IOWA OPIOID ALLOCATION
MEMORANDUM OF UNDERSTANDING

A. Definitions

As used in this Memorandum of Understanding ("MOU" or "Agreement"):

1. "Local Government" shall mean all Iowa Counties (regardless of population) and cities, villages, and towns located within the geographic boundaries of the State of Iowa with a population exceeding 10,000.[1]

2. "Opioid Funds" shall mean monetary amounts obtained through a Settlement as defined in this MOU, including amounts obtained under Sections IV and V of the Distributor Master Settlement Agreement and Sections V and VI of the J&J Master Settlement Agreement. Separate amounts allocated to the State as restitution pursuant to Sections IX of the Distributor Master Settlement Agreement and Sections X of the J&J Master Settlement Agreement and amounts for reimbursement of attorneys' fees and costs as set forth in Sections X of the Distributor Master Settlement Agreement and Section XI of the J&J Master Settlement Agreement and from similar state specific or private attorneys' fees funds created by other Settlements are not "Opioid Funds." For avoidance of doubt, payments to the Iowa Backstop Fund will be paid out of Opioid Funds as more specifically set forth in Section D of this MOU.

3. "Opioid Related Expenditure" shall mean an expenditure consistent with the categories enumerated in Exhibit E to the Distributor Master Settlement Agreement and the J&J Master Settlement Agreement found at https://nationalopioidsettlement.com/ and attached hereto as Exhibit 1.

4. "Parties" shall mean the State of Iowa and Participating Local Governments.

5. "Pharmaceutical Supply Chain Participant" shall mean any entity that engages in or has engaged in the manufacture, marketing, promotion, distribution or dispensing of an opioid analgesic, including but not limited to those persons or entities identified as Defendants in the matter captioned *In re: Opioid Litigation*, MDL 2804 pending in the United States District Court for the Northern District of Ohio.

6. "Participating Local Government" is any Local Government that agrees to be bound by a Settlement by Participation Agreement necessary to effectuate that Settlement or other similar document.

7. "Settlement" shall mean the negotiated resolution of legal or equitable claims regarding opioids against a Pharmaceutical Supply Chain Participant when that resolution has been

[1] The population figures contained in this MOU shall be derived from the published U.S. Census Bureau's population estimates for July 1, 2019, released May 2020 as set for in the Distributor Master Settlement Agreement and the J&J Master Settlement Agreement.

jointly entered into by the Parties. For avoidance of doubt, a Settlement shall not include (i) any negotiated resolution of legal or equitable claims between the State and a Supply Chain Participant that is unrelated to the claims at issue in the matter captioned *In re: Opioid Litigation*, MDL 2804 pending in the United States District Court for the Northern District of Ohio or (ii) any negotiated resolution of legal or equitable claims between the State and a Supply Chain Participant that requires the Parties to allocate settlement proceeds in a specific manner or using specified allocation percentages inconsistent with this MOU

8. "Master Settlement Agreement" shall mean the agreements documenting a Settlement. For the purposes of this MOU the Distributor Master Settlement Agreement and the J&J Master Settlement Agreement found at https://nationalopioidsettlement.com/ are Master Settlement Agreements under the meaning of this MOU.

9. "State" shall mean the State of Iowa.

B. Allocation of the Opioid Settlement Proceeds

1. Opioid Funds shall be allocated as follows: (i) 50% to the Iowa Abatement Fund ("Iowa Abatement Share") and (ii) 50% to Participating Local Governments, less fees and costs allocated to the Iowa Backstop Fund as set forth in Section D ("LG Abatement Share").

2. The Participating Local Governments may elect to use a Settlement Administrator ("Settlement Administrator") to receive and distribute Opioid Funds allocated to the LG Abatement Share pursuant to this MOU.

3. Opioid Funds shall not be considered funds of the Iowa Abatement Fund or any Local Government unless and until such time as an allocation is made to the Iowa Abatement Fund or any Participating Local Government pursuant to this Section.

4. The LG Abatement Share shall be distributed in direct payments to the Counties that are Participating Local Governments according to the National Negotiation Class Formula, in the amounts set forth on Exhibit 2 ("Direct Distribution Amount").

