LOUISIANA STATE-LOCAL GOVERNMENT
OPIOID LITIGATION
MEMORANDUM OF UNDERSTANDING – PARISH ALLOCATION PERCENTAGE
**BASED ON AN ASSUMED TOTAL SETTLEMENT AMOUNT OF $325,000,000.00**[1]

| PARISH | PERCENT OF SETTLEMENT FUNDS | TOTAL DOLLAR AMOUNT | ANNUAL DIVIDED BY EIGHTEEN (18) (YEARS) |
|---|---|---|---|
| **Acadia Parish** | 1.57% | $5,102,500.00 | $283,472.22 |
| **Allen Parish** | 0.46% | $1,495,000.00 | $83,055.56 |
| **Ascension Parish** | 2.27% | $7,377,500.00 | $409,861.11 |
| **Assumption Parish** | 0.37% | $1,202,500.00 | $66,805.56 |
| **Avoyelles Parish** | 0.84% | $2,730,000.00 | $151,666.67 |
| **Beauregard Parish** | 0.65% | $2,112,500.00 | $117,361.11 |
| **Bienville Parish** | 0.20% | $650,000.00 | $36,111.11 |
| **Bossier Parish** | 1.83% | $5,947,500.00 | $330,416.67 |
| **Caddo Parish** | 4.47% | $14,527,500.00 | $807,083.33 |
| **Calcasieu Parish** | 4.03% | $13,097,500.00 | $727,638.89 |
| **Caldwell Parish** | 0.19% | $617,500.00 | $34,305.56 |
| **Cameron Parish** | 0.10% | $325,000.00 | $18,055.56 |
| **Catahoula Parish** | 0.22% | $715,000.00 | $39,722.22 |
| **Claiborne Parish** | 0.28% | $910,000.00 | $50,555.56 |
| **Concordia Parish** | 0.33% | $1,072,500.00 | $59,583.33 |
| **De Soto Parish** | 0.35% | $1,137,500.00 | $63,194.44 |

[1] Please note that the final amounts add up to more than $325M (see Totals, below)

| PARISH | PERCENT OF SETTLEMENT FUNDS | TOTAL DOLLAR AMOUNT | ANNUAL DIVIDED BY EIGHTEEN (18) (YEARS) |
|---|---|---|---|
| **East Baton Rouge Parish*** | 9.19% | $29,867,500.00 | **$1,659,305.56** |
| **East Carroll Parish** | 0.08% | $260,000.00 | **$14,444.44** |
| **East Feliciana Parish** | 0.26% | $845,000.00 | **$46,944.44** |
| **Evangeline Parish** | 0.79% | $2,567,500.00 | **$142,638.89** |
| **Franklin Parish** | 0.27% | $877,500.00 | **$48,750.00** |
| **Grant Parish** | 0.34% | $1,105,000.00 | **$61,388.89** |
| **Iberia Parish** | 1.32% | $4,290,000.00 | **$238,333.33** |
| **Iberville Parish** | 0.70% | $2,275,000.00 | **$126,388.89** |
| **Jackson Parish** | 0.24% | $780,000.00 | **$43,333.33** |
| **Jefferson Davis Parish** | 0.69% | $2,242,500.00 | **$124,583.33** |
| **Jefferson Parish*** | 13.17% | $42,802,500.00 | **$2,377,916.67** |
| **Lafayette Parish** | 5.12% | $16,640,000.00 | **$924,444.44** |
| **Lafourche Parish** | 1.82% | $5,915,000.00 | **$328,611.11** |
| **Lasalle Parish** | 0.35% | $1,137,500.00 | **$63,194.44** |
| **Lincoln Parish** | 0.52% | $1,690,000.00 | **$93,888.89** |
| **Livingston Parish** | 4.97% | $16,152,500.00 | **$897,361.11** |
| **Madison Parish** | 0.12% | $390,000.00 | **$21,666.67** |

