ONE WASHINGTON MEMORANDUM OF UNDERSTANDING BETWEEN WASHINGTON MUNICIPALITIES

Whereas, the people of the State of Washington and its communities have been harmed by entities within the Pharmaceutical Supply Chain who manufacture, distribute, and dispense prescription opioids;

Whereas, certain Local Governments, through their elected representatives and counsel, are engaged in litigation seeking to hold these entities within the Pharmaceutical Supply Chain of prescription opioids accountable for the damage they have caused to the Local Governments;

Whereas, Local Governments and elected officials share a common desire to abate and alleviate the impacts of harms caused by these entities within the Pharmaceutical Supply Chain throughout the State of Washington, and strive to ensure that principals of equity and equitable service delivery are factors considered in the allocation and use of Opioid Funds; and

Whereas, certain Local Governments engaged in litigation and the other cities and counties in Washington desire to agree on a form of allocation for Opioid Funds they receive from entities within the Pharmaceutical Supply Chain.

Now therefore, the Local Governments enter into this Memorandum of Understanding ("MOU") relating to the allocation and use of the proceeds of Settlements described.

A. Definitions

As used in this MOU:

1. "Allocation Regions" are the same geographic areas as the existing nine (9) Washington State Accountable Community of Health (ACH) Regions and have the purpose described in Section C below.

2. "Approved Purpose(s)" shall mean the strategies specified and set forth in the Opioid Abatement Strategies attached as Exhibit A.

3. "Effective Date" shall mean the date on which a court of competent jurisdiction enters the first Settlement by order or consent decree. The Parties anticipate that more than one Settlement will be administered according to the terms of this MOU, but that the first entered Settlement will trigger allocation of Opioid Funds in accordance with Section B herein, and the formation of the Opioid Abatement Councils in Section C.

4. "Litigating Local Government(s)" shall mean Local Governments that filed suit against any Pharmaceutical Supply Chain Participant pertaining to the Opioid epidemic prior to September 1, 2020.

5. “Local Government(s)” shall mean all counties, cities, and towns within the geographic boundaries of the State of Washington.

6. “National Settlement Agreements” means the national opioid settlement agreements dated July 21, 2021 involving Johnson & Johnson, and distributors AmerisourceBergen, Cardinal Health and McKesson as well as their subsidiaries, affiliates, officers, and directors named in the National Settlement Agreements, including all amendments thereto.

7. “Opioid Funds” shall mean monetary amounts obtained through a Settlement as defined in this MOU.

8. “Opioid Abatement Council” shall have the meaning described in Section C below.

9. “Participating Local Government(s)” shall mean all counties, cities, and towns within the geographic boundaries of the State that have chosen to sign on to this MOU. The Participating Local Governments may be referred to separately in this MOU as “Participating Counties” and “Participating Cities and Towns” (or “Participating Cities or Towns,” as appropriate) or “Parties.”

10. “Pharmaceutical Supply Chain” shall mean the process and channels through which controlled substances are manufactured, marketed, promoted, distributed, and/or dispensed, including prescription opioids.

11. “Pharmaceutical Supply Chain Participant” shall mean any entity that engages in or has engaged in the manufacture, marketing, promotion, distribution, and/or dispensing of a prescription opioid, including any entity that has assisted in any of the above.

12. “Qualified Settlement Fund Account,” or “QSF Account,” shall mean an account set up as a qualified settlement fund, 468b fund, as authorized by Treasury Regulations 1.468B-1(c) (26 CFR §1.468B-1).

13. “Regional Agreements” shall mean the understanding reached by the Participating Local Counties and Cities within an Allocation Region governing the allocation, management, distribution of Opioid Funds within that Allocation Region.

14. “Settlement” shall mean the future negotiated resolution of legal or equitable claims against a Pharmaceutical Supply Chain Participant when that resolution has been jointly entered into by the Participating Local Governments. “Settlement” expressly does not include a plan of reorganization confirmed under Title 11of the United States Code, irrespective of the extent to which Participating Local Governments vote in favor of or otherwise support such plan of reorganization.

15. "Trustee" shall mean an independent trustee who shall be responsible for the ministerial task of releasing Opioid Funds from a QSF account to Participating Local Governments as authorized herein and accounting for all payments into or out of the trust.

16. The "Washington State Accountable Communities of Health" or "ACH" shall mean the nine (9) regions described in Section C below.

B. Allocation of Settlement Proceeds for Approved Purposes

1. All Opioid Funds shall be held in a QSF and distributed by the Trustee, for the benefit of the Participating Local Governments, only in a manner consistent with this MOU. Distribution of Opioid Funds will be subject to the mechanisms for auditing and reporting set forth below to provide public accountability and transparency.