5. A County may elect to forego its Direct Distribution Amount by notifying the Settlement Administrator in writing of its decision. If a County makes an election to forego its Direct Distribution Amount, that amount reverts to the LG Abatement Share unless the County specifically designates that its share should revert to the Iowa Abatement Share.

6. Except as provided herein, nothing shall prohibit a County from sub-allocating any portion of its Direct Distribution Amount to the Iowa Abatement Fund or to a City that is a Participating Local Government within its jurisdiction provided, however, that the Iowa Abatement Fund or City must expend any such sub-allocation only on an Opioid Related Expenditure.

7. If a County sub-allocates Opioid Funds to a City within its jurisdiction, such suballocation shall be made according to an agreement between the County and the City requiring the use of the suballocated funds for an Opioid Related Expenditure and further providing that a use of funds inconsistent with an Opioid Related Expenditure shall make the funds subject to recoupment and otherwise disqualify the City from a future sub-allocation.

8. Except as provided herein, 100% of the Iowa Abatement Share and the LG Abatement Share, regardless of allocation, shall be utilized only for Opioid Related Expenditures incurred after the Effective Date of this MOU. The list of approved Opioid Related Expenditures are set forth in Exhibit 1 to this MOU . The Parties agree that at least 75% of the Iowa Abatement Share and the LG Abatement Share shall be utilized for only the "Core Strategies" listed in Schedule A of Exhibit 1 to this MOU.

9. The Parties may use up to 2.5% of the Iowa Abatement Share and the LG Abatement Share for administrative costs for Opioid Related Expenditures.

C. Compliance Reporting and Accountability

1. Every Participating Local Government that receives a Direct Distribution Amount shall create a separate fund on its financial books and records that is designated for the receipt and expenditure of the entity's Direct Distribution Amount, called the "LG Abatement Fund." Funds in an LG Abatement Fund shall not be commingled with any other money or funds of the Participating Local Government. A Participating Local Government may invest LG Abatement Fund funds consistent with the investment of other funds of a Participating Local Government.

2. Funds in a LG Abatement Fund may be expended by a Participating Local Government only for Opioid Related Expenditures. For avoidance of doubt, funds in a LG Abatement Fund may not be expended for costs, disbursements or payments made or incurred prior to the Settlement.

3. Each LG Abatement Fund shall be subject to audit in a manner consistent with Code of Iowa §§331.402(2)(i) and 11.6. Any such audit shall be a financial and performance audit to ensure that the LG Abatement Fund disbursements are consistent with the terms of this MOU. If any such audit reveals an expenditure inconsistent with the terms of this MOU, the Participating Local Government shall immediately redirect the funds associated with the inconsistent expenditure to an Opioid Related Expenditure.

4. Reporting

    a. Each Participating Local Government that receives a Direct Distribution Amount must prepare and file a public annual report describing the expenditure of its Direct Distribution Amount. The report shall include, though is not limited to, a

narrative description of the funded programs; the dollar amount provided; and progress and/or outcomes of funded programs. Participating Local Governments may work together to prepare and file joint reports if they so choose.

b. A Participating Local Government taking a suballocation of some amount of its Direct Distribution Amount pursuant to Section B(7) is responsible for including the expenditure of those funds and outcomes from those expenditures in the annual report required by Section C(4)(a), above.

c. The State may utilize the reports in order to report to the public on the use and effectiveness of the Opioid Funds in addressing the opioid crisis in Iowa.

5. Two or more Participating Local Governments may combine their respective Direct Distribution Amounts.

6. Nothing shall prohibit Participating Local Governments from acting alone or together pursuant to Paragraph 5 or from entering into an agreement(s) relating to the securitization of Opioid Funds (and any allocation thereof) that are scheduled under a Settlement to be paid at a future date.

7. Pursuant to Section B of this MOU the Iowa Abatement Fund and all Participating Local Governments shall use 100% of the Iowa Abatement Share and the LG Abatement Share for Opioid Related Expenditures.

