

SOUTH CAROLINA OPIOID SETTLEMENT ALLOCATION AGREEMENT

WHEREAS, the people of the State of South Carolina and its local governments and communities have been harmed by an epidemic of opioid use and abuse, which has been caused by the conduct of various entities and individuals in the opioid supply chain in their efforts to market, promote, sell, distribute, dispense, and/or supply opioid products;

WHEREAS, the State of South Carolina, through its Attorney General, Alan Wilson, and Political Subdivisions within the State of South Carolina, through their elected representatives, officials, and counsel, are separately engaged in litigation against a number of entities and individuals in the opioid supply chain, seeking to hold them accountable for the damage they have caused and will continue to cause within the State of South Carolina;

WHEREAS, the State of South Carolina, through its Attorney General, and the Political Subdivisions share a common desire to abate and alleviate the impacts of the opioid epidemic throughout the State of South Carolina;

WHEREAS, because of the efforts of the State of South Carolina, through its Attorney General, and the Litigating Political Subdivisions in bringing litigation, the State and its Political Subdivisions will receive the benefits of the opioid-related settlements contemplated herein; now,

THEREFORE, the State of South Carolina and its Political Subdivisions, subject to executing formal documents effectuating the Parties' agreements, enter into this South Carolina Opioid Settlement Allocation Agreement ("Agreement"), which relates to the allocation and use of any proceeds of the Opioid-Related Settlements described herein.

I. Definitions

As used in this Agreement, the following definitions shall apply:

1. "Agreement" shall mean this South Carolina Opioid Settlement Allocation Agreement and all exhibits attached hereto.
2. "Approved Abatement Strategy(ies)" shall mean those uses identified in **Exhibit C** hereto.
3. "The Board" or the "South Carolina Opioid Recovery Fund Board" shall mean the entity that has the purpose of administering and distributing the South Carolina Opioid Recovery Fund and shall have the composition and responsibilities as set forth in **Exhibit A** hereto.
4. "The Court" or the "*In re South Carolina Opioid Litigation Court*" means the Court assigned by the South Carolina Supreme Court to dispose of all matters arising out of the opioid litigation currently pending and to be filed in the South Carolina state court system by the Attorney General and/or any Political Subdivisions.
5. "Discretionary Subfund" shall mean that portion of the South Carolina Opioid Recovery Fund from which the Board will allocate amounts on a discretionary basis as set forth in **Exhibit A** hereto.

6. “Guaranteed Political Subdivision Subfund” shall mean that portion of the South Carolina Opioid Recovery Fund from which the Board will direct payments as requested by the Political Subdivisions for Approved Abatement Strategies as set forth in **Exhibit A** hereto.
7. “Litigating Political Subdivision” means a Political Subdivision that filed suit in federal court or the state courts of the State of South Carolina prior to the Execution Date of this Agreement.
8. “National Fund” shall mean any nationwide fund(s) established for the payment of opioid attorney’s fees and costs as part of any Opioid-Related Settlements and in which counsel for the South Carolina Political Subdivisions are eligible to participate.
9. “Opioid-Related Settlement(s)” shall mean the negotiated resolution of legal or equitable claims involving the manufacture, marketing, promotion, distribution, dispensing, or supply of an opioid product against a Pharmaceutical Supply Chain Participant that includes the State and Political Subdivisions as plaintiffs or claimants.
10. “Opioid Funds” and “Opioid Settlement Funds” shall mean any monetary amount(s) obtained in the State of South Carolina through any Opioid-Related Settlement(s) as defined in this Agreement. For the avoidance of doubt, this term does not include the “Additional Restitution Amount” paid to the State of South Carolina by Janssen in lieu of attorneys’ fees.
11. “The Parties” shall mean the State of South Carolina and the Political Subdivisions.
12. “Pharmaceutical Supply Chain” shall mean the process and channels through which opioids or opioid products are manufactured, marketed, promoted, distributed, dispensed, or supplied.
13. “Pharmaceutical Supply Chain Participant” shall mean Purdue Pharma, L.P.; Purdue Pharma, Inc.; the Purdue Frederick Company; McKesson Corporation; Cardinal Health, Inc.; AmerisourceBergen Drug Corporation; Johnson & Johnson; Ortho-McNeil-Janssen Pharmaceuticals, Inc., n/k/a Janssen Pharmaceuticals, Inc.; Janssen Pharmaceutical, Inc. n/k/a Janssen Pharmaceuticals, Inc.; Janssen Pharmaceuticals, Inc.; Mallinckrodt plc; Mallinckrodt LLC; and/or SpecGX LLC.
14. “The Plaintiffs’ Liaison Committee” shall mean the Plaintiffs’ Liaison Committee established by the *In re South Carolina Opioid Litigation* Court.
15. “Political Subdivision(s)” or “Subdivisions” shall mean any South Carolina county or municipality that participates in one or more Opioid-Related Settlements.
16. “SFAA” shall mean the State Fiscal Affairs Authority, the state agency under which the South Carolina Opioid Recovery Fund Board will be organized and operate.
17. “South Carolina Opioid Fee Fund” shall mean a fund for the monetary amounts allocated for the fair compensation of all counsel for Litigating Political Subdivisions and certain counsel for the State. The South Carolina Opioid Fee Fund shall be funded pursuant to the terms of this Agreement.

