PURDUE PHARMA L.P.

ABATEMENT PLAN TERM SHEET

SUMMARY OF TERMS AND CONDITIONS

THIS TERM SHEET DOES NOT CONSTITUTE (NOR SHALL IT BE CONSTRUED AS) AN OFFER, AGREEMENT OR COMMITMENT[1]

Issue	Description
1. APPLICABILITY OF AGREEMENT	These terms (once agreed) shall apply to the allocation of value received under, and shall be incorporated into, any plan of reorganization (the "**Chapter 11 Plan**") in the chapter 11 cases of Purdue Pharma L.P. and its affiliates (collectively, "**Purdue**") pending in the U.S. Bankruptcy Court for the Southern District of New York (the "**Bankruptcy Court**") between the states, territories and the District of Columbia (each a "**State**") on the one hand, each county, city, town, parish, village, municipality that functions as a political subdivision under State law, or a governmental entity that has the authority to bring Drug Dealer Liability Act ("**DDLA Claims**") under State law (collectively, the "**Local Governments**"), and each federally recognized Native American, Native Alaskan or American Indian Tribe (each a "**Tribe**") on the other.
2. PURPOSE	Virtually all creditors and the Court itself in the Purdue bankruptcy recognize the need and value in developing a comprehensive abatement strategy to address the opioid crisis as the most effective use of the funds that can be derived from the Purdue estate (including without limitation insurance proceeds and, if included in the Chapter 11 Plan, payments by third-parties seeking releases). Because of the unique impact the crisis has had throughout all regions of the country, and as repeatedly recognized by Judge Drain, division of a substantial portion of the bankruptcy estate should occur through an established governmental structure, with the use of such funds strictly limited to abatement purposes as provided herein.[2]

[1] As a condition to participating in this abatement structure, the settlements that the states of Kentucky and Oklahoma separately entered into with Purdue must be taken into account in any allocation to them or flowing through them. Potential adjustments may include a different Government Participation Mechanism structure for the disbursement of funds to benefit Local Governments in those states or some redirection of funds, which would still be used solely for abatement purposes.

[2] *See, e.g.,* Hrg. Tr at 149:22-150:5 (Oct. 11, 2019)(' "I would hope that those public health steps, once the difficult allocation issues that the parties have addressed here, can be largely left up to the states and municipalities so that they can use their own unique knowledge about their own citizens and how to address them. It may be that some states think it's more of a law enforcement issue, i.e. interdicting illegal opioids at this point. Others may think education is more important. Others may think treatment is more important."); *id.* At 175:24-176:6 ("I also think, and again, I didn't say this lightly, that my hope in the allocation process is that there would be an understanding between the states and the municipalities and localities throughout the whole process that[,] subject to general guidelines on how the money should be used, specific ways to use it would be left up to the states and the municipalities, with guidance from the states primarily."); Hr'g Tr. At 165:3-165:14 (Nov. 19, 2019) ("I continue to believe that the states play a major role in [the allocation] process. The role I'm envisioning for them is not one where they say we get everything.

Issue	Description
	This approach recognizes that funding abatement efforts – which would benefit most creditors and the public by reducing future effects of the crisis through treatment and other programs – is a much more efficient use of limited funds than dividing thin slices among all creditors with no obligation to use it to abate the opioid crisis. Because maximizing abatement of the opioid crisis requires coordination of efforts by all levels of government, particularly when the abatement needs far exceed the available funds, this structure requires a collaborative process between each State and its Local Governments. This Term Sheet is intended to establish the mechanisms for distribution and allocation of funds to States, Local Governments and Tribes (the "**Abatement Funds**") to be incorporated into the Chapter 11 Plan and any order approving the Chapter 11 Plan (**Abatement Funds** net of the portion thereof allocated to a Tribal Abatement Fund under Section 5 hereof are referred to herein as "**Public Funds**"). The parties agree that 100% of the Public Funds distributed under the Chapter 11 Plan shall be used to abate the opioid crisis. Specifically, (i) no less than ninety five percent (95%)of the Public Funds distributed under the Chapter 11 Plan shall be used for abatement of the opioid crisis by funding opioid or substance use disorder related projects or programs that fall within the list of uses in **Schedule B** (the "**Approved Opioid Abatement Uses**"); (ii) priority shall be given to the core abatement strategies ("**Core Strategies**") as identified on **Schedule A**; and (iii) no more than five percent (5%) of the Public Funds may be used to fund expenses incurred in administering the distributions for the Approved Opioid Abatement Uses, including the process of selecting programs to receive distributions of **Public Funds** for implementing those programs and in connection with the Government Participation Mechanism[3] (**"Allowed Administrative Expenses**," and together with the **Approved Opioid Abatement Uses**, "**Approved Uses**").[4] Notwithstanding anything in this term sheet that might imply to the contrary, projects or programs that constitute **Approved Opioid Abatement Uses** may be provided by States, State agencies, Local Governments, Local Government agencies or nongovernmental parties and funded from Public Funds.
3. GENERAL NOTES	The governmental entities maintain that the most beneficial and efficient use of limited bankruptcy funds is to dedicate as large a portion as possible to abatement programs addressing the opioid crisis. If this

