Recommendations for the Use of Janssen/Johnson & Johnson (J&J) and Distributors National Opioid Settlement Funds

Prepared by the Governor's Advisory Council on Opioid Remediation
Submitted November 1, 2022

Executive Summary

While communities and authorities in the United States work to address the opioid crisis, they are facing a significant increase in the prevalence of illicit fentanyl and resulting increase in overdoses. In 2021, Alaska experienced the largest percent increase in overdose deaths of any state in the United States, losing at least 253 people to overdose, with 196 deaths attributed to opioid overdose. 150 or seventy-six percent (76%) of the deaths involved synthetic narcotics, a category that includes fentanyl. Of the 778 total overdose deaths that occurred between 2017–2021, fifty-eight percent (58%) involved drugs from more than one narcotic, sedative, or psychotropic category, including thirty-four percent (34%) that involved drugs from three or more categories.[1]

The opioid settlement lawsuits filed against multiple manufacturers and distributors assert that their business practices were a major contributing factor to the U.S. opioid epidemic. In February 2022, a $26 billion settlement was finalized between most states and local governments and the manufacturer Janssen/Johnson & Johnson (J&J), and three major pharmaceutical distributors: Amerisource Bergen, Cardinal Health, and McKesson.[2] Native American tribes settled a separate agreement with these parties in May 2022.[3] Through the state and local government agreements, Alaska will receive approximately $58.5 million over the next eighteen years.

Governor Michael Dunleavy's Administrative Order No. 324, established the Governor's Advisory Council on Opioid Remediation (GACOR).[4] By December 1 of each year, the council must deliver a report to the Commissioner of the Department of Health with input and recommendations regarding: 1) The management and allocation of the opioid remediation funds 2) A process, or improvements to the process for receiving input from communities regarding remediation strategies and responses to their specific opioid remediation needs and 3) Implementing efficient, evidence-based approaches to opioid remediation statewide.

Remediating the impacts of the opioid epidemic in Alaska requires a comprehensive and community-based approach. The most impact will be made by Alaskans working together to address the conditions that lead to substance misuse and addiction in the first place and by cultivating empathy to help those struggling with addiction.

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1) 2021 State of Alaska Drug Overdose Mortality Update https://health.alaska.gov/dph/VitalStats/Documents/PDFs/DrugOverdoseMortalityUpdate_2021.pdf

2) February 25, 2022, Settlement Press Release https://nationalopioidsettlement.com/wp-content/uploads/2022/02/Opioids_release_20220225.pdf

3) Tribal Opioid Settlement Webpage https://www.tribalopioidsettlements.com/

4) Administrative Order 324 https://gov.alaska.gov/wp-content/uploads/sites/2/10.01.21-Adminstrative-Order-324-Governors-Advisory-Council-on-Opioid-Remediation.pdf

Acknowledgements

Development of this report was informed by those with lived experience who shared their personal stories with the council, comments received through a formal public comment process, presentations from state experts, and in consultation with staff at the Divisions of Public Health and Behavioral Health. Existing state plans known to address opioid prevention and treatment were reviewed, and national guidance and evidence-based and culturally appropriate strategies for prevention and abatement were collected. A list of resources is included as an attachment. Administrative support in the form of guidance and writing of this report was provided by staff at the Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse.

The recommendations that follow aim to embrace the values of saving lives, equity, transparency, being locally driven, evidence-based and culturally appropriate, measurable, effective and efficient, and long-term sustainability.

The Governor's Advisory Council on Opioid Remediation members contributing their time and thoughts to this report include:

Tom Begich, Senate Minority Leader
Brian Fechter, Department of Revenue Deputy Commissioner
Daniel Grimes, Soldotna Deputy Fire Chief
Anita Halterman, Alaska Mental Health Trust Authority Board of Trustees Chair
George Hays, Matanuska-Susitna Deputy Borough Manager
Heidi Hedberg, Director of Alaska Division of Public Health, Chair of Council
Kolby Hickel, Anchorage Deputy Municipal Manager
Ken McCarty, House Representative
Liz Snyder, House Representative
W. Glenn Steckman, Nome City Manager
Bryce Ward, Fairbanks North Star Borough Mayor
David Wilson, Senator
Diana Zirul, Kenaitze Tribal Council Treasurer, Alaska Native Health Board Chair

A special thank you to the federal, state, Tribal, and local governments, community organizations, families, and individuals who work hard to prevent or mitigate substance misuse.

We extend our sincere condolences to those who have lost someone to the opioid epidemic.

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Introduction

The origins of opioid and other substance misuse in the United States dates to the 1800s, but increased prescription of opioid medications beginning in the 1990s was a significant driver to the opioid epidemic. From 1991 to 2011, the number of opioid prescriptions dispensed by U.S. pharmacies nearly tripled: from 76 million to 219 million.[5] Pharmaceutical companies downplayed the risks as they marketed their products to providers. The subsequent increase in prescription of opioid medications led to widespread misuse, and many pills were diverted to friends and family or to illegal markets.

The rise in opioid overdose deaths is often described in three waves: a rise in prescription overdose deaths beginning in 1999, a rise in heroin overdose deaths in 2010, and a rise in synthetic opioid overdose deaths beginning in 2013. As authorities began regulating the amount of prescription pills available and companies changed their formulations, heroin became the more accessible and cheaper option for many. Data show transitioning to heroin use is rare for people who first take prescription opioids but for those who do use heroin, a significant number began their opioid use with prescription opioids. Most recently, there are rising rates of overdose driven by potent synthetic opioids, including illicitly manufactured fentanyl, along with an increase in overdoses involving stimulants and polysubstance use.[6] This is occurring despite a forty-four percent (44%) decrease in opioid prescriptions from 2011 to 2020 and significant increase in state prescription drug monitoring programs.[7]

Evidence-based strategies exist to mitigate the opioid epidemic. Upstream prevention can increase protective factors in youth and reduce access to non-prescription pain relievers; harm reduction techniques such as naloxone work to reverse opioid overdose; and medications exist to treat opioid use disorders. A continued multipronged approach is necessary to address the many factors contributing to both the ongoing opioid epidemic and other co-occurring substance use and mental health disorders.

