Meeting packet

Oregon Opioid Settlement Prevention, Treatment, and Recovery Board

Kickoff meeting

November 2, 2022

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OPIOID SETTLEMENT
PREVENTION, TREATMENT, AND RECOVERY BOARD MEETING

November 2, 10:00 am - 1:00 pm

Zoom Meeting Link (accessible for public observation):
https://www.zoomgov.com/j/1615281501?pwd=MTE2eGhHWDRyTktMN0ozS0xSWnNOZz09
Meeting ID: **161 528 1501** Passcode: **720243**
Dial by your location +1 669 254 5252 US (San Jose) +1 646 828 7666 US (New York)

10:00AM Welcome, roll call, and Introductions
Lisa Shields and all Board Members

10:30 Opening Remarks
Jackie Yerby, Policy Advisor for Behavioral Health and Health Licensing, Office of Governor Kate Brown

10:35 Purpose of Opioid Settlement Prevention, Treatment and Recovery Board and Overview of House Bill 4098
Kimberly McCullough, Legislative Director, OR Dept. Of Justice

11:00 OHA Implementation Team update, budget and timeline
Lisa Shields

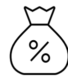
11:20 BREAK (10 min)

11:30 Initial Board tasks and assignments
- Nomination and election of Chair and Vice-Chair – Group
- Review draft board bylaws – Lisa Shields
- Future meeting topics and timeline – Group discussion

12:45 Public comment period

1:00 PM Adjourn

Opioid Settlement Prevention, Treatment & Recovery (OSPTR) Fund & Board

 Oregon Opioid Settlement

Approximately $333 million is coming to Oregon in 18 payments through July 2038 from Janssen & Distributor Settlements. Purdue Pharma settlement is still pending; there may be additional opioid settlements. Allocations are limited to prevention, treatment, and recovery strategies outlined in the settlement.

55% ➡ **Subdivision Fund: Distributed directly by the national settlement administrator to cities and counties** with population ≥ 10,000 based on percentages established in the settlement. Allocation decisions about these funds are made locally.

45% ➡ **State of Oregon Opioid Settlement Prevention, Treatment & Recovery Fund:** Allocation decisions will be made by an 18-person Board, for:

1) Statewide and regional prevention, treatment, and recovery strategies (see reverse)
2) Development of a data system to track availability & efficacy of substance use prevention, treatment and recovery services in Oregon
3) Fund administration (capped at 5%)

Approximately $503 million is going directly to Tribes and tribal health organizations from Janssen & Distributor Settlements. All federally recognized Tribes are eligible to participate in the Tribal Opioid Settlements, regardless of whether a Tribe filed an opioid lawsuit. More info at www.tribalopioidsettlements.com

2022 House Bill 4098

- Requires alignment with the **Alcohol & Drug Policy Commission Strategic Plan**
- Created the **OSPTR Fund** within the Department of Administrative Services
- Created the **OSPTR Board**, to be administered through OHA, consisting of:
  - 4 state agency representatives (DOJ, OHA, ODHS, Governor's policy advisor)
  - Directors of Alcohol & Drug Policy Comm. and BM110 Oversight & Accountability Council
  - 2 county representatives
    - Clackamas, Washington or Multnomah
    - Clatsop, Columbia, Coos, Curry, Jackson, Josephine, Lane, or Yamhill
  - 3 city representatives
    - Portland
    - City with population > 10,000
    - City with population < 10,000
  - 1 Coalition of Local Health Officials representative
  - 1 Community mental health program representative
  - 1 person with or representing lived experience of substance use disorder
  - 1 law enforcement, first responder, or jail commander/warden representative
  - 2 state legislators – one from House and one from Senate (non-voting)
  - 1 State Court Administrator (non-voting)

Contact: Lisa Shields, Project Manager, IVPP Section, Public Health Division Lisa.m.shields@dhsoha.state.or.us