D. Payment of Counsel and Opioid Litigation Expenses

1. Sixty-six of the Participating Local Governments ("Litigating Local Governments") have contracted with outside counsel ("Counsel") for representation in litigation against certain Pharmaceutical Supply Chain Participants and Counsel has been representing some of those entities since 2018. The Litigating Local Governments are set forth on Exhibit 2. In consideration for Counsel's representation, each of the Litigating Local Governments entered into a contract with its Counsel for a 25% contingency fee applied to each Litigating Local Government's recovery.

2. The Distributor Master Settlement Agreement and the J&J Master Settlement Agreement provide for the payment of attorneys' fees and legal expenses owed by States and Participating Local Governments to outside counsel retained for litigation against the Defendants in those agreements. To effectuate this, the Court in the MDL Litigation has established a fund to compensate attorneys for services rendered and expenses incurred that have benefitted plaintiffs generally in the litigation (the "National Attorney Fee Fund").

3. Counsel for the Litigating Local Governments intends to make application to the National Attorney Fee Fund. Because there is still uncertainty regarding what Counsel will recover as compensation for the large volume of work done and the large out of pocket expense of the Litigation, and whereas the Litigating Local Governments desire

to fairly compensate Counsel for the work done on behalf of Litigating Local Governments, the Parties agree that the Participating Local Governments will create an Iowa attorneys' fees and costs fund (the "Iowa Backstop Fund") to compensate Counsel only in the event Counsel does not recover from the National Attorney Fee Fund an amount equal to 15 % of the LG Abatement Share attributable to the Litigating Local Governments, less any amounts a Litigating Local Government suballocates to one or more Cities within its jurisdiction ("Net Direct Distribution Amount"). For the avoidance of doubt, collectively, Counsel are limited to being paid, at most, and assuming adequate funds are available under the National Attorney Fee Fund and the Iowa Backstop Fund, attorneys' fees totaling fifteen percent (15%) of the total Net Direct Distribution Amount for all Litigating Local Governments.

4. Counsel must first seek recovery at the National Attorney Fee Fund before applying to the Iowa Backstop Fund and may not recover from the Iowa Backstop Fund any amounts recovered at the National Attorney Fee Fund.

5. Counsel can seek payment from the Iowa Backstop Fund only for the difference between what they have collected from the National Attorney Fee Fund and the amount to which they are entitled under Paragraph D(3), above.

6. If Counsel receives fees/costs for common benefit work from the National Attorney Fee Fund, when determining "amounts recovered" for purposes of this Section D, those fees/costs received from the National Attorney Fee Fund for common benefit work will be allocated proportionately across all of their local governmental clients based on the Negotiation Class Model to allocate the appropriate portion to Iowa Litigating Local Governments.

7. The Iowa Backstop Fund shall be funded as follows: from the Opioid Funds Allocated to Participating Local Governments pursuant to this MOU, the Settlement Administrator shall deposit in the Iowa Backstop Fund an amount equal to 15% of the total Net Direct Distribution Amount for all Litigating Local Governments and distribute the remainder of the funds allocated to Participating Local Governments as set forth in Section B above. No funds from the Iowa Abatement Share shall be used to pay attorneys' fees and no funds from the Iowa Abatement Share shall be paid to the Iowa Backstop Fund.

8. Any funds remaining in the Iowa Backstop Fund in excess of the amounts needed to cover the deficiency in attorneys' fees as provided in this Section shall revert back to the LG Abatement Share and shall be allocated to the Participating Local Governments as provided in Section B.

9. The Settlement Administrator shall be responsible for receiving requests for and allocating payments to Counsel from the Iowa Backstop Fund. Counsel seeking payment from the Iowa Backstop Fund shall provide all documents and information required and/or sought by the Settlement Administrator.

10. The Settlement Administrator is authorized to provide information regarding requests for and payment from the Iowa Backstop Fund to the Attorney General, upon request.

11. The Iowa Backstop Fund will not be funded by proceeds from any resolution in the matter of *In re Purdue Pharma L.P., et. al.,* Docket No. 19-23649 in the Bankruptcy Court for the Southern District of New York.