2. All Opioid Funds, regardless of allocation, shall be utilized pursuant to Approved Purposes as defined herein and set forth in Exhibit A. Compliance with this requirement shall be verified through reporting, as set out in this MOU.

3. The division of Opioid Funds shall first be allocated to Participating Counties based on the methodology utilized for the Negotiation Class in *In Re: National Prescription Opiate Litigation*, United States District Court for the Northern District of Ohio, Case No. 1:17-md-02804-DAP. The allocation model uses three equally weighted factors: (1) the amount of opioids shipped to the county; (2) the number of opioid deaths that occurred in that county; and (3) the number of people who suffer opioid use disorder in that county. The allocation percentages that result from application of this methodology are set forth in the "County Total" line item in Exhibit B. In the event any county does not participate in this MOU, that county's percentage share shall be reallocated proportionally amongst the Participating Counties by applying this same methodology to only the Participating Counties.

4. Allocation and distribution of Opioid Funds within each Participating County will be based on regional agreements as described in Section C.

C. Regional Agreements

1. For the purpose of this MOU, the regional structure for decision-making related to opioid fund allocation will be based upon the nine (9) pre-defined Washington State Accountable Community of Health Regions (Allocation Regions). Reference to these pre-defined regions is solely for the purpose of

drawing geographic boundaries to facilitate regional agreements for use of Opioid Funds. The Allocation Regions are as follows:

- King County (Single County Region)
- Pierce County (Single County Region)
- Olympic Community of Health Region (Clallam, Jefferson, and Kitsap Counties)
- Cascade Pacific Action Alliance Region (Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum Counties)
- North Sound Region (Island, San Juan, Skagit, Snohomish, and Whatcom Counties)
- SouthWest Region (Clark, Klickitat, and Skamania Counties)
- Greater Columbia Region (Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Walla Walla, Whitman, and Yakima Counties)
- Spokane Region (Adams, Ferry, Lincoln, Pend Oreille, Spokane, and Stevens Counties)
- North Central Region (Chelan, Douglas, Grant, and Okanogan Counties)

2. Opioid Funds will be allocated, distributed and managed within each Allocation Region, as determined by its Regional Agreement as set forth below. If an Allocation Region does not have a Regional Agreement enumerated in this MOU, and does not subsequently adopt a Regional Agreement per Section C.5, the default mechanism for allocation, distribution and management of Opioid Funds described in Section C.4.a will apply. Each Allocation Region must have an OAC whose composition and responsibilities shall be defined by Regional Agreement or as set forth in Section C.4.

3. King County's Regional Agreement is reflected in Exhibit C to this MOU.

4. All other Allocation Regions that have not specified a Regional Agreement for allocating, distributing and managing Opioid Funds, will apply the following default methodology:

a. Opioid Funds shall be allocated within each Allocation Region by taking the allocation for a Participating County from Exhibit B and apportioning those funds between that Participating County and its Participating Cities and Towns. Exhibit B also sets forth the allocation to the Participating Counties and the Participating Cities or Towns within the Counties based on a default allocation formula. As set forth above in Section B.3, to determine the allocation to a county, this formula utilizes: (1) the amount of opioids shipped to the county; (2) the number of opioid deaths that occurred in that county; and (3) the number of people who suffer opioid use disorder in that county. To determine the allocation within a county, the formula utilizes historical federal data showing how the specific Counties and the Cities and Towns within the Counties have

made opioids epidemic-related expenditures in the past. This is the same methodology used in the National Settlement Agreements for county and intra-county allocations. A Participating County, and the Cities and Towns within it may enter into a separate intra-county allocation agreement to modify how the Opioid Funds are allocated amongst themselves, provided the modification is in writing and agreed to by all Participating Local Governments in the County. Such an agreement shall not modify any of the other terms or requirements of this MOU.

b. 10% of the Opioid Funds received by the Region will be reserved, on an annual basis, for administrative costs related to the OAC. The OAC will provide an annual accounting for actual costs and any reserved funds that exceed actual costs will be reallocated to Participating Local Governments within the Region.

c. Cities and towns with a population of less than 10,000 shall be excluded from the allocation, with the exception of cities and towns that are Litigating Participating Local Governments. The portion of the Opioid Funds that would have been allocated to a city or town with a population of less than 10,000 that is not a Litigating Participating Local Government shall be redistributed to Participating Counties in the manner directed in C.4.a above.