| PARISH | PERCENT OF SETTLEMENT FUNDS | TOTAL DOLLAR AMOUNT | ANNUAL DIVIDED BY EIGHTEEN (18) (YEARS) |
|---|---|---|---|
| **Morehouse Parish** | 0.45% | $1,462,500.00 | $81,250.00 |
| **Natchitoches Parish** | 0.50% | $1,625,000.00 | $90,277.78 |
| **Orleans Parish*** | 6.29% | $20,442,500.00 | $1,135,694.44 |
| **Ouachita Parish** | 2.42% | $7,865,000.00 | $436,944.44 |
| **Plaquemines Parish** | 0.46% | $1,495,000.00 | $83,055.56 |
| **Pointe Coupee Parish** | 0.39% | $1,267,500.00 | $70,416.67 |
| **Rapides Parish** | 3.25% | $10,562,500.00 | $586,805.56 |
| **Red River Parish** | 0.13% | $422,500.00 | $23,472.22 |
| **Richland Parish** | 0.24% | $780,000.00 | $43,333.33 |
| **Sabine Parish** | 0.35% | $1,137,500.00 | $63,194.44 |
| **St Bernard Parish** | 1.77% | $5,752,500.00 | $319,583.33 |
| **St Charles Parish** | 1.17% | $3,802,500.00 | $211,250.00 |
| **St Helena Parish** | 0.20% | $650,000.00 | $36,111.11 |
| **St James Parish** | 0.29% | $942,500.00 | $52,361.11 |
| **St John The Baptist Parish** | 0.79% | $2,567,500.00 | $142,638.89 |
| **St Landry Parish** | 1.85% | $6,012,500.00 | $334,027.78 |
| **St Martin Parish** | 0.84% | $2,730,000.00 | $151,666.67 |
| **St Mary Parish** | 1.06% | $3,445,000.00 | $191,388.89 |
| **St Tammany Parish** | 7.83% | $25,447,500.00 | $1,413,750.00 |

| PARISH | PERCENT OF SETTLEMENT FUNDS | TOTAL DOLLAR AMOUNT | ANNUAL DIVIDED BY EIGHTEEN (18) (YEARS) |
|---|---|---|---|
| **Tangipahoa Parish** | 3.47% | $11,277,500.00 | $626,527.78 |
| **Tensas Parish** | 0.06% | $195,000.00 | $10,833.33 |
| **Terrebonne Parish** | 2.31% | $7,507,500.00 | $417,083.33 |
| **Union Parish** | 0.31% | $1,007,500.00 | $55,972.22 |
| **Vermilion Parish** | 0.96% | $3,120,000.00 | $173,333.33 |
| **Vernon Parish** | 0.90% | $2,925,000.00 | $162,500.00 |
| **Washington Parish** | 1.70% | $5,525,000.00 | $306,944.44 |
| **Webster Parish** | 0.72% | $2,340,000.00 | $130,000.00 |
| **West Baton Rouge Parish** | 0.53% | $1,722,500.00 | $95,694.44 |
| **West Carroll Parish** | 0.15% | $487,500.00 | $27,083.33 |
| **West Feliciana Parish** | 0.22% | $715,000.00 | $39,722.22 |
| **Winn Parish** | 0.31% | $1,007,500.00 | $55,972.22 |
| **TOTALS** | **100.03%** | **$325,097,500.00** | $18,060,972.19 |
| | | | $325,097,499.42 |

* Qualified Parish

EXHIBIT B


**Lead Parishes**

Region 1. St. Bernard Parish (Orleans Parish and Jefferson Parish are excluded);

Region 2. Ascension Parish (East Baton Rouge Parish is excluded);

Region 3. Lafourche Parish;

Region 4. Lafayette Parish;

Region 5. Calcasieu Parish;

Region 6. Rapides Parish;

Region 7. Caddo Parish;

Region 8. Ouachita Parish; and

Region 9. St. Tammany Parish

# LOUISIANA STATE-LOCAL GOVERNMENT
# OPIOID LITIGATION
# MEMORANDUM OF UNDERSTANDING

Whereas, the people of the State and its communities have been harmed by misfeasance, nonfeasance, and malfeasance committed by certain entities within the Pharmaceutical Supply Chain; and,