18. “South Carolina Opioid Recovery Fund” shall mean those settlement proceeds that shall be allocated and distributed by the Board pursuant to the terms of this Agreement.
19. “The State” shall mean the State of South Carolina acting through its Attorney General.

II. Allocation of Opioid Settlement Funds

1. This Agreement is a State-Subdivision Agreement for purposes of any Opioid-Related Settlements. The Parties recognize that the terms of Opioid-Related Settlements contain default intra-state allocation provisions, and this Agreement is expressly intended to supersede any default allocation set forth in any Opioid-Related Settlements.
2. All Opioid Settlement Funds shall be divided pursuant to the terms of this Agreement and its Exhibits.
3. All Opioid Settlement Funds shall initially be paid directly to the Office of the South Carolina State Treasurer (“Treasurer”), which shall thereafter immediately disburse the Opioid Settlement Funds as set further set forth in Paragraph II.4, below.
4. The Treasurer shall disburse all Opioid Settlement Funds, in the following manner:
 - a. To the South Carolina Opioid Recovery Fund to be administered by the Board pursuant to the terms of this Agreement, in the following manner:
 - i. For Opioid Settlement Funds paid by a Pharmaceutical Supply Chain Participant in 2021 through 2027, eighty-two percent (82%);
 - ii. For Opioid Settlement Funds paid by a Pharmaceutical Supply Chain Participant in 2028 or thereafter, one hundred percent (100%).
 - b. To the South Carolina Opioid Fee Fund for the payment of attorney’s fees and unreimbursed expenses of outside counsel for the State and the Political Subdivisions, to be administered as set forth in Section III, in the following manner:
 - i. For Opioid Settlement Funds paid by a Pharmaceutical Supply Chain Participant in 2021 through 2027, eighteen percent (18%);
 - ii. For Opioid Settlement Funds paid by a Pharmaceutical Supply Chain Participant in 2028 or thereafter, zero percent (0%).
 - c. In the event that the South Carolina Opioid Fee Fund cannot be funded fully without violating a court order or settlement agreement involving a Pharmaceutical Supply Chain Participant, the South Carolina Opioid Fee Fund shall be funded to the maximum amount permissible.
5. The South Carolina Opioid Recovery Fund shall be divided into the Guaranteed Political Subdivision Subfund and the Discretionary Subfund, and the Board shall transfer funds into each in the following manner:

- a. For Opioid Settlement Funds paid by a Pharmaceutical Supply Chain Participant in 2021 through 2029, eighty-five percent (85%) to the Guaranteed Political Subdivision Subfund and fifteen percent (15%) to the Discretionary Subfund;
 - b. For Opioid Settlement Funds paid by a Pharmaceutical Supply Chain Participant in 2030 or thereafter, fifty percent (50%) to the Guaranteed Political Subdivision Subfund and fifty percent (50%) to the Discretionary Subfund.
6. Funds obtained by the State or a Political Subdivision via grant, bequest, gift, or the like, separate and distinct from the Litigation, may be directed by the State or the Political Subdivisions to the South Carolina Opioid Recovery Fund and disbursed as set forth in this Agreement, but neither the State nor the Political Subdivision receiving any such funds is under any obligation to do so.
7. Nothing in this Agreement is intended to alter or change any Political Subdivision's rights to pursue its own claim, other than claims released as part of the settlements contemplated herein. Rather, the intent of this Agreement is to reflect the Parties' agreement on allocation with respect to any settlement involving the Parties and the Pharmaceutical Supply Chain Participants defined herein.
8. The State of South Carolina directs that the "Additional Restitution Amount" paid by Janssen in lieu of attorneys' fees shall be distributed as follows:
 - a. Eighty percent (80%) to the Discretionary Subfund; and
 - b. Twenty percent (20%) to the Guaranteed Political Subdivision Subfund for the sole and exclusive use of the Kershaw County Hospital Board d/b/a The Health Services District of Kershaw County, and otherwise subject to the same terms as other funds in the Guaranteed Political Subdivision Subfund.

III. Payment of Counsel and Litigation Expenses

1. The Parties recognize that the Opioid-Related Settlements contemplated in this Agreement will likely result in the establishment of one or more National Funds for attorney's fees and costs and the availability of these funds substantially increases the amount of Opioid Settlement Funds available for Approved Abatement Strategies in South Carolina.
2. Therefore, in order to maximize the Opioid Settlement Funds available for Approved Abatement Strategies, and in lieu of enforcing their fee agreements as to any Opioid-Related Settlement, counsel for the Litigating Political Subdivisions and the State agree to accept fees as set forth herein.
3. The Parties agree that all attorney's fees and costs owed by the Litigating Political Subdivisions and the State to their counsel as a result of the Opioid-Related Settlements shall be paid only out of any National Fund and the South Carolina Opioid Fee Fund, as provided herein.