E. Minimum Participation

1. This Agreement shall become effective at the time when Litigating Local Governments comprising 95% of the total Litigating Local Government population and Local Governments comprising 80% of the total population of eligible Primary Subdivisions as defined and described in in the Settlement Agreements with a population over 30,000 people sign this MOU ("MOU Effective Date").

2. For avoidance of doubt, a list of the Litigating Local Governments and eligible Primary Subdivisions with a population over 30,000 people whose participation is required to achieve the MOU Effective Dates as set forth above is attached hereto as Exhibit 3.

F. Other Terms

1. The Parties agree to make such amendments as necessary to implement the intent of this agreement. After this Agreement becomes effective, amendments may only be made to this Agreement if approved in writing by the Attorney General and at least 51% of the Participating Local Governments.

2. This Agreement shall be governed by and construed under the laws of the State of Iowa using Iowa law. Any action related to the provisions of this Agreement, except as otherwise provided in the Master Settlement Agreements or Future Resolutions, must be adjudicated by the Iowa state courts of Polk County in the State of Iowa.

3. This Agreement does not supersede or alter the terms of the Master Settlement Agreements except to the extent those terms allow for a State-Subdivision Agreement to do so.

4. If any part of this Agreement is declared invalid or becomes inoperative for any reason, such invalidity or failure shall not affect the validity and enforceability of any other provision.

5. This Agreement may be executed in counterparts, each of which shall be deemed an original and all of which together shall be considered one and the same agreement. A signature transmitted by facsimile or electronic image shall be deemed an original signature for purposes of executing this Agreement.

6. Each person signing this Agreement represents that he or she is fully authorized to enter into the terms and conditions of, and to execute, this Agreement on behalf of the named governmental entity, and that all necessary.

IN WITNESS WHEREOF, the parties hereby execute this MOU as of the date set forth below.

ON BEHALF OF THE STATE OF IOWA:

_____ Date: _____
Attorney General Thomas J. Miller

ON BEHALF OF THE LOCAL GOVERNMENTS:

_____ Date: _____
Adair County
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Adams County
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Allamakee County
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Exhibit 1

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

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

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

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

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

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

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

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

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

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

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

C. **PREGNANT & POSTPARTUM WOMEN**

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

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

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

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

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

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

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

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

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

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

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

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

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

F. **TREATMENT FOR INCARCERATED POPULATION**

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

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

G. **PREVENTION PROGRAMS**

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

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

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

4. Funding for community drug disposal programs; and

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

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

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

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

Schedule B
Approved Uses

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

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Create and/or support recovery high schools.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART TWO: PREVENTION

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

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

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

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

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

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

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

1. Increase the number of prescribers using PDMPs;

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

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

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

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Funding media campaigns to prevent opioid misuse.

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

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Public education relating to emergency responses to overdoses.

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

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

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

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

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

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

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

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

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

J. LEADERSHIP, PLANNING AND COORDINATION

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

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

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

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

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

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

K. TRAINING

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

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

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

L. RESEARCH

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

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

2. Research non-opioid treatment of chronic pain.

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

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

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

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

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

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

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

Exhibit 2

Exhibit 2 - Direct Distribution Percentages

	99	66	100%
Local Government	**County**	**Litigating Entity**	**% of LG bucket**
Adair County	Adair	Yes	0.256%
Adams County	Adams	Yes	0.112%
Allamakee County	Allamakee	Yes	0.446%
Appanoose County	Appanoose	Yes	0.532%
Audubon County	Audubon	Yes	0.121%
Benton County	Benton	Yes	0.519%
Black Hawk County	Black Hawk	Yes	3.342%
Boone County	Boone		0.823%
Bremer County	Bremer	Yes	0.731%
Buchanan County	Buchanan	Yes	0.377%
Buena Vista County	Buena Vista	Yes	0.327%
Butler County	Butler		0.271%
Calhoun County	Calhoun	Yes	0.189%
Carroll County	Carroll	Yes	0.603%
Cass County	Cass		0.336%
Cedar County	Cedar	Yes	0.366%
Cerro Gordo County	Cerro Gordo	Yes	1.630%
Cherokee County	Cherokee	Yes	0.238%
Chickasaw County	Chickasaw	Yes	0.243%
Clarke County	Clarke		0.305%
Clay County	Clay	Yes	0.296%
Clayton County	Clayton	Yes	0.457%
Clinton County	Clinton	Yes	1.459%
Crawford County	Crawford		0.331%
Dallas County	Dallas	Yes	1.478%
Davis County	Davis		0.154%