5) 2018 National Institute on Drug Abuse Prescription Opioids and Heroin Research Report https://nida.nih.gov/publications/research-reports/prescription-opioids-heroin/increased-drug-availability-associated-increased-use-overdose

6) United States Department of Health & Human Services Overdose Prevention Strategy https://www.hhs.gov/overdose-prevention/background

7) 2022 American Medical Association Overdose Epidemic Report https://www.ama-assn.org/system/files/ama-overdose-epidemic-report.pdf

Overview of Settlement Agreement and Establishment of Advisory Council

The national opioid settlement consists of two agreements: an agreement with the manufacturer Janssen/Johnson & Johnson (J&J), and another with the three pharmaceutical distributors: Amerisource Bergen, Cardinal Health, and McKesson. In addition to sending money to states, Janssen/J&J agrees not to manufacture, sell, promote, or distribute any opioid products nor lobby for prescription opioids for the next ten years. J&J will also make clinical trial data for its opioid products available for medical research via the Yale University Open Data Access Project.

The three distributors are required to establish a third-party clearinghouse that serves as a data repository, monitoring where each opioid dose is destined. The distributors must check the database before sending out each shipment and must notify state and federal authorities and hold the shipment if it appears that the recipient drugstore or other facility is asking for an extraordinary number of drugs.

Funding For Alaska

The amount of funding sent to participating states and political subdivisions was based on the population, number of opioids shipped to the area, number of opioid-related deaths that occurred, and the number of people who suffer from opioid use disorder. The political subdivisions in Alaska were defined as populations of 10,000 or more and include the: Municipality of Anchorage, City of Fairbanks, Fairbanks North Star Borough, Juneau City and Borough, Kenai Peninsula Borough, Ketchikan Gateway Borough, Kodiak Island Borough, Matanuska-Susitna Borough, and City of Wasilla.

In total, over eighteen years, Alaska will receive $58,566,779. The settlement default allocation is fifteen percent (15%) to political subdivisions, fifteen percent (15%) to the state fund and seventy percent (70%) to an abatement account fund. Political subdivisions entered into individual agreements with the State of Alaska, and they will govern how their funds will be distributed.

Abatement and Remediation Strategies

The settlement requires at least eighty-five percent (85%) of funds be spent on opioid remediation, meaning activities designed to 1) address the misuse of opioids, 2) treat or mitigate opioid use disorder or related disorders, or 3) mitigate other effects of the opioid epidemic. A fifteen-page section titled, “Exhibit E”, provides a broad spectrum of example strategies ranging from improvements to infrastructure, to direct services, to research and evaluation of the effectiveness of the strategies. The target population is also broad, but a section titled, “Schedule A Core Strategies” highlights services for individuals who are: uninsured or whose insurance does not cover the needed service (e.g. naloxone, medications for addiction treatment, screening, brief intervention, referral and treatment); incarcerated or transitioning back to the community; pregnant or postpartum with opioid use disorder or with co-occurring other substance use disorder or mental health disorder; diagnosed with neonatal abstinence syndrome; in need of medication-assisted treatment or other opioid-related treatment; in recovery; in need of comprehensive syringe service programs; and in need of naloxone.

Advisory Council

The settlement agreement dictates that states designate an advisory committee to provide input and recommendations regarding remediation spending from the state's abatement account fund. Administrative Order No. 324 established the Governor's Advisory Council on Opioid Remediation (GACOR) with the intent to provide an efficient and transparent way to engage Alaskans statewide regarding the management and allocation of opioid abatement funds. The council has nine voting members and four non-voting ex-officio members. Emphasis was placed on equal numbers of state and local representatives that collectively represent Alaska's geographically, demographically, economically, and culturally diverse communities.

Development of Recommendations

The council first met in December 2021 and continued to meet monthly, learning from various subject matter experts and from individuals with lived experience. In June 2022, the council met for a full day in Fairbanks where they made decisions about fund management and allocation. Council members created a small advisory subcommittee which met in July to discuss recommendations on abatement strategies. The Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse planning staff summarized these recommendations for the council and the report was posted September 2022 for public comment. The council reviewed the comments in October and decided no changes to the recommendations were necessary. A summary of all public comment received is included in Appendix C of this report.

Recommendations on the Management and Allocation of the Opioid Remediation Funds

The council prioritizes collaboration and consultation with local, state, and national experts, transparency on the use of funds, geographical and demographical equity, and internal and external measurability to track effectiveness and efficiency.[8] There are currently multiple sources of funding actively addressing the opioid epidemic in Alaska. The council emphasizes the importance of a strategic and tactical approach which creates a stable funding source available for long-term use.

The council recommends:

1) Maintaining the default allocation terms of the settlement agreement and not amending them through a state-subdivision agreement or legislation: fifteen percent (15%) to the Subdivision Fund; seventy percent (70%) to the Abatement Accounts Fund; and fifteen percent (15%) to the State Fund which will be directed into the Abatement Accounts Fund.

8) 2021 American Public Health Association Policy Statement: An Equitable Response to the Ongoing Opioid Crisis https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2022/01/07/An-Equitable-Response-to-the-Ongoing-Opioid-Crisis

2) Securitizing opioid settlement payments scheduled to be deposited into the State Fund and Abatement Accounts Fund (i.e., exchanging the right to receive future payments for a one-time lump sum payment through a bond transaction). These securitized funds, in addition to amounts already received and any supplemental legislative appropriations made during the 2023 legislative session shall be deposited into a new account. The account will be invested under the Commissioner of Revenue's fiduciary duty and with the advice of the Investment Advisory Council used to establish asset allocations for other state funds.