I think that should be clear and I think it is clear to them. But, rather, where they act – in the best principles of federalism, for their state, the coordinator for the victims in their state."); Hr'g Tr. at 75:19-76:1 (Jan. 24, 2020) ("Even if there ultimately is an allocation here – and there's not a deal now, obviously, at this point on a plan. But if there is an allocation that leaves a substantial amount of the Debtors' value to the states and territories, one of the primary benefits of a bankruptcy case is that the plan can lock in, perhaps only in general ways, but perhaps more in specific ways, how the states use that money . . . .").

[3] Capitalized terms not defined where first used shall have the meanings later ascribed to them in this Term Sheet.

[4] Nothing in this term sheet is intended to, nor does it, limit or permit the ability of funds from the Purdue estate (other than Public Funds) to be used to pay for legal fees and expenses incurred in anticipation of or during Purdue's chapter 11 case, or once confirmed, in implementing the Chapter 11 Plan.

Issue	Description
	approach is taken, the governmental entities involved in the mediation – states, territories, tribes, counties, cities and others – would commit the Public Funds allocated to them to such future abatement, in lieu of direct payment for their claims. a. Resolution of States' and Local Governments' claims under this model presumes signoff by and support of the federal government, including an agreement that the federal government will also forego its past damages claims. Continued coordination with the federal government therefore is necessary as this model is finalized. b. This outline addresses the allocation of Abatement Funds among governmental entities to provide abatement programs to the public for the benefit of not only the governmental entities and their constituents, but also a substantial number of other creditors. The States and Local Governments welcome other, private-side creditor groups to enter discussions concerning how such creditors may participate in, contribute to and/or benefit from the government-funded abatement programs contemplated herein in lieu of direct payment on their claims for past damages. c. In addition to providing abatement services, it is understood that, if their claims are to be released in a reorganization plan, a portion of the Purdue estate will also need to be dedicated to personal injury claimants. A proposal regarding such claims is being developed separately. d. All **Public Funds** distributed from the Purdue bankruptcy estate as part of this abatement structure shall be used only for such **Approved Uses**. Compliance with these requirements shall be verified through reporting, as set out in Section 8. This outline and the terms herein are intended to apply solely to the use and allocation of Public Funds in the Purdue Chapter 11 Plan, and do not apply to the use or allocation of funds made available as the result of judgments against or settlements with any party other than those released as part of the Chapter 11 Plan.
4. DISBURSEMENT OF FUNDS	**Disbursement of Abatement Funds** The Bankruptcy Court shall appoint [a third-party administrator ("**Administrator**")] [Trustee(s)] who will perform the ministerial task of overseeing distribution of all Abatement Funds, which will consist of all assets transferred to such fund by way of the confirmed Chapter 11 Plan, and any, growth, earnings, or revenues from such assets, as well as proceeds from any future sale of such assets. The [Administrator] [Trustees] shall distribute the Abatement Fund consistent with the Chapter 11 Plan and shall provide to the Bankruptcy Court an annual report on such distributions. [Points to be addressed regarding disbursements:

Issue	Description
	• Trigger and timing for disbursements. • Insert details to show how these funds shall be distributed for abatement uses and that the funds will not flow into the state general revenue accounts (unless constitutionally required and, in that event, the funds shall still be disbursed for abatement uses as required by the terms of the document), including possible distribution to state points of contact and block grant recipients. • Possible creation of template document for Abatement Funds distribution requests. • If trust mechanism is employed, trust location and governing law.]
5. ATTORNEYS' FEES AND COSTS FUND	A separate fund will be established for attorneys' fees and litigation costs in the final bankruptcy plan. Agreement by the parties to this Abatement Plan Term Sheet is contingent upon the establishment of this fund and the details of the fund, which are subject to further negotiation, including without limitation the participants, amount, jurisdiction, oversight, and administration. Participation in an abatement program, receipt of abatement services or benefits will not affect, and specific percentages in the abatement structure received by various parties will not determine, the amount of fees and costs that may be recovered.
6. TRIBAL ABATEMENT FUNDING	a. [X%] of the **Abatement Funds** will be allocated to a Tribal Abatement Fund and these funds will not be a part of the structure involving abatement programs funded by state and local governments. b. The Tribes are working on their proposal for allocation among Tribes, which would be included as part of the overall abatement plan. c. The Tribes will use the tribal allocation of Abatement Funds for programs on the approved list of abatement strategies (see **Schedule B**) and also for culturally appropriate activities, practices, teachings or ceremonies that are, in the judgment of a tribe or tribal health organization, aimed at or supportive of remediation and abatement of the opioid crisis within a tribal community.[5] The Tribes will have a list of representative examples of such culturally appropriate abatement strategies, practices and programs which is attached as **Schedule [ ]**. The separate allocation of abatement funding and illustrative list of culturally appropriate abatement strategies recognizes that American Indian and Alaska Native Tribes and the communities they serve possess unique cultural histories, practices, wisdom, and needs that are highly relevant to the health and well-being of American Indian and Alaska Native

[5] [NTD: Discuss how private claimants will be treated under Tribal Allocation, if at all.]

Issue	Description
	people and that may play an important role in both individual and public health efforts and responses in Native communities.
7. DIVISION OF PUBLIC FUNDS	**Public Funds** are allocated among the States, the District of Columbia and Territories in the percentages set forth on **Schedule C**. Except as set forth below in section 7(C) for the District of Columbia and Territories, each State's Schedule C share shall then be allocated within the State in accordance with the following: 1. **Statewide Agreement**. Each State and its Local Governments will have until [the later of 60 days from entry of an order confirming the Chapter 11 Plan or the Effective Date of the Chapter 11 Plan][6] (the "**Agreement Date**") to file with the Bankruptcy Court an agreed-upon allocation or method for allocating the Public Funds for that State dedicated only to Approved Uses (each a "**Statewide Abatement Agreement**" or "**SAA**"). Any State and its Local Governments that have reached agreement before the Effective Date of the Chapter 11 Plan that satisfies the metric for approval as described in the immediately following paragraph shall file a notice with the Bankruptcy Court that it has adopted a binding SAA and either include the SAA with its filing or indicate where the SAA is publicly available for the SAA to be effective for the Purdue Bankruptcy. Any dispute regarding allocation within a State will be resolved as provided by the Statewide Abatement Agreement. A **Statewide Abatement Agreement** shall be agreed when it has been approved by the State and either (a) representatives[7] of its Local Governments whose aggregate Population Percentages, determined as set forth below, total more than Sixty Percent (60%), or (b) representatives of its Local Governments whose aggregate Population Percentages total more than fifty percent (50%) provided that these Local Governments also represent 15% or more of the State's counties or parishes (or, in the case of States whose counties and parishes that do not function as Local Governments, 15% of or more of the State's incorporated cities or towns), by number.[8]

[6] Should there be provision for extension of the date for filing Statewide Abatement Agreement?

[7] An authorized "representative" of local, or even State, government can differ in this Term Sheet depending on the context.

[8] All references to population in this Term Sheet shall refer to published U. S. Census Bureau population estimates as of July 1, 2019, released March 2020, and shall remain unchanged during the term of this agreement. These estimates can currently be found at https://www.census.gov/data/datasets/time-series/demo/popest/2010s-counties-total.html

Issue	Description
	Population Percentages shall be determined as follows: For States with counties or parishes that function as Local Governments,[9] the Population Percentage of each county or parish shall be deemed to be equal to (a) (1) 200% of the population of such county or parish, minus (2) the aggregate population of all Primary Incorporated Municipalities located in such county or parish,[10] divided by (b) 200% of the State's population. A "**Primary Incorporated Municipality**" means a city, town, village or other municipality incorporated under applicable state law with a population of at least 25,000 that is not located within another incorporated municipality The Population Percentage of each primary incorporated municipality shall be equal to its population (including the population of any incorporated or unincorporated municipality located therein) divided by 200% of the State's population; provided that the Population Percentage of a primary incorporated municipality that is not located within a county shall be equal to 200% of its population (including the population of any incorporated or unincorporated municipality located therein) divided by 200% of the State's population. For all States that do not have counties or parishes that function as Local Governments, the Population Percentage of each incorporated municipality (including any incorporated or unincorporated municipality located therein), shall be equal to its population divided by the State's population. The Statewide Abatement Agreement will become effective within fourteen (14) days of filing, unless otherwise ordered by the Bankruptcy Court. A State and its Local Governments may revise, supplement, or refine a Statewide Abatement Agreement by filing an amended Statewide Abatement Agreement that has been approved by the State and sufficient Local Governments to satisfy the approval standards set forth above with the Bankruptcy Court, which shall become effective within fourteen (14) days of filing, unless otherwise ordered by the Bankruptcy Court. 2. **Default Allocation Mechanism (excluding Territories and DC addressed below).** The **Public Funds** allocable to a State that is not party to a **Statewide Abatement Agreement** as defined in 7(1) above (each a "**Non-SAA State**") shall be allocated as between the State and its Local Governments to be