d. Each Participating County, City, or Town may elect to have its share re-allocated to the OAC in which it is located. The OAC will then utilize this share for the benefit of Participating Local Governments within that Allocation Region, consistent with the Approved Purposes set forth in Exhibit A. A Participating Local Government's election to forego its allocation of Opioid Funds shall apply to all future allocations unless the Participating Local Government notifies its respective OAC otherwise. If a Participating Local Government elects to forego its allocation of the Opioid Funds, the Participating Local Government shall be excused from the reporting requirements set forth in this Agreement.

e. Participating Local Governments that receive a direct payment maintain full discretion over the use and distribution of their allocation of Opioid Funds, provided the Opioid Funds are used solely for Approved Purposes. Reasonable administrative costs for a Participating Local Government to administer its allocation of Opioid Funds shall not exceed actual costs or 10% of the Participating Local Government's allocation of Opioid Funds, whichever is less.

f. A Local Government that chooses not to become a Participating Local Government will not receive a direct allocation of Opioid Funds. The portion of the Opioid Funds that would have been allocated to a Local Government that is not a Participating Local Government shall be

redistributed to Participating Counties in the manner directed in C.4.a above.

g. As a condition of receiving a direct payment, each Participating Local Government that receives a direct payment agrees to undertake the following actions:

i. Developing a methodology for obtaining proposals for use of Opioid Funds.

ii. Ensuring there is opportunity for community-based input on priorities for Opioid Fund programs and services.

iii. Receiving and reviewing proposals for use of Opioid Funds for Approved Purposes.

iv. Approving or denying proposals for use of Opioid Funds for Approved Purposes.

v. Receiving funds from the Trustee for approved proposals and distributing the Opioid Funds to the recipient.

vi. Reporting to the OAC and making publicly available all decisions on Opioid Fund allocation applications, distributions and expenditures.

h. Prior to any distribution of Opioid Funds within the Allocation Region, The Participating Local Governments must establish an Opioid Abatement Council (OAC) to oversee Opioid Fund allocation, distribution, expenditures and dispute resolution. The OAC may be a preexisting regional body or may be a new body created for purposes of executing the obligations of this MOU.

i. The OAC for each Allocation Region shall be composed of representation from both Participating Counties and Participating Towns or Cities within the Region. The method of selecting members, and the terms for which they will serve will be determined by the Allocation Region's Participating Local Governments. All persons who serve on the OAC must have work or educational experience pertaining to one or more Approved Uses.

j. The Regional OAC will be responsible for the following actions:

i. Overseeing distribution of Opioid Funds from Participating Local Governments to programs and services within the Allocation Region for Approved Purposes.

ii. Annual review of expenditure reports from Participating Local Jurisdictions within the Allocation Region for compliance with Approved Purposes and the terms of this MOU and any Settlement.

iii. In the case where Participating Local Governments chose to forego their allocation of Opioid Funds:

(i) Approving or denying proposals by Participating Local Governments or community groups to the OAC for use of Opioid Funds within the Allocation Region.
(ii) Directing the Trustee to distribute Opioid Funds for use by Participating Local Governments or community groups whose proposals are approved by the OAC.
(iii) Administrating and maintaining records of all OAC decisions and distributions of Opioid Funds.

iv. Reporting and making publicly available all decisions on Opioid Fund allocation applications, distributions and expenditures by the OAC or directly by Participating Local Governments.

v. Developing and maintaining a centralized public dashboard or other repository for the publication of expenditure data from any Participating Local Government that receives Opioid Funds, and for expenditures by the OAC in that Allocation Region, which it shall update at least annually.

vi. If necessary, requiring and collecting additional outcome-related data from Participating Local Governments to evaluate the use of Opioid Funds, and all Participating Local Governments shall comply with such requirements.

vii. Hearing complaints by Participating Local Governments within the Allocation Region regarding alleged failure to (1) use Opioid Funds for Approved Purposes or (2) comply with reporting requirements.

5. Participating Local Governments may agree and elect to share, pool, or collaborate with their respective allocation of Opioid Funds in any manner they choose by adopting a Regional Agreement, so long as such sharing, pooling, or collaboration is used for Approved Purposes and complies with the terms of this MOU and any Settlement.

6. Nothing in this MOU should alter or change any Participating Local Government's rights to pursue its own claim. Rather, the intent of this MOU is to join all parties who wish to be Participating Local Governments to agree upon an allocation formula for any Opioid Funds from any future binding Settlement with one or more Pharmaceutical Supply Chain Participants for all Local Governments in the State of Washington.