3) Securitized funds shall be used only for opioid remediation activities and spent from using a Percent-Of-Market-Value (POMV) approach that balances structure and sustainability to ensure funds are available long-term.

4) Depositing any funds received by the State now, or in the future, relating to litigation over liability for the opioid epidemic, into the same opioid abatement account as the securitized funds. Funds in this account will be used only for future opioid remediation activities.

5) The Legislature and Governor support a one-time state general fund match up to one hundred percent (100%) of the opioid settlement for the initial lump sum deposit into the opioid abatement account.

6) Assigning responsibility for the allocation and distribution of funds to the Alaska Department of Health. The council will work with the Department to develop the process for equitable allocation that accounts for the diverse geographic and demographic makeup of Alaska.

7) Distributing funds to entities that are addressing opioid remediation efforts in Alaska. An entity is defined as a 501(c)(3) non-profit, healthcare facility, private institution of higher education, city or borough that has signed or is willing to sign the settlement agreements, or a state or tribal government.

8) Creating a robust, cross-sector steering committee tasked with review of draft funding announcements and proposals/applications from entities. The steering committee will be made of at least fifty percent (50%) local government representation to meet the requirements of the current settlement and the bankruptcy settlements. Excluding conflicts of interest, recommended core representation includes local government representatives, the Alaska Division of Public Health, Alaska Division of Behavioral Health, Alaska Mental Health Trust Authority, Alaska Mental Health Board/Advisory Board on Alcoholism and Drug Abuse, Alaska Behavioral Health Association, University of Alaska Anchorage Center for Alcohol and Addiction Studies, Alaska Native Health Board, Tribes/Tribal Health Organizations (T/THOs), and individuals with lived experience. In addition to the above, subject matter experts will be included as applicable, to include but not be limited to: Alaska Department of Corrections, Alaska Division of Juvenile Justice, Alaska Office of Children's Services, Alaska Department of Labor and Workforce Development, Alaska Division of Health Care Services, Alaska Prescription Drug Monitoring Program, and non-profit organizations.

9) Beginning in FY 2024 (July 1, 2023), make annual withdraws not to exceed five percent (5%) of principle to fund new statewide or community level opioid abatement programs and/or enhancements to existing programs. The council chose this percent in congruence to the Alaska Permanent Fund's percent of market value (POMV) approach.

10) Creating a process for tracking funds and publicly reporting allocations online, including a published report of which entities receive funding and what it was used for.

11) Requiring the outcome measures on reports from fund recipients be taken into consideration along with other sources of new information and data when writing each year's annual report to the Commissioner of the Department of Health.

Recommendations On a Process, or Improvements to the Process for Receiving Input from Communities Regarding Remediation Strategies and Responses to Their Specific Opioid Remediation Needs

The council believes in the importance of allowing funding applicants to rank their needs regarding opioid abatement. The council prioritizes being open to feedback from Alaskans both on this report and the overall process. In addition to posting this report for public comment, there are multiple opportunities throughout the year where citizens can contribute their voice and the council encourages development of additional opportunities.

The council recommends:

1. Incorporating feedback received through existing mechanisms. Examples include but are not limited to stakeholder budget planning and board meetings, contract and grantee meetings, state plan reviews, substance use and mental health public comment opportunities, community cafes, community opioid and wellness coalitions and the Opioid Working Group. Refer to Appendix A for more detail.

2. Accepting ongoing feedback via an online portal or designated contact posted on an appropriate State of Alaska website.

3. Requiring reports that provide feedback on program implementation and effectiveness from entities who receive funding.

4. Encouraging and assisting council members to engage with individuals and agencies within their respective regions.

5. Continuing to publicly notice all meetings of the council, providing a virtual means to attend the meetings and accepting feedback during the meeting and through public testimony.

6. Posting the council's annual report for public comment prior to submission to the commissioner and including public comment received with the report.

Recommendations on Implementing Efficient, Evidence-Based Approaches to Opioid Remediation Statewide

The council emphasizes using a broad strategic framework as a guide for choosing which evidence-based and culturally appropriate activities to fund. These activities should be actionable, measurable, effective and efficient. When possible, approaches should also be holistic, multidisciplinary, trauma-informed, family-inclusive, and peer-supported.

The council recommends:

1. Focusing first on funding that targets the core abatement strategies and populations listed under Exhibit E, Schedule A in the settlement agreement, allowing funding applicants to propose priorities specific to their community.

2. Using a population/public health approach when allocating funds which focuses on upstream/primary prevention, treatment, harm reduction and recovery services.

	Final Agreement Settlement Document Exhibit E, Schedule A Core Strategies
Upstream/ Primary Prevention	• Evidence-Based Prevention Programs in Schools • Provider Education and Outreach on Best Prescribing Practices • Community Drug Disposal Programs • Media Campaigns to Prevent Opioid Use Disorder
Treatment	• Workforce Education on Medications for Addiction Treatment • Pre-Arrest Diversion and Post-Overdose Response Training for First Responders • Targeted Screening • Targeted Distribution of Medications for Addiction Treatment and Integration Across Continuum of Care • Wraparound Services for People w/Opioid Use Disorder • Services for Babies w/Neonatal Abstinence Syndrome and Caregiver • Treatment for Women with Opioid Use Disorder and Co-Occurring Substance Use and Mental Health Disorders Twelve-Months Postpartum
Harm Reduction	• Naloxone Training • Targeted Naloxone Distribution • Syringe Exchange and Wrap Around Services Including Linkage to Opioid Use Disorder Treatment • Access to Sterile Syringes and Linkage to Care and Treatment of Infectious Diseases
Recovery	• Wraparound Services and Housing for Opioid Use Disorder and Co-Occurring Substance Use and Mental Health Disorders

3. Using a systems-based approach when allocating funds that encourages cost effectiveness and quality assurance. [9,10]
    - Leveraging and braiding funds from other sources to ensure the most collective impact and efficient use
    - Training workforce in addiction science
    - Evaluating data infrastructure needs to support measuring progress of opioid abatement strategies
    - Using outcome-based measures that reflect intent of opioid abatement
    - Using internal processed-based measures to ensure transparency and effective management

Conclusion

The intent of the council is to get the funding to entities that are focused on opioid abatement. The council encourages the Administration to use evidence-based and culturally appropriate methods as they respond to the emerging needs of the state. The council encourages empathy toward individuals with pain and addiction and supports integrated/holistic care which means meeting each person where they are at. This includes behavioral health and primary care integration but also emergency and law enforcement co-response. The council acknowledges the existing advisory groups, planning and funding infrastructure within Alaska (refer to Appendix A) and emphasizes the importance of involving these entities in conversations related to opioid abatement planning.