[9] The following states do not have counties or parishes that function as Local Governments: Alaska, Connecticut, Massachusetts, Rhode Island, and Vermont [INSERT OTHERS]. All other States have counties or parishes that function as Local Governments.
[10] Discuss how to deal with cities and towns that straddle counties.

Issue	Description
	used only for **Approved Uses**, in accordance with this Section (B) (the "**Default Allocation Mechanism**"). a. **Regions.** Except as provided in the final sentence of this paragraph, each **Non-SAA State** shall be divided into "**Regions**" as follows: (a) each **Qualifying Block Grantee** (as defined below) shall constitute a **Region**; and (b) the balance of the State shall be divided into **Regions** (such **Regions** to be designated by the State agency with primary responsibility for substance abuse disorder services employing to the maximum extent practical, existing regions established in that State for opioid abuse treatment or similar public health purposes); such non-**Qualifying Block Grantee Regions** are referred to herein as "**Standard Regions**"). The **Non-SAA States** which have populations under 4 million and do not have existing regions described in the foregoing clause (b) shall not be required to establish **Regions**;[11] such a State that does not establish **Regions** but which does contain one or more **Qualifying Block Grantees** shall be deemed to consist of one **Region** for each **Qualifying Block Grantee** and one **Standard Region** for the balance of the State. b. **Regional Apportionment**. **Public Funds** shall be allocated to each **Non-SAA State, as defined in 7(1) above,** as (a) a **Regional Apportionment** or (b) a **Non-Regional Apportionment** based on the amount of Public Funds dispersed under a confirmed Chapter 11 Plan as follows: i. **First $1 billion** – 70% Regional Apportionment/30% Non-Regional Apportionment ii. **$1-$2.5 billion** – 64% Regional Apportionment /36% Non-Regional Apportionment iii. **$2.5-$3.5 billion** – 60% Regional Apportionment /40% Non-Regional Apportionment iv. **Above $3.5 billion** – 50% Regional Apportionment /50% Non-Regional Apportionment

[11] To the extent they are not parties to a Statewide Abatement Agreement, the following States will qualify as a Non-SAA State that does not have to establish Regions: Connecticut, Delaware, Hawai'i, Iowa, Maine, Nevada, New Hampshire, New Mexico, Rhode Island, Vermont [INSERT OTHERS].

Issue	Description
	c. **Qualifying Block Grantee.** A "**Qualifying Local Government**" means a county or parish (or in the cases of States that do not have counties or parishes that function as political subdivision, a city), that (a) either (i) has a population of 400,000 or more or (ii) in the case of California has a population of 750,000 or more and (b) has funded or otherwise manages an established, health care and/or treatment infrastructure (*e.g.*, health department or similar agency) to evaluate, award, manage and administer a Local Government Block Grant.[12] A **Qualifying Local Government** that elects to receive **Public Funds** through Local Government Block Grants is referred to herein as a **Qualifying Block Grantee**.[13] d. **Proportionate Shares of Regional Apportionment**. As used herein, the "**Proportionate Share**" of each **Region** in each **Non-SAA State** shall be (a) for States in which counties or parishes function as Local Governments, the aggregate shares of the counties or parishes located in such **Region** under the allocation model employed in connection with the Purdue Bankruptcy (the "**Allocation Model**"),[14] divided by the aggregate shares for all counties or parishes in the State under the **Allocation Model**; and (b) for all other States, the aggregate shares of the cities and towns in that **Region** under the **Allocation Model's** intra-county allocation formula, divided by the aggregate shares for all cities and towns[15] in the State under the **Allocation Model**. e. **Expenditure or Disbursement of Regional Apportionment**. Subject to 7(2)(i) below regarding **Allowed Administrative Expenses**, all **Regional Apportionments** shall be disbursed or expended in the form of **Local Government Block Grants** or otherwise for **Approved Opioids Abatement Uses** in the **Standard Regions** of each **Non-SAA State**.

