LEGISTAR #220026

VILLAGE OF LOMBARD
REQUEST FOR BOARD OF TRUSTEES ACTION
For Inclusion on Board Agenda

_____ Resolution or Ordinance (Blue) _____*Waiver of First Requested*
_____ Recommendations of Boards, Commissions & Committees (Green)
__X_____ Other Business (Pink)

TO: PRESIDENT AND BOARD OF TRUSTEES

FROM: Scott Niehaus, Village Manager

DATE: January 3, 2022 (COW)(B of T) January 6, 2022

TITLE: Motion to Ratify Joinder Agreement for the Illinois Opioid Allocation Agreement

SUBMITTED BY: Tim Sexton, Finance Director

BACKGROUND/POLICY IMPLICATIONS:
Illinois has been involved with litigation against opioid manufacturers and distributors. Many of these lawsuits are coming to settlements at this point. The attached State-Subdivision Agreement will govern the allocation of funds received by Illinois pursuant to these settlement agreements, as well as sums collected through future national settlements with Opioid Defendants. At this point, no information is available for what these settlement amounts may mean for the Village.

The Village received this agreement from the Illinois Attorney General's office on Thursday, December 23, 2021, and it needed to be submitted by January 2, 2022. Therefore, Village Manager Scott Niehaus executed the Joinder Agreement on December 29, 2021. Staff is requesting that the Village Board ratify the Joinder Agreement for the Illinois Opioid Allocation Agreement.

Review (as necessary):
Village Attorney X_____ Date _____
Finance Director X_____ Date _____
Village Manager X_____ Date _____

NOTE: All materials must be submitted to and approved by the Village Manager's Office by 12:00 noon, Wednesday, prior to the Agenda Distribution.

ILLINOIS OPIOID ALLOCATION AGREEMENT

This Agreement is entered into by and among the following Parties: (i) the People of the State of Illinois by Kwame Raoul, the Attorney General of the State of Illinois (the "Attorney General"); and (ii) Cook County, DuPage County, Kane County, Lake County, Madison County, McHenry County, St. Clair County, Will County, and Winnebago County (the "Original Participating Local Governments" or "Original-PLGs").

WHEREAS, a number of the Original-PLGs are investigating and prosecuting their claims as detailed in a consolidated lawsuit currently pending in the Circuit Court of Cook County as case number 2017-L-013180 (the "OPLG-Lawsuit"), seeking (and intending to seek) penalties, restitution, disgorgement of revenues, and costs to remediate the public nuisance as well as damages against numerous pharmaceutical manufacturers, distributors, and other related persons and entities arising from their actions and/or inactions which contributed to the opioid epidemic and resulting public health crisis;

WHEREAS, the Attorney General is investigating and prosecuting claims, as detailed in lawsuits currently pending in the Circuit Court of Cook County as case numbers 2019-CH-04406 and 2019-CH-10481 (the "IAG-Lawsuits"), seeking (and intending to seek) penalties, restitution, disgorgement of revenues, and costs to remediate the public nuisance as well as injunctions against numerous pharmaceutical manufacturers, distributors, and other related persons and entities arising from their actions and/or inactions which contributed to the opioid epidemic and resulting public health crisis;

WHEREAS, the OPLG-Lawsuit includes claims brought in the name of the People of the State of Illinois under Section 7 of the Consumer Fraud and Deceptive Business Practices Act by multiple Original-PLGs (the "Section 7 Claims");

WHEREAS, the Attorney General also asserts Section 7 claims on behalf of the People of the State of Illinois, which are currently pending, and has filed a motion, seeking to stay the OPLGs' Section 7 claims while the Attorney General continues to investigate the opioid crisis and prosecute the IAG-Lawsuits. The OPLGs oppose the motion;

WHEREAS, the Parties desire to allow other local Illinois governmental units to join this Agreement in the future and to ensure the fair apportionment of all sums collected from any Opioid Defendant, as defined below, by way of judgment or settlement to best serve the People of the State of Illinois;

NOW, THEREFORE, in consideration of the above recitals and the mutual covenants and conditions contained herein, the sufficiency of which is hereby acknowledged, the Parties agree as follows:

1. **Definitions**

A. "Illinois Remediation Fund" means the escrow fund that will be established to hold certain monies distributed or directed to be distributed by the Attorney General into such fund pursuant to Section 3 of this Agreement which are directed for distribution by an agency of the State of Illinois and shall be exclusively used for programs and purposes that address Illinois' opioid crisis and its collateral damage, including but not limited to programs and grants that address the opioid epidemic through prevention, treatment, harm reduction and sustained recovery.