Oregon Health Authority

Opioid Settlement Priority Prevention, Treatment, and Recovery Strategies*

Implementation Milestones

Administration

- Governor signs bill
- DAS creates OSPTR fund
- OHA administrative staff hired
- Communications & facilitation contract
- Evaluation contract

Coordination & Communication

- Legal consultation
- Tribal communication
- Communications planning
- Community & partner outreach
- Public website

Board

- Board member appointments
- Board onboarding & training
- Select co-chairs
- Adopt by-laws
- Develop allocation structure

For more information

- Oregon opioid settlement page: Oregon.gov/opioidsettlement
- National opioid settlement: https://nationalopioidsettlement.com/
- House Bill 4098: https://olis.oregonlegislature.gov/liz/2022R1/Downloads/MeasureDocument/HB4098/Enrolled
- Oregon statewide strategic plan: Oregon.gov ADPC statewide strategic plan

*Full list of Distributor Settlement Agreement and Janssen Settlement Agreement approved opioid abatement strategies (Exhibit E): https://nationalopioidsettlement.com/wp-content/uploads/2022/03/Final_Distributor_Settlement_Agreement_3.25.22_Final.pdf

Enrolled
House Bill 4098

Sponsored by Representative SANCHEZ, Senators SOLLMAN, MANNING JR, FREDERICK; Representatives ALONSO LEON, DEXTER, HIEB, HOY, NELSON, NOSSE, WILLIAMS, Senators GELSER BLOUIN, JAMA, PATTERSON (at the request of Alcohol and Drug Policy Commission) (Presession filed.)

CHAPTER ....

AN ACT

Relating to behavioral health; creating new provisions; amending ORS 430.220, 430.221 and 430.223; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 430.220 is amended to read:

430.220. (1) The Governor shall appoint a Director of the Alcohol and Drug Policy Commission who shall serve at the pleasure of the Governor and be responsible for the dissemination and implementation of the Alcohol and Drug Policy Commission's policies and the performance of the commission's duties, functions and powers.

(2) The director shall be paid a salary as provided by law or, if not so provided, as prescribed by the Governor.

(3) Subject to ORS chapter 240, the director shall appoint all employees of the commission, prescribe their duties and fix their compensation.

(4) The director has all powers necessary to effectively and expeditiously carry out the duties, functions and powers of the commission.

(5) The director shall enter into agreements with [*the Oregon Health Authority, the Department of Justice, the Department of Human Services and other state and local*] **participating state** agencies for the sharing of information as necessary to carry out the duties of the commission. The agreements shall ensure the confidentiality of all information that is protected from disclosure by state and federal laws.

SECTION 2. ORS 430.221 is amended to read:

430.221. (1) As used in this section and ORS **430.220 and** 430.223:

(a) "Participating state agency" means the Department of Corrections, the Department of Human Services, the Oregon Health Authority, the Department of Education, the Oregon Criminal Justice Commission, the Oregon State Police, the Oregon Youth Authority**,** [*or any other state agency that is approved by the Alcohol and Drug Policy Commission to license, contract for, provide or coordinate*] **the Department of Consumer and Business Services, the Housing and Community Services Department, the Youth Development Division, the Higher Education Coordinating Commission, the Oregon State Lottery Commission, the Oregon Liquor and Cannabis Commission, the Department of Veterans' Affairs or any state agency that administers or funds** alcohol or drug abuse prevention or treatment services.

(b) "Provider" means any person that is licensed by the Oregon Health Authority to provide alcohol or drug abuse prevention or treatment services.

(2) There is created the Alcohol and Drug Policy Commission, which is charged with improving the effectiveness and efficiency of state and local alcohol and drug abuse prevention and treatment services.

