at Tribal Nations	6.0
Subtotal	$17.0
Phase 3	
Improve DHS Overdose Central Alert System	$0.5
K-12 Evidence-Based Substance Use Prevention Curriculums or Programs	2.0
Expand Medication Assistance Treatment (MAT) Services	1.0
Fund Room and Board Costs for Residential Treatment Services for Substance Use Disorder	2.5
Family Support Programs	2.0
Subtotal	$8.0
Grand Total	$31.0

Phase One

Expand Narcan Direct Program. Narcan is a prescription brand-name medication, approved by the U.S. Food and Drug administration to treat opioid overdoses in adults. It can be administered through an injection or nasal spray. Narcan is used to block or reverse the effect of opioid medication, such as extreme drowsiness, slow-breathing, and loss of consciousness.

Under the current Narcan Direct program, DHS provides free Narcan to agencies that serve people who are using opioids and others who may witness an opioid overdose. Individuals who receive the Narcan must attend a training hosted by a trainer associated with the program on how to identify an opioid overdose and how to use Narcan to reverse an Opioid overdose. The following agencies may participate in the program: (a) county and municipal public health departments, or their designees; (b) tribal health clinics or their designees; (c) syringe access programs; (d) recovery community organizations, which are programs with recovery coaches and certified peer specialists or certified parent peer specialists; (e) DHS-certified opioid treatment programs; (f) emergency department induction sites; and (g) county jails.

In federal fiscal year 2021-22, the program is supported from federal funds the state receives from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration under the state opioid response (SOR) grant program ($1.0 million) and a one-time supplement to the state's substance abuse prevention and treatment block grant ($0.75 million).

Under the DHS plan, $3.0 million would be provided to expand the Narcan Direct program and broaden the list of community agencies eligible to participate in the program.

Fund Fentanyl Test Strips. Fentanyl is a synthetic opioid, which is 50 to 100 times stronger than morphine. Originally developed as a prescription drug for pain management for the treatment of cancer, it is also made and used illegally. Synthetic opioids, including fentanyl, are the most common drugs involved in drug overdose deaths in Wisconsin and the United States. Fentanyl is often mixed with other drugs, such as heroin, cocaine, and methamphetamines because it is a potent, relatively inexpensive additive. Users are usually unaware of the presence of fentanyl in the drugs they abuse.

Fentanyl test strips are used to detect the presence of fentanyl. Prior to the enactment of 2021 Wisconsin Act 180, fentanyl test strips were considered "drug paraphernalia," which prohibited individuals from using or distributing them. However, Wisconsin Act 180 exempts fentanyl testing strips from the definition of "drug paraphernalia," enabling individuals in Wisconsin to purchase and use them.

Under the DHS plan, $2.0 million would be allocated to establish a program to purchase and distribute fentanyl strips to agencies that offer preventive and harm reduction services, modeled after the Narcan Direct program. DHS would prioritize providers offering services and working directly with active drug users.

Prevention Services. The DHS plan would allocate $1.0 million to address root causes of substance abuse in communities.

The administration cites studies that show that people who have experienced adverse childhood experiences and emotional trauma are at a disproportionate risk of harmful substance use and negative health outcomes.

This component of the plan is intended to increase efforts to address these root causes of substance abuse by awarding grants of $10,000 to $100,000 to fund interventions for both individuals and communities, including: (a) promoting housing, economic stability , and family well-being; (b) incorporating social determinants of health into existing programs and services; (c) increasing participation of individuals with lived experiences into program and service planning; and (d) increasing focus on cultural identity and belonging. Examples of programs that may receive funding include Support for Students Exposed to Trauma, Botvin LifeSkills Training Middle School Program; Prelminary Protective Hearing Benchcard, and Housing First.

