MINI-GRANT AGREEMENT

THIS MINI-GRANT AGREEMENT (hereinafter "AGREEMENT"), dated this 10th day of September, 2024, made between Huerfano County (hereinafter referred to as "Grantee") and Crowley County, Colorado, (hereinafter referred to as "County") on behalf of the Southeast Colorado Opioid Response Settlement Region 19 (hereinafter referred to as "SECOR"). County and Grantee may individually be referred to as "Party", or collectively as "Parties".

WHEREAS, Grantee agrees to provide services for prevention and education services related to the Opioid Epidemic for the Southeast Colorado Opioid Response Settlement Region 19, as more fully defined in the Scope of Work provided by Grantee in response to the Request for Proposal; and

WHEREAS, County on behalf of SECOR agrees to fulfill the responsibilities and to pay Grantee for said services, as more fully defined below in Memorandum of Understanding, Exhibits A and E;

WHEREAS, the parties have reached an agreement concerning the engagement of Grantee, the work to be performed, payment for the work, and related matters and now desire to set forth the same in writing.

NOW THEREFORE, in consideration of the promises and considerations herein contained, County and Grantee hereby agree as follows:

ENGAGEMENT OF SERVICES

County, on behalf of SECOR, hereby engages and Grantee hereby accepts such engagement and is hired to perform the work and services upon all the terms and conditions set forth in this Agreement. Noncompliance may result in cancellation of the Contract by County, on behalf of SECOR.

SCOPE OF WORK AND ESTIMATED COST

The Scope of Work (or Work) to be performed by Grantee is more particularly described in Exhibits A and E, hereto and incorporated herein by this reference. The parties agree that the Scope of Work includes the items set forth in Exhibits A and E. The parties further agree that as Work commences, the Scope may change and, in such case, the parties agree to jointly prepare a written Amendment or an Addendum to this Agreement to reflect any such change, definition, and/or refinement as may occur and be agreed upon by both parties, after approval by the SECOR Board. Specifically, the parties agree that they will undertake such procedure if the Scope changes as a result of updates from the State regarding the Opioid settlement and related funds.

Based upon the information provided by Grantee, SECOR has awarded Grantee **$10,000** for the year following execution of this contract and payment shall be provided at the commencement of the contract and any unexpended funds remaining at the end of the contract term must be returned to County for SECOR.

COMPENSATION

All costs shall be in the performance of the Work in accordance with Exhibits A and E as described for Fiscal Year 2024, not to exceed the stated amounts.

As the Work commences and proceeds, Grantee agrees to keep County informed if it anticipates the existence of any unexpended funds. Any unexpended funds existing at the termination of this agreement must be returned to County for SECOR.

No Multi-Fiscal Year Obligation on County. This Agreement is expressly made subject to the limitations of the Colorado Constitution. Nothing herein shall constitute, nor deemed to constitute, the creation of a debt or multi-year fiscal obligation or an obligation of future appropriations by the County, contrary to Article X, § 20 Colorado Constitution or any other constitutional or statutory debt limitation. The obligations of the County under this Agreement are subject to annual appropriations made for that purpose. Additionally, the obligations of the County under this Agreement are subject to the continued funding pursuant to the State Contract.

MONITORING ACTIVITIES

The County may require the Grantee to provide copies of other program progress or financial reports or documentation, including those reports or documentation that the Grantee may submit to other funding entities. The County may conduct other monitoring activities as necessary throughout the period of this Agreement to determine program progress and for purposes of data base computation and/or program evaluation. Such monitoring activities may include, but not be limited to, receipt of Grantee's monthly Board meeting agenda, minutes, etc.; attendance at Grantee's Board meetings; and on-site visits, including access to all records and documentation maintained by the Grantee.

ADDITIONAL RESPONSIBILITIES OF COUNTY

The County, at its sole cost and expense, shall cooperate with Grantee in all respects, including but not limited to, the provision of information pertaining to the Scope of Work to be performed by Grantee.

County designates **Rose Pugliese, SECOR Facilitator and Legal Counsel**, to act as County representative(s) for the Work to be performed under this Agreement. Such person(s) shall have the authority to transmit instructions to Grantee through Grantee designated representative(s), to receive information, and to interpret and define County's policies and decisions with respect to all aspects of the Work covered by this Agreement.

ADDITIONAL RESPONSIBILITIES OF GRANTEE

Grantee agrees to perform Work with the same degree of care, skill and diligence as is ordinarily possessed and exercised in the same profession under similar circumstances. Grantee shall ensure that its subcontractors, if any, have the level of skill in the area commensurate with the requirements of the scope of services to be performed, and that any work performed by such subcontractors will comply with SECOR Policies. Grantee shall at all times serve the best interests of County in connection with such services and shall advise County when services it requests are not in the County's best interests.