Whereas, the State, though its Attorney General, and certain Local Governments, through their elected representatives and counsel, are separately engaged in litigation seeking to hold Pharmaceutical Supply Chain Participants accountable for the damage caused by their misfeasance, nonfeasance and malfeasance; and,

Whereas, the State, through its Attorney General, and its Local Governments share a common desire to abate and alleviate the impacts of that misfeasance, nonfeasance and malfeasance throughout the State;

Now therefore, the State and its Local Governments, subject to completing formal documents effectuating the Parties' agreements, enter into this Memorandum of Understanding ("MOU") relating to the allocation and use of the proceeds of Settlements described.

A. Definitions

As used in this MOU:

1. "The State" shall mean the State of Louisiana acting through the Attorney General.

2. "Local Government(s)" or "LG" shall mean all parishes, incorporated municipalities, and other certain local government political subdivisaions and Sheriffs within the geographic boundaries of the State.

3. "The Parties" shall mean the State and the Local Governments.

4. "Settlement" shall mean the negotiated resolution of legal or equitable claims against a Pharmaceutical Supply Chain Participant when that resolution has been jointly entered into by the State and the Local Governments.

5. "Opioid Funds" shall mean monetary amounts obtained through a Settlement as defined in this Memorandum of Understanding.

6. "Approved Purpose(s)" shall mean evidence-based forward-looking strategies, programming and services used to (i) provide treatment for citizens of the State of Louisiana affected by substance use disorders, (ii) provide support for citizens of the State of Louisiana in recovery from addiction who are under the care of Substance Abuse & Mental Health

Services Administration "SAMHSA" qualified and appropriately licensed health care providers, (iii) target treatment of citizens of the State of Louisiana who are not covered by Medicaid or not covered by private insurance for addictive services. See Exhibit A.

7. "Pharmaceutical Supply Chain" shall mean the process and channels through which Controlled Substances are manufactured, marketed, promoted, distributed or dispensed.

8. "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.

9. "Municipalities" shall mean cities, towns, or villages of a Parish within the State with a Population greater than 10,000 individuals and shall also include cities, towns or villages within the State with a Population equal to or less than 10,000 individuals which filed a Complaint in this litigation against Pharmaceutical Supply Chain Participants. The singular "Municipality" shall refer to a singular of the Municipalities.

10. "Negotiation Class Metrics" shall mean those county and city settlement allocations which come from the official website of the Negotiation Class of counties and cities certified on September 11, 2019 by the U.S. District for the Northern District of Ohio in *In re National Prescription Opiate Litigation*, MDL No. 2804 (N.D. Ohio). The website is located at https://allocationmap.iclaimsonline.com.

11. "Qualified Parish" shall mean a parish within the State that has a Population of least 300,000 individuals. For the avoidance of doubt, Qualified Parishes include: East Baton Rouge Parish, Jefferson Parish, and Orleans Parish.

12. "Parish" shall refer to one of the 64 parish governments in the State of Louisiana.

13. "Sheriff" shall refer to the sheriff in each of the 64 parishes in the State of Louisiana.

14. "Population" shall refer to published U.S. Census Bureau population estimates as of July 1, 2019, released March 2020, and shall remain unchanged during the term of this MOU. These estimates can currently be found at https://www.census.gov

B. Opioids Abatement Taskforce. The State will create an Opioid Abatement Taskforce (hereinafter "Taskforce") to advise the Attorney General and the Parishes and Municipalities on the priorities that should be addressed as part of the opioid epidemic and to review how monies have been spent and the results that have been achieved with the Opioid Funds.

1. Size. The Taskforce shall have five (5) members.

2. Appointments: Local Governments

   a. The Lousiana Municipal Association shall appoint one member.

   b. The Police Jury Association shall appoint one member.

   c. The Louisiana Sheriff's Association shall appoint one member.

3. Appointments: State.

   a. The Secretary of the Louisiana Department of Public Health or his/her designee shall appoint one member.

   b. The Governor shall appoint one member who is a licensed SAMSHA provider.