(3) The membership of the commission consists of:

(a) No more than 17 members appointed by the Governor, subject to confirmation by the Senate in the manner prescribed in ORS 171.562 and 171.565 and appointed, as the Governor deems practicable, to ensure representation from stakeholders directly impacted by the work of the commission, as follows:

(A) At least 75 percent of the members appointed by the Governor must be representatives of the following public health and health care stakeholder groups:

(i) County commissioners, managers and administrators;

(ii) Indian tribes;

(iii) The following providers of addiction prevention and recovery services:

(I) Treatment providers employed by an outpatient addiction treatment program;

(II) Directors of inpatient addiction treatment centers;

(III) Addiction treatment providers who are culturally competent to serve specific cultural or ethnic populations;

(IV) Certified prevention specialists;

(V) Certified addiction counselors; and

(VI) Certified addiction recovery mentors;

(iv) Alcohol or drug treatment researchers or epidemiologists;

(v) The health insurance industry or hospitals;

(vi) Consumers of addiction recovery services who are in recovery and the family members of consumers;

(vii) Experts in addiction medicine;

(viii) Entities that provide housing to individuals who are in recovery; and

(ix) Social service providers.

(B) Up to 25 percent of the members appointed by the Governor shall be representatives of one or more of the following stakeholder groups:

(i) District attorneys.

(ii) County sheriffs.

(iii) Chiefs of police.

(iv) Criminal defense attorneys.

(v) County community corrections agencies.

(b) Two members of the Legislative Assembly appointed to the commission as nonvoting members of the commission, acting in an advisory capacity only and including:

(A) One member from among members of the Senate appointed by the President of the Senate; and

(B) One member from among members of the House of Representatives appointed by the Speaker of the House of Representatives.

(c) A judge of a circuit court appointed to the commission as a nonvoting member by the Chief Justice of the Supreme Court.

(d) The director of the behavioral health program of the Oregon Health Authority as a nonvoting member.

(e) A representative of a coordinated care organization appointed to the commission as a nonvoting member by the Governor.

(4) The Alcohol and Drug Policy Commission shall select one of its members as chairperson and another as vice chairperson, for such terms and with duties and powers necessary for the performance of the functions of such offices as the commission determines.

(5)(a) A majority of the voting members of the commission constitutes a quorum for the transaction of business.

(b) If a member of the commission is absent for more than two consecutive scheduled meetings of the commission, the Director of the Alcohol and Drug Policy Commission appointed under ORS 430.220 may recommend to the Governor that the member be replaced.

(6) Official action of the commission requires the approval of a majority of a quorum.

(7) The commission may establish a steering committee and subcommittees. These committees may be continuing or temporary. A person who is not a member of the commission may be appointed by the commission to serve on a subcommittee. The commission shall appoint subcommittee members to ensure representation from all stakeholders directly impacted by the work of the commission.

(8) The term of office of each commission member appointed by the Governor is four years, but a member serves at the pleasure of the Governor. If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective.

(9) The Oregon Health Authority shall provide staff support to the commission. Subject to available funding, the commission may contract with a public or private entity to provide staff support.

(10) Members of the commission who are not members of the Legislative Assembly are entitled to compensation and expenses incurred by them in the performance of their official duties in the manner and amounts provided for in ORS 292.495. Claims for compensation and expenses shall be paid out of funds appropriated to the Oregon Health Authority or funds appropriated to the commission for purposes of the commission.

SECTION 3. ORS 430.223 is amended to read:

430.223. (1) For purposes of this section, "program" means a state, local or tribal alcohol and drug abuse prevention and treatment program.

(2) The Alcohol and Drug Policy Commission established under ORS 430.221 shall develop a comprehensive addiction, prevention, treatment and recovery plan for this state. The plan must include, but is not limited to, recommendations regarding:

(a) Capacity, type and utilization of programs;

(b) Methods to assess the effectiveness and performance of programs;

(c) The best use of existing programs;

(d) Budget policy priorities for participating state agencies;

(e) Standards for licensing programs;

(f) Minimum standards for contracting for, providing and coordinating alcohol and drug abuse prevention and treatment services among programs that use federal, private or state funds administered by the state; and

(g) The most effective and efficient use of participating state agency resources to support programs.