7. If any Participating Local Government disputes the amount it receives from its allocation of Opioid Funds, the Participating Local Government shall alert its respective OAC within sixty (60) days of discovering the information underlying the dispute. Failure to alert its OAC within this time frame shall not constitute a waiver of the Participating Local Government's right to seek recoupment of any deficiency in its allocation of Opioid Funds.

8. If any OAC concludes that a Participating Local Government's expenditure of its allocation of Opioid Funds did not comply with the Approved Purposes listed in Exhibit A, or the terms of this MOU, or that the Participating Local Government otherwise misused its allocation of Opioid Funds, the OAC may take remedial action against the alleged offending Participating Local Government. Such remedial action is left to the discretion of the OAC and may include withholding future Opioid Funds owed to the offending Participating Local Government or requiring the offending Participating Local Government to reimburse improperly expended Opioid Funds back to the OAC to be re-allocated to the remaining Participating Local Governments within that Region.

9. All Participating Local Governments and OAC shall maintain all records related to the receipt and expenditure of Opioid Funds for no less than five (5) years and shall make such records available for review by any other Participating Local Government or OAC, or the public. Records requested by the public shall be produced in accordance with Washington's Public Records Act RCW 42.56.001 *et seq*. Records requested by another Participating Local Government or an OAC shall be produced within twenty-one (21) days of the date the record request was received. This requirement does not supplant any Participating Local Government or OAC's obligations under Washington's Public Records Act RCW 42.56.001 *et seq*.

D. Payment of Counsel and Litigation Expenses

1. The Litigating Local Governments have incurred attorneys' fees and litigation expenses relating to their prosecution of claims against the Pharmaceutical Supply Chain Participants, and this prosecution has inured to the benefit of all Participating Local Governments. Accordingly, a Washington

Government Fee Fund ("GFF") shall be established that ensures that all Parties that receive Opioid Funds contribute to the payment of fees and expenses incurred to prosecute the claims against the Pharmaceutical Supply Chain Participants, regardless of whether they are litigating or non-litigating entities.

2. The amount of the GFF shall be based as follows: the funds to be deposited in the GFF shall be equal to 15% of the total cash value of the Opioid Funds.

3. The maximum percentage of any contingency fee agreement permitted for compensation shall be 15% of the portion of the Opioid Funds allocated to the Litigating Local Government that is a party to the contingency fee agreement, plus expenses attributable to that Litigating Local Government. Under no circumstances may counsel collect more for its work on behalf of a Litigating Local Government than it would under its contingency agreement with that Litigating Local Government.

4. Payments from the GFF shall be overseen by a committee (the "Opioid Fee and Expense Committee") consisting of one representative of the following law firms: (a) Keller Rohrback L.LP.; (b) Hagens Berman Sobol Shapiro LLP; (c) Goldfarb & Huck Roth Riojas, PLLC; and (d) Napoli Shkolnik PLLC. The role of the Opioid Fee and Expense Committee shall be limited to ensuring that the GFF is administered in accordance with this Section.

5. In the event that settling Pharmaceutical Supply Chain Participants do not pay the fees and expenses of the Participating Local Governments directly at the time settlement is achieved, payments to counsel for Participating Local Governments shall be made from the GFF over not more than three years, with 50% paid within 12 months of the date of Settlement and 25% paid in each subsequent year, or at the time the total Settlement amount is paid to the Trustee by the Defendants, whichever is sooner.

6. Any funds remaining in the GFF in excess of: (i) the amounts needed to cover Litigating Local Governments' private counsel's representation agreements, and (ii) the amounts needed to cover the common benefit tax discussed in Section C.8 below (if not paid directly by the Defendants in connection with future settlement(s), shall revert to the Participating Local Governments *pro rata* according to the percentages set forth in Exhibits B, to be used for Approved Purposes as set forth herein and in Exhibit A.

7. In the event that funds in the GFF are not sufficient to pay all fees and expenses owed under this Section, payments to counsel for all Litigating Local Governments shall be reduced on a *pro rata* basis. The Litigating Local Governments will not be responsible for any of these reduced amounts.

8. The Parties anticipate that any Opioid Funds they receive will be subject to a common benefit "tax" imposed by the court in *In Re: National Prescription Opiate Litigation*, United States District Court for the Northern District of Ohio, Case No. 1:17-md-02804-DAP ("Common Benefit Tax"). If this occurs, the Participating Local Governments shall first seek to have the settling defendants pay the Common Benefit Tax. If the settling defendants do not agree to pay the Common Benefit Tax, then the Common Benefit Tax shall be paid from the Opioid Funds and by both litigating and non-litigating Local Governments. This payment shall occur prior to allocation and distribution of funds to the Participating Local Governments. In the event that GFF is not fully exhausted to pay the Litigating Local Governments' private counsel's representation agreements, excess funds in the GFF shall be applied to pay the Common Benefit Tax (if any).