Decatur County	Decatur		0.253%
Delaware County	Delaware	Yes	0.302%
Des Moines County	Des Moines	Yes	1.568%
Dickinson County	Dickinson		0.332%
Dubuque County	Dubuque		2.745%
Emmet County	Emmet	Yes	0.175%
Fayette County	Fayette	Yes	0.528%
Floyd County	Floyd		0.329%
Franklin County	Franklin		0.211%
Fremont County	Fremont	Yes	0.205%
Greene County	Greene		0.358%
Grundy County	Grundy		0.323%
Guthrie County	Guthrie		0.231%
Hamilton County	Hamilton	Yes	0.350%
Hancock County	Hancock	Yes	0.190%
Hardin County	Hardin	Yes	0.449%
Harrison County	Harrison	Yes	0.618%
Henry County	Henry	Yes	0.445%
Howard County	Howard	Yes	0.171%
Humboldt County	Humboldt	Yes	0.193%
Ida County	Ida	Yes	0.168%
Iowa County	Iowa		0.266%
Jackson County	Jackson		0.549%
Jasper County	Jasper	Yes	1.678%
Jefferson County	Jefferson		0.573%
Johnson County	Johnson	Yes	3.822%
Jones County	Jones	Yes	0.388%
Keokuk County	Keokuk	Yes	0.198%
Kossuth County	Kossuth		0.348%
Lee County	Lee	Yes	1.459%
Linn County	Linn		7.329%
Louisa County	Louisa		0.336%

Lucas County	Lucas		0.330%
Lyon County	Lyon	Yes	0.162%
Madison County	Madison	Yes	0.403%
Mahaska County	Mahaska	Yes	0.716%
Marion County	Marion	Yes	1.179%
Marshall County	Marshall		1.036%
Mills County	Mills	Yes	0.495%
Mitchell County	Mitchell	Yes	0.190%
Monona County	Monona		0.446%
Monroe County	Monroe	Yes	0.216%
Montgomery County	Montgomery	Yes	0.531%
Muscatine County	Muscatine	Yes	1.061%
O Brien County	O Brien	Yes	0.235%
Osceola County	Osceola	Yes	0.145%
Page County	Page		0.582%
Palo Alto County	Palo Alto		0.167%
Plymouth County	Plymouth	Yes	0.445%
Pocahontas County	Pocahontas	Yes	0.117%
Polk County	Polk	Yes	22.811%
Pottawattamie County	Pottawattamie	Yes	3.615%
Poweshiek County	Poweshiek	Yes	0.475%
Ringgold County	Ringgold		0.120%
Sac County	Sac	Yes	0.220%
Scott County	Scott	Yes	8.861%
Shelby County	Shelby	Yes	0.286%
Sioux County	Sioux	Yes	0.410%
Story County	Story		2.166%
Tama County	Tama	Yes	0.345%
Taylor County	Taylor	Yes	0.178%
Union County	Union	Yes	0.463%
Van Buren County	Van Buren		0.153%
Wapello County	Wapello		1.003%

Warren County	Warren		1.332%
Washington County	Washington		0.554%
Wayne County	Wayne		0.244%
Webster County	Webster	Yes	1.596%
Winnebago County	Winnebago	Yes	0.234%
Winneshiek County	Winneshiek	Yes	0.367%
Woodbury County	Woodbury		2.566%
Worth County	Worth	Yes	0.235%
Wright County	Wright	Yes	0.281%