4. Chair. The members of the taskforce shall designate the chair of such Taskforce.

5. Term. Members will be appointed to serve 3 year terms.

6. Meetings. The Taskforceshall meet in person or virtually each year.

7. At least annually, each Qualified Parish and Lead Parish shall provide to the State and the Taskforce a report detailing for the preceding time-period (1) the amount of the LG Share received by each Participating Local Government within the Parish, (2) the allocation of any awards approved (listing the recipient, the amount awarded, the program to be funded, and disbursement terms), and (3) the amounts disbursed for approved allocations.

8. At least annually, the State and the Taskforce shall publish a report detailing for the preceding time-period (1) the amount of the State Share received, (2) the allocation of any awards approved (listing the recipient, the amount awarded, the program to be funded, and disbursement terms), and (3) the amounts disbursed for approved allocations.

C. Allocation of Settlement Proceeds

1. All of the Opioid Settlement Funds shall be received on behalf of the Local Goverments and will be placed into one fund (hereinafter, "Opioid Abatement Fund") for the benefit of the Parishes and Municipalities of the state after deducting costs of the Local Government Fee Fund detailed in paragraph D below:

   a. The amounts received shall by the Local Governments shall be allocated with twenty percent (20%) going to the benefit of Sheriffs and the remaining eighty percent (80%) going to the benefit of the other Local

Governments , all as provided hereinafter.

b. The amounts to be distributed to each Parish and Municipalities shall be determined by the Negotiation Class Metrics or other metrics agreed upon, in writing, by the Parishes and Municipalities. The amounts to be distributed to each Sheriff shall be determined by the Negotiation Class Metrics or other metrics agreed upon, in writing, in the same way allocated to the Parishes.

c. The Opioid Taskforce will annually calculate the share of each Parish within the State utilizing the sliding scale in section 4 of the allocation contained in the Negotiation Class Metrics or other metrics that the Parties agree upon.

d. For Qualified Parishes, the Qualified Parish's share, including the Municipalities within that Parish, will be paid to the Qualified Parish and expended for Approved Purposes, including the Core Strategies identified in Exhibit A, if applicable. A priority shall be given to treatment of citizens with opioid use disorder who are not covered by Medicaid or not covered by private insurance for such treatment.

e. For all other Parishes, the funds allocated for those Parishes and Municipalities shall be paid on a regional basis consistent with Louisiana Department of Health Regions, as set forth in Exhibit B. The regional share of the funds will be paid to the designated Parish as set forth in Exhibit B and expended for Approved Purposes, including the Core Strategies identified in Exhibit A, if applicable in that Region. A priority shall be given to treatment of citizens with opioid use disorder who are not covered by Medicaid or not covered by private insurance for such treatment.

f. To the extent that funds in the Opioid Abatement Fund are not appropriated and expended in a year by the Taskforce , the Taskforce shall identify the investments where settlement funds will be deposited. Any gains, profits, or interest accrued from the deposit of the Opioid Funds to the extent that any funds are not appropriated and expended within a calendar year, shall be the sole property of the Party that was entitled to the initial deposit.

g. The Taskforce may take no more than 3% administrative fee from the Opioid Abatement Fund ("Administrative Costs") for operation of the Taskforce .

D. Payment of Counsel and Litigation Expenses

1. This section D shall only apply to any settlement funds or fees derived from settlement(s) with McKesson Corporation, Cardinal Health, Inc., and AmerisourceBergen Corporiation (hereinafter, "Settling Distributors") and Johnson & Johnson, Janssen Pharmaceuticals, Inc., Ortho- McNeil-Janssen Pharmaceuticals, Inc., and Janssen Pharmaceutica, Inc.

2. The Parties anticipate that any national settlement will provide for the partial payment of fees and litigation expenses to counsel representing Local Governments. If the court in *In Re: National Prescription Opiate Litigation*, MDL No. 2804 (N.D. Ohio) or a national global settlement otherwise establishes a separate fund or similar device for the payment of fees and expenses to counsel or requires any governmental plaintiffs to pay a share of their recoveries from defendants into an attorney fee and expense fund as a "tax," then Participating Local Governments shall first seek to have the settling defendants pay the requisite amounts into that fund. If the settling defendants do not agree, then the amounts due to the fee and expense fund shall be paid from the State of Louisiana's recovery, prior to the allocation and distribution of any settlement funds to the State or Participating Local Governments.