4. Counsel for the Litigating Political Subdivisions and the State shall first seek attorney's fees and costs from all National Funds at the earliest possible opportunity. Any award of attorney's fees and costs from a National Fund to counsel for the Litigating Political Subdivisions or the State shall be separate from the South Carolina Opioid Fee Fund.
5. In no event shall total attorney's fees paid to counsel for the Litigating Political Subdivisions and the State from Opioid Settlement Funds, exclusive of funds received from any National Fund, exceed eight percent (8%) of the Opioid Settlement Funds.
 - a. In no event shall attorney's fees paid to counsel for the Litigating Political Subdivisions from Opioid Settlement Funds, exclusive of funds received from any National Fund, exceed five and fifteen hundredths percent (5.15%) of the Opioid Settlement Funds.
 - b. In no event shall attorney's fees paid to counsel for the State from Opioid Settlement Funds, exclusive of funds received from any National Fund, exceed two and eighty-five hundredths percent (2.85%) of the Opioid Settlement Funds.
6. Funds in the South Carolina Opioid Fee Fund shall be distributed to and among counsel for the Litigating Political Subdivisions and the State pursuant to either a future written agreement by eligible counsel or, if no agreement is reached after twelve (12) months, in accordance with subparagraphs (e) and (f). These funds shall be divided between counsel for the Litigating Political Subdivisions and counsel for the State as follows:
 - a. For funds in the South Carolina Opioid Fee Fund paid by a Pharmaceutical Supply Chain Participant in 2021, thirty-five percent (35%) to counsel for the State and sixty-five percent (65%) to counsel for the Litigating Political Subdivisions;
 - b. For funds in the South Carolina Opioid Fee Fund paid by a Pharmaceutical Supply Chain Participant in 2022, thirty-five point zero eight zero six nine nine four percent (35.0806994%) to counsel for the State and sixty-four point nine one nine three zero zero six percent (64.9193006%) to counsel for the Litigating Political Subdivisions; and
 - c. For funds in the South Carolina Opioid Fee Fund paid by a Pharmaceutical Supply Chain Participant in 2023 through 2027, thirty-six percent (36%) to counsel for the State and sixty-four percent (64%) to counsel for the Litigating Political Subdivisions.
 - d. Counsel for the State shall jointly submit a written fee split arrangement to the Attorney General for approval prior to receiving any funds.
 - e. Unless agreed otherwise by all counsel for the Litigating Political Subdivisions, attorney's fees payable to counsel for the Litigating Political Subdivisions shall be distributed pro rata in accordance with their respective clients' percentage of the Litigating Political Subdivisions' total recovery from the Guaranteed Political Subdivision Subfund, as set forth in **Exhibit B**, and further divided based on the percentages set forth in the respective special counsel agreements for each Litigating Political Subdivision.

- f. Upon petition to the *In re South Carolina Opioid Litigation* Court, up to 5% of the portion of the South Carolina Opioid Fee Fund that is allocated to counsel for the Litigating Political Subdivisions may be available to attorneys demonstrating efforts that helped effectuate results for the common benefit of all Litigating and Non-Litigating Political Subdivisions.
- g. To the extent there is an Order imposing a common benefit assessment over Opioid Related Settlements as defined herein against Litigating Political Subdivisions involved in the federal opioid MDL, Counsel for those Litigating Political Subdivisions involved in the federal opioid MDL must ensure that their client's share of those obligations are satisfied as a condition to participation in the South Carolina Opioid Fee Fund. Nothing in this provision shall be interpreted as holding any Litigating Political Subdivision or their counsel liable for any common benefit assessments owed by any other Litigating Political Subdivision or their counsel.
- h. The *In re South Carolina Opioid Litigation* Court shall issue a final order approving the allocation of attorney's fees and retain jurisdiction in the event of any fee disputes.

IV. The South Carolina Opioid Recovery Fund and the South Carolina Opioid Recovery Fund Board

- 1. The South Carolina Opioid Recovery Fund and the South Carolina Opioid Recovery Fund Board are described in detail in **Exhibit A** hereto, incorporated herein by reference.

V. Settlement

- 1. Any Opioid-Related Settlement shall be subject to the approval and jurisdiction of the *In re South Carolina Opioid Litigation* Court.

VI. Amendments

- 1. The Parties agree to make such amendments as are necessary to implement the intent of this agreement.