9) Guide for Future Directions for the Addiction and OUD Treatment Ecosystem https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8406500/

10) Applying the Balanced Scorecard to Local Public Health Performance Measurement: Deliberations and Decisions https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-9-127

Appendix A: Alaska's Existing Opioid Advisory, Planning and Response Infrastructure

Alaska Native Health Board

The Alaska Native Health Board (ANHB), established in 1968, is recognized as the statewide voice on Alaska Native health issues. The mission of the ANHB is to promote the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people. ANHB is a 28-member board entity, consisting of one representative of the Board of Directors or health committees from each of Alaska's Tribes/Tribal Health Organizations (T/THOs) and independent tribal public Law 93-638 compactors/contractors.[11] ANHB's ongoing mission centers on fostering constructive communication with government agencies, elected officials, and industry stakeholders to raise awareness of Tribal health issues and to promote meaningful dialogue and effective policy change at the state and federal levels.

Advisory Board on Alcoholism and Drug Abuse

The Advisory Board on Alcoholism and Drug Abuse (ABADA) was established in 1988 by the Alaska State Legislature (AS 44.29.100) and Executive Order #71. Co-located with the Alaska Mental Health Board (AMHB) and Statewide Suicide Prevention Council, AMHB/ABADA are statutorily charged with advising, planning, and coordinating behavioral health services and programs funded by the State of Alaska. AMHB/ABADA holds a public board meeting at least twice a year, with one meeting held in a community located off the road system. These meetings host panels of citizens and formal public comment so citizens can share how substance use and mental health is affecting their community. AMHB/ABADA considers this input as they work to advocate and assist in the coordination and creation of state planning processes related to substance use and mental health.

Alaska Mental Health Trust Authority

The Alaska Mental Health Trust Authority (Trust) was established in 1994. Trust funding promotes long-term systemic change and improves the lives and circumstances of Trust beneficiaries. Beneficiaries include Alaskans who experience mental illness, intellectual and developmental disabilities, substance use disorders, Alzheimer's Disease and related dementia, and traumatic brain injuries. The Trust provides leadership in advocacy, planning, and the implementation of beneficiary services and programs. In partnership with its advisory boards and the Departments of Health and Family and Community Services, the Trust maintains the Comprehensive Integrated Mental Health Program Plan. Each year the Trust convenes stakeholder meetings informing the development of their next year's budget.[12]

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11) Alaska Native Health Board website http://www.anhb.org/about-anhb/
12) FY24/25 Alaska Mental Health Trust Budget Development Stakeholder Meeting Summary Notes https://alaskamentalhealthtrust.org/wp-content/uploads/2022/07/Final-FY-24-25-Stakeholder-Meeting-Summary-Notes.pdf

Alaska Opioid Policy Task Force, Opioid Work Group

To address the rising incidence of heroin and opioid misuse in Alaska, in 2016, ABADA, the Division of Public Health, and the Trust co-facilitated an Alaska Opioid Policy Task Force (AOPTF).[13] The goal of this taskforce was to provide recommendations to the Governor and Legislature.[14] This group continues meeting monthly as the "Opioid Work Group" with the intent of coordinating and leveraging efforts across State of Alaska Departments.

Alaska Office of Substance Misuse and Addiction Prevention and Statewide Opioid Action Plan

In July 2017, the Office of Substance Misuse and Addiction Prevention (OSMAP) was created within the Division of Public Health. A planning summit was held August 2018, and based on recommendations from the AOPTF, the 2018-2022 Statewide Opioid Action Plan (SOAP) was created.[15] The mission of the plan is to save lives in the present and to work to prevent future opioid and substance misuse. To ensure the plan is dynamic, OSMAP held a virtual review of the plan in 2020. OSMAP is currently conducting public community cafes around the state in preparation for the plan's extension in 2023. The office works with many stakeholders including staff with the High Intensity Drug Trafficking Area office, and Centers for Disease Control and Prevention staff supporting Alaska's Overdose Response Strategy and Opioid Rapid Response Program.[16,17]

Alaska Division of Behavioral Health

The Division of Behavioral Health (DBH) administers publicly funded statewide behavioral health services (mental health and substance use). In Alaska, the State Opioid Treatment Authority (SOTA) is housed within DBH. The SOTA provides oversight for opioid treatment programs (OTPs) statewide. In partnership with others, DBH created a Medications for Addiction Treatment Guide to assist providers in implementing opioid treatment services.[18] DBH uses the Substance Abuse and Mental Health Services Administration (SAMHSA) Combined Mental Health Block Grant and Substance Abuse

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13) Alaska Opioid Policy Task Force Website https://health.alaska.gov/AKOpioidTaskForce/Pages/default.aspx#:~:text=Legis%E2%80%8Blature.,the%20diversity%20of%20Alaska's%20communities.