(3) All participating state agencies shall:

(a) Meet with the commission on a quarterly basis to review and report on each agency's progress on implementing the plan; and

(b) Report to the commission, in the manner prescribed by the commission, each agency's process and outcome measures established under the plan.

[*(3)*] **(4)** The commission shall review and update the plan [*developed under subsection (2) of this section*] no later than July 1 of each even-numbered year **and shall produce and publish a report on the metrics and other indicators of progress in achieving the goals of the plan**.

[*(4)*] **(5)** The commission may:

(a) Conduct studies related to the duties of the commission in collaboration with other state agencies;

(b) Apply for and receive gifts and grants for public and private sources; and

(c) Use funds received by the commission to carry out the purposes of ORS 430.220 and 430.221 and this section.

[*(5)*] **(6)** All **participating** state **agencies** and local agencies shall assist the commission in developing the comprehensive addiction, prevention, treatment and recovery plan.

[*(6)*] **(7)** The commission may adopt rules to carry out its duties under this section.

SECTION 4. As used in sections 4 to 6 of this 2022 Act:

(1) "Distributor Settlement Agreement" means the settlement agreement between the State of Oregon and participating subdivisions and McKesson, Cardinal and AmerisourceBergen dated as of July 21, 2021, and any revision thereto.

(2) "Janssen Settlement Agreement" means the settlement agreement between the State of Oregon and participating subdivisions and Johnson & Johnson, Janssen Pharmaceuticals, Incorporated, and Ortho-McNeil-Janssen Pharmaceuticals, Incorporated, dated as of July 21, 2021, and any revision thereto.

(3) "Participating subdivisions" means cities and counties in this state with populations of at least 10,000 residents.

SECTION 5. (1) The Opioid Settlement Prevention, Treatment and Recovery Fund is established in the State Treasury, separate and distinct from the General Fund, consisting of moneys, other than attorney fees and costs, paid to the state pursuant to:

(a) The Distributor Settlement Agreement;

(b) The Janssen Settlement Agreement; and

(c) Judgments or settlements identified by the Attorney General as arising from the liability of distributors of opioids, manufacturers of opioids, pharmacies for the selling of opioids or the consultants, agents or associates of distributors, manufacturers or pharmacies.

(2) Moneys in the Opioid Settlement Prevention, Treatment and Recovery Fund are continuously appropriated to the Oregon Health Authority for the purpose of administering the Opioid Settlement Prevention, Treatment and Recovery Board and for the allocation of moneys as directed by the board in accordance with section 6 of this 2022 Act.

SECTION 6. (1) The Opioid Settlement Prevention, Treatment and Recovery Board is created in the Oregon Health Authority for the purpose of determining the allocation of funding from the Opioid Settlement Prevention, Treatment and Recovery Fund established in section 5 of this 2022 Act. The board consists of:

(a) The following members appointed by the Governor:

(A) A policy advisor to the Governor;

(B) A representative of the Department of Justice;

(C) A representative of the Oregon Health Authority; and

(D) A representative of the Department of Human Services;

(b) The Director of the Alcohol and Drug Policy Commission or the director's designee;

(c) The chairperson of the Oversight and Accountability Council established in ORS 430.388 or the chairperson's designee;

(d) The following members appointed by the Governor from a list of candidates provided by the Association of Oregon Counties and the League of Oregon Cities or the successor organizations to the Association of Oregon Counties and the League of Oregon Cities:

(A) An individual representing Clackamas, Washington or Multnomah County;

(B) An individual representing Clatsop, Columbia, Coos, Curry, Jackson, Josephine, Lane or Yamhill County;

(C) An individual representing the City of Portland;

(D) An individual representing a city with a population above 10,000 residents as of July 21, 2021;

(E) An individual representing a city with a population at or below 10,000 residents as of July 21, 2021; and

(F) A representative of the Oregon Coalition of Local Health Officials or its successor organization;