[12] As noted in footnote 8, the population for each State shall refer to published U. S. Census Bureau population estimates as of July 1, 2019, released March 2020, and shall remain unchanged during the term of this agreement. These estimates can currently be found at https://www.census.gov/data/datasets/time-series/demo/popest/2010s-counties-total.html

[13] [NTD: Perhaps provide for a Qualifying Political Subdivision to expand to include neighboring areas that are part of its metro area?]

[14] Need to address whether to use the Negotiation Class Allocation Model or other metric to determine Proportionate Share.

[15] Should this be all cities and towns or only primary incorporated municipalities?

Issue	Description
	f. **Qualifying Block Grantees.** Each **Qualifying Block Grantee** shall receive its **Regional Apportionment** as a block grant (a "**Local Government Block Grant**"). **Local Government Block Grants** shall be used only for **Approved Opioid Abatement Uses** by the **Qualifying Block Grantee** or for grants to organizations within its jurisdiction for **Approved Opioid Abatement Uses** and for **Allowed Administrative Expenses** in accordance with 7(2)(i) below. Where a municipality located wholly within a **Qualifying Block Grantee** would independently qualify as a block grant recipient ("**Independently Qualifying Municipality**"), the **Qualifying Block Grantee** and **Independently Qualifying Municipality** must make a substantial and good faith effort to reach agreement on use of Abatement Funds as between the qualifying jurisdictions. If the **Independently Qualifying Municipality** and the **Qualifying Block Grantee** cannot reach such an agreement on or before the **Agreement Date [or some later specified date]**, the **Qualifying Block Grantee** will receive the **Local Government Block Grant** for its full **Proportionate Share** and commit programming expenditures to the benefit of the **Independently Qualifying Municipality** in general proportion to **Proportionate Shares** (determined as provided in 7(2)(d) above) of the municipalities within the **Qualifying Block Grantee**. Notwithstanding the allocation of the Proportionate Share of each Regional Apportionment to the Qualifying Block Grantee, a Qualifying Block Grantee may choose to contribute a portion of its Proportionate Share towards a Statewide program. g. **Standard Regions.** The portions of each **Regional Apportionment** not disbursed in the form of **Local Government Block Grants** shall be expended throughout the **Standard Regions** of each **Non-SAA State** in accordance with 95%-105% of the respective **Proportionate Shares** of such **Standard Regions**. Such expenditures will be in a manner that will best address Opioid abatement within the State as determined by the State with the input, advice and recommendations of the **Government Participation Mechanism** described in Section 8 below. This regional spending requirement may be met by delivering **Approved Opioid Abatement Use** services or programs to a **Standard Region** or its residents. Delivery of such services or programs can be

Issue	Description
	accomplished directly or indirectly through many different infrastructures and approaches, including without limitation the following: i. State agencies, including local offices; ii. Local governments, including local government health departments; iii. State public hospital or health systems; iv. Health care delivery districts; v. Contracting with abatement service providers, including nonprofit and commercial entities; or vi. Awarding grants to local programs. h. **Expenditure or Disbursement of Public Funds Other Than Regional Apportionment**. All **Public Funds** allocable to a **Non-SAA State** that are not included in the State's **Regional Apportionment** shall be expended only on **Approved Uses**. The expenditure of such funds shall be at the direction of the State's lead agency (or other point of contact designated by the State) and may be expended on a statewide and/or localized manner, including in the manners described in herein. **Qualifying Block Grantees** will be eligible to participate in or receive the benefits of any such expenditures on the same basis as other **Regions.** i. **Allowed Administrative Expenses**. **Qualifying Block Grantees** States may use up to 5% of their Non-Regional Apportionments plus 5% of the Regional Apportionment not used to fund **Local Government Block Grants,** for **Allowed Administrative Expenses**. **Qualifying Block Grantees** may use up to 5% of their **Local Government Block Grants** to fund their **Allowed Administrative Expenses.** 3. **Records.** The State shall maintain records of abatement expenditures and its required reporting will include data on regional expenditures so it can be verified that the Regional Distribution mechanism guarantees are being met.[16] **Qualifying Block Grantees** shall maintain records of abatement expenditures and shall provide those records periodically to their State for inclusion in the State's required periodic reporting, and shall be subject to audit consistent with State law applicable to the granting of State funds.

[16] Additional records and reporting requirements?