14) 2017 Alaska Opioid Policy Task Force Final Recommendations https://health.alaska.gov/AKOpioidTaskForce/Documents/AOPTF-Recommendations-1-19-17.pdf

15) State of Alaska 2018-2022 Statewide Opioid Action Plan https://health.alaska.gov/dph/Director/Documents/opioids/Statewide-Opioid-Action-Plan-2018-2022.pdf

16) High Intensity Drug Trafficking Areas Overdose Response Strategy (ORS) https://www.hidtaprogram.org/ors.php

17) CDC Opioid Rapid Response Program https://www.cdc.gov/opioids/opioid-rapid-response-program.html:~:text=Opioid%20Rapid%20Response%20Program%20(ORRP)%20is%20an%20interagency%2C%20coordinated,disorder%20(MAT%2FMOUD).

18) State of Alaska Medications for Addiction Treatment Guide https://health.alaska.gov/dbh/Documents/TreatmentRecovery/MAT/MATGuide--May2021.pdf

Block Grant Behavioral Health Assessment and Plan to communicate priority areas, strategies, and annual performance indicators to SAMHSA and to plan, implement, and evaluate activities that prevent and treat substance misuse.[19] Since 2018, DBH manages Alaska's 1115 Behavioral Health Medicaid Demonstration Waiver (1115 Waiver), which consists of a substance use disorder (SUD) and behavioral health component. The 1115 SUD Waiver equips Alaska's behavioral health providers with Medicaid funded treatment options to address addiction and substance misuse through local, community-based treatment providers.[20] DBH co-leads the Statewide Epidemiology Workgroup (SEW) with the Division of Public Health. The intent of SEW is to emphasize outcomes-based prevention; adopt a public health approach to preventing and reducing substance use and related problems, as well as mental, emotional and behavioral disorders; and use epidemiological data as a primary foundation for all planning and decision-making at state and community levels.[21]

Tribes/Tribal Health Organizations (T/THOs)

The Alaska Tribal Health System (ATHS) is a diverse and multifaceted healthcare system developed over the last forty years. ATHS is comprised of approximately thirty independently operating Tribes/Tribal Health Organizations (T/THOs) and has a robust referral and care coordination system.[22] ATHS invests in multiple strategic efforts to address concerns related to opioid use disorder, including prevention and intervention efforts with culturally appropriate programs based in traditional values. Organizations invest in data analytic strategies to empower their providers to reduce the number of prescriptions of opioids being written within their regions. Many T/THOs provide medication assisted treatment (MAT) to individuals who experience an opioid use disorder, community and provider education and training regarding the risks of opioids, treatment, and harm-reduction strategies and supplies. T/THOs in most areas are the only healthcare providers available, and therefore serve everyone in the area regardless of race. The ATHS also works to coordinate training and education for Community and Behavioral Health Aides, who are critical in rural areas with limited infrastructure. In response to the need for improved MAT coordination, the Alaska Native Tribal Health Consortium created a Medication Assisted Treatment (MAT) Toolkit to aid providers in rural Alaska.[23]

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19) Combined MHBH/SABG Behavioral Health Assessment and Plan https://bgas.samhsa.gov/ (username: citizenak and password: citizen, Existing Applications, View Application)
20) The 1115 (SUD) Medicaid Waiver Demonstration Implementation Plan https://health.alaska.gov/dbh/Documents/1115/AK_1115waiver_ImplementationPlan.pdf
21) Data-Based Planning for Effective Prevention: State Epidemiological Outcomes Workgroups https://store.samhsa.gov/sites/default/files/d7/priv/sma12-4724.pdf
22) Alaska Tribal Health System Overview https://alaskamentalhealthtrust.org/wp-content/uploads/2019/09/HandOut-AlaskaTribalHealthSystemOverview-by-ANHB-and-ANTHC-BH.pdf
23) Alaska Native Tribal Health Consortium Medication Assisted Treatment Toolkit: Empowering Recovery from Substance Use Disorders in Rural Alaska https://www.anthc.org/wp-content/uploads/2021/09/ANTHC-MAT-Toolkit_FINAL.pdf

Prescription Drug Monitoring Program (PDMP)

The Prescription Drug Monitoring Program (PDMP) housed under the Alaska Board of Pharmacy, was created in 2008, with Senate Bill 196 by the Twenty-Sixth Alaska State Legislature. The PDMP serves as a data repository used to improve patient care by monitoring and promoting judicious prescribing and dispensing practices; reducing inappropriate prescribing; identifying and preventing instances of misuse, abuse, and drug diversion; and increasing provider communication across provider settings.[24] The PDMP provides clinical alerts to providers alerting them if a patient has had multiple provider episodes, is taking a dangerous combination of medication, or has exceeded fifty morphine milligram equivalents (MME)/day. The PDMP also contains interactive modules to help providers understand their own prescribing behavior as it compares to their peers (provider report cards) and provides the option for providers to monitor their mandatory use. These tools give providers information to be able to monitor their patients' care and evaluate their own compliance with statutory requirements. The 2022 Quarter 1 reports show that 7,098/7,823 or ninety point seven percent (90.7%) of providers in Alaska with Drug Enforcement Administration registration are registered with the PDMP. 426, or five point four percent (5.4%) of those providers directly dispense. Providers include dentists, physician assistants, physicians (including podiatrists and medical residents), nurses, optometrists, and veterinarians. There are 781 of 1,114 licensed pharmacists in Alaska registered with the PDMP even though they are not required by statute or regulations to register.[25]

Federal Funding to Alaska

Per the Opioid Response 2020-2021 Report to Legislature, in the past 8 years, the State of Alaska has received at least $86 million in federal grant funds to address the opioid response. From October 2021 to September 2022, the State of Alaska received $17,060,389 in federal funding. Pages 12-14 of the report go into detail how these funds are broken out and the 2021 Drug Overdose Mortality Update highlights a few programs.[26] The reports show the breadth of State of Alaska Departments and agencies involved in Alaska's opioid response, and grants including: High Intensity Drug Trafficking Areas, Opioid Crisis Intervention and Community Involvement Project, Project AWARE, Overdose Data to Action, Alaska Public Safety and Public Health Drug Overdoses Committee, Prescription Drug/Opioid Overdose-Related Deaths Prevention Initiative – Project HOPE, State Opioid Response, Restore Hope in Linkage to Care Collaboration Program, Substance Abuse Prevention and Treatment Block Grant, and more.[27]

