Exhibit: C

ONE UTAH
OPIOID SETTLEMENT MEMORANDUM OF UNDERSTANDING

1. Recitals and General Principles.

1.1. The people of the State of Utah, its counties, and its communities have been harmed by the opioid epidemic, which was caused by Pharmaceutical Supply Chain Participants.[1]

1.2. The State of Utah, *ex rel.* Sean Reyes, Attorney General (the "State"), and most of the counties in Utah are separately engaged in litigation and other actions seeking to hold the Pharmaceutical Supply Chain Participants accountable for the opioid epidemic.

1.3. The Parties desire to abate and alleviate the impacts of the Pharmaceutical Supply Chain Participants' misfeasance, malfeasance, and nonfeasance throughout their respective geographic areas.

1.4. The Parties enter into this One Utah Opioid Settlement Memorandum of Understanding ("MOU") to determine the allocation of Settlement Funds and set forth certain other terms under which the Parties may jointly agree to a Settlement.

1.5. The parties recognize that, based on settlement discussions under consideration with certain Pharmaceutical Supply Chain Participants, theanticipated amount of Settlement Funds increases as more counties, cities, and towns participate in a Settlement, and that the maximum amount of Settlement Funds may be achieved only if the State and all counties, cities, and towns agree to a Settlement. Without such global agreement within Utah, the amount of Settlement Funds is likely to be reduced.

1.6. Any Settlement will require subsequent acceptance and approval by any settling Parties of a formal written Settlement agreement, including the execution of required releases of claims.

1.7. By entering into this MOU, each Party reserves, in its sole discretion, its rights to:

1.7.1 Participate or not participate in any Settlement;
1.7.2 Maintain, pursue, and prosecute its existing and potential legal claims;
1.7.3 Resolve its claims as it sees fit; and
1.7.4 Resolve its claims independent of the other Parties.

Provided, however, if a County elects not to enter into a settlement of the Litigation, the County shall not participate or be entitled to, Settlement Funds.

1.8. By entering this MOU, no Party is acquiescing to or giving jurisdiction over any element of its actions, including control over payment of attorney fees, to any federal court, including MDL 2804 - National Prescription Opiate Litigation. The parties enter this MOU relating to the allocation as a preliminary non-binding agreement understanding that it only provides a basis to draft formal documents which will effectuate the Parties' agreement.

[1] Capitalized terms not defined contemporaneously are defined in Section 2.

1.9 This MOU has been drafted collaboratively by the Parties to maintain the Parties' existing or potential legal claims (to the extent legally cognizable) while allowing the Partiesto cooperate in exploring all possible means of resolution.

2. Definitions.

As used in this MOU:

2.1. "Administrator" shall mean the person or entity responsible for compiling data and information from the Settling Parties.

2.2. "Approved Uses" shall mean those uses identified in Exhibit A, Opioid Settlement Funds – Approved Uses.

2.3. "County(ies)" shall mean each county that has signed this MOU on its own behalf as a political subdivision of the state pursuant to Utah Code Ann. § 17-50-101(1).

2.4. "Litigation" means existing or potential legal claims against Pharmaceutical Supply Chain Participants AmerisourceBergen, Cardinal, McKesson, and Janssen seeking to hold them accountable for the opioid epidemic, including any kind of injury caused by their misfeasance, nonfeasance, and malfeasance relating to the unlawful manufacture, marketing, promotion, distribution, or dispensing of prescription opioids. It is the intent of this MOU that that the term litigation shall apply to all claims, whether or not asserted by a Party.

2.5. "Local Governments" shall mean all counties and municipalities located within the geographic boundaries of the State.

2.6. "Municipalities" shall mean those entities defined in Utah Code Ann. § 10-1-104.

2.7. "National Settlement Fund Administrator" shall mean the person or entity responsible for enforcing the provisions of any national Settlement or bankruptcy plan, whether called an "administrator," "trustee," "board," or the functional equivalent of those terms.

2.8. "Opioid Litigation Settlement Restricted Account" shall mean the restricted account established within the General Fund pursuant to Utah Code Ann. § 51-9-801.

2.9. "Party(ies)" shall mean the State and all Local Governments, whether represented by outside counsel or not, whether involved in Litigation or not, which have signed this MOU.

2.10."Pharmaceutical Supply Chain Participant" shall mean any entity or individual that engages in or has engaged in the manufacture, marketing, promotion, distribution, or dispensing of prescription opioids.

2.11."Settlement" shall mean the negotiated resolution of the Litigation when that resolution has been jointly entered into by all the Parties, or if jointly entered into by fewer than all the Parties, this MOU is incorporated by the Settling Parties.