B. "LGs" mean "Local Governmental Units" and includes all Illinois counties and municipalities.

C. "LG Recovery Fund" means the escrow fund that will be established to hold certain monies distributed by the Attorney General into such fund pursuant to Section 3 of this Agreement, consisting of the LGs' share of any settlements or recoveries from Opioid Defendants.

D. "LPLGs" means "Litigating Participating Local Governmental Units" and includes the OPLGs who filed a lawsuit on or before September 1, 2020, all LGs represented by OPLG-Counsel (regardless of whether such LGs appeared in a lawsuit) and Subsequent-PLGs, provided such Subsequent-PLGs filed their appearance in Opioid Litigation on or before September 1, 2020.

E. "LPLG-Counsel" means law firms representing LPLGs who were retained to represent an LPLG in Opioid Litigation on or before September 1, 2020.

F. "NP-LGs" means "Non-Participating Local Governmental Units" and includes all LGs which are not PLGs (defined below).

G. "National Multistate Opioid Settlement" means any agreement to which (i) the State of Illinois and at least two other states are parties and (ii) in which the State of Illinois agrees to release claims that is has brought or could have brought in an action against an Opioid Defendant or has such claims released in a final order entered by a court. "National Multistate Opioid Settlement" includes (i) any form or resolution reached in a bankruptcy proceeding, provided that the Attorney General both agrees to the specific terms of such resolution or agreement in a bankruptcy proceeding and announces his or her agreement in the record of such bankruptcy proceeding, or (ii) a final order entered by the bankruptcy court.

H. "OPLG-Counsel" means "Counsel for the Original Participating Local Governments" and includes the outside counsel who have executed fee agreements with the Original-PLGs and who were retained to represent the Original Participating Local Governments.

I. "Opioid Defendant(s)" means: (i) any and all presently named or subsequently added defendants in the Opioid Litigation (defined below); and (ii) any other person or entity that, in return for a release from liability related to the Opioid Litigation, makes a payment directly or indirectly to the State of Illinois or to any PLG. For purposes of clarity, this Agreement shall not apply to any settlement or judgment involving McKinsey or Insys nor shall it apply to any settlement or judgment involving an Opioid Defendant for any claim or other matters unrelated to the opioid epidemic and resulting public health crisis.

J. "Opioid Litigation" means: (i) the OPLG-Lawsuit, (ii) the IAG-Lawsuits, and (iii) any judgment or settlement resolving civil claims brought by or that could have been brought by the PLGs or the Attorney General relating to the opioid epidemic and resulting public health crisis. For purposes of clarity, Medicaid Fraud qui tam claims are not included in the definition of "Opioid Litigation" and are not subject to this Agreement.

K. "Original-PLGs" means "Original Participating Local Governments" and includes the following local Illinois governmental units: Cook County; DuPage County; Kane County; Lake County; Madison County; McHenry County; St. Clair County; Will County; and Winnebago County.

L. "PLGs" means "Participating Local Governments" and includes the Original-PLGs and the Subsequent-PLGs (defined below).

M. "Subsequent-PLGs" means Local Governmental Units, other than Original-PLGs, which (i) execute a Joinder Agreement in the form attached as **Exhibit D** no later than January 2, 2022, in order to maximize recovery for the State of Illinois under such National Multistate Opioid Settlement unless granted a lengthier period of time to join this agreement by the Attorney General, and (ii) provide the Attorney General written notice and evidence of such execution within 2 business days thereafter.

2. **Litigation and Resolutions**

A. The Attorney General has filed in the OPLG-Lawsuit a Notice to Exercise the Right to Prosecute Litigation Brought in the Name of the People of the State of Illinois and Motion to Stay. Any PLG that has brought a claim that purports to be on behalf of the People of the State of Illinois will agree to the entry of an Agreed Order or filed Stipulation: (i) staying their claims brought in the name of the State of Illinois pursuant to the Illinois Consumer Fraud and Deceptive Business Practices Act and the Illinois Uniform Deceptive Trade Practices Act and any other claims purported to be brought on behalf of the People of the State of Illinois; and, (ii) subject to the terms of Section 2(B) below, which provides that LPLGs may, in their discretion, continue to prosecute their remaining causes of action.