Phase Two

Capital Projects. The plan would allocate $11.0 million for capital projects that would expand prevention, harm reduction, treatment, and recovery services through the construction of new facilities in areas of the state where there are no such facilities, and to renovate existing facilities to improve services. DHS anticipates awarding two to three one-time grants, based on a competitive procurement, based on factors such as demonstrated need, anticipated number of individuals that

would be served annually, the demographics of individuals who would be served, project readiness and anticipated completion date, and the scope of services that would be provided. DHS has indicated that the awards would not fully fund each project, but rather serve to complete financing packages developed by service providers.

Tribal Allocations. The plan would allocate $6.0 million to federally-recognized tribes. As part of their grant applications, each tribe would indicate their prevention, harm reduction, and treatment and recovery strategies. The DHS plan is intended to address significantly higher opioid overdose death rates among American Indians than Whites, both nationally and in Wisconsin. DHS reports that in 2020, the opioid overdose death rate for American Indians was double that of the White population (39.6 vs. 19.8 deaths per 100,000) including deaths caused by prescription opioids (10.2 vs. 5.7 per 100,000) and deaths caused by synthetic opioids (35.8 vs. 16.8 deaths per 100,000).

Phase Three

Overdose Central Alert System. Currently, DHS monitors and disseminates information on the opioid epidemic using several different sources, including death certificates, and data on hospital inpatient discharges, emergency departments encounters, the state's prescription drug monitoring program administered by the Department of Safety and Professional Services, local medical examiner and coroner offices, and information reported by ambulances. DHS uses this data to provide local health departments weekly suspected overdose alerts, which enables these agencies and service providers to provide coordinated responses to spikes in suspected overdoses.

The plan would allocate $0.5 million to improve the central alert system, enabling DHS to provide near real-time overdose surveillance for use by counties and service providers. DHS is currently piloting this near-real time overdose surveillance project in 15 counties, and would expand the near-real time alert system to additional counties. The project's goals are to make the data DHS currently collects more useful to local health agencies and providers, and increase collaboration between agencies in responding to spikes in overdose counts.

K-12 Evidence-Based Substance Use Prevention Curriculums and Programs. The plan would allocate $2 million to fund evidence-based substance use prevention programming in schools. Such programs are listed on the federal Substance Abuse and Mental Health Services Administration's website (https://www.samhsa.gov/resource-search/ebp**)** and the Education Development Center's website (https://www.edc.org/body-work/opioid-and-other-substance-misuse-prevention). (The Education Development Center is a nonprofit agency dedicated to improving education, and health by creating resources such as curricula, toolkits and online courses that offer learning opportunities). Generally, these programs are intended to reduce risk factors and promote protective factors, such as school connectedness and positive peer relationships.

DHS, in collaboration with the Department of Public Instruction, would provide funds to local education agencies (LEAs), and provide training and technical assistance to LEAs to implement substance abuse education and prevention programming.

Medication-Assisted Treatment Services. DHS would allocate $1 million to expand

medication-assisted treatment (MAT) services to areas with limited access to services. MAT, considered the most effective treatment for opioid use disorder (OUD), combines medication with comprehensive care services. The funding would support MAT providers in underserved areas of the state where access to one or more MAT options is limited or non-existent. In its 2020 report, Preventing and Treating Harms of the Opioid Crisis, the Department identified areas of the state with high rates of opioid overdoses and infections from drug use and an assessment of service gaps. See https://www.dhs.wisconsin.gov/publications/p02605.pdf.

Room and Board Costs for Residential Substance Use Disorder Treatment. The plan would allocate $2.5 million to fund room and board costs for Medicaid recipients who receive services under Medicaid's residential substance use disorder (RSUD) treatment program. These facilities are licensed either as a transitional residential treatment service or a medically monitored treatment service. Transitional residential treatment services are provided in a clinically supervised, peer-supported, therapeutic environment with clinical counseling for three to eleven hours per week. A medically-monitored treatment service is a 24-hour service that provides observation, monitoring, and treatment by a multi-disciplinary team, with a minimum of 12 hours of counseling per week. Typically, patients use RSUD services if they have severe or complex substance use disorders. Patients with physiological withdrawal symptoms or other acute medical conditions must receive monitored detoxification treatment as a hospital inpatient before receiving RSUD treatment.