(e) The following members appointed by the Governor from a list of candidates provided by the members described in paragraphs (a) to (d) of this subsection:

(A) A representative of a community mental health program;

(B) An individual who has experienced a substance use disorder or a representative of an organization that advocates on behalf of individuals with substance use disorders; and

(C) An individual representing law enforcement, first responders or jail commanders or wardens;

(f) A member of the House of Representatives appointed by the Speaker of the House of Representatives, who shall be a nonvoting member of the board;

(g) A member of the Senate appointed by the President of the Senate, who shall be a nonvoting member of the board; and

(h) The State Court Administrator or the administrator's designee, who shall be a nonvoting member of the board.

(2) The Governor shall select from the members described in subsections (1)(a), (b) and (c) of this section one cochairperson to represent state entities, and the members described in subsection (1)(d) of this section shall select from one of their members a cochairperson to represent cities or counties.

(3) The term of each member of the board who is not an ex officio member is four years, but a member serves at the pleasure of the appointing authority. Before the expiration of a member's term, the appointing authority shall appoint a successor whose term begins on January 1 next following. A member is eligible for reappointment. If there is a vacancy for any cause, the appointing authority shall make an appointment to become immediately effective for the unexpired term.

(4) Decision-making by the board shall be based on consensus and supported by at least a majority of the members. The board shall document all objections to board decisions.

(5) The board shall conduct at least four public meetings in accordance with ORS 192.610 to 192.690, which shall be publicized to facilitate attendance at the meetings and during which the board shall receive testimony and input from the community. The board shall also establish a process for the public to provide written comments and proposals at each meeting of the board.

(6) In determining the allocation of moneys from the Opioid Settlement Prevention, Treatment and Recovery Fund:

(a) No more than five percent of the moneys may be spent on administering the board and the fund.

(b) A portion of the moneys shall be allocated toward a unified and evidence-based state system for collecting, analyzing and publishing data about the availability and efficacy of substance use prevention, treatment and recovery services statewide.

(c) Moneys remaining after allocations in accordance with paragraphs (a) and (b) of this subsection shall be allocated for funding statewide and regional programs identified in the Distributor Settlement Agreement, the Janssen Settlement Agreement and any other judgment or settlement described in section 5 (1)(c) of this 2022 Act, including but not limited to:

(A) Programs that use evidence-based or evidence-informed strategies to treat opioid use disorders and any co-occurring substance use disorders or mental health conditions;

(B) Programs that use evidence-based or evidence-informed strategies to support individuals in recovery from opioid use disorders and any co-occurring substance use disorders or mental health conditions;

(C) Programs that use evidence-based or evidence-informed strategies to provide connections to care for individuals who have or are at risk of developing opioid use disorders and any co-occurring substance use disorders or mental health conditions;

(D) Programs that use evidence-based or evidence-informed strategies to address the needs of individuals with opioid use disorders and any co-occurring substance use disorders

or mental health conditions and who are involved in, at risk of becoming involved in, or in transition from, the criminal justice system;

(E) Programs that use evidence-based or evidence-informed strategies to address the needs of pregnant or parenting women with opioid use disorders and any co-occurring substance use disorders or mental health conditions, and the needs of their families, including babies with neonatal abstinence syndrome;

(F) Programs that use evidence-based or evidence-informed strategies to support efforts to prevent over-prescribing of opioids and ensure appropriate prescribing and dispensing of opioids;

(G) Programs that use evidence-based or evidence-informed strategies to support efforts to discourage or prevent misuse of opioids;

(H) Programs that use evidence-based or evidence-informed strategies to support efforts to prevent or reduce overdose deaths or other opioid-related harms;

(I) Programs to educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with users of fentanyl or other opioids;

(J) Programs to provide wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events;

(K) Programs to support efforts to provide leadership, planning, coordination, facilitation, training and technical assistance to abate the opioid epidemic through activities, programs or strategies; or

(L) Funding to support opioid abatement research.