3. Any governmental entity which seeks attorneys' fees and expenses for its counsel shall first seek to recover those amounts from the national settlement. Anticipating that any fund established as part of a national settlement will not be sufficient to pay all contingency fee contracts for Participating Local Governments in the State of Louisiana, the Parties agree to create a supplemental fee and expense fund (the "Local Government Fee Fund" or "LGFF").

4. The LGFF is to be used to compensate counsel for Participating Local Governments that filed opioid lawsuits by the Effective Date of this Agreement ("Litigating Participating Local Governments").

5. The LGFF shall be used to pay the fees and expenses of Participating Local Governments in the State of Louisiana who filed opioid lawsuits on or before the date of this agreement The amount of funds to be deposited in the LGFF shall be contingent upon the overall percentage of Incentive Payments awarded to the State of Louisiana under the national settlement, pursuant to the following table, with the LGFF percentage being a percentage of the Total Cash Value of payments to the State of Louisiana before any allocation of funds to the State or any Participating Local Governments. In no circumstances shall the LGFF receive more than 7.5% of the Total Cash Value received by the State of Louisiana including any funds received from a national fee fund as described in Paragraph D(2) above. If the State of Louisiana does not receive at least 65% of the total available Incentive

Payments, then the LGFF shall be null and void and no amounts shall be paid into the LGFF.

| PERCENTAGE OF INCENTIVE PAYMENTS AWARDED | LGFF PERCENTAGE |
|---|---|
| 65% | 2% |
| 70% | 3% |
| 75% | 4% |
| 80% | 5% |
| 85% | 6% |
| 90% | 6.5% |
| 95% | 7% |
| 100% | 7.5% |

6. The Parties further agree no counsel for any Litigating Participating Local Government shall recover, from any national fee fund and the LGFF, a combined contingency fee of more than 7.5% (plus expenses). Additionally, counsel for any Litigating Participating Local Government shall not be paid a contingency fee, from any national fee fund and the LGFF, that exceeds the amount due under its fee contract. If there are any funds remaining in the LGFF after payment of fees and expenses consistent with the terms of this agreement, those funds shall revert pro rata to the Participating LGs.

7. Although the amount of the LGFF shall be calculated based on the entirety of payments due to the LGs over a 10 to 18 year period, the LGFF shall be funded and made payable over a period of 7 years.

E. Accountability

1. The State and Participating Local Governments may object to an allocation of Opioid Funds solely on the basis that the allocation at issue (1) is inconsistent with provision B(1) hereof with respect to the amount of the State Share or LG Share; (2) is inconsistent with an agreed-upon allocation, or the default allocations in Exhibit B or (3) violates the limitations set forth in Exhibit A.

2. The Parties shall maintain, for a period of at least five years, records of abatement expenditures and documents underlying those expenditures, so that it can be verified that funds are being or have been utilized in a manner consistent with the Approved Purposes definition.

3. The Louisiana Legislative Auditor shall have the right to audit the Opioid Funds.

4. In an action brought pursuant to E(1), attorney's fees and costs shall not be recoverable.

F. Settlement Negotiations

1. The State and the Participating Local Governments agree to inform each other in advance of any negotiations relating to a Louisiana-only settlement with a Pharmaceutical Supply Chain Participant that includes both the State and the Participating Local Governments and shall provide each other the opportunity to participate in all such negotiations.

2. The State and the Participating Local Governments further agree to keep each other reasonably informed of all other global settlement negotiations with Pharmaceutical Supply Chain Participants. Neither this provision, nor any other, shall be construed to state or imply that either the State or the Participating Local Governments (collectively, the "Louisiana Parties") are unauthorized to engage in settlement negotiations with Pharmaceutical Supply Chain Participants without prior consent or contemporaneous participation of the other, or that either party is entitled to participate as an active or direct participant in settlement negotiations with the other. Rather, while the State's and the Participating Local Government's efforts to achieve worthwhile settlements are to be collaborative, incremental stages need not be so.