B. LPLGs may, in their discretion, continue to prosecute their remaining claims (other than the claims stayed by operation of the foregoing paragraph) unless and until the

Attorney General notifies LPLG-Counsel that Illinois has reached a settlement with one or more of the Opioid Defendants that requires the release of the PLGs' claims against such settling Opioid Defendant(s). In such event, the LPLGs, including any LPLG's respective State's Attorneys, shall release all of their claims against such settling Opioid Defendant(s) in accordance with the terms of the settlement agreement negotiated by the Attorney General, provided that any recovery from such settling Opioid Defendant(s) shall be distributed by the Attorney General in accordance with the terms of Section 3 of this Agreement.

C. If the Attorney General notifies the PLGs that Illinois has reached a settlement with one or more of the Opioid Defendants that requires the release of the PLGs' claims against such settling Opioid Defendant(s), the PLGs, including any PLG's respective State's Attorneys, shall release all of their claims against such settling Opioid Defendant(s) in accordance with the terms of the settlement agreement negotiated by the Attorney General. Any recovery from such settling Opioid Defendant(s) shall be distributed by the Attorney General in accordance with the terms of Section 3 of this Agreement.

3. **Distribution of Settlements or other Recoveries**

A. Any sums collected related to Opioid Litigation by the Attorney General from any Opioid Defendant by way of judgment or settlement in a National Multistate Opioid Settlement shall be distributed as follows to ensure, among other things, that 70% of all such judgment or settlement proceeds are used to support specified opioid remediation or abatement programs:

a. Twenty percent (20.0%) shall be distributed to the State of Illinois, at least one-quarter (1/4th) of which shall be used to support opioid remediation programs included in the list of Approved Abatement Programs attached as **Exhibit B.** The State shall track and report all spending used to support opioid remediation programs.

b. (i) Fifteen percent (15%) shall be distributed into the LG Recovery Fund and shall be allocated in accordance with the percentages set forth in the Municipalities and Townships Allocation Table attached hereto as **Exhibit A-1** to (1) municipalities and townships who are PLGs and who have filed a lawsuit against an Opioid Defendant by September 1, 2020, and (2) municipalities who are PLGs with a population of at least 30,000 according to the 2019 United States Census Population Estimate whether or not they have filed a lawsuit against an Opioid Defendant. Any amount remaining in the LG Recovery Fund following this distribution shall be allocated among counties who are PLGs in accordance with the percentages set forth in the Counties Allocation Table attached hereto as **Exhibit A-2**.

(ii) In addition to any amounts remaining following the allocation in paragraph 3(A)(b)(i) of this agreement, Ten percent (10%) shall be distributed into the LG Recovery Fund to be allocated among counties who are PLGs in accordance with the procedures set forth in **Exhibit A-2** of this Agreement. Counties who receive an

allocation from this portion of the LG Recovery Fund are obligated to use such distributions to support opioid remediation programs in their community through uses included in the list of Approved Abatement Programs attached as **Exhibit B**. Each LG receiving an allocation from this portion of the LG Recovery Fund shall track and quarterly report to the Attorney General all monies spent to support opioid remediation programs.

c. Fifty-Five Percent (55%) shall be distributed into the Illinois Remediation Fund. A Remediation Fund Advisory Board shall be appointed to provide nonbinding recommendations regarding the administration and distribution of the Illinois Remediation Fund. The Remediation Fund Advisory Board, when making recommendations, will seek to ensure an equitable allocation of resources to all parts of the state, taking into consideration population as well as other factors relevant to opioid abatement, including rates of Opioid Use Disorder, Overdose Deaths, and amounts of opioids shipped into each region as measured in Morphine Milligram Equivalents. All funds disbursed from the Remediation Fund shall go to support uses included in the list of Approved Abatement Programs attached as **Exhibit B**. In addition, funds disbursed from the Remediation Fund shall go to support abatement uses that provide services in each of the seven regions identified in **Exhibit C**, with the allocation of resources being equitable across regions, taking into consideration population as well as other factors relevant to opioid abatement, including rates of Opioid Use Disorder, Overdose Deaths, and amounts of opioids shipped into each region as measured in Morphine Milligram Equivalents. The Attorney General or his delegate shall appoint the members of the Remediation Fund Advisory Board at his sole discretion, provided that at least one half (1/2) of the voting members of the Advisory Board shall be representatives of the PLGs as determined by the PLGs.

B. Any sums collected related to Opioid Litigation by a PLG from any Opioid Defendant by way of judgment or settlement shall be turned over to the Attorney General for distribution pursuant to this Section 3.