Issue	Description
	(C) Allocation for Territories and the District of Columbia Only The allocation of Public Funds within a Territory or the District of Columbia will be determined by its local legislative body [within one year of the Agreement Date], unless that legislative body is not in session, in which case, the allocation of Public Funds shall be distributed pursuant to the direction of the Territory's or District of Columbia's executive, in consultation – to the extent applicable – with its Government Participation Mechanism [within ninety (90) days of the Agreement Date].[17]
8. GOVERNMENT PARTICIPATION MECHANISM	In each **Non-SAA State**, as defined in 7(1) above, there shall be a process, preferably pre-existing, whereby the State shall allocate funds under the Regional Distribution mechanism only after meaningfully consulting with its respective Local Governments. Each such State shall identify its mechanism (whether be it a council, board, committee, commission, taskforce, or other efficient and transparent structure) for consulting with its respective Local Governments (the "**Government Participation Mechanism**" or "**GPM**") in a notice filed with the Bankruptcy Court identifying what GPM has been formed and describing the participation of its Local Governments in connection therewith. States may combine these notices into one or more notices for filing with the Bankruptcy Court. These notices are reviewable by the Bankruptcy Court upon the motion of any Local Government in that State asserting that no GPM has been formed. Government Participation Mechanisms shall conform to the following: (A) ***Composition***. For each State, a. the State, on the one hand, and State's Local Governments, on the other hand, shall have equal representation on a GPM; b. Local Government representation on a GPM shall be weighted in favor of the Standard Regions but can include representation from the State's Qualifying Block Grantees; c. the GPM will be chaired by a non-voting Chairperson appointed by the State; d. Groups formed by the States' executive or legislature may be used as a GPM, provided that the group has equal representation by the State and the State's Local Governments.[18] Appointees should possess experience, expertise and education with respect to public health, substance abuse, and other related

[17] Territory and DC provisions to be discussed

[18] Additional potential terms: mechanism for state and local appointment; duration of term, reimbursement of expenses.

Issue	Description
	topics as is necessary to assure the effective functioning of the GPM. (B) ***Consensus***. Members of the GPMs should attempt to reach consensus with respect to **GPM Recommendations** and other actions of the GPM. Consensus is defined in this process as a general agreement achieved by the members that reflects, from as many members as possible, their active support, support with reservations, or willingness to abide by the decision of the other members. Consensus does not require unanimity or other set threshold and may include objectors. In all events, however, actions of a GPM shall be effective if supported by at least a majority of its Members. **GPM Recommendations** and other action shall note the existence and summarize the substance of objections where requested by the objector(s). (C) ***Proceedings***. Each GPM shall hold no fewer than four public meetings annually, to be publicized and located in a manner reasonably designed to facilitate attendance by residents throughout the State. Each GPM shall function in a manner consistent with its State's open meeting, open government or similar laws, and with the Americans with Disabilities Act. GPM members shall be subject to State conflict of interest and similar ethics in government laws. (D) ***Consultation and Discretion***. The GPM shall be a mechanism by which the State consults with community stakeholders, including Local Governments (including those not a part of the GPM), state and local public health officials and public health advocates, in connection with opioid abatement priorities and expenditure decisions for the use of Public Funds on Approved Opioid Abatement Uses.[19] (E) ***Recommendations***. A GPM shall make recommendations regarding specific opioid abatement priorities and expenditures for the use of Public Funds on Approved Opioid Abatement Uses to the State or the agency designated by a State for this purpose (**"GPM Recommendations"**). In carrying out its obligations to provide **GPM Recommendations,** a GPM may consider local, state and federal initiatives and activities related to education, prevention, treatment and services for individuals and families experiencing and affected by opioid use disorder; recommend priorities to address the State's opioid epidemic, which recommendations may be Statewide or specific to **Regions**; recommend Statewide or **Regional** funding with respect to specific programs or initiatives; recommend measurable outcomes to determine the effectiveness of funds expended for

[19] Address form of consultation with non-GPM members, public hearings, etc.