VII. Other Terms

- 1. *Further Approval.* This Agreement is subject to further approval by the *In re South Carolina Opioid Litigation* Court. The Parties will collectively work on enabling legislation necessary to support the terms of this Agreement.
- 2. *Severability.* The invalidity or unenforceability of any provision(s) of this Agreement shall not affect the other provisions, and this Agreement shall be construed in all respects as if any invalid or unenforceable provisions were omitted.
- 3. *Jurisdiction.* This Agreement is subject to and shall be governed by and interpreted in accordance with the laws of the State of South Carolina. The *In re South Carolina Opioid Litigation* Court shall have continuing jurisdiction to enforce the provisions of this Agreement.

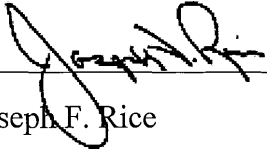
4. *No Construction Against Drafter.* No provision of this Agreement shall be construed against or interpreted to the disadvantage of any Party hereto by reason of such party having drafted such provision.
5. *Counterparts.* This Agreement may be executed in any number of counterparts, each of which constitutes an original, and all of which, collectively, constitute only one Agreement. Delivery of any executed counterpart signature page by facsimile or electronic mail is as effective as executing and delivering the original.

Attorney General of South Carolina

Alan Wilson

Alan Wilson

Date: 2/9/22



Joseph F. Rice

Motley Rice LLC

Counsel for the State of South Carolina

Date: 1/28/2022

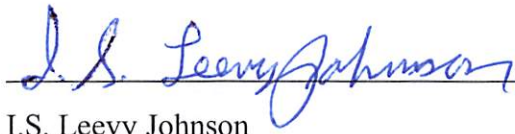
Karl S. Bowers

Karl S. Bowers, Jr.

Bowers Law Office LLC

Counsel for the State of South Carolina

Date: 2-4-22

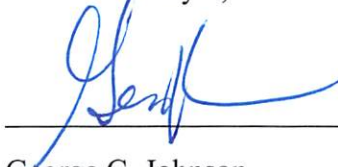


I.S. Leevy Johnson

Johnson, Toal & Battiste, P.A.

Counsel for the State of South Carolina

Date: February 3, 2022



George C. Johnson

Johnson, Toal & Battiste, P.A.

Counsel for the State of South Carolina

Date: February 2, 2022

J. Stephen Schmutz

J. Stephen Schmutz

Schmutz & Schmutz, PA

Date: Feb 3 2022



Paul R. Thurmond

Thurmond Kirchner and Timbes, P.A.

Counsel for the State of South Carolina

Date: 2/4/22



James E. Smith, Jr.

James E. Smith, Jr., P.A.

Counsel for the State of South Carolina

Date: February 4, 2022:



James W. Fayssoux, Jr.

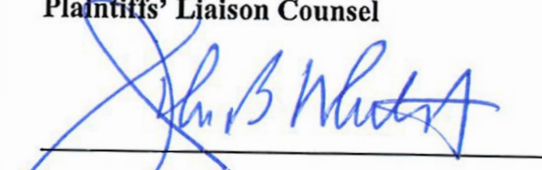
Fayssoux & Landis, P.A.

Counsel for the State of South Carolina

Date:

2/8/2012

Plaintiffs' Liaison Counsel



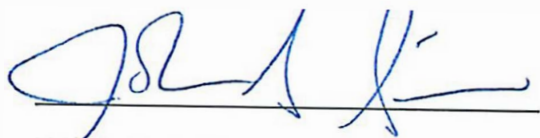
John B. White, Jr.

Date: Jan 26, 2022



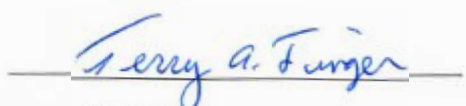
Joseph J. Cappelli

Date: January 26, 2022



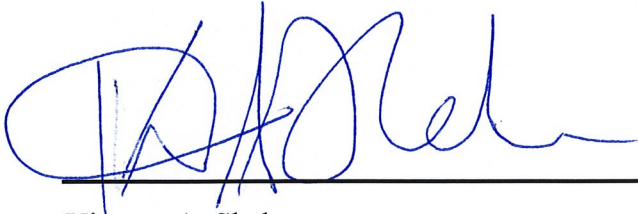
John S. Simmons

Date: Jan. 26, 2022



Terry A. Finger

Date: 1/26/22



Vincent A. Sheheen

Counsel for:

Chesterfield County

Kershaw County

Lee County

Fairfield County

Kershaw Health District

Date: 2/19/22



Philip C. Federico

Brent Ceryes

Schochor, Federico & Staton, P.A.

*Counsel for Charleston County, South Carolina; Richland County, South Carolina;
Georgetown County, South Carolina; City of Georgetown, South Carolina; City of
Orangeburg, South Carolina; City of Chester, South Carolina*

Date: 01/26/2022



Paul Novak

Weitz & Luxenberg P.C.