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24) 2022 Alaska Prescription Drug Monitoring Program Report to the 32nd Alaska State Legislature https://www.commerce.alaska.gov/web/portals/5/pub/PHA_PDMP_2022_LegislativeReport.pdf

25) PDMP Board Reports https://www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/PrescriptionDrugMonitoringProgram/PDMPBoardReports.aspx

26) Alaska's Opioid Response 2020-2021 Report to Legislature https://health.alaska.gov/dph/Director/Documents/opioids/AlaskaOpioidResponse-2020-2021.pdf

27) 2021 State of Alaska Drug Overdose Mortality Update https://health.alaska.gov/dph/VitalStats/Documents/PDFs/DrugOverdoseMortalityUpdate_2021.pdf

Appendix B: Further Reference

State of Alaska Plans Known to Address Opioid Use, Treatment or Prevention Strategies:

- Statewide Opioid Action Plan 2018-2022
- Healthy Alaskans 2030 State Health Improvement Plan (page 25/98, page 44/98, page 76/98)
- Strengthening the System: Alaska's Comprehensive Integrated Mental Health Program Plan (2020-2024) (Goal 4)
- Alaska Statewide Violence and Injury Prevention Plan 2018-2022 (page 42/62)
- Recasting the Net: Promoting Wellness to Prevent Suicide in Alaska, 2018-2022 Statewide Suicide Prevention Plan (Goals 2 and 3)
- Alaska State Plan for Senior Services FY 2020-FY 2023 (page 34/170)

Evidence-Based Guidance

- Evidence Based Strategies for Abatement of Harms
- Evidence-Based Strategies for Preventing Opioid Overdose: What's Working in the United States
- A Guide to SAMHSA's Strategic Prevention Framework
- From the War on Drugs to Harm Reduction: Imagining a Just Response to the Overdose Crisis
- Brandeis Opioid Resource Connector
- CLOUD: The Curated Library about Opioid Use for Decision-makers
- SAMHSA Resource Center
- Blueprints for Healthy Youth Development website

Settlement Guidance

- Johns Hopkins: Principles for the Use of Funds from the Opioid Litigation (interactive website) or (.pdf link)
- American Society of Addiction Medicine: March 2021 Opioid Settlement Funds State Brief
- Association of State and Territorial Health Officials: States Using Settlement Fund Legislation to Enhance Response to the Opioid Crisis (January 26, 2022)
- Rand Corporation: Strategies for Effectively Allocating Opioid Settlement Funds
- Social Current: Opioid Settlement Toolkit for Community-Based Organizations (Tool for organizations/the public to make suggestions to policy makers and state officials)

Appendix C: Summary of September 2022 Public Comment Received

Comments received from 69 individuals and entities:

- 1 handwritten letter by mail
- 56 written comments by email
- 12 verbal comments via Zoom

Comments received from entities representing Alaskans statewide, several private businesses and treatment provider agencies, and individuals in Anchor Point, Anchorage, Chugiak, Cooper Landing, Fairbanks, Haines, Homer, Juneau, Ketchikan, Kodiak, Ninilchik, Palmer, Soldotna, Tenakee Springs, Valdez and Wasilla.

11 of the individuals who submitted comment shared that they were a person with lived experience of addiction or a family member of someone with lived experience.

Regarding the management of funds, comments generally agreed with the idea of securitization and lump-sum investment to create a dedicated abatement account. Highlights include:

- The Alaska Advisory Board on Alcoholism and Drug Abuse encourages the dedicated account be established in statute as designated funds.
- One individual as well as the Alaska Municipal League disagreed with the securitization and lump-sum investment approach and suggested the funds need spent now, or at the least a strategic spend-down of the funds with a greater portion spent on today's crisis. The Alaska Municipal League suggested the council consider something other than default allocation between state and political subdivisions (15%, 15%, and 70%) and instead, suggested a jointly administered structure where local governments and state co-manage allocation and distribution of funds.
- Several comments supported requesting that the legislature and Governor match the lump sum investment.
- One elected representative stated he would like to charge those responsible with the management of these funds with a mandate to report to the legislature what annual appropriations are necessary to adequately mitigate opioid addiction and reduce onset of addiction in youth.

Regarding allocation and distribution of funds, there were several comments received. Highlights include:

- The Advisory Board on Alcoholism and Drug Abuse asks that they take on a convening role or representation on any oversight committee that may be created for planning fund allocation and distribution.
- The Alaska Native Health Board stated they too wish to be on this steering committee and emphasized whatever process be developed that it does not result in tribal entities having a competitive bidding process against one another.

- The Alaska Primary Care Association wrote to request they also have representation on any planning committee.
- A rural addiction specialist provider asked to be involved in future planning as a subject matter expert.
- Several individuals requested more detail on the specific plan for fair and equitable distribution.
- Two private providers wanted to know how they could be eligible for funds, as did a member of church leadership.
- Many comments expressed the need for rural Alaska to receive this funding.

Regarding types of activities and programs to fund, the majority of comments were in support of the topics listed in Exhibit E, with several comments wanting to ensure items in Schedule B are included in addition to Schedule A.

Many comments focused on equal treatment in corrections, upstream prevention and treatment to pregnant and parenting individuals with opioid use disorder, harm reduction services and supplies, housing, paying for treatment for people who cannot afford, and changing the culture of how Alaskans view individuals with addiction. Several comments emphasized that culturally relevant services be funded even if they are not considered "evidence-based" by Western standards.

There was overwhelming gratitude from the public to the council for accepting public comment.