Issue	Description
	Approved Opioid Abatement Uses; monitor the level of **Allowed Administrative Expenses** expended from **Public Funds**. The goal is for a process that produces **GPM Recommendations** that are recognized as being an efficient, evidence-based approach to abatement that addresses the State's greatest needs while also including programs reflecting particularized needs in local communities. It is anticipated that such a process, particularly given the active participation of state representatives, will inform and assist the state in making decisions about the spending of the **Public Funds**. To the extent a State chooses not to follow a **GPM Recommendation**, it will make publicly available within 14 days after the decision is made a written explanation of the reasons for its decision, and allow 7 days for the GPM to respond. (F) ***Review***. Local Governments and States may object to an allocation or expenditure of **Public Funds (**whether a **Regional Apportionment** or **Non-Regional** Apportionment) solely on the basis that the allocation or expenditure at issue (i) is inconsistent with the provisions of Section 7(B)2 hereof with respect to the levels of **Regional Apportionments** and **Non-Regional** Apportionments; (ii) is inconsistent with the provisions of Section 7(B)(5) hereof with respect to the amounts of **Local Government Block Grants** or **Regional Apportionment** expenditures; (iii) is not for an **Approved Use,** or (iv) violates the limitations set forth herein with respect to **Allowed Administrative Fees**. The objector shall have the right to bring that objection to either (a) a court with jurisdiction within the applicable State ("**State Court**") or (b) the Bankruptcy Court if the Purdue chapter 11 case has not been closed; provided that nothing herein is intended to expand the scope of the Bankruptcy Court's post-confirmation jurisdiction or be deemed to be a consent to any expanded post-confirmation jurisdiction by the Bankruptcy Court (each an "**Objection**"). If an Objection is filed within fourteen (14) days of approval of an Allocation, then no funds shall be distributed on account of the aspect of the Allocation that is the subject of the Objection until the Objection is resolved or decided by the Bankruptcy Court or State Court, as applicable. There shall be no other basis for bringing an Objection to the approval of an Allocation.
8. COMPLIANCE, REPORTING, AUDIT AND ACCOUNTABILITY	At least annually, each State shall publish on the lead State Agency's website or on its Attorney General's website a report detailing for the preceding time period, respectively (i) the amount of Public Funds received, (ii) the allocation awards approved (indicating the recipient, the

Issue	Description
	amount of the allocation, the program to be funded and disbursement terms), and (iii) the amounts disbursed on approved allocations, to Qualifying Local Governments for Local Government Block Grants and Allowed Administrative Fees. At least annually, each **Qualifying Block Grantee** which has elected to take a Local Government Block Grant shall publish on its lead Agency's or Local Government's website a report detailing for the preceding time period, respectively (i) the amount of **Local Government Block Grants** received, (ii) the allocation awards approved (indicating the recipient, the amount of the grant, the program to be funded and disbursement terms), and (iii) the amounts disbursed on approved allocations. As applicable, each State or Local Government shall impose reporting requirements on each recipient to ensure that **Public Funds** are only being used for **Approved Uses**, in accordance with the terms of the allocation, and that the efficacy of the expenditure of such **Public Funds** with respect to opioids abatement can be publicly monitored and evaluated. The expenditure and disbursement of **Public Funds** shall be subject to audit by States as follows: [details of audit scope, process, output, etc.] (a) A court with jurisdiction within the applicable State ("**State Court**") or (b) the Bankruptcy Court if the Purdue chapter 11 case has not been closed shall have jurisdiction to enforce the terms of this agreement, and as applicable, a Statewide Abatement Agreement or Default Mechanism; provided that nothing herein is intended to expand the scope of the Bankruptcy Court's post-confirmation jurisdiction.

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**")[, such that a minimum of __% of the [aggregate] state-level abatement distributions shall be spent on [one or more of] them annually].

A. Naloxone/Narcan

1. Expand training for first responders, EMTs, law enforcement, schools, community support groups and families; and
2. Increase distribution to non-Medicaid eligible or uninsured individuals.

B. Medication Assisted Treatment ("MAT") Distribution and other opioid-related treatment

1. Increase distribution of MAT to non-Medicaid eligible or uninsured individuals;
2. Provide MAT services to youth and 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. Non-MAT treatment, including addition and expansion of services for managing withdrawal and related systems such as detox, residential, hospitalization, intensive outpatient, outpatient, recovery housing, and treatment facilities.

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 from 60 days postpartum to 12 months (post-Medicaid coverage); and
3. Provide comprehensive wrap-around services to individuals in recovery including housing, transportation, job placement/training, and childcare.

D. Expanding Treatment for Neonatal Abstinence Syndrome

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 other polysubstance abuse problems;
4. Provide comprehensive wrap-around services to individuals in recovery including housing, transportation, job placement/training, and childcare; and
5. Hire additional social 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 that currently have or had detox units to treat 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 school-based prevention programs, beyond education about MAT mentioned above, including evidence-based school-wide programs;
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 for additional city police officers/county sheriffs to specifically address OUD and opioid-related ODs.

H. Expanding Syringe Service Programs

1. Provide comprehensive syringe exchange services programs with more wrap-around services including treatment information.

I. Evidence based data collection and research analyzing the effectiveness of the abatement strategies within the State.

Schedule B
Approved Uses[20]

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

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 services that include the full American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions, including but not limited to:
    a. Medication-Assisted Treatment (MAT);
    b. Abstinence-based treatment;
    c. Treatment, recovery, or other services provided by states, subdivisions, community health centers; non-for-profit providers; or for-profit providers;
    d. Treatment by providers that focus on OUD treatment as well as treatment by providers that offer OUD treatment along with treatment for other SUD/MH conditions; or
    e. Evidence-informed residential services programs, as noted below.