Counsel for Berkeley County, South Carolina

Date: 1/26/22

EXHIBIT A

SOUTH CAROLINA OPIOID RECOVERY FUND

As part of the South Carolina Opioid Settlement Allocation Agreement and upon its execution, the Parties, by and through the *In re South Carolina Opioid Litigation Court*, and in contemplated enabling legislation which supports the terms of this Agreement, will form the South Carolina Opioid Recovery Fund Board to manage and disburse the South Carolina Opioid Recovery Fund as set forth in this Agreement for Approved Abatement Strategies.

I. Structure

The Board will be formed when the *In re South Carolina Opioid Litigation Court* enters an order approving this Agreement, and appropriate enabling legislation authorizing the Board under South Carolina law and approving its disbursement of the Opioid Funds pursuant to the terms of this Agreement is signed by the Governor. Such enabling legislation shall not contradict or otherwise be inconsistent with the terms of this Agreement, any Opioid-Related Settlement, or any applicable court order.

A. Membership

The Board shall be comprised of the following nine (9) members, who shall be appointed as follows:

- One member, who shall serve as Chair of the Board, shall be appointed by the Governor;
- One member will be appointed by the President Pro Tempore of the Senate;
- One member will be appointed by the Speaker of the House;
- Five members shall be appointed by the counties of South Carolina, with at least one member from each of the South Carolina Public Health Regions as defined by the South Carolina Department of Health and Environmental Control;¹ and
- One member shall be appointed by the cities of South Carolina.

The members appointed by the Association of Counties and the Municipal Association of South Carolina shall name one of their members to serve as Vice-Chair of the Board.

¹ Those regions are the **Upstate** (consisting of Oconee, Pickens, Anderson, Greenville, Spartanburg, Cherokee, Union, Laurens, Abbeville, Greenwood, and McCormick counties); the **Midlands** (consisting of York, Chester, Lancaster, Fairfield, Kershaw, Newberry, Saluda, Lexington, Richland, Edgefield, and Aiken counties); the **Pee Dee** (consisting of Chesterfield, Marlboro, Lee, Darlington, Dillon, Florence, Marion, Sumter, Clarendon, Williamsburg, Georgetown, and Horry counties), and the **Low Country** (consisting of Calhoun, Orangeburg, Barnwell, Bamberg, Allendale, Hampton, Colleton, Dorchester, Berkeley, Charleston, Jasper, and Beaufort counties).

1. *Qualifications of Members.*

All members of the Board shall be academic, medical, licensed health, or other professionals with significant experience in opioid intervention, treatment, or prevention. In addition, best efforts will be made to identify and appoint one or more Board members who can represent the interests of the victims of opioid overuse or misuse and their families.

2. *Appointment of Initial Members*

The Board's initial members must be appointed within sixty (60) days of the date the order is entered, unless otherwise specified by legislation.

3. *Legal Counsel for the Board.*

The Attorney General shall appoint an attorney from the Attorney General's Office to serve as legal counsel to the Board. The attorney shall not have any voting rights, but he or she will provide legal advice to the Board upon request and shall otherwise ensure that the Board appropriately follows the provisions of this Agreement, the Opioid-Related Settlements, and all applicable laws and court orders.

4. *Conflicts of Interest*

Board members must disclose to the Board, refrain from participating in discussions, and recuse themselves from voting on any matter before the Board if the member has a conflict of interest. A conflict of interest means a financial association that has the potential to bias or have the appearance of biasing a Board member's decision related to the grant decision process or other Board activities.

B. Terms

All members of the Board will be appointed to serve staggered four-year terms, with the terms of members commencing on April 1 and expiring on March 31 of the relevant years. For the first term, four (4) of the members appointed by the counties, as well as the Chair of the Board appointed by the Governor, will serve six-year terms. A vacancy on the Board shall be filled for the unexpired term in the same manner as the original appointment.

C. Governance

1. *Administration*

The Board is an independent, quasi-governmental agency responsible for the statewide distribution of the South Carolina Opioid Recovery Fund. The Board is exempt from the following statutes: the S.C. Consolidated Procurement Code, S.C. Code Ann. § 11-35-10 et seq. [*others to be added if necessary*].

2. *Transparency*

The Board will abide by state laws relating to open meetings and public information, including Title 30, Chapter 4 of the South Carolina Code (the Freedom of Information Act).

- a. The Board shall hold at least four regular meetings each year. The Board may hold additional meetings on the request of the Chair or on the written request of five other members of the Board. All meetings shall be open to the public, and public notice of meetings shall be given as required by state law.
- b. The Board may convene in a closed, non-public meeting pursuant to section 30-4-70 of the South Carolina Code. All minutes and documents of a closed meeting shall remain under seal, subject to release only upon order of a court of competent jurisdiction.