E. General Terms

1. If any Participating Local Government believes another Participating Local Government, not including the Regional Abatement Advisory Councils, violated the terms of this MOU, the alleging Participating Local Government may seek to enforce the terms of this MOU in the court in which any applicable Settlement(s) was entered, provided the alleging Participating Local Government first provides the alleged offending Participating Local Government notice of the alleged violation(s) and a reasonable opportunity to cure the alleged violation(s). In such an enforcement action, any alleging Participating Local Government or alleged offending Participating Local Government may be represented by their respective public entity in accordance with Washington law.

2. Nothing in this MOU shall be interpreted to waive the right of any Participating Local Government to seek judicial relief for conduct occurring outside the scope of this MOU that violates any Washington law. In such an action, the alleged offending Participating Local Government, including the Regional Abatement Advisory Councils, may be represented by their respective public entities in accordance with Washington law. In the event of a conflict, any Participating Local Government, including the Regional Abatement Advisory Councils and its Members, may seek outside representation to defend itself against such an action.

3. Venue for any legal action related to this MOU shall be in the court in which the Participating Local Government is located or in accordance with the court rules on venue in that jurisdiction. This provision is not intended to expand the court rules on venue.

4. This MOU may be executed in two or more counterparts, each of which shall be deemed an original, but all of which shall constitute one and the same instrument. The Participating Local Governments approve the use of electronic signatures for execution of this MOU. All use of electronic signatures

shall be governed by the Uniform Electronic Transactions Act. The Parties agree not to deny the legal effect or enforceability of the MOU solely because it is in electronic form or because an electronic record was used in its formation. The Participating Local Government agree not to object to the admissibility of the MOU in the form of an electronic record, or a paper copy of an electronic document, or a paper copy of a document bearing an electronic signature, on the grounds that it is an electronic record or electronic signature or that it is not in its original form or is not an original.

5. Each Participating Local Government represents that all procedures necessary to authorize such Participating Local Government's execution of this MOU have been performed and that the person signing for such Party has been authorized to execute the MOU.

[Remainder of Page Intentionally Left Blank – Signature Pages Follow]

This One Washington Memorandum of Understanding Between Washington Municipalities is signed this _____ day of _____, 2022 by:

_____

Name & Title _____

On behalf of _____

4894-0031-1574, v. 2

EXHIBIT A

O P I O I D A B A T E M E N T S T R A T E G I E S

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, co-usage, and/or co-addiction through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

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

2. Support and reimburse services that include the full American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including but not limited to:

    a. Medication-Assisted Treatment (MAT);

    b. Abstinence-based treatment;

    c. Treatment, recovery, or other services provided by states, subdivisions, community health centers; non-for-profit providers; or for-profit providers;

    d. Treatment by providers that focus on OUD treatment as well as treatment by providers that offer OUD treatment along with treatment for other SUD/MH conditions, co-usage, and/or co-addiction; or

    e. Evidence-informed residential services programs, as noted below.

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

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

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

6. Support treatment of mental health trauma resulting from the traumatic experiences of the opioid user (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose

or overdose fatality), and training of health care personnel to identify and address such trauma.

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

8. Support training on MAT for health care providers, 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, co-usage, and/or co-addiction.

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

11. 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.

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

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

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

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

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

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

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

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

7. 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.

8. 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 manage the opioid user in the family.

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

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

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, co-usage, and/or co-addiction through evidence-based, evidence-informed, or promising programs or strategies that may include, but are not limited to, the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    g. County prosecution diversion programs, including diversion officer salary, only for counties with a population of 50,000 or less. Any diversion services in matters involving opioids must include drug testing, monitoring, or treatment.

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

3. Support treatment and recovery courts for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, but only if these courts provide referrals to evidence-informed treatment, including MAT.

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

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

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

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

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

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

3. 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 Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

4. 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.

5. Offer enhanced family supports and home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including but not limited to parent skills training.

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

PART TWO: PREVENTION

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

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

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

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

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

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

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

    a. Increase the number of prescribers using PDMPs;

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

    c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD.