In February, 2021, the MA program began providing coverage for medically necessary RSUD treatment services and stability and support services. However, since federal Medicaid law generally prohibits states from receiving federal MA matching funds for room and board costs, MA patients must pay these costs, unless a county program or charitable organization supports these costs. Due to funding limitations, counties may establish waiting lists for individuals to access RSUD services. DHS indicates that, if county funds are not available to support room and board costs, few MA recipients who require RSUD services can afford to pay these costs themselves. DHS would make this funding available to counties and tribes, who would negotiate rates with RSUD providers, and reimburse them for room and board costs.

In April, 2022, DHS provided $2.5 million from the settlement with pharmaceutical consultant McKinsey and Company to counties to support room and board costs, but indicates that the demand for reimbursement of room and board costs exceeded the allocated funding.

Family Support Center Pilots. The plan would provide $2.0 million to fund a pilot program under which family support centers would offer a range of services to family members and others who support individuals who are actively using drugs, have experienced an overdose or death, or have died from an overdose. The centers would be staffed by experts in substance use disorders (SUDs), who would assist family and friends at no cost, or minimal cost. The centers would offer information and education on substance use, stress and crisis managing strategies, counseling, recovery and peer services.

ANALYSIS

In reviewing the administration's plan, the Committee could consider the following

information relating to the request.

Permissible Uses. The master settlement agreements indicate the parties' intent that the moneys disbursed from the settlement funds be used for opioid remediation, subject to documented exceptions, and that at least 85% of the total distributor settlement funds and 86.5% of the Janssen settlement funds, over the entirety of all payment years, be spent on opioid remediation. (Legal and administrative costs are expected to be funded by the remaining settlement funds.)

The agreements define "opioid remediation" as activities that are 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. While "Exhibit E" to the settlement provides a list of expenditures that qualify as "opioid remediation," the list is not exhaustive.

If Janssen or the distributors believe that states and localities are not meeting the 85% or 86.5% minimum thresholds contained in the settlement agreements, any party may request that an Enforcement Committee meet and confer regarding the use of funds. (The bylaws of the Enforcement Committee are listed as exhibits in each of the two settlement agreements.) The committees could attempt to resolve the matter informally, or choose to seek resolution in a state court as to whether expenditures qualify as "opioid remediation." In this occurs, Janssen and the distributors actions are limited to seeking to reduce their annual payments.

Although the agreements reference opioid remediation activities, current substance abuse treatment and recovery programs often provide services to persons with other SUDs, such as methamphetamine use disorder, in addition to OUD. In order to ensure that funding is used for "opioid remediation," it could be directed exclusively to services to prevent opioid use and support OUD treatment services, rather than general SUD-related services. Alternatively, DHS may require that agencies that receive the state allocations document services that are targeted to individuals with, or at risk of, OUD. However, it is not known how broadly the enforcement committees and courts would interpret the scope of permissible remediation activities if there were a challenge to the state or local governments' use of the settlement funds.

Tribal Allocations. The administration's plan would allocate $6.0 million of the state's share of settlement funds to Wisconsin's tribes.

Under the two separate settlement agreements with the tribes, a total of $655.0 million (less administrative costs) will be available to tribes that agree to be part of the distributor settlement ($515.0 million) and the Janssen settlement ($150.0 million). Similar to the agreements with states and localities, approximately 15% of the funds are set aside to pay legal fees, and 85% will be used for abatement of the opioid epidemic in tribal communities. Tribes will be able to use these funds for the same opioid remediation activities that states and local governments may support, and, in addition, traditional activities associated with cultural identity and healing.

It is not yet known which tribes will participate in the settlement agreements, nor how much of the total settlement funds will be allocated to each tribe in Wisconsin. The administration's

proposal would ensure the immediate allocation of funds to all tribes in Wisconsin. Once the tribal allocations from the national settlement agreements are known, the need for allocating a portion of the state's funding for Wisconsin's tribes could be reassessed as part of a future allocation plan.