3. *Authority*

The Board has general rulemaking authority to establish its governing regulations and bylaws. However, the terms of this Agreement, enabling legislation, any order by the *In re South Carolina Opioid Litigation* Court, and the terms of any Opioid-Related Settlement control the authority of the Board, and the Board may not stray outside the bounds of the authority and power vested by such terms. The Board may seek amendments and modifications to this Agreement and to applicable laws and court orders as needed to carry out its responsibilities, but the Board may not seek to modify the allocations provided for in this Agreement, including the amounts paid into the Guaranteed Political Subdivision Subfund and the Discretionary Subfund. Additionally, the Board may not seek to modify the allocations provided for in **Exhibit B** to this Agreement.

D. Operation and Expenses

The Board shall establish one or more accounts for the management of the South Carolina Opioid Recovery Fund, the Guaranteed Political Subdivision Subfund, and the Discretionary Subfund, including for administrative purposes. Upon written request, the South Carolina Treasurer will disburse money into each of these accounts as directed by the Board, so long as such disbursement does not contradict the terms of this Agreement.

The Board may receive up to one percent (1%) of the South Carolina Opioid Recovery Fund for costs and expenses associated with their administration of the Guaranteed Political Subdivision Subfund and the Discretionary Subfund. These costs and expenses include educational activities, staff and equipment costs, as well as costs associated with developing a grant application process, transferring funds to grant recipients, reviewing grant submissions, publishing information to the public, and reporting as required under the Opioid-Related Settlements. This amount may also be used to reimburse Board members for reasonable costs and expenses associated with travel necessary to attend Board meetings and perform Board duties. A member of the Board may be reimbursed for actual expenses for meals, lodging, transportation, and incidental expenses in accordance with travel rates set by the South Carolina Comptroller General. The Board shall prepare an annual budget for administration costs and expenses to ensure proposed expenditures fall within these parameters and publish an annual report of these expenditures.

II. **Duties/Roles**

The Board shall develop all needed written materials in order to carry out its duties under this Agreement and enabling legislation. The duties and roles of the Board with respect to the Guaranteed Political Subdivision Subfund are ministerial only, and the Board has no discretion

with respect to disbursing amounts allocated to the Political Subdivisions so long as the Political Subdivision's application seeks funding for one of more of the Approved Abatement Strategies set forth in **Exhibit C**.

A. Guaranteed Political Subdivision Subfund

Each Political Subdivision will be allocated funds from the Guaranteed Political Subdivision Subfund on an annual basis pursuant to the percentages in **Exhibit B**. However, a Political Subdivision's available allocation shall be calculated based only on the Opioid-Related Settlements in which that Political Subdivision participates. To the extent a Political Subdivision does not participate in an Opioid-Related Settlement, the Board shall transfer the share assigned to that Political Subdivision to the Discretionary Subfund.

Any money allocated to a Political Subdivision in a given year which is unused at the end of that year will remain available to that Political Subdivision for three (3) additional years, after which the money shall be moved to the Discretionary Subfund. A Political Subdivision can elect to have some or its entire allocated share transferred to the Discretionary Subfund by informing the Board in writing of this election.

In the event a Political Subdivision merges, dissolves, or ceases to exist, the allocation percentage for that Political Subdivision shall be transferred by the Board to the Discretionary Subfund.

Requests for funding from the Guaranteed Political Subdivision Subfund shall be approved by the Board if the following requirements are met:

- The request is made by a Political Subdivision or by another entity with the explicit written approval of a Political Subdivision;
- The request seeks funding for an Approved Abatement Strategy listed on **Exhibit C**; and
- Sufficient funds are available for use by that Political Subdivision.

The Board shall make best efforts to review and approve these requests as quickly as possible, but the Board shall approve or reject the request no later than forty-five (45) days following receipt of the application. If the request is approved, the Board shall direct the disbursement of the funds as requested by the Political Subdivision. The Board shall have the ***mandatory ministerial obligation*** to distribute funds to the Political Subdivision upon receipt and review of an application that meets the requirements set forth herein.

The Board and the recipients of funds will comply with any reporting obligations established in any Opioid-Related Settlements. The Court shall have continuing jurisdiction to ensure that the funds are used for their approved purpose, and the Court shall have jurisdiction to enforce any reporting requirements in the Opioid-Related Settlements and any requirements of this Agreement.

B. Discretionary Subfund

The Board will use the Approved Abatement Strategies listed in **Exhibit C** for considering applications for funding from the Discretionary Subfund. The Board shall not approve any funding request unless it is for an Approved Abatement Strategy.

The Board shall publish a list of eligibility requirements for applications for funding. Unlike the Guaranteed Political Subdivision Subfund, requests for funding from the Discretionary Subfund need not be made by a Political Subdivision or on its behalf. By way of examples only, requests for funding from the Discretionary Subfund could be made by state agencies, medical treatment providers, mental health treatment providers, educational providers, legal services providers, researchers, nonprofits, and any other person or entity for an Approved Abatement Strategy, subject to the Board's eligibility requirements.