(d) The board shall be guided and informed by:

(A) The comprehensive addiction, prevention, treatment and recovery plan developed by the Alcohol and Drug Policy Commission in accordance with ORS 430.223;

(B) The board's ongoing evaluation of the efficacy of the funding allocations;

(C) Evidence-based and evidence-informed strategies and best practices;

(D) Input the board receives from the public;

(E) Equity considerations for underserved populations; and

(F) The terms of the settlement agreements.

(7) The Oregon Health Authority shall provide staff support to the board.

SECTION 7. Notwithstanding the term of office specified by section 6 of this 2022 Act, of the members first appointed by the Governor to the Opioid Settlement Prevention, Treatment and Recovery Board:

(1) Four shall serve for terms ending January 2, 2024;

(2) Four shall serve for terms ending January 2, 2025; and

(3) Five shall serve for terms ending January 2, 2026.

SECTION 8. Sections 4 to 7 of this 2022 Act are repealed on January 2, 2040.

SECTION 9. Notwithstanding any other law limiting expenditures, the amount of $625,733 is established for the biennium ending June 30, 2023, as the maximum limit for payment of expenses from fees, moneys or other revenues, including Miscellaneous Receipts, tobacco tax receipts, marijuana tax receipts, beer and wine tax receipts, provider taxes and Medicare receipts, but excluding lottery funds and federal funds not described in this section, collected or received by the Oregon Health Authority, for carrying out section 6 of this 2022 Act.

SECTION 10. This 2022 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2022 Act takes effect on its passage.

Passed by House March 2, 2022

....
Timothy G. Sekerak, Chief Clerk of House

....
Dan Rayfield, Speaker of House

Passed by Senate March 3, 2022

....
Peter Courtney, President of Senate

Received by Governor:

........................M.,..., 2022

Approved:

........................M.,..., 2022

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Kate Brown, Governor

Filed in Office of Secretary of State:

........................M.,..., 2022

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Shemia Fagan, Secretary of State

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*").[1]

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.

[1] 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:[2]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Create and/or support recovery high schools.

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

C. <u>CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)</u>

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. <u>PREVENT MISUSE OF OPIOIDS</u>

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.