Grantee designates Carl Young to act as Grantee's representative(s) for the Work to be performed under this Agreement. County acknowledges and understands that Grantee personnel involvement will be based on specific task needs.

Grantee agrees to undertake the following obligations during the term of this Agreement and perform such services in accordance with the terms of this Agreement. Grantee shall adhere to principles of harm reduction when delivering all services.

INVOICING AND EXPENSE TRACKING

Full disbursement of monies will commence within fourteen (14) days of the execution of this agreement. The funds shall remain available to Grantee for one (1) year from the date of execution. Grantee shall submit a report at end of the grant cycle. Reports shall include all relevant receipts. Such reports shall be provided electronically to the following contacts for the County and SECOR:

Rose Pugliese
SECOR Facilitator
puglieselawfirm@gmail.com

LaShelle Benbow
Crowley County Finance Director
Lashelle.benbow@crowleycounty.net

AMENDMENTS

SECOR may, from time to time, request changes in the Scope of Services of the Grantee to be performed hereunder. Such changes that are mutually agreed upon by and between SECOR and the Grantee shall be incorporated in a written amendment to this agreement executed by County, on behalf of SECOR, and Grantee.

COMMENCEMENT AND COMPLETION

Grantee agrees to begin performance of the Work following disbursement of the funds. Thereafter, Grantee shall execute the Work with due diligence and the Work shall be completed in a timely manner commensurate with the tasks involved in the Exhibits A and E, which Grantee has agreed

to perform.

Grantee will take reasonable steps to mitigate the impact of any delay in performing the Scope of Work, even if it results from causes beyond the reasonable control or contemplation of Grantee. This Agreement shall remain in effect for one (1) calendar year following the execution of this Agreement. Any extension of time or further award to Grantee by SECOR must be approved by the SECOR Board and shall require a written amendment or addendum to this Contract executed by the County, on behalf of SECOR, and Grantee.

CONFIDENTIALITY AND WORK PRODUCT

Grantee and County agree that all work product, including data gathered and reports generated pursuant to this engagement, are to be kept confidential between County and Grantee, except for disclosures required pursuant to SECOR. The parties agree that County and SECOR will be free under this Agreement to make any disclosure of information required by the Colorado Open Records Act. It is the expectation of County that much of the Work performed including data gathered and reports generated may become public records and at such time as the County and/or SECOR makes the same public records then the obligation of confidentiality shall expire and be of no further force and effect as to those records made public by the County.

Grantee and County recognize and agree that any work product submitted by Grantee and any subcontractors in the performance of this Agreement are a part of the services rendered and are intended only for SECOR and County's use and benefit.

LIABILITY INSURANCE

Grantee shall procure and maintain until all of their obligations have been discharged, including any warranty periods under this Agreement are satisfied, insurance against claims for injury to persons or damage to property which may arise from or in connection with the performance of the work hereunder by Grantee, agents, representatives, employees or sub-consultants.

The insurance requirements herein are minimum requirements for this Agreement and in no way limit the indemnity covenants contained in this Agreement.

The County in no way warrants that the minimum limits contained herein are sufficient to protect Grantee from liabilities that might arise out of the performance of the work under this Agreement by Grantee, its agents, representatives, employees, or sub-consultants. Grantee shall assess its own risks and if it deems appropriate and/or prudent, maintain higher limits and/or broader coverages. Grantee is not relieved of any liability or other obligations assumed or pursuant to the Agreement by reason of its failure to obtain or maintain insurance in sufficient amounts, duration, or types.

Grantee shall provide coverage with limits of liability not less than those stated below. An excess liability policy or umbrella liability policy may be used to meet the minimum liability requirements provided that the coverage is written on a "following form" basis.

Workers' Compensation Insurance. Grantee and all subcontractor(s), if any, engaged by Grantee

shall comply with the requirements of the Workers' Compensation Act of Colorado, as amended, and shall provide Workers' Compensation Insurance, including Occupational Disease Provision, to protect Grantee and its subcontractors, if any, from and against any and all Workers' Compensation claims arising from performance of Work under the Agreement. This requirement shall not apply when Grantee or a subcontractor is exempt under the Workers' Compensation Act of Colorado.

Professional Liability (Errors and Omissions Liability). Grantee shall procure and maintain at its own expense during the term of this Agreement and for such additional time as Work is being performed, Professional Liability Insurance covering all Work to be performed under this Agreement. This insurance shall be written with a minimum limit of $1,000,000.00 for each claim and annual aggregate. In the event that any professional liability insurance required by this Agreement is written on a claims- made basis, Grantee warrants that any retroactive date under the policy shall precede the effective date of this Agreement; and that either continuous coverage will be maintained, or an extended discovery period will be exercised for a period of three (3) years beginning at the time work under this Agreement is completed. The Policy shall contain a waiver of subrogation against the County.