In addition to ensuring that the request is for an Approved Abatement Strategy, the following non-exhaustive general criteria shall be weighed by the Board in considering and approving grants upon application to the Discretionary Fund:

1. Whether a requesting subdivision was a South Carolina Bellwether Plaintiff;
2. Whether the requesting subdivision was a Litigating Subdivision;
3. The cooperative and regional nature of a proposal (whether one or more subdivisions and/or non-government partners are applying jointly to address regional concerns);
4. The poverty level of the subdivision at issue;
5. The extent of direct payments received by municipalities within a County; and
6. Any other special needs described in the application relative to opioid use, abuse, opioid related crime, or unique abatement needs or strategies.

The Board will also develop metrics to evaluate the success of programs funded by the South Carolina Opioid Recovery Fund, and shall publish an annual report which details the expenditures, outcomes, and performance of each funded program in relation to the performance metrics the Board has established. The first report shall be published no later than July 1, 2023, with future annual reports to be published each year by July 1. The Board shall also develop any reports required by any Opioid-Related Settlement or any court or trust directing money into the South Carolina Opioid Recovery Fund.

Political Subdivisions are permitted and encouraged to seek funds from the Discretionary Subfund both for additional projects and to supplement projects funded by the Guaranteed Political Subdivision Subfund.

C. South Carolina Opioid Recovery Fund Point of Contact

The Board is the sole entity authorized to receive requests for funds in South Carolina and to order the release of funds from the South Carolina Opioid Recovery Fund, subject to the terms of this Agreement and any orders of the *In re South Carolina Opioid Litigation* Court.

D. Auditor

Audits of the Board's Bank Accounts will be conducted by the State Auditor's Office annually and its findings, if any, will be reported to the Board.

EXHIBIT B

ALLOCATIONS TO SOUTH CAROLINA COUNTIES AND CITIES

The following table is to be used by the Board for the purpose of allocating money in the Guaranteed Political Subdivision Subfund to the counties and cities of South Carolina:

SC1	Abbeville County, South Carolina	0.3350059823%
SC2	Aiken City, South Carolina	0.7838026892%
SC3	Aiken County, South Carolina	2.5661670597%
SC4	Allendale County, South Carolina	0.1220441823%
SC5	Anderson City, South Carolina	1.1735303052%
SC6	Anderson County, South Carolina	3.3392231904%
SC7	Bamberg County, South Carolina	0.2705913372%
SC8	Barnwell County, South Carolina	0.4653224769%
SC9	Beaufort City, South Carolina	0.0769982478%
SC10	Beaufort County, South Carolina	2.3364418352%
SC11	Berkeley County, South Carolina	2.0961440294%
SC12	Bluffton Town, South Carolina	0.0481968917%
SC13	Calhoun County, South Carolina	0.1833260393%
SC14	Cayce City, South Carolina	0.2572136960%
SC15	Charleston City, South Carolina	2.3004340552%
SC16	Charleston County, South Carolina	3.8016438488%
SC17	Cherokee County, South Carolina	0.9440700745%
SC18	Chester City, South Carolina	0.1299573133%
SC19	Chester County, South Carolina	0.3947965211%
SC20	Chesterfield County, South Carolina	0.9443488664%
SC21	Clarendon County, South Carolina	0.5705383575%
SC22	Clemson City, South Carolina	0.3311616877%
SC23	Colleton County, South Carolina	0.8589365535%
SC24	Columbia City, South Carolina	2.3918060702%
SC25	Conway City, South Carolina	0.2894739402%
SC26	Darlington County, South Carolina	1.6906462867%
SC27	Dillon County, South Carolina	0.6608411417%
SC28	Dorchester County, South Carolina	1.6015765975%
SC29	Easley City, South Carolina	0.8565835771%
SC30	Edgefield County, South Carolina	0.3586097074%
SC31	Fairfield County, South Carolina	0.3536421891%
SC32	Florence City, South Carolina	1.0065336904%
SC33	Florence County, South Carolina	2.2059006272%
SC34	Forest Acres City, South Carolina	0.0995929056%
SC35	Fort Mill Town, South Carolina	0.1714974802%
SC36	Fountain Inn City, South Carolina	0.1975697094%
SC37	Gaffney City, South Carolina	0.2044353782%
SC38	Georgetown City, South Carolina	0.2626233562%
SC39	Georgetown County, South Carolina	1.1895098900%
SC40	Goose Creek City, South Carolina	0.5473575768%