3. By virtue of executing this MOU, Participating Local Governments give the State the right to execute a settlement agreement with certain entities in the Pharmaceutical Supply Chain for those entities' role in the opioid epidemic. The Attorney General shall have the ability to release any and all claims said Participating Local Governments may have with those entities provided such settlement comports with the parameters of this MOU, including Exhibit A and Exhibit B. Furthermore, Local Governments shall not initiate any new litigation against any entity in the Pharmaceutical Supply Chain for harm caused by misfeasance, nonfeasance, and malfeasance committed by said entities that resulted in the opioid epidemic, unless the Local Government is granted written permission from the Attorney General. For the avoidance of doubt, in the event that a Participating Litigating Local Governments seeks to add additional defendants to its lawsuit, or desires to file new litigation against an entity in the Pharmaceutical Supply Chain related to the opioid epidemic, the Participating Litigating Local Government must first receive written permission from the Attorney General.

G. Amendments, Choice of Law, Venue, Consent Decree

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

2. The Parties agree that this MOU, any amendments thereto, and any dispute arising out of or related to this MOU, shall be governed by and interpreted according to the laws of the State of Louisiana. Any action to enforce or interpret this MOU, or to resolve any dispute concerning it, shall be commenced and maintained only by a court of competent jurisdiction in East Baton Rouge Parish, Louisiana. The Parties understand and agree that, in connection with a settlement with any Pharmaceutical Supply Chain Participant, the State may file an appropriate action in a court of competent jurisdiction in East Baton Rouge, Louisiana seeking a consent decree approving such settlement and the allocation of settlement funds within the State of Louisiana pursuant to this MOU.

Acknowledgment of Agreement

The undersigned has participated in the drafting of the above Memorandum of Understanding including consideration based on comments solicited from Local Governments. This document has been collaboratively drafted to maintain all individual claims while allowing the State and Local Governments to cooperate in exploring all possible means of resolution. Nothing in this agreement binds any party to a specific outcome. Any resolution under this document will require acceptance by the State and the Local Governments.

FOR THE STATE:

Attorney General

**EXHIBIT A**

**APPROVED PURPOSES**

# OPIOID ABATEMENT STRATEGIES

## PART ONE: TREATMENT

**Approved Purpose(s)" shall mean evidence-based forward-looking strategies, programming and services used to (i) provide treatment for citizens of the State of Louisiana affected by substance use disorders, (ii) provide support for citizens of the State of Louisiana in recovery from addiction who are under the care of SAMHSA qualified and appropriately licensed health care providers, (iv) target treatment of citizens of the State of Louisiana who are not covered by Medicaid or not covered by private insurance for addictive services. Approved purposes shall include, but shall not me limited to the following:**

### 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) issues through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

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

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

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

4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based, evidence-informed, or promising practices such as adequate methadone dosing.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals, for persons with OUD and any co-occurring SUD/MH issues or persons who have experienced an opioid overdose.

6. Treatment of mental health trauma issues resulting from the traumatic experiences of the opioid user (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such mental health trauma.

7. Support detoxification (detox) services for persons with OUD and any co-occurring SUD/MH issues, including medical detox, referral to treatment, or connections to other services or supports.

8. Training on MAT for health care providers, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists.

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

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

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

12. Scholarships for persons to become certified addiction counselors, licensed alcohol and drug counselors, licensed clinical social workers, and licensed mental health counselors practicing in the SUD field, and scholarships for certified addiction counselors, licensed alcohol and drug counselors, licensed clinical social workers, and licensed mental health counselors practicing in the SUD field for continuing education and licensing fees.

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

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

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

## B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

1. Provide the full continuum of care of recovery services for OUD and any co-occurring SUD/MH 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. 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 issues.

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

4. Provide community support services to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH issues

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

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

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

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

9. Engage non-profits, the faith community, and community coalitions to support people in treatment and recovery and to support family members in their efforts to manage the opioid user in the family.