SUSPENSION OF WORK

Work under this Agreement may be suspended in accordance with the following provisions:

By County. Upon written notice to Grantee, SECOR, through the County, may suspend all or a portion of the Work under this Agreement if unforeseen circumstances make normal progress of the Work impracticable. Grantee shall be compensated for its reasonable expenses resulting from such suspension including the expenses of mobilization and demobilization, subject to the availability of grant funding. If any such suspension is greater than 30 days, then Grantee shall have the right to terminate this Agreement in accordance with the termination language provided herein.

By Grantee. Upon written notice to County, Grantee may suspend the Work if Grantee reasonably determines that circumstances not caused by Grantee substantially interfere with normal progress of the Work.

TERMINATION

This Agreement may be terminated as follows:

By County. (i) SECOR, through the County, may termination this Agreement for its convenience with 30 days' notice to Grantee, or (ii) for cause if Grantee materially breaches this Agreement through no fault of SECOR or County and Grantee neither cures such material breach nor makes reasonable progress towards cure within ten days after County has given written notice of the alleged breach to Grantee .

By Grantee. (i) For cause, if County materially breaches this Agreement through no fault of Grantee and County neither cures such material breach nor makes reasonable progress towards cure within ten days after Grantee has given written notice of the alleged breach to SECOR and

County, or (ii) upon five days' notice if Work under this Agreement has been suspended by either County or Grantee in the aggregate for more than 30 days.

Payment Upon Termination. In the event of termination, Grantee shall perform such additional work at the direction of the SECOR and County as is reasonably necessary for the orderly closing of the Work. Grantee shall be compensated for all work performed prior to the effective date of termination, plus work required by SECOR and County for the orderly closing of the Work. All remaining funds shall be returned to County for SECOR within seven (7) days of termination of all Work.

INDEPENDENT CONTRACTOR

The parties understand and agree that Grantee shall, at all times during the term of this Agreement, be deemed an independent contractor and not an employee of the County, and shall be responsible for, and obligated to pay on behalf of its employees, all withholding taxes, social security, unemployment, Workers' compensation, and/or other taxes and shall indemnify and hold the County harmless from and against any and all claims for the same period. Grantee acknowledges and agrees that all of its personnel are its employees only, and not employees or agents of the County for any purpose whatsoever, including for purposes of Workers' Compensation. Grantee has no authority to enter into contracts or other binding obligations on behalf of the County.

NOTICES

Any notices required or permitted under this Agreement shall be by personal delivery, electronic mail, or Certified Mail sent the United States Post Office at the addresses set forth below:

Notice to County

Rose Pugliese, SECOR Facilitator and Legal Counsel
9235 N. Union Blvd., Suite 150, #128
Colorado Springs, Colorado 80920
Puglieselawfirm@gmail.com

_____

Notice to Grantee:

Huerfano County Board of County Commissioners
401 Main Street, Suite 201
Walsenburg, Colorado 81089
commissioners@huerfano.us and cc: administrator@huerfano.us

GOVERNING LAW

This Agreement shall be construed and interpreted under the laws of the State of Colorado.

SEVERABILITY

In the event one or more, but not all, of the provisions of this Agreement are declared to be unlawful or unenforceable by a Court of competent jurisdiction, such determination shall not affect the legality or enforceability of the remainder of the terms and provisions of this Agreement.

BINDING

When executed by the parties hereto, this Agreement shall be a binding agreement and shall inure to the benefit of and be binding upon the parties hereto, their successors and permitted assigns. Neither party may assign this Agreement without the express written permission of the other party which permission may be denied for any reason, including an arbitrary reason.

DUPLICATES

This Agreement may be executed in duplicate original counterparts, each of which shall constitute an original but all which shall constitute one and the same document.

IN WITNESS WHEREOF, the parties have executed this Agreement effective the day and date first set forth above.

Grantee BY: Arica Andreatta, Chair, Board of County Commissioners

_____

Date

Crowley County

BY: Roy Elliott

_____

Date

Exhibit A

POTENTIAL OPIOID ABATEMENT APPROVED PURPOSES

I. TREATMENT

A. TREATMENT OF OPIOID USE DISORDER AND ITS EFFECTS

1. Expand availability of treatment, including Medication-Assisted Treatment (MAT), for Opioid Use Disorder (OUD) and any co-occurring substance use or mental health issues.

2. Supportive housing, all forms of FDA-approved MAT, counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it.

3. Treatment of mental health trauma issues that resulted from the traumatic experiences of the opioid user (e.g., violence, sexual assault, human trafficking) and for family members (e.g., surviving family members after an overdose or overdose fatality).