November 2022

Opioid Settlement Prevention, Treatment & Recovery (OSPTR) Fund implementation

Contact: Lisa Shields, Lisa.m.shields@dhsoha.state.or.us (971) 258-4995

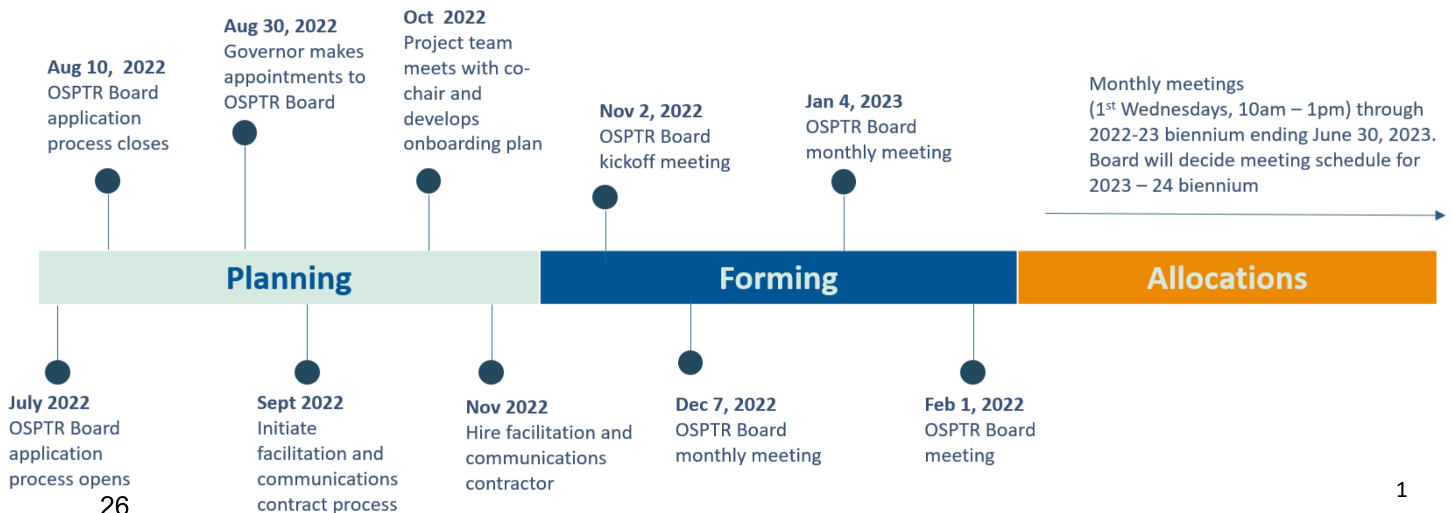
HB 4098 Implementation team

Public Health	Health Systems	Alcohol and Drug Policy Commission	Government Relations
Lisa Shields Laura Chisholm Courtney Fultineer Savanna Santarpio Tatiana Dierwechter Tim Noe	Nicole Corbin John McIlveen Kelsey Smith-Payne	Reginald Richardson Jill Gray	Cynthia Branger-Muñoz Coline Benson

October Highlights

- OSPTR Board positions are all filled
- The Board will meet every first Wednesday from 10am – 1pm, starting Nov. 2
  - Nov 2 kickoff: orientation and housekeeping
  - Dec 7: guest presenters from OHSU and Johns Hopkins to provide context for the overdose crisis and the national opioid settlement landscape
- Our website is live: oregon.gov/opioidsettlement

OSPTR Board Timeline



Oregon Health Authority

Communications and evaluation

Press release

- OHA put out a press release on the opioid settlement fund on Aug 8, directing people to the new website

Communications and facilitation contract

- We will hire a vetted communications/facilitation contractor through the Health Promotion and Chronic Disease Prevention Communications Work Order Request by December

Evaluation contract

- Program Design and Evaluation Services is developing a budget and scope of work for a process evaluation to begin in November

Communication and coordination with leadership and partners

Governor's Office

- The Governor's Office finalized all Board appointments on Aug. 30
- No new Board appointments until after the new Governor is appointed

Department of Justice

- Shannon O'Fallon, Lead Counsel for the OHA, will orient the OSPTR Board to public meeting ethics tentatively on Dec. 7

Tribal

- We drafted a Dear Tribal Leader letter requesting consultation – it is under review

What's next?

Communications

- New quarterly newsletter for the public coming soon!

OSPTR Board

- Work with co-chairs on meeting agendas and bylaws

Meetings and presentations

- Lisa and Cynthia presented on HB4098 to the Council of Local Health Officials (CLHO) and Association of Oregon Community Mental Health Programs (AOCMPH) October 20
- County Health Officers have requested a meeting to hear about OSPTR Board allocation plans