C. Funds allocated to LGs or LPLG-Counsel under Exhibit R (Agreement on Attorney's Fees, Expenses, & Costs) of the Distributor Settlement Agreement and the Janssen Settlement Agreement, or to the State under Exhibit N (Additional Restitution Amount) or Exhibit T (Agreement on the State Cost Fund Administration) of those settlement agreements shall be in addition to the allocations set forth in paragraph 3 of this Agreement and are not subject to the allocations in this Agreement. Funds allocated pursuant to provisions which are substantially similar in any subsequent settlement shall not be subject to the allocations in this Agreement.

4. **Miscellaneous**

A. Each PLG agrees to take all necessary actions and to cooperate with each other to cause this Agreement to become effective, to obtain all necessary approvals, consents, and authorizations, if any, and to execute all documents, including any necessary sign-on forms

that may be required in connection with any National Multistate Opioid Settlement, and to take such other action as may be appropriate in connection herewith.

B. This Agreement may be executed in counterparts, each of which shall constitute one and the same document. The Parties acknowledge that facsimile or electronically transmitted signatures shall be valid for all purposes.

C. The State of Illinois shall not be responsible for any attorney's fees or expenses payable by an LG to LPLG-Counsel or any other legal counsel and payment of all attorney's fees and expenses to LPLG-Counsel or any other legal counsel shall be made in accordance with the provisions of Exhibit A (the Administration of the LG Recovery Fund) and Exhibit A-3 (the Back-Stop Agreement).

D. This Agreement shall be enforceable only upon execution by the Attorney General.

E. All expenditures made by the State or LGs from funds allocated under this Agreement must comply with the provisions of applicable Settlement Agreements.

F. Other provisions of this Agreement notwithstanding, all funds received from *In Re: Purdue Pharma L.P., et al., 19-23649 (RDD)*, shall be used only for permissible abatement purposes.

G. This Agreement shall be considered an "intrastate allocation agreement" as that term is used in 735 ILCS 5/13-226(b)(2) and (d).

H. This Agreement shall be considered a "Statewide Abatement Agreement" for purposes of *In Re: Purdue Pharma, L.P., et al., 19-23649*, and a "State-Subdivision Agreement" for purposes of the Distributor and Janssen Settlement Agreements.

I. Backstop Agreement

a. An LPLG, in accordance with paragraph D in Exhibit A relating to Administration of the LG Recovery Fund, may separately agree to use its share of the LG Recovery Fund to pay for fees or costs incurred by its contingency-fee counsel ("State Backstop Agreement") so long as such contingency fees do not exceed a total contingency fee of 25% of the total gross recovery of the PLG, inclusive of contingency fees from any Multistate Attorney Contingency Fee Fund and the State Backstop Agreement.

b. Before seeking fees or litigation costs and expenses from a State Backstop Agreement, private counsel representing a LPLG must first seek contingency fees and costs from any Attorney Contingency Fee Fund or Cost Funds created under a National Opioid Multistate Settlement. Further, private counsel may only seek reimbursement for litigation fees and costs that have not previously been reimbursed through prior settlements or judgments.

c. To effectuate a State Backstop Agreement pursuant to this section, an agreement in the form of Exhibit A-3 may be entered into by a LPLG, private counsel, and the Attorney General. The Attorney General shall, upon the request of a LPLG, execute any

agreement executed by a LPLG and its private counsel if it is in the form of Exhibit A-3. For the avoidance of doubt, this section does not require a LPLG to request or enter into a State Backstop Agreement, and no State Backstop Agreement shall impose any duty or obligation on the State of Illinois or any of its agencies or officers, including without limitation the Attorney General.

IN WITNESS WHEREOF, the Parties have executed this Agreement by their representatives as of the dates set forth below

SIGNATURE PAGES FOLLOW

KWAME RAOUL Date
ILLINOIS ATTORNEY GENERRAL
On behalf of the STATE OF ILLINOIS

KIMBERLY M. FOXX Date
As State's Attorney of Cook County and on behalf of Cook County

ROBERT B. BERLIN Date
As State's Attorney of DuPage County and on behalf of DuPage County

JAMIE L. MOSSER Date
As State's Attorney of Kane County and on behalf of Kane County

ERIC RINEHART Date
As State's Attorney of Lake County and on behalf of Lake County

PATRICK D. KENNEALLY Date
As State's Attorney of McHenry County and on behalf of McHenry County

TOM HAINE Date
As State's Attorney of Madison County and on behalf of Madison County

JAMES GOMRIC Date
As State's Attorney of St. Clair County and on behalf of St. Clair County