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, evidence-informed, or promising 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

[20] [NTD: Discuss expanded list of Approved Uses to be included. Discuss "self-executing" function based on additional information received from NCSG.]

OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Treatment of mental health trauma resulting from the traumatic experiences of the opioid user (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 detoxification (detox) and withdrawal management services for persons with OUD and any co-occurring SUD/MH conditions, including medical detox, referral to treatment, or connections to other services or supports.

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

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

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

11. Scholarships and supports for certified addiction counselors and other mental and behavioral health providers involved in addressing OUD any co-occurring SUD/MH 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. Scholarships for persons to become certified addiction counselors, licensed alcohol and drug counselors, licensed clinical social workers, and licensed mental health counselors practicing in the SUD field, and scholarships for certified addiction counselors, licensed alcohol and drug counselors, licensed clinical social workers, and licensed mental health counselors practicing in the SUD field for continuing education and licensing fees.

13. 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.

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

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

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

2. 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.

3. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, or training for housing providers.

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

5. 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.

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

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

8. 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.

9. 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 manage the opioid user in the family.

10. Training and development of procedures for government staff to appropriately interact and provide social and other services to current and recovering opioid users, including reducing stigma.

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

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

13. Create and/or support recovery high schools.

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

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

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

2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders.

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

6. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into community treatment or recovery services through a bridge clinic or similar approach.

7. 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.

8. 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.

9. 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.

10. Provide funding for peer navigators, recovery coaches, care coordinators, or care managers that offer assistance to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced on opioid overdose.

11. 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.

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

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

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

15. 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.

16. Create or support intake and call centers to facilitate education and access to treatment, prevention, and recovery services for persons with OUD and any co-occurring SUD/MH conditions.

17. Develop or support a National Treatment Availability Clearinghouse – a multistate/nationally accessible database whereby health care providers can list locations for currently available in-patient and out-patient OUD treatment services that are accessible on a real-time basis by persons who seek treatment.

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 – or are at risk of becoming involved – in the criminal justice system through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:
    a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);
    b. Active outreach strategies such as the Drug Abuse Response Team (DART) model;
    c. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;
    d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;
    e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

f. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise and to reduce perceived barriers associated with law enforcement 911 responses.

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 for persons with OUD and any co-occurring SUD/MH conditions, but only if these courts provide referrals to evidence-informed treatment, including MAT.

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

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

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

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

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

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

1. Support evidence-based, evidence-informed, or promising 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 educate and provide support to families affected by Neonatal Abstinence Syndrome.

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

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

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

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

6. 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.

7. 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.

8. 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, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

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

2. Academic counter-detailing to educate prescribers on appropriate opioid prescribing.

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

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

5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:
    a. Increase the number of prescribers using PDMPs;
    b. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or
    c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD.

6. Development and implementation of a national PDMP – Fund development of a multistate/national PDMP that permits information sharing while providing appropriate safeguards on sharing of private health information, including but not limited to:
    a. Integration of PDMP data with electronic health records, overdose episodes, and decision support tools for health care providers relating to OUD.
    b. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database.

7. Increase electronic prescribing to prevent diversion or forgery.

8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

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

2. Public education relating to drug disposal.

3. Drug take-back disposal or destruction programs.

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

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

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

7. Support evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

8. 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.

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

10. 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.

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

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

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

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, opioid users, families and friends of opioid users, schools, community navigators and outreach workers, drug offenders upon release from jail/prison, or other members of the general public.

2. Public health entities provide free naloxone to anyone in the community, including but not limited to provision of intra-nasal naloxone in settings where other options are not available or allowed.

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

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

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

6. Public education relating to emergency responses to overdoses.

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

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

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

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

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

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

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items C8, D1 through D7, H1, H3, and H8, support the following:

1. Law enforcement expenditures relating to the opioid epidemic.

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

3. 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, and coordination to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Community regional planning to identify goals for reducing harms related to the opioid epidemic, to identify areas and populations with the greatest needs for treatment

intervention services, or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A government dashboard to track key opioid-related indicators and supports as identified through collaborative 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 in items A7, A8, A9, A12, A13, A14, A15, B7, B10, C3, C5, D7, E2, E4, F1, F3, F8, G5, H3, H12, and I-2, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

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

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

L. RESEARCH

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

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

b. Research non-opioid treatment of chronic pain.

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

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

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

f. 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).

g. Research on expanded modalities such as prescription methadone that can expand access to MAT.

h. 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.

i. 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.

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

Schedule C
State Allocation Percentages

[TO BE INSERTED]

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