OREGON HEALTH AUTHORITY

BYLAWS OF THE OREGON OPIOID SETTLEMENT PREVENTION, TREATMENT, AND RECOVERY BOARD

Section I

PURPOSE

1. Purpose. 2022 House Bill 4098, Section 6, defines the purpose of the Opioid Settlement Prevention, Treatment, and Recovery (OSPTR) Board, which is to determine the allocation of funding from the Opioid Settlement Prevention, Treatment and Recovery Fund established in section 5 of 2022 House Bill 4098. OHA provides staff support and works with OSPTR Board members to convene and organize board meetings.
2. Statutory rules of fund allocation. In determining the allocation of moneys from the Opioid Settlement Prevention, Treatment and Recovery Fund:
    a. No more than five percent of the moneys may be spent on administering the board and the fund.
    b. A portion of the moneys shall be allocated toward a unified and evidence-based state system for collecting, analyzing and publishing data about the availability and efficacy of substance use prevention, treatment and recovery services statewide.
    c. Remaining opioid settlement funds shall be allocated for funding evidence-based or evidence-informed statewide and regional programs identified in the Distributor Settlement Agreement, the Janssen Settlement Agreement and any other judgment or judgment or settlement described in HB4098, including but not limited to programs that:
        i. Treat opioid use disorders and any co-occurring substance use disorders or mental health conditions
        ii. Support individuals in recovery from opioid use disorders and any co-occurring substance use disorders or mental health conditions
        iii. Provide connections to care for individuals who have or are at risk of developing opioid use disorders and any co-occurring substance use disorders or mental health conditions

iv. Address the needs of individuals with opioid use disorders and any co-occurring substance use disorders or mental health conditions and who are involved in, at risk of becoming involved in, or in transition from, the criminal justice system
v. Address the needs of pregnant or parenting women with opioid use disorders and any co-occurring substance use disorders or mental health conditions, and the needs of their families, including babies with neonatal abstinence syndrome
vi. Support efforts to prevent over-prescribing of opioids and ensure appropriate prescribing and dispensing of opioids
vii. Support efforts to discourage or prevent misuse of opioids
viii. Support efforts to prevent or reduce overdose deaths or other opioid-related harms
ix. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with users of fentanyl or other opioids
x. Provide wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events
xi. Support efforts to provide leadership, planning, coordination, facilitation, training and technical assistance to abate the opioid epidemic through activities, programs or strategies
xii. Provide funding to support opioid abatement research

3. Guiding principles. The board shall be guided and informed by:
   a. The comprehensive addiction, prevention, treatment and recovery plan developed by the Alcohol and Drug Policy Commission
   b. The board's ongoing evaluation of the efficacy of the funding allocations
   c. Evidence-based and evidence-informed strategies and best practices
   d. Input the board receives from the public
   e. Equity considerations for underserved populations
   f. The terms of the settlement agreements.

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Section II

OFFICERS AND ELECTIONS

1. Officers. The officers of the OSPTR Board shall be two co-chairpersons. One co-chairperson will represent state entities, and co-chairperson will represent cities or counties.
    a. The co-chairpersons' responsibilities shall include the following:
        i. Preside at OSPTR Board meetings and official Board functions
        ii. Coordinate Board meeting agenda with OHA staff and contracted meeting facilitator
2. Terms of Office. The term of each member of the board who is not an ex officio member is four years, but a member serves at the pleasure of the appointing authority.
    a. Before the expiration of a member's term, the appointing authority shall appoint a successor whose term begins on January 1 next following.
    b. A member is eligible for reappointment.
    c. If there is a vacancy for any cause, the appointing authority shall make an appointment to become immediately effective for the unexpired term.

Section III

Subcommittees?

Section IV

ADMINISTRATIVE PROVISIONS

1. Decision-making. Decision-making by the board shall be based on consensus and supported by at least a majority of the members. The board shall document all objections to board decisions.
2. Quorum requirements. A minimum of XX (majority?) of voting Board members is required for recommendations or resolutions to be valid.
3. Meeting frequency. The board shall conduct at least four public meetings in accordance with Oregon Public Meetings laws and Oregon Public Records

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laws. However, meetings will be scheduled monthly or more or less frequently depending on allocation needs.

4. Public comment. The board shall establish a process for the public to provide written and/or verbal comments and proposals at each meeting of the board.
5. Public notice. Notice of this meeting is required to be posted a minimum of one week prior to the meeting.
6. Amendments to by-laws. These by-laws may be altered, amended or repealed by the membership at any regularly scheduled board meeting.
7. Rules of procedure. Robert's Rules of Order, or other?

The above by-laws were adopted by the Oregon Opioid Settlement Prevention, Treatment, and Recovery Board on *date*

Chairperson signatures

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