_____

JAMES W. GLASGOW Date

As State's Attorney of Will County and on behalf of Will County

_____

J. HANLEY Date

As State's Attorney of Winnebago County and on behalf of Winnebago County

EXHIBIT A TO ILLINOIS OPIOID ALLOCATION AGREEMENT

ADMINISTRATION OF THE LG RECOVERY FUND

Each Original-PLG who executed the Illinois Opioid Allocation Agreement and any Subsequent-PLG who executed the Joinder to the Illinois Opioid Allocation Agreement acknowledges and agrees that all sums deposited by the Attorney General into the LG Recovery Fund shall be administered as follows:

A. A Special Master shall be nominated by the majority of PLG votes, with each County PLG with a population of ten thousand or more residents and each other PLG with a population of thirty thousand or more residents receiving one vote for each ten thousand residents within its jurisdictional borders based upon the 2019 United States Census Population Estimate. The Special Master shall be nominated within sixty (60) days of the initial funding of the LG Recovery Fund. The person so nominated shall not be appointed Special Master unless he or she receives the written approval of the Attorney General. If the Attorney General does not approve the nomination, then the process shall repeat and the PLGs shall nominate another person to be Special Master, until a nomination is approved by the Attorney General. Such subsequent nomination shall occur within 30 days of the Attorney General declining to give written approval of the initially nominated Special Master.

B. All costs associated with the work of the Special Master shall be paid from funds in the LG Recovery Fund prior to any distribution to counties that are PLGs or their counsel.

C. The Special Master shall direct the Settlement Administrator and administer the LG Recovery Fund to ensure that all distributions from the LG Recovery Fund to PLGs shall be made in accordance with the relative percentages set forth in **Exhibit A-1 and Exhibit A-2**, except that any distribution to any county who is a Non-Participating Local Governmental Unit (the "NP-LGs") shall be discounted by two-fifths (2/5) and such discounted amount shall be added to the pool of distributions payable to the Participating Local Governmental Units (the "PLGs") in accordance with the same percentages set forth in **Exhibit A-2**.

D. For any National Opioid Multistate Settlement with an Opioid Defendant, each such LPLG authorizes and agrees that the Special Master shall direct the Settlement Administrator to pay their LPLG-Counsel from its individual distributions from the LG Recovery Fund in accordance with the fee agreements entered into between the LPLG and LPLG-Counsel.

E. For any National Opioid Multistate Settlement for which the Attorney General requests PLGs release their claims, the Special Master shall have the discretion to assess common benefit attorneys' fees against distributions made to any county which is a PLG and which is not represented by LPLG-Counsel, provided any such common benefit attorneys' fees, if any, shall be assessed on no more than forty percent (40.0%) of the total distribution made to any county PLG not represented by LPLG-Counsel, and under no circumstances shall the common benefit fee assessed by the Special Master exceed 25%. The Special Master shall be given broad discretion to assess and apportion common benefit attorneys' fees and, absent fraud or gross misconduct, the decisions of the Special Master shall be final, binding, and not appealable. For the avoidance of doubt, nothing in this section requires the recovery by LPLG-Counsel of money in excess of their fee agreements if LPLG-Counsel receive payments from a national attorneys' fees fund or otherwise not directly from the LG Recovery Fund. In the event that a common benefit fee is assessed against a county PLG not represented by LPLG-

Counsel, the Special Master is directed to notify the Settlement Administrator of any such assessment.

EXHIBIT A-1 TO ILLINOIS OPIOID ALLOCATION AGREEMENT

MUNICIPALITIES AND TOWNSHIPS ALLOCATION TABLE

EXHIBIT A-2 TO ILLINOIS OPIOID ALLOCATION AGREEMENT

COUNTIES ALLOCATION TABLE

EXHIBIT A-3 TO ILLINOIS OPIOID ALLOCATION AGREEMENT

BACK-STOP AGREEMENT

At the request of [LPLG], the [LPLG], its counsel [COUNSEL], and the Attorney General are entering into this Backstop Agreement (Backstop Agreement).

The Parties acknowledge that this Agreement will apply to all National Multistate Opioid Settlement agreements which establish a multistate fund for the payment of attorney's fees and expenses (a "Multistate Contingency Fee Fund") but that payments to LPLG-Counsel from such funds will not be sufficient to pay the entirety of the fees and expenses incurred by contingency-fee counsel who have been retained by LPLGs. Therefore, consistent with Exhibit R, section I(R) of the National Multistate Opioid Settlement agreement entered into between three pharmaceutical distributors, namely, McKesson Corporation, Cardinal Health, Inc., and AmerisourseBergen Corporation (the "Distributor Settlement Agreement"), the Parties agree to this Backstop Agreement.