6. Development and implementation of a national PDMP – Fund development of a multistate/national PDMP that permits information sharing while providing appropriate safeguards on sharing of private health information, including but not limited to:

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

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

7. Increase electronic prescribing to prevent diversion or forgery.

8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

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

2. Public education relating to drug disposal.

3. Drug take-back disposal or destruction programs.

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

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

6. Engage non-profits and faith-based communities as systems to support prevention.

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

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

9. Support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.

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

11. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses or other school staff, to

address mental health needs in young people that (when not properly addressed) increase the risk of opioid or other drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS

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

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

2. Provision by public health entities of free naloxone to anyone in the community, including but not limited to provision of intra-nasal naloxone in settings where other options are not available or allowed.

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

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

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

6. Public education relating to emergency responses to overdoses.

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

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

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

10. Support mobile units that offer or provide referrals to 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, co-usage, and/or co-addiction.

11. Provide training in treatment and recovery 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, co-usage, and/or co-addiction.

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

1. Current and future law enforcement expenditures relating to the opioid epidemic.

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

J. LEADERSHIP, PLANNING AND COORDINATION

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

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

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

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

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

K. TRAINING

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

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

2. Invest in 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, co-usage, and/or co-addiction, or implement other

strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

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

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

2. Research non-opioid treatment of chronic pain.

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

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

5. 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).

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

EXHIBIT B

County	Local Government	% Allocation
Adams County		
	Adams County	0.1638732475%
	Hatton	
	Lind	
	Othello	
	Ritzville	
	Washtucna	
	County Total:	0.1638732475%
Asotin County		
	Asotin County	0.4694498386%
	Asotin	
	Clarkston	
	County Total:	0.4694498386%
Benton County		
	Benton County	1.4848831892%
	Benton City	
	Kennewick	0.5415650564%
	Prosser	
	Richland	0.4756779517%
	West Richland	0.0459360490%
	County Total:	2.5480622463%
Chelan County		
	Chelan County	0.7434914485%
	Cashmere	
	Chelan	
	Entiat	
	Leavenworth	
	Wenatchee	0.2968333494%
	County Total:	1.0403247979%
Clallam County		
	Clallam County	1.3076983401%
	Forks	
	Port Angeles	0.4598370527%
	Sequim	
	County Total:	1.7675353928%

EXHIBIT B

County	Local Government	% Allocation
Clark County		
	Clark County	4.5149775326%
	Battle Ground	0.1384729857%
	Camas	0.2691592724%
	La Center	
	Ridgefield	
	Vancouver	1.7306605325%
	Washougal	0.1279328220%
	Woodland***	
	Yacolt	
	County Total:	6.7812031452%
Columbia County		
	Columbia County	0.0561699537%
	Dayton	
	Starbuck	
	County Total:	0.0561699537%
Cowlitz County		
	Cowlitz County	1.7226945990%
	Castle Rock	
	Kalama	
	Kelso	0.1331145270%
	Longview	0.6162736905%
	Woodland***	
	County Total:	2.4720828165%
Douglas County		
	Douglas County	0.3932175175%
	Bridgeport	
	Coulee Dam***	
	East Wenatchee	0.0799810865%
	Mansfield	
	Rock Island	
	Waterville	
	County Total:	0.4731986040%
Ferry County		
	Ferry County	0.1153487994%
	Republic	
	County Total:	0.1153487994%

*** - Local Government appears in multiple counties

EXHIBIT B

County	Local Government	% Allocation
Franklin County		
	Franklin County	0.3361237144%
	Connell	
	Kahlotus	
	Mesa	
	Pasco	0.4278056066%
	County Total:	0.7639293210%
Garfield County		
	Garfield County	0.0321982209%
	Pomeroy	
	County Total:	0.0321982209%
Grant County		
	Grant County	0.9932572167%
	Coulee City	
	Coulee Dam***	
	Electric City	
	Ephrata	
	George	
	Grand Coulee	
	Hartline	
	Krupp	
	Mattawa	
	Moses Lake	0.2078293909%
	Quincy	
	Royal City	
	Soap Lake	
	Warden	
	Wilson Creek	
	County Total:	1.2010866076%

*** - Local Government appears in multiple counties

EXHIBIT B

County	Local Government	% Allocation
Grays Harbor County		
	Grays Harbor County	0.9992429138%
	Aberdeen	0.2491525333%
	Cosmopolis	
	Elma	
	Hoquiam	
	McCleary	
	Montesano	
	Oakville	
	Ocean Shores	
	Westport	
	County Total:	1.2483954471%
Island County		
	Island County	0.6820422610%
	Coupeville	
	Langley	
	Oak Harbor	0.2511550431%
	County Total:	0.9331973041%
Jefferson County		
	Jefferson County	0.4417137380%
	Port Townsend	
	County Total:	0.4417137380%