4. Expand telehealth to increase access to OUD treatment, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

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

6. Scholarships for certified addiction counselors.

7. Clinicians to obtain training and a waiver under the federal Drug Addiction Treatment Act to prescribe MAT for OUD.

8. Training for health care providers, students, and other supporting professionals, such as peer recovery coaches/recovery outreach specialists, including but not limited to training relating to MAT and harm reduction.

9. Dissemination of accredited 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.

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

11. Development of a multistate/nationally accessible database whereby health care providers can list currently available in-patient and out-patient OUD treatment services that are accessible on a real-time basis.

12. Support and reimburse services that include the full American Society of Addiction Medicine (ASAM) continuum of care for OUD.

13. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-informed practices such as adequate methadone dosing.

B. INTERVENTION

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

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

3. Training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on the late adolescence and young adulthood when transition from misuse to opioid disorder is most common.

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

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

6. Support 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.

7. Create school-based contacts whom parents can engage to seek immediate treatment services for their child.

8. Develop best practices on addressing OUD in the workplace.

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

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

C. CRIMINAL-JUSTICE-INVOLVED PERSONS

1. Address the needs of persons involved in the criminal justice system who have OUD and any co-occurring substance use disorders or mental health (SUD/MH) issues.

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

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

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

    c. "Naloxone Plus" strategies, which work to ensure that individuals who have received Naloxone to reverse the effects of an overdose are then linked to treatment programs;

    d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model; or

    e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network.

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

4. Support treatment and recovery courts for persons with OUD and any co-occurring SUD/MH issues, but only if they provide referrals to evidence-informed treatment, including MAT.

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 issues who are incarcerated, on probation, or on parole.

6. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate re-entry services to individuals with OUD and any co-occurring SUD/MH issues who are leaving jail or prison or who have recently left jail or prison.

7. 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.

D. WOMEN WHO ARE OR MAY BECOME PREGNANT

1. Evidence-informed treatment, including MAT, recovery, and prevention services for pregnant women or women who could become pregnant and have OUD.

2. Training for obstetricians and other healthcare personnel that work with pregnant women and their families regarding OUD treatment.

3. Other measures to address Neonatal Abstinence Syndrome, including prevention, care for addiction and education programs.

4. Child and family supports for parenting women with OUD.

5. Enhanced family supports and child care services for parents receiving treatment for OUD.

E. PEOPLE IN TREATMENT AND RECOVERY

1. The full continuum of care of recovery services for OUD and any co-occurring substance use or mental health issues, including supportive housing, residential treatment, medical detox services, peer support services and counseling, community navigators, case management, and connections to community-based services.

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

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

4. Community-wide stigma reduction regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

5. Engaging non-profits and faith community as a system to support family members in their efforts to help the opioid user in the family.

II. PREVENTION

F. PRESCRIBING PRACTICES

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

2. Academic counter-detailing.

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

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

5. Fund development of a multistate/national prescription drug monitoring program (PDMP) that permits information sharing while providing appropriate safeguards on sharing of private information, including but not limited to:

a. Integration of PDMP data with electronic health records, overdose episodes, and decision support tools for health care providers relating to OUD.

b. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database.

6. Educating dispensers on appropriate opioid dispensing.

G. MISUSE OF OPIOIDS

1. Corrective advertising/affirmative public education campaigns.

2. Public education relating to drug disposal.

3. Drug take-back disposal or destruction programs.

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

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

6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, or training of coalitions in evidence-informed implementation.

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

8. Engaging non-profits and faith community as a system to support prevention.

H. OVERDOSE DEATHS AND OTHER HARMS

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

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

L. STAFFING AND TRAINING

1. Funding for programs and services regarding staff training and networking to improve staff capability to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-systems coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD (e.g., health care, primary care, pharmacies, PDMPs, etc.).

M. RESEARCH

1. Funding opioid abatement research.

2. Research improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to OUD.

3. Support research for novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

4. Support for innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

5. Expanded research for 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).

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

N. OTHER

1. Administrative costs for any of the approved purposes on this list.

3. Developing data tracking software and applications for overdoses/naloxone revivals.

4. Public education relating to emergency responses to overdoses.

5. Free naloxone for anyone in the community.

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

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

8. Syringe service programs, including supplies, staffing, space, peer support services, and the full range of harm reduction and treatment services provided by these programs.

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

III. ADDITIONAL AREAS

I. SERVICES FOR CHILDREN

1. 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.

J. FIRST RESPONDERS

1. Law enforcement expenditures relating to the opioid epidemic.

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

3. Increase electronic prescribing to prevent diversion and forgery.

K. COMMUNITY LEADERSHIP

1. Regional planning to identify goals for opioid reduction and support efforts or to identify areas and populations with the greatest needs for treatment intervention services.

2. Government dashboard to track key opioid-related indicators and supports as identified through collaborative community processes.

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:[2]

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.

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

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 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.