2.12. "Settlement Funds" shall mean monetary amounts obtained through a Settlement on or after the date of this MOU.

2.13. "Settling Parties" shall mean the State and any Local Governments which accept a Settlement and sign the corresponding Settlement agreement.

3. Allocation of Settlement Funds.

3.1. All Settlement Funds, other than those directed to attorney fees and costs, regardless of allocation, shall be utilized consistent with theApproved Uses, as ultimately memorialized in a written Settlement agreement which shall become an order of the Litigation courts or other tribunals, including bankruptcy courts. Compliance with the Approved Uses shall be verified as set forth in Section 7.

3.2. 50% of the Settlement Funds shall be allocated to the State ("State Share").

3.3. 50% of the Settlement Funds shall be allocated to the Settling Party Counties ("Local Government Share").

4. Mechanism for Directing Settlement Funds to Approved Uses.

4.1. The State Share shall be deposited by the National Settlement Fund Administrator into the Opioid Litigation Settlement Restricted Account and disbursed pursuant tothe terms of that statute.

4.2. The Settling Party Local Governments' Share shall be distributed by the National Settlement Fund Administrator directly to each settling County pursuant to the percentages set forth in Exhibit B (adopted from https://allocationmap.iclaimsonline.com/) or, on County instructions, to the Utah attorney fee and expense fund established in Section 6.

5. Local Government Allocation.

5.1. As provided for in this Agreement the funds allocated to Each settling County shall be paid to the County directly and the County and its constituent municipalities may distribute the settling County's share of the Settlement Funds among all of the jurisdictions in that county in any manner they choose, consistent with the requirements set forth in the Settlements.

5.2. This Memorandum of Understanding shall apply only to settlements with AmerisourceBergen, Cardinal, McKesson, and Janssen, and provided that 95%, by population, of the litigating political subdivisions agrees to participate in the relevant settlement agreement.

6. Payment of Counsel and Litigation Expenses.

6.1. The parties anticipate that any national Settlement will provide for the payment of all or a portion of the fees and litigation expenses of certain state and local governments.

6.2. In the event that there is a national fund established to pay attorney fees related to a Settlement ("National Fund"), the Counties may, but are not required to, in a formal Settlement agreement establish a Utah attorney fee and expense fund ("Utah Fund") from which counsel for the Settling Parties may seek payment of their attorney fees and costs not paid from a National Fund. Prior to applying to a Utah Fund, counsel for the Settling Parties must first apply for payment of attorney fees from a National Fund, after which it may seek its fees from the Utah Fund for any deficiency.

6.3. No portion of the State Share shall be used for the payment of Settling Party Local Government attorney fees and no portion of the State Share shall be used to establish the Utah Fund; no Settling Party Local Government Settlement Funds and no part of the Utah Fund shall be used for the payment of State attorney fees.

6.4. If a Utah Fund is insufficient to pay the total amount of contingency fees to all counsel for the Settling Parties, all fees will be reduced proportionately, i.e., all fees will be reduced by the same percentage so that no counsel shall receive a higher percentage of its allowed fee than any other counsel. In other words, counsel for the Settling Parties shall apply for an allocation from a Utah Fund based on its clients' recovery and calculated by its fee percentage in the contract, but pro-rated to the extent the Utah Fund is insufficient for complete recovery of all fees to all counsel.

6.5. In no event shall counsel for any Settling Party receive an attorney fee in excess of the amount or percentage set forth in its representation agreement or 15%, whichever is the smaller amount, nor shall counsel for any Settling Party receive reimbursement for costs and expenses in excess of its actual costs and expenses or in excess of its reimbursement rights under its representation agreement.

6.6. Counties which did not retain outside counsel may not apply to any Utah Fund for payment of any attorney fees or costs.

6.7. The Counties participating in the Settlement pursuant to this MOU shall oversee any Utah Fund. The State shall bear no responsibility and waives any right it may have to oversee any Utah Fund. All expenses in administering the Utah Fund are the responsibility of the participating Counties.

6.8. If any Party is represented by more than one law firm, the Party shall be responsible for distribution of their client's attorney fees and costs.

6.9. Any funds remaining in the Utah Fund in excess of the amounts needed to cover private counsels'representation agreements shall revert to the Counties according to the percentages set forth in thisMOU.

7. Compliance Reporting and Accountability.

7.1. At least annually, the Administrator shall provide an up-to-date accounting of payments and uses of Settlement Funds. The Administrator shall also provide an up-to-date accounting of payments and uses of Settlement Funds upon written request of a Settling Party.

7.2. Settling Party Local Governments shall file with the Administrator on or before May 30 of each year a proposed plan detailing the anticipated use of the Settlement Funds including (1) the amount of funds it anticipates disbursing; and (2) the proposed uses of those funds. For the State, on or before May 30 of each year, the Administrator shall make available to the other Settling Parties a plan detailing the same categories of information.