Pursuant to this Backstop Agreement, [LPLG] may, subject to the limitations of any National Multistate Opioid Settlement, as well as any other limitations imposed by law, use funds that it receives from a National Multistate Opioid Settlement to pay a contingent fee to [COUNSEL]. Any such payment from [LPLG] to [COUNSEL], together with any contingency fees that [COUNSEL] may receive from the Multistate Contingency Fee Fund, will not exceed a total contingency fee of [PERCENTAGE NOT TO EXCEED 25%] of the total gross recovery of [LPLG] from the LG Recovery Fund in a National Multistate Opioid Settlement.

[COUNSEL] certify that they first sought fees and costs from the Multistate Contingency Fee Fund before seeking or accepting payment under this backstop agreement. [COUNSEL] further certify that they are not seeking and will not accept payment under this Backstop Agreement of any litigation fees or costs that have been reimbursed through prior settlements or judgments.

The Attorney General is executing this agreement solely because the definition of "State Backstop Agreement" in Exhibit R of the Distributor Settlement Agreement requires such agreements to be between "a Settling State" and private counsel for a participating subdivision. Neither the Attorney General nor the State of Illinois have any obligations under this Backstop Agreement, and this Backstop Agreement does not require the payment of any state funds to [LPLG], [COUNSEL], or any other party.

KWAME RAOUL Date
ILLINOIS ATTORNEY GENERRAL
On behalf of the STATE OF ILLINOIS

[LPLG] Date

[COUNSEL] Date

EXHIBIT B TO ILLINOIS OPIOID ALLOCATION AGREEMENT

APPROVED ABATEMENT PROGRAMS

EXHIBIT C TO ILLINOIS OPIOID ALLOCATION AGREEMENT

ILLINOIS ABATEMENT FUND-SEVEN SERVICE REGIONS

Jo Daviess
Stephenson
Winnebago
Rockford
Boone
Mc Henry
Lake
Carroll
Ogle
DeKalb
Kane
DuPage
Bellwood
Evanston
Skokie
Oak Park
Chicago
Stickney Twp
Whiteside
Lee
West Chicago
Kendall
Cook
Will
Rock Island
Henry
Bureau
La Salle
Grundy
Mercer
Putnam
Stark
Marshall
Kankakee
Knox
Henderson
Warren
Peoria
Woodford
Livingston
Iroquois
Peoria
Hancock
Mc Donough
Fulton
Tazewell
Mc Lean
Ford
Champaign Co.
Mason
Schuyler
Logan
DeWitt
Piatt
Champaign-Urbana
Vermilion
Adams
Brown
Cass
Menard
Champaign
Macon
Morgan
Sangamon
Douglas
Pike
Scott
Moultrie
Edgar
Christian
Coles
Greene
Shelby
Clark
Calhoun
Macoupin
Montgomery
Cumberland
Jersey
Fayette
Effingham
Jasper
Crawford
Edwardsville
Bond
Madison
Clay
Richland
Lawrence
East Side
Clinton
Marion
St. Clair
Wayne
Edwards
Wabash
Washington
Monroe
Jefferson
Randolph
Perry
Hamilton
Franklin
Williamson
Jackson
Egyptian
Marion
Southern Seven

EXHIBIT D TO ILLINOIS OPIOID ALLOCATION AGREEMENT

JOINDER AGREEMENT

Reference is made to that Agreement attached hereto as **Exhibit 1** to this Joinder Agreement between the People of the State of Illinois and the Original-PLGs, namely: Cook County; DuPage County; Kane County; Madison County; McHenry County; Lake County; St. Clair County; Will County; and Winnebago County (the "Illinois Opioid Allocation Agreement").

> WHEREAS, the State of Illinois and the Original-PLGs entered into the Illinois Opioid Allocation Agreement to pursue their common interests and to maximize the benefits obtained for their constituents with respect to their claims against the persons and entities responsible for the opioid crisis which has ravaged Illinois communities.
>
> WHEREAS, Illinois and the Original-PLGs have agreed to allow additional counties and municipalities to join and participate in the Illinois Opioid Allocation Agreement (such additional counties and municipalities are referred to as "Subsequent-PLGs" in the Illinois Opioid Allocation Agreement) by executing this Joinder to the Illinois Opioid Allocation Agreement and thereby become a Participating Local Government (a "PLG" as defined in the Illinois Opioid Allocation Agreement) entitled to share in the expected benefits to be derived therefrom.