*** - Local Government appears in multiple counties

EXHIBIT B

County	Local Government	% Allocation
King County		
	King County	13.9743722662%
	Algona	
	Auburn***	0.2622774917%
	Beaux Arts Village	
	Bellevue	1.1300592573%
	Black Diamond	
	Bothell***	0.1821602716%
	Burien	0.0270962921%
	Carnation	
	Clyde Hill	
	Covington	0.0118134406%
	Des Moines	0.1179764526%
	Duvall	
	Enumclaw***	0.0537768326%
	Federal Way	0.3061452240%
	Hunts Point	
	Issaquah	0.1876240107%
	Kenmore	0.0204441024%
	Kent	0.5377397676%
	Kirkland	0.5453525246%
	Lake Forest Park	0.0525439124%
	Maple Valley	0.0093761587%
	Medina	
	Mercer Island	0.1751797481%
	Milton***	
	Newcastle	0.0033117880%
	Normandy Park	
	North Bend	
	Pacific***	
	Redmond	0.4839486007%
	Renton	0.7652626920%
	Sammamish	0.0224369090%
	SeaTac	0.1481551278%
	Seattle	6.6032403816%
	Shoreline	0.0435834501%
	Skykomish	
	Snoqualmie	0.0649164481%
	Tukwila	0.3032205739%
	Woodinville	0.0185516364%
	Yarrow Point	
	County Total:	26.0505653608%

*** - Local Government appears in multiple counties

EXHIBIT B

County	Local Government	% Allocation
Kitsap County		
	Kitsap County	2.6294133668%
	Bainbridge Island	0.1364686014%
	Bremerton	0.6193374389%
	Port Orchard	0.1009497162%
	Poulsbo	0.0773748246%
	County Total:	3.5635439479%
Kittitas County		
	Kittitas County	0.3855704683%
	Cle Elum	
	Ellensburg	0.0955824915%
	Kittitas	
	Roslyn	
	South Cle Elum	
	County Total:	0.4811529598%
Klickitat County		
	Klickitat County	0.2211673457%
	Bingen	
	Goldendale	
	White Salmon	
	County Total:	0.2211673457%
Lewis County		
	Lewis County	1.0777377479%
	Centralia	0.1909990353%
	Chehalis	
	Morton	
	Mossyrock	
	Napavine	
	Pe Ell	
	Toledo	
	Vader	
	Winlock	
	County Total:	1.2687367832%

*** - Local Government appears in multiple counties

EXHIBIT B

County	Local Government	% Allocation
Lincoln County		
	Lincoln County	0.1712669645%
	Almira	
	Creston	
	Davenport	
	Harrington	
	Odessa	
	Reardan	
	Sprague	
	Wilbur	
	County Total:	0.1712669645%
Mason County		
	Mason County	0.8089918012%
	Shelton	0.1239179888%
	County Total:	0.9329097900%
Okanogan County		
	Okanogan County	0.6145043345%
	Brewster	
	Conconully	
	Coulee Dam***	
	Elmer City	
	Nespelem	
	Okanogan	
	Omak	
	Oroville	
	Pateros	
	Riverside	
	Tonasket	
	Twisp	
	Winthrop	
	County Total:	0.6145043345%
Pacific County		
	Pacific County	0.4895416466%
	Ilwaco	
	Long Beach	
	Raymond	
	South Bend	
	County Total:	0.4895416466%

*** - Local Government appears in multiple counties

EXHIBIT B

County	Local Government	% Allocation
Pend Oreille County		
	Pend Oreille County	0.2566374940%
	Cusick	
	Ione	
	Metaline	
	Metaline Falls	
	Newport	
	County Total:	0.2566374940%
Pierce County		
	Pierce County	7.2310164020%
	Auburn***	0.0628522112%
	Bonney Lake	0.1190773864%
	Buckley	
	Carbonado	
	DuPont	
	Eatonville	
	Edgewood	0.0048016791%
	Enumclaw***	0.0000000000%
	Fife	0.1955185481%
	Fircrest	
	Gig Harbor	0.0859963345%
	Lakewood	0.5253640894%
	Milton***	
	Orting	
	Pacific***	
	Puyallup	0.3845704814%
	Roy	
	Ruston	
	South Prairie	
	Steilacoom	
	Sumner	0.1083157569%
	Tacoma	3.2816374617%
	University Place	0.0353733363%
	Wilkeson	
	County Total:	12.0345236870%
San Juan County		
	San Juan County	0.2101495171%
	Friday Harbor	
	County Total:	0.2101495171%