7.3. Settling Party Local Governments shall file with the Administrator, and the Administrator shall make available for the State to the Settling Parties, on June 30 of each year in which Settlement Funds are received, an annual report detailing the use of the Settlement Funds received including (1) the amount of funds received by that Settling Party; (2) the allocation of the funds received (listing the recipient of a third party, the program funded, and disbursementterms), and (3) the amounts disbursed on approved allocations. The State shall provide this information separately to the appropriate authority designated in a Settlement document.

7.4. Out of any Settlement Funds, administrative expenses shall not exceed 1% of the Settlement Funds recovered by the State or any Settling Party.

7.5. Each Settling Party shall maintain, for at least the prior five (5) years, records of expenditures of Settlement Funds and documents underlying those expenditures, so the Settling Party can verify that all Settlement Funds are utilized consistent with this MOU, including the Approved Uses.

7.6. At least annually, each Settling Party shall publish on its website a report detailing for the preceding year (1) the amount of Settlement Funds received, and (2) the allocation of any distributions from the Settling Party's Settlement allocation (listing the recipient, the amount distributed, the program funded, and disbursement terms).

7.7. If it appears to any Settling Party that another Settling Party is using or has used Settlement Funds for non-Approved Uses, the objecting Settling Party may on written request seek the documentation underlying the report(s) described in this MOU. The Settling Party receiving such request shall have fourteen (14) days to provide the requested information. The objecting Settling Party and the Setting Party receiving such request may extend the time for compliance with the request only upon mutual written agreement.

7.8. Each Settling Party may object to an allocation or expenditure of Settlement Funds by any other Settling Party solely on the basis that the allocation or expenditure at issue (1) is inconsistent with provisions this MOU, including the Approved Uses; or (2) violates the limitations set forth in Section 7.4. with respect to compensation of the Trustee.

7.9. Following a request and production of information pursuant to Section 7.7. and when it appears that Settlement Funds are being or have been spent on non-Approved Uses, the objecting Settling Party may seek and obtain in an action in the Third District Court of Utah in Salt Lake County an injunction prohibiting the misusing Party from spending any Opioid Funds on non-Approved Uses and requiring the misusing Party to return the monies that were spent on

non-Approved Uses after notice as is required by the rules of civil procedure. So long as an action is pending, distribution to the misusing Party of Opioid Funds temporarily will be suspended. Once the action is resolved, the suspended payments will resume, less any amounts that were ordered returned but which have not been returned by the time the action is resolved.

7.10. In an action brought pursuant to Section 7.9., attorney fees and costs shall not be recoverable.

ACCEPTED by the undersigned and executed this 25th day of March, 2022.

Signature:

Name: Spencer E. Austin

Title: Chief Criminal Deputy

Subdivision: Utah Attorney General's Office

Exhibit: C-A

List of Opioid Remediation Uses

Schedule A
Core Strategies

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

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

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

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

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

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

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

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

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

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

C. **PREGNANT & POSTPARTUM WOMEN**

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

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

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

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

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

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

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

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

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

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

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

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

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

F. **TREATMENT FOR INCARCERATED POPULATION**

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

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

G. **PREVENTION PROGRAMS**

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

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

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

4. Funding for community drug disposal programs; and

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

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

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

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

Schedule B
Approved Uses

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

PART ONE: TREATMENT

A. <u>TREAT OPIOID USE DISORDER (OUD)</u>

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. <u>SUPPORT PEOPLE IN TREATMENT AND RECOVERY</u>

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. <u>ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME</u>

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. <u>TRAINING</u>

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. <u>RESEARCH</u>

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

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

2. Research non-opioid treatment of chronic pain.

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

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

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

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

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

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

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

Exhibit: C-B

Exhibit B to One Utah Opioid Settlement MOU
County Allocations

County	Allocation Percentage
Beaver	0.228%
Box Elder	1.464%
Cache	2.649%
Carbon	2.718%
Daggett	0.028%
Davis	8.695%
Duchesne	0.641%
Emery	0.938%
Garfield	0.147%
Grand	0.304%
Iron	1.622%
Juab	0.352%
Kane	0.439%
Millard	0.355%
Morgan	0.216%
Piute	0.022%
Rich	0.061%
Salt Lake	42.271%
San Juan	0.249%
Sanpete	1.013%
Sevier	0.661%
Summit	0.944%
Tooele	2.233%
Uintah	0.866%
Utah	15.426%
Wasatch	0.601%
Washington	4.865%
Wayne	0.109%
Weber	9.883%