NOW THEREFORE, the undersigned municipality/county hereby agrees to become a party to and be bound by and subject to the terms and conditions of the Illinois Opioid Allocation Agreement as well as to the terms and conditions of the Exhibits attached thereto which govern the administration and distribution of the LG Recovery Fund, as defined in the Illinois Opioid Allocation Agreement, amongst Illinois counties and municipalities ("LGs" as defined in the Illinois Opioid Allocation Agreement).

Dated: December 29, 2021

VILLAGE OF LOMBARD
LOCAL GOVERNMENTAL UNIT

By: _____
Its authorized representative

EXHIBIT 1 TO JOINDER AGREEMENT

COPY OF ILLINOIS OPIOID ALLOCATION AGREEMENT

EXHIBIT B

APPROVED ABATEMENT PROGRAMS

List of Opioid Remediation Uses

Schedule A
Core Strategies

Priority shall be given to the following core abatement strategies ("*Core Strategies*").

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.

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:

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.

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

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

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

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

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

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

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

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

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Create and/or support recovery high schools.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART TWO: PREVENTION

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

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

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

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

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

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

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

1. Increase the number of prescribers using PDMPs;

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

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

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

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Funding media campaigns to prevent opioid misuse.

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

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Public education relating to emergency responses to overdoses.

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

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

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

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

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

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

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

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

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

J. LEADERSHIP, PLANNING AND COORDINATION

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

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

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

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

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

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

K. TRAINING

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

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

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

L. RESEARCH

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

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

2. Research non-opioid treatment of chronic pain.

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

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

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

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

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

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

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

State of Illinois
Qualifying Municipality
Exhibit G Allocation Percentages

Qualifying Subdivision	Distributors Exhibit G Percentage
Addison Village	0.1789163143%
Algonquin Village	0.1102023571%
Anna City	0.0351784549%
Arlington Heights Village	0.2647476580%
Aurora City	1.1285112946%
Bartlett Village	0.1012637420%
Bedford Park Village	0.0908134228%
Belleville City	0.2800912041%
Bellwood Village	0.0636018022%
Bensenville Village	0.0698164453%
Benton City	0.0648747331%
Berkeley Village	0.0152507249%
Berwyn City	0.2349799824%
Bloomington City	0.4210280112%
Bolingbrook Village	0.3965448276%
Bridgeview Village	0.0500143261%
Broadview Village	0.0576947589%
Buffalo Grove Village	0.2068406914%
Burbank City	0.0690685990%
Calumet City	0.0970812870%
Carbondale City	0.1954958522%
Carol Stream Village	0.1407965379%
Carpentersville Village	0.1363950647%
Champaign City	0.4052254107%
Chicago City	15.6332843102%
Chicago Heights City	0.1217857439%
Chicago Ridge Village	0.0524909103%
Cicero Town	0.2786347507%
Countryside City	0.0301223625%
Crystal Lake City	0.3158354713%
Danville City	0.2559565285%
Decatur City	0.4645929351%
Dekalb City	0.1798256279%
Des Plaines City	0.2324422843%
Dolton Village	0.0603302846%

State of Illinois
Qualifying Municipality
Exhibit G Allocation Percentages

Downers Grove Village	0.3224473331%
Elgin City	0.5305768766%
Elk Grove Village	0.1757993182%
Elmhurst City	0.2577623917%
Evanston City	0.2696457560%
Evergreen Park Village	0.0597799426%
Forest Park Village	0.0453425079%
Franklin Park Village	0.0785284649%
Galesburg City	0.1473738962%
Glendale Heights Village	0.0836866697%
Glenview Village	0.1572220054%
Granite City	0.4907786518%
Gurnee Village	0.2256865903%
Hanover Park Village	0.1439424898%
Harrisburg City	0.1363861795%
Harvey City	0.0542520318%
Harwood Heights Village	0.0264961580%
Herrin City	0.1579067080%
Hillside Village	0.0587648633%
Hodgkins Village	0.0232613539%
Hoffman Estates Village	0.1751755942%
Joliet City	0.8239848961%
Kankakee City	0.3012693137%
La Grange Park Village	0.0306665705%
Lombard Village	0.2672806655%
Lyons Township	0.0242947899%
Lyons Village	0.0362495516%
Marion City	0.3397669146%
Maywood Village	0.0867531057%
McCook Village	0.0198186268%
Melrose Park Village	0.1186181878%
Merrionette Park Village	0.0076009169%
Metropolis City	0.0947332002%
Moline City	0.2352551083%
Mount Prospect Village	0.1704792853%
Mundelein Village	0.1639685886%
Naperville City	0.7685669619%
Normal Town	0.2474856274%
North Riverside Village	0.0551815063%
Northbrook Village	0.1427173226%