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

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

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

13. Create and/or support recovery high schools.

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

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

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

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

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

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

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

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

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

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

9. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and

any co-occurring SUD/MH issues or to persons who have experienced an opioid overdose.

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

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

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

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

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

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

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

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

## D. ADDRESS THE NEEDS OF CRIMINAL-JUSTICE-INVOLVED PERSONS

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

Support pre-arrest or pre-arraignment 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 the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);

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

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

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

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

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

g. County prosecution diversion programs, including diversion officer salary. Any diversion services in matters involving opioids must include drug testing, monitoring, or treatment.

2. 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.

3. 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.

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 issues 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 issues who are leaving jail or prison have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

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

7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH issues 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 issues, and the needs of their families, including babies with neonatal abstinence syndrome, through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

1. Support evidence-based, evidence-informed, or promising treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH issues.

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

3. Other measures to address Neonatal Abstinence Syndrome, including prevention, education, and treatment of OUD and any co-occurring SUD/MH issues.

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

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

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

7. 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.

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

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

## PART TWO: PREVENTION

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

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

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

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

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

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

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

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

7. Increase electronic prescribing to prevent diversion or forgery

8. Educate Dispensers on appropriate opioid dispensing.

## G. PREVENT MISUSE OF OPIOIDS

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

1. Corrective advertising or affirmative public education campaigns.

2. Public education relating to drug disposal.

3. Drug take-back disposal or destruction programs.

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

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

6. Engage non-profits and faith community as a system to support prevention.

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

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

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

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

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

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

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

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

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

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

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

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

6. Public education relating to emergency responses to overdoses.

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

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

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

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

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

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

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

## PART THREE: OTHER STRATEGIES

### I. FIRST RESPONDERS

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

1. Law enforcement expenditures relating to the opioid epidemic.

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

### J. LEADERSHIP, PLANNING AND COORDINATION

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

1. Community regional planning to identify goals for reducing harms related to the opioid epidemic, to identify areas and populations with the greatest needs for treatment intervention services, or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

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

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

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

### K. TRAINING

In addition to the training referred to in the items above, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

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

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH issues, 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, 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. Research on expanded modalities such as prescription methadone that can expand access to MAT.

LOUISIANA STATE-LOCAL GOVERNMENT
OPIOID LITIGATION
MEMORANDUM OF UNDERSTANDING

**Exhibit B**

| Parish | Allocation Percentage |
|---|---|
| Acadia Parish | 1.57% |
| Allen Parish | 0.46% |
| Ascension Parish | 2.27% |
| Assumption Parish | 0.37% |
| Avoyelles Parish | 0.84% |
| Beauregard Parish | 0.65% |
| Bienville Parish | 0.20% |
| Bossier Parish | 1.83% |
| Caddo Parish | 4.47% |
| Calcasieu Parish | 4.03% |
| Caldwell Parish | 0.19% |
| Cameron Parish | 0.10% |
| Catahoula Parish | 0.22% |
| Claiborne Parish | 0.28% |
| Concordia Parish | 0.33% |
| De Soto Parish | 0.35% |
| East Baton Rouge Parish* | 9.19% |
| East Carroll Parish | 0.08% |
| East Feliciana Parish | 0.26% |
| Evangeline Parish | 0.79% |
| Franklin Parish | 0.27% |
| Grant Parish | 0.34% |
| Iberia Parish | 1.32% |
| Iberville Parish | 0.70% |
| Jackson Parish | 0.24% |
| Jefferson Davis Parish | 0.69% |
| Jefferson Parish* | 13.17% |
| Lafayette Parish | 5.12% |
| Lafourche Parish | 1.82% |
| Lasalle Parish | 0.35% |
| Lincoln Parish | 0.52% |
| Livingston Parish | 4.97% |
| Madison Parish | 0.12% |
| Morehouse Parish | 0.45% |