Ideas for funding outside of Exhibit E included:

- Compensation to families who lost loved ones during the epidemic
- Compensation to families who spent money on treatment for their loved ones and for college education that was not completed due to their child's opioid use disorder
- Compensation to individuals who have had their property damaged or stolen due to an individual experiencing an opioid addiction
- Reproductive Health education and services including long-acting reversible contraception
- Microgrants to grow small businesses

Summaries from each comment received include:

1. Recovery Services: Wraparound - Housing First
2. Support of asking for matching funds from legislature for the lump sum investment into an abatement account. Agree with Alaska Native Health Board being part of steering committee, with emphasis that process does not result in tribal entities having a competitive bid process. Recommend a simple process be developed for reporting requirements. Traditional practices and culturally relevant methods that may not be considered "evidence-based" by Western standards. Workforce education and expanded medications for addiction treatment especially in rural areas.
3. Treatment facilities including Corrections. Centralized directory to support people wanting services.

4. Prioritize services for veterans
5. Choose something and do it well. Anti-stigma campaign Wraparound services with treatment is also upstream prevention because it's treating the family.
6. Harm Reduction through nonprofits, access to buprenorphine in corrections, follow Statewide Opioid Action Plan, fund prescriptions for people who cannot afford, recovery housing/housing first
7. Community residential centers/transitional living for furlough, parole or ankle monitoring in all rural communities. Sober living event centers. Substance use treatment and long-term vocational training for people while they are incarcerated that allows them to reenter community with a skilled trade.
8. Fund treatment for people who cannot afford, research drug prevention programs in schools before applying it to them
9. Support workforce to alleviate secondhand trauma, harm reduction, anti-stigma campaigns. Support family and caregivers.
10. Anti-stigma campaign
11. Alaska-specific research on successes and barriers for opioid use disorder treatment in Alaska.
12. Consider private organizations and support patients who cannot afford treatment
13. Financial and legal support for grandparents taking care of children of people with addiction.
14. Support people who cannot afford treatment - start a healthcare plan
15. A centralized place to call when they need help. Transparency and reporting of money. Narcan is $43 through Medicare (unaffordable to many)
16. Immediate housing for people ready for treatment - more beds in treatment, prevention programs in high schools, triage self-assessment tool to figure out best fit treatment, research on people who are denied acceptance and their outcomes - overdose death review.
17. Pre-arrest diversion programs, medications for addiction treatment in corrections, get people on prescription opioids or whatever they want if the alternative is street drugs with risk of fentanyl.
18. Focus on core issues of why people are using in the first place.
19. Trauma informed. Whole-family treatment. Cultural-based approaches.
20. Homeless population. Support shelters.
21. Drug courts
22. Detox facility in Homer. Affordable, transitional housing. Subsidizing costs of syringes, fentanyl test strips, naloxone and other medical supplies.
23. Parenting classes. Housing first.
24. Funding for their residential treatment program so they can expand medications for addiction treatment, treatment for incarcerated population, and pregnant and postpartum women, peer support services and outpatient treatment
25. Prevention and treatment of pregnant and postpartum people. More interpersonal violence resources to address source of pain. Access to free legal advice.
26. Equal treatment for all in corrections facilities. Centralized treatment provider for corrections with significant oversight. Workforce to support treatment in Department of Corrections. Research involving Department of Corrections frontline staff on their opinions of service needs and gaps. Holistic treatment approach and support qualifying for Medicaid.

27. Compensate families who lost loved ones to the epidemic
28. Early intervention services for prenatal and postpartum women. Parenting programs specific for parents who are in recovery. Home visiting model.
29. Low to no cost treatment. Reparation for people who are the victims of the opioid pandemic (victim defined as people who have property stolen or trashed by people with opioid addiction). More strict punishment for people convicted of crimes who have opioid use disorder. Force people into treatment so they can have a productive life.
30. Harm reduction: Supervised injection sites, needle exchanges, pharmaceutical grade drugs.
31. Peer support training, recruitment of counselors to be counselor techs. Training for trauma informed care.
32. Medications for Addiction Treatment in corrections. Remote monitoring/directly observed therapy (DOT) to protect against diversion, pilot project of Bridge device
33. Inpatient rehabilitation. Fund long term rehabilitation for people. Pre-arrest diversion and trauma informed training for law enforcement.
34. Support of recommendations
35. Compensate families for cost of previously sending their family member to rehabilitation or for loss of college funds.
36. Medication for Addiction Treatment in corrections. Observed dosing to prevent diversion.
37. Expanding medication for addiction treatment, increased access and distribution of naloxone, syringe service programs, pregnant and postpartum people, medication for addiction treatment in corrections. Funds for for-profit through contracts with local governments/non-profits to cover medication for addiction treatment services for people who cannot afford.
38. Increased access to treatment and support services
39. Funds to Department of Corrections, Department of Public Safety, Office of Children's Services (OCS), Department of Labor and Workforce Development, and Department of Education and Early Development (DEED) which are then granted out to private sector/tribal or behavioral health services for recovery. For DEED, drug addiction education in schools. Microgrants to grow small businesses, not just people with opioid use disorder. Sex/drug traffic training for OCS-involved system. Housing for transitional aged youth. Vocational rehab, recovery housing. Engagement: Letter to Alaska Federation of Natives. Review system of checks and balances to ensure policies are protecting people.
40. Sublocade in corrections. More detox and treatment beds across Alaska.
41. prescription digital therapeutics
42. Recovery services, housing, job training or related programs to assist people with addiction.
43. Drug education programs for youth, starting with middle school through university. Expand counseling in schools. Expand youth crisis shelters with wrap around services, outpatient and long-term residential programs. Engaging youth and their parents in local coalitions. Support of measurable outcomes. Support Red Ribbon Week & Drug Enforcement Administration's One Pill Can Kill campaign
44. Invest money
45. Provide grants to rec centers so they can give free memberships to people struggling with addiction so they can get exercise and create new positive relationships.