Exhibit 3

Litigating Subdivisions		
Subdivision	**Population**	**Percentage of Litigating Subdivision Population**
Adair	7,152	0.329%
Adams	3,602	0.166%
Allamakee	13,687	0.630%
Appanoose	12,426	0.572%
Audubon	5,496	0.253%
Benton	25,645	1.181%
Black Hawk	131,228	6.041%
Bremer	25,062	1.154%
Buchanan	21,175	0.975%
Buena Vista	19,620	0.903%
Calhoun	9,668	0.445%
Carroll	20,165	0.928%
Cedar	18,627	0.857%
Cerro Gordo	42,450	1.954%
Cherokee	11,235	0.517%
Chickasaw	11,933	0.549%
Clay	16,016	0.737%
Clayton	17,549	0.808%
Clinton	46,429	2.137%
Dallas	93,453	4.302%
Delaware	17,011	0.783%
Des Moines	38,967	1.794%
Emmett	9,208	0.424%
Fayette	19,650	0.905%
Fremont	6,960	0.320%
Hamilton	14,773	0.680%
Hancock	10,630	0.489%
Hardin	16,846	0.775%
Harrison	14,049	0.647%
Henry	19,954	0.919%
Howard	9,158	0.422%
Humboldt	9,558	0.440%
Ida	6,860	0.316%
Jasper	37,185	1.712%
Johnson	151,140	6.957%
Jones	20,681	0.952%
Keokuk	10,246	0.472%
Lee	33,657	1.549%
Lyon	11,755	0.541%
Madison	16,338	0.752%
Mahaska	22,095	1.017%
Marion	33,253	1.531%

Mills	15,109	0.696%
Mitchell	10,586	0.487%
Monroe	7,707	0.355%
Montgomery	9,917	0.457%
Muscatine	42,664	1.964%
O'Brien	13,753	0.633%
Osceola	5,958	0.274%
Plymouth	25,177	1.159%
Pocahontas	6,619	0.305%
Polk	490,161	22.564%
Pottawattamie	93,206	4.291%
Powesheik	18,504	0.852%
Sac	9,721	0.447%
Scott	172,943	7.961%
Shelby	11,454	0.527%
Sioux	34,855	1.604%
Tama	16,854	0.776%
Taylor	6,121	0.282%
Union	12,241	0.563%
Webster	35,904	1.653%
Winnebago	10,354	0.477%
Winneshiek	19,991	0.920%
Worth	7,381	0.340%
Wright	12,562	0.578%
TOTAL	**2,172,334**	**100%**
95% of Total	**2,063,717.30**	**95%**

Primary Subdivisions Over 30,000 Population		
Subdivision	**Population**	**Percentage of Primary Subdivision Over 30,000 Population**
Ames City	66,258	2.02%
Ankeny City	67,355	2.05%
Bettendorf City	36,543	1.11%
Black Hawk	131,228	3.99%
Cedar Falls City	40,536	1.23%
Cedar Rapids City	133,562	4.07%
Cerro Gordo	42,450	1.29%
Clinton	46,429	1.41%
Council Bluffs City	62,166	1.89%
Dallas	93,453	2.84%
Davenport City	101,590	3.09%
Des Moines	214,237	6.52%
Des Moines City	38,967	1.19%
Dubuque City	57,882	1.76%
Dubuque County	97,311	2.96%
Iowa City	75,130	2.29%

Jasper	37,185	1.13%
Johnson	151,140	4.60%
Lee	33,657	1.02%
Linn County	226,706	6.90%
Marion	40,359	1.23%
Marion City	33,253	1.01%
Marshall County	39,369	1.20%
Muscatine	42,664	1.30%
Polk	490,161	14.92%
Pottawattamie	93,206	2.84%
Scott	172,943	5.26%
Sioux	82,651	2.52%
Sioux City	34,855	1.06%
Story County	97,117	2.96%
Urbandale City	44,379	1.35%
Wapello County	34,969	1.06%
Warren County	51,466	1.57%
Waterloo City	67,328	2.05%
Webster	35,904	1.09%
West Des Moines City	67,899	2.07%
Woodbury County	103,107	3.14%
TOTAL	**3,285,415**	**100%**
80% of Total	**2,628,332**	**80%**