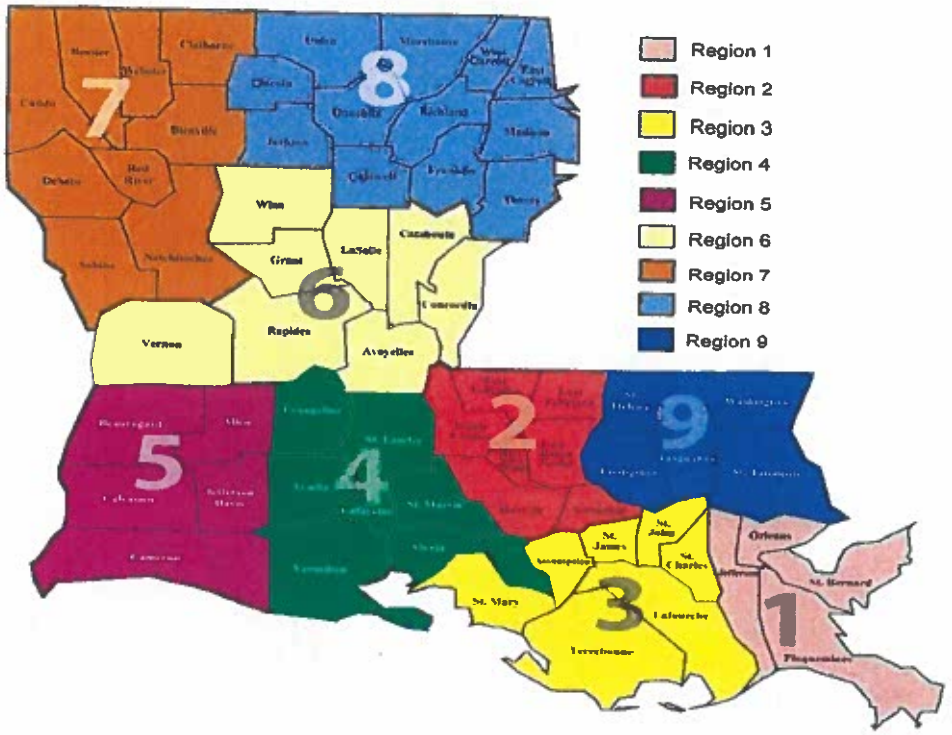
LOUISIANA STATE-LOCAL GOVERNMENT
OPIOID LITIGATION
MEMORANDUM OF UNDERSTANDING

**Exhibit B**

| | |
|---|---|
| Natchitoches Parish | 0.50% |
| Orleans Parish* | 6.29% |
| Ouachita Parish | 2.42% |
| Plaquemines Parish | 0.46% |
| Pointe Coupee Parish | 0.39% |
| Rapides Parish | 3.25% |
| Red River Parish | 0.13% |
| Richland Parish | 0.24% |
| Sabine Parish | 0.35% |
| St Bernard Parish | 1.77% |
| St Charles Parish | 1.17% |
| St Helena Parish | 0.20% |
| St James Parish | 0.29% |
| St John The Baptist Parish | 0.79% |
| St Landry Parish | 1.85% |
| St Martin Parish | 0.84% |
| St Mary Parish | 1.06% |
| St Tammany Parish | 7.83% |
| Tangipahoa Parish | 3.47% |
| Tensas Parish | 0.06% |
| Terrebonne Parish | 2.31% |
| Union Parish | 0.31% |
| Vermilion Parish | 0.96% |
| Vernon Parish | 0.90% |
| Washington Parish | 1.70% |
| Webster Parish | 0.72% |
| West Baton Rouge Parish | 0.53% |
| West Carroll Parish | 0.15% |
| West Feliciana Parish | 0.22% |
| Winn Parish | 0.31% |

* Qualified Parish

EXHIBIT B




**Lead Parishes**

Region 1. St. Bernard Parish (Orleans Parish and Jefferson Parish are excluded);

Region 2. Ascension Parish (East Baton Rouge Parish is excluded);

Region 3. Lafourche Parish;

Region 4. Lafayette Parish;

Region 5. Calcasieu Parish;

Region 6. Rapides Parish;

Region 7. Caddo Parish;

Region 8. Ouachita Parish; and

Region 9. St. Tammany Parish