State and County Remediation Efforts. The same list of eligible opioid remediation activities in the settlement agreements applies to both the state and local governments. However, the state may be better positioned than the counties to conduct some activities. For example, it may be more cost effective for DHS to expand the current Narcan Direct program and create a similar program for purchasing and distributing fentanyl test strips than for counties to create similar programs. Similarly, a statewide, competitive capital project grant program administered by DHS could address geographical service gaps, particularly in rural areas of the state. Further, the administration's proposal to use funding to develop evidence-based substance use prevention curriculum for school children would serve all school districts statewide.

DHS Feedback from Stakeholders. In January, 2022, DHS held 12 listening sessions, attended by 518 individuals in total, which enabled substance use service providers and people with SUD and their families and friends to recommend how the state should allocate opioid settlement funds. In addition, a DHS survey seeking suggestions for the use of the settlement funds resulted in 897 comments from 326 individuals. As DHS summarized the public feedback it received from these meetings and surveys, common themes and suggestions for the use of the funds emerged, including:

- Supporting people in recovery, such as increasing options for transitional housing, building social support systems for individuals in recovery and their families, empowering those with lived experience and their families to create solutions, and providing direct support for families and children after loss;

- Expanding treatment options, including providing funding for diverse, equitable treatment options, increasing the number, diversity and training of providers, and increasing the availability of medication assisted treatment;

- Addressing root causes of OUD, by addressing social determinants of health, improving mental health services, and reducing adverse childhood experiences and trauma;

- Prevention through education, including educating children and youth, and educating the public as a means of reducing stigma;

- Enhancing harm reduction by increasing the availability of Narcan and fentanyl test strips, facilitating needle exchange programs, and creating safe spaces where individuals can use opioids while being monitored, and connected to services and helped quickly when needed.

Some of the themes raised at the listening sessions and through survey responses do not directly correspond with the opioid remediation measures specified in the settlement agreement. However, the administration's plan attempts to address each of these major themes.

SUMMARY

Each of the components of the Department's proposal appears to be an allowable use of the settlement funds, as identified in the attachment. The amounts reflect an initial allocation of funding the state expects to receive in 2022. By April 1, 2023, DHS will submit another plan, outlining the proposed use of the state's share of additional settlement funds, in the 2023-24 fiscal year, for the Committee's review and approval. At that time, the Committee will have an opportunity to review the Department's grant awards it made under each of this plan's expenditure categories.

The Committee could amend the plan by reducing or eliminating funding for any of the items in the Department's plan, and reallocate funding to reflect the Committee's priorities, either by increasing funding for other elements in the administration's plan, or funding services or activities that were not included in the Department's plan. However, all funded programs and projects must be an eligible use of the settlement agreement funds. If the request were denied, funding could not be allocated until a plan was approved by the Committee.

ALTERNATIVES

1. Approve the Department's request.

2. Modify the amount provided to one or more of the components of the plan and direct funding to other services or activities.

a.	Expand NARCAN Direct Program	($3.0 million)
b.	Fund Fentanyl Test Strips	($2.0 million)
c.	Prevention Services	($1.0 million)
d.	Capital Projects	($11.0 million)
e.	Tribal Allocations	($6.0 million)
f.	Overdose Central Alert System	($0.5 million)
g.	K-12 Evidence-Based Substance Use Prevention Curriculums and Programs	($2.0 million)
h.	Medication Assisted Treatment Services	($1.0 million)
i.	Room and Board Costs for RSUD	($2.5 million)
j.	Family Support Center Pilots	($2.0 million)

3. Deny the Department's request.

Prepared by: Charlie Morgan
Attachment

ATTACHMENT

Distributor Settlement Agreement (Excerpt)

DISTRIBUTORS' 12.23.21
EXHIBIT UPDATES

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.