46. Treatment facilities, affordable housing for those who are homeless or at risk. Social services for individuals experiencing homelessness. Youth sports, arts, rec programs and pay for education overall.
47. Harm Reduction
48. Collaborate with Alaska Health Centers to provide services and Alaska Primary Care Association for planning
49. Consider something other than default allocation between state and political subdivisions; Jointly administered structure where local governments and state co-manage allocation and distribution of funds; Treatment facility infrastructure - spend money on this now; Or consider a strategic spend-down of these funds, greater portion be spent on today's crisis – and then program funds that are available in future years to continue to support remediation.
50. More outreach. A clear plan to fix structural, racial and colonization inequities in substance use treatment programs. Spend funds now to make treatment available.
51. Funding officer training that includes evidence-based education on addiction disease models, crisis intervention, and naloxone administration. Request police department policy require officers to carry naloxone.
52. Support of lump sum investment in new account and matching funds from legislature. Educate public and do advocacy work on opioid addiction in Alaska.
53. Support of pregnancy and perinatal family supports for opioid use disorders
54. Support securitization. Recommended designated fund be established in statute and that funds are not used to replace or supplant existing general fund spent on the behavioral health continuum of care. Fund allocation should be adaptive to current influences of the epidemic. Request that Advisory Board on Alcoholism and Drug Abuse have a convening role or representation on the oversight committee of these funds. Recommend funding for: wrap-around services for youth or youth's families which have opioid use disorders, recovery coaching, substance misuse prevention, and medications for addiction treatment in correctional facilities.
55. Mass distribution of naloxone kits throughout places of work, schools, and travel related sites.
56. Training for churches in substance use and mental health.
57. Fund SHARP Loan Repayment program for behavioral health providers to recruit and retain for a minimum number of years
58. Harm Reduction, syringe exchange (with funding to purchase sterile syringes), naloxone, infectious disease testing.
59. Wraparound services and housing for treatment and recovery, policy to ensure law enforcement carry naloxone and receive trauma informed training
60. Contingency management, universal medications for opioid use disorder in corrections, harm reduction supplies in rural Alaska including syringe access programs.
61. Supporting pregnant and postpartum people through the hiring of 3 new positions for the Substance-Exposed Newborns Initiative
62. Targeted naloxone training for law enforcement and post-overdose engagement model linking individuals to treatment and follow-up services

63. Education on difference between opioid dependence and Opioid Use Disorders including withdrawal experiences for different opioids and medications for addiction treatment prescriptions; separate treatment options and guidance for opioid use disorders and physical dependence; fund treatment and development of new treatment for opioid dependence and the symptoms of opioid withdrawal
64. Broad approaches to substance misuse including root causes, polysubstance use, and co-occurring mental health needs, with culturally appropriate care. Addressing alcohol in each aspect. Inclusive criteria for who can be served and funded including evidence based and culturally informed. School-based prevention programs including alcohol education. School-based mental health. Consider policy change age of consent for mental health to 14, or 12, or at whichever age a child feels they need help. Youth and/or parent voice media campaigns. Support Pre-Arrest Diversion and Post-Overdose Response Training for First Responders and connecting at-risk individuals to behavioral health services and supports. Stigma reduction training across the spectrum. Provide evidence-based treatment and recovery support, including medications for addiction treatment for persons with opioid use disorder and co-occurring substance use and mental health disorders within and transitioning out of the criminal justice system. Definition of "targeted". How will these targeted populations vary between urban and rural? Expand services such as navigators and on-call teams to begin medications for addiction treatment in hospital emergency departments; Expand warm hand-off services; comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; additional social workers or other behavioral health workers to facilitate expansions. Prioritize peer support programs particularly in Treatment and Recovery.
65. When considering treatment, only spend money on treatments covered by Medicaid, nothing unproven or experimental.
66. Evidence-informed programs not just evidence-based, fund afterschool programs, reproductive health education and support for pregnant and perinatal people including making long-acting reversible contraception and other forms of reproductive health available.
67. Funding for their program to train 18–25-year-olds to become "drug abuse prevention specialists" All-inclusive $7000/student, 6 students per month, 4 sessions a year = $168,000/year
68. Focus on prevention, youth, families and schools. Teach about how to manage pain and stress.
69. In support of lump sum, percent of market value model and youth intervention. Questions media campaign as effective approach - should instead use funds to reduce factors for addiction. Asks that the council tell the legislature what appropriations are needed to mitigate opioid addiction and reduce addiction onset in youth.

Response to comments received

- The council decided the default allocation for funding should remain and emphasizes that their recommendations include 50% local government representation on the grant steering committee.
- The council recommended membership for the grant steering committee includes the Advisory Board on Alcoholism and Drug Abuse though it does not designate that they have a convening role.
- Questions received regarding eligibility for funds are addressed in #7, on page 7 of this report.
- The council agrees that a specific plan for fair and equitable distribution be developed and made available to the public. While the council expresses empathy and understanding to those who requested personal compensation, the parameters of the settlement are that the funds go to future remediation efforts.
- Council members emphasized that public comment received be reviewed by the grant steering committee that will provide grant funding allocation recommendations to the Department of Health.

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

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

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

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

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

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

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

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

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

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

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

C. **PREGNANT & POSTPARTUM WOMEN**

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

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

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

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

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

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

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

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

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

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

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

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

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

F. **TREATMENT FOR INCARCERATED POPULATION**

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

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

G. **PREVENTION PROGRAMS**

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

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

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

4. Funding for community drug disposal programs; and

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

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

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

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

Schedule B
Approved Uses

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

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Create and/or support recovery high schools.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART TWO: PREVENTION

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

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

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

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

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

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

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

1. Increase the number of prescribers using PDMPs;

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

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

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

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Funding media campaigns to prevent opioid misuse.

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

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Public education relating to emergency responses to overdoses.

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

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

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

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

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

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

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

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

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

J. LEADERSHIP, PLANNING AND COORDINATION

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

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

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

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

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

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

K. TRAINING

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

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

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

L. RESEARCH

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

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

2. Research non-opioid treatment of chronic pain.

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

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

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

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

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

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

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