SC41	Greenville City, South Carolina	2.2705648395%
SC42	Greenville County, South Carolina	7.1502328364%
SC43	Greenwood City, South Carolina	0.0308220618%
SC44	Greenwood County, South Carolina	1.3388944490%
SC45	Greer City, South Carolina	0.5590564672%
SC46	Hampton County, South Carolina	0.3450376919%
SC47	Hanahan City, South Carolina	0.2279684840%
SC48	Hilton Head Island Town, South Carolina	0.2323878458%
SC49	Horry County, South Carolina	5.2166718879%
SC50	Irmo Town, South Carolina	0.0942740906%
SC51	James Island Town, South Carolina	0.0461551887%
SC52	Jasper County, South Carolina	0.4278548317%
SC53	Kershaw County, South Carolina	1.0780892823%
SC54	Lancaster County, South Carolina	1.4809282603%
SC55	Laurens County, South Carolina	1.3598442946%
SC56	Lee County, South Carolina	0.2176621820%
SC57	Lexington County, South Carolina	4.4881391605%
SC58	Lexington Town, South Carolina	0.2342104062%
SC59	Marion County, South Carolina	0.6973242307%
SC60	Marlboro County, South Carolina	0.4878238042%
SC61	Mauldin City, South Carolina	0.4253253929%
SC62	McCormick County, South Carolina	0.1281623493%
SC63	Moncks Corner Town, South Carolina	0.1965426445%
SC64	Mount Pleasant Town, South Carolina	0.5750801889%
SC65	Myrtle Beach City, South Carolina	1.9068234068%
SC66	Newberry City, South Carolina	0.0344864657%
SC67	Newberry County, South Carolina	0.5656551710%
SC68	North Augusta City, South Carolina	0.5139678525%
SC69	North Charleston City, South Carolina	1.7751090959%
SC70	North Myrtle Beach City, South Carolina	0.6366313248%
SC71	Oconee County, South Carolina	2.8099515214%
SC72	Orangeburg City, South Carolina	0.0468940344%
SC73	Orangeburg County, South Carolina	1.4543982912%
SC74	Pickens County, South Carolina	2.8143347165%
SC75	Port Royal Town, South Carolina	0.0206098617%
SC76	Richland County, South Carolina	3.8816723839%
SC77	Rock Hill City, South Carolina	1.3120073555%
SC78	Saluda County, South Carolina	0.2604801809%
SC79	Simpsonville City, South Carolina	0.3497064495%
SC80	Spartanburg City, South Carolina	1.1890308958%
SC81	Spartanburg County, South Carolina	6.4084293395%
SC82	Summerville Town, South Carolina	0.6446011912%
SC83	Sumter City, South Carolina	0.5390642671%
SC84	Sumter County, South Carolina	0.9480995733%
SC85	Tega Cay City, South Carolina	0.0433365022%
SC86	Union County, South Carolina	0.6499524020%

SC87	West Columbia City, South Carolina	0.3943858322%
SC88	Williamsburg County, South Carolina	0.4931357629%
SC89	York County, South Carolina	2.5800878865%

EXHIBIT C

LIST OF APPROVED OPIOID REMEDIATION USES

All funds in the South Carolina Opioid Recovery Fund must be used for one or more of the following approved opioid remediation uses. Priority shall be given to the following core abatement strategies (“Core Strategies”).

Schedule A

Core Strategies

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

1. Expand training for first responders, schools, community support groups and families; and
2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. MEDICATION-ASSISTED TREATMENT (“MAT”) DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;
2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;
3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and
4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

C. PREGNANT & POSTPARTUM WOMEN

1. Expand Screening, Brief Intervention, and Referral to Treatment (“SBIRT”) services to non-Medicaid eligible or uninsured pregnant women;
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder (“OUD”) and other Substance Use Disorder (“SUD”)/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and
3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

D. EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME (“NAS”)

1. Expand comprehensive evidence-based and recovery support for NAS babies;
2. Expand services for better continuum of care with infant-need dyad; and

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

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

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;
2. Expand warm hand-off services to transition to recovery services;
3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;
4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and
5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. TREATMENT FOR INCARCERATED POPULATION

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

G. PREVENTION PROGRAMS

1. Funding for media campaigns to prevent opioid use (similar to the FDA’s “Real Cost” campaign to prevent youth from misusing tobacco);
2. Funding for evidence-based prevention programs in schools;
3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);
4. Funding for community drug disposal programs; and
5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. EXPANDING SYRINGE SERVICE PROGRAMS

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

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

Schedule B

Approved Uses

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

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

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

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (“MAT”) approved by the U.S. Food and Drug Administration.
2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (“ASAM”) continuum of care for OUD and any co-occurring SUD/MH conditions.
3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.
4. Improve oversight of Opioid Treatment Programs (“OTPs”) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.
5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.
6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.
7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.
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 medication with other support services.
5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.
6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.
7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.
8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.
9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.
11. 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:
 - a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (“*PAARP*”);
 - b. Active outreach strategies such as the Drug Abuse Response Team (“*DART*”) model;
 - c. “Naloxone Plus” strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;
 - d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (“*LEAD*”) model;
 - e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or
 - f. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.
2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.
3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.
4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison 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 (“CTP”), 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:
 - a. Increase the number of prescribers using PDMPs;
 - b. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or
 - c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.
6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation’s Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.
7. 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.