*** - Local Government appears in multiple counties

EXHIBIT B

County	Local Government	% Allocation
Skagit County		
	Skagit County	1.0526023961%
	Anacortes	0.1774962906%
	Burlington	0.1146861661%
	Concrete	
	Hamilton	
	La Conner	
	Lyman	
	Mount Vernon	0.2801063665%
	Sedro-Woolley	0.0661146351%
	County Total:	1.6910058544%
Skamania County		
	Skamania County	0.1631931925%
	North Bonneville	
	Stevenson	
	County Total:	0.1631931925%
Snohomish County		
	Snohomish County	6.9054415622%
	Arlington	0.2620524080%
	Bothell***	0.2654558588%
	Brier	
	Darrington	
	Edmonds	0.3058936009%
	Everett	1.9258363241%
	Gold Bar	
	Granite Falls	
	Index	
	Lake Stevens	0.1385202891%
	Lynnwood	0.7704629214%
	Marysville	0.3945067827%
	Mill Creek	0.1227939546%
	Monroe	0.1771621898%
	Mountlake Terrace	0.2108935805%
	Mukilteo	0.2561790702%
	Snohomish	0.0861097964%
	Stanwood	
	Sultan	
	Woodway	
	County Total:	11.8213083387%

*** - Local Government appears in multiple counties

EXHIBIT B

County	Local Government	% Allocation
Spokane County		
	Spokane County	5.5623859292%
	Airway Heights	
	Cheney	0.1238454349%
	Deer Park	
	Fairfield	
	Latah	
	Liberty Lake	0.0389636519%
	Medical Lake	
	Millwood	
	Rockford	
	Spangle	
	Spokane	3.0872078287%
	Spokane Valley	0.0684217500%
	Waverly	
	County Total:	8.8808245947%
Stevens County		
	Stevens County	0.7479240179%
	Chewelah	
	Colville	
	Kettle Falls	
	Marcus	
	Northport	
	Springdale	
	County Total:	0.7479240179%
Thurston County		
	Thurston County	2.3258492094%
	Bucoda	
	Lacey	0.2348627221%
	Olympia	0.6039423385%
	Rainier	
	Tenino	
	Tumwater	0.2065982350%
	Yelm	
	County Total:	3.3712525050%
Wahkiakum County		
	Wahkiakum County	0.0596582197%
	Cathlamet	
	County Total:	0.0596582197%

*** - Local Government appears in multiple counties

EXHIBIT B

County	Local Government	% Allocation
Walla Walla County		
	Walla Walla County	0.5543870294%
	College Place	
	Prescott	
	Waitsburg	
	Walla Walla	0.3140768654%
	County Total:	0.8684638948%
Whatcom County		
	Whatcom County	1.3452637306%
	Bellingham	0.8978614577%
	Blaine	
	Everson	
	Ferndale	0.0646101891%
	Lynden	0.0827115612%
	Nooksack	
	Sumas	
	County Total:	2.3904469386%
Whitman County		
	Whitman County	0.2626805837%
	Albion	
	Colfax	
	Colton	
	Endicott	
	Farmington	
	Garfield	
	LaCrosse	
	Lamont	
	Malden	
	Oakesdale	
	Palouse	
	Pullman	0.2214837491%
	Rosalia	
	St. John	
	Tekoa	
	Uniontown	
	County Total:	0.4841643328%

*** - Local Government appears in multiple counties

EXHIBIT B

County	Local Government	% Allocation
Yakima County		
	Yakima County	1.9388392959%
	Grandview	0.0530606109%
	Granger	
	Harrah	
	Mabton	
	Moxee	
	Naches	
	Selah	
	Sunnyside	0.1213478384%
	Tieton	
	Toppenish	
	Union Gap	
	Wapato	
	Yakima	0.6060410539%
	Zillah	
	County Total:	2.7192887991%

*** - Local Government appears in multiple counties

Exhibit C

KING COUNTY REGIONAL AGREEMENT

King County intends to explore coordination with its cities and towns to facilitate a Regional Agreement for Opioid Fund allocation. Should some cities and towns choose not to participate in a Regional Agreement, this shall not preclude coordinated allocation for programs and services between the County and those cities and towns who elect to pursue a Regional Agreement. As contemplated in C.5 of the MOU, any Regional Agreement shall comply with the terms of the MOU and any Settlement. If no Regional Agreement is achieved, the default methodology for allocation in C.4 of the MOU shall apply.