State of Illinois
Qualifying Municipality
Exhibit G Allocation Percentages

Northlake City	0.0381023667%
Oak Lawn Village	0.1589709041%
Oak Park Village	0.2093093375%
Orland Park Village	0.1051852784%
Oswego Village	0.1197866160%
Palatine Village	0.2160969641%
Palos Heights City	0.0290094105%
Palos Hills City	0.0251753281%
Park Ridge City	0.1116349061%
Pekin City	0.3387071386%
Peoria City	1.0471081247%
Plainfield Village	0.1401767830%
Posen Village	0.0146759373%
Princeton City	0.2434249044%
Quincy City	0.2800247680%
River Forest Village	0.0488586169%
River Grove Village	0.0284407118%
Riverside Village	0.0269914748%
Rock Island City	0.2048536960%
Rockford City	1.8636718830%
Romeoville Village	0.2124235372%
Schaumburg Village	0.2968023515%
Schiller Park Village	0.0601957886%
Sesser City	0.0116834244%
Skokie Village	0.1964801264%
Springfield City	0.9971442684%
St. Charles City	0.2062203953%
Stone Park Village	0.0241358032%
Streamwood Village	0.0878171213%
Streator City	0.1400665973%
Summit Village	0.0312780717%
Tinley Park Village	0.1419492253%
Urbana City	0.2112740522%
Waukegan City	0.4111769252%
West Frankfort City	0.1255886605%
Wheaton City	0.2463124635%
Wheeling Village	0.1229353643%
Woodridge Village	0.1148193756%

State of Illinois
Counties Only Percentages

Qualifying Subdivision	Counties Only Percentage
Adams County	0.5325627744%
Alexander County	0.0431846002%
Bond County	0.1313618076%
Boone County	0.3993006496%
Brown County	0.0455436631%
Bureau County	0.2675493675%
Calhoun County	0.0374496996%
Carroll County	0.1059047501%
Cass County	0.0902574340%
Champaign County	1.5953670185%
Christian County	0.2717469407%
Clark County	0.1346384837%
Clay County	0.1009205688%
Clinton County	0.2710071787%
Coles County	0.3899340741%
Cook County	39.7070170529%
Crawford County	0.1502157232%
Cumberland County	0.0765804365%
De Witt County	0.1343763530%
Dekalb County	0.7648068692%
Douglas County	0.1396209979%
Dupage County	6.9961301825%
Edgar County	0.1369536821%
Edwards County	0.0557876634%
Effingham County	0.2745921107%
Fayette County	0.1730292191%
Ford County	0.1050766592%
Franklin County	0.3753293914%
Fulton County	0.2857420449%
Gallatin County	0.0461748227%
Greene County	0.1120932638%
Grundy County	0.4447604831%
Hamilton County	0.0586888564%
Hancock County	0.1237654700%
Hardin County	0.0525232340%
Henderson County	0.0468231560%

State of Illinois
Counties Only Percentages

Henry County	0.3631064984%
Iroquois County	0.2340046386%
Jackson County	0.4766842676%
Jasper County	0.0729264789%
Jefferson County	0.3076865268%
Jersey County	0.2029662011%
Jo Daviess County	0.1594100240%
Johnson County	0.0934835787%
Kane County	3.7592516293%
Kankakee County	0.8907176656%
Kendall County	0.9152447008%
Knox County	0.4095413266%
Lake County	5.4323006331%
Lasalle County	1.0382633595%
Lawrence County	0.1362169504%
Lee County	0.2713491451%
Livingston County	0.3277646387%
Logan County	0.2230314720%
Macon County	0.8339920017%
Macoupin County	0.3637461000%
Madison County	2.5601663484%
Marion County	0.3444624326%
Marshall County	0.0878603767%
Mason County	0.1123492816%
Massac County	0.1236043365%
McDonough County	0.2216295193%
McHenry County	2.3995936239%
McLean County	1.3208345544%
Menard County	0.0917783576%
Mercer County	0.1144419910%
Monroe County	0.2714501969%
Montgomery County	0.2342865810%
Morgan County	0.2708645052%
Moultrie County	0.1003140855%
Ogle County	0.3811415242%
Peoria County	1.5640744904%
Perry County	0.1751336763%
Piatt County	0.1214359333%
Pike County	0.1155220743%
Pope County	0.0347091515%
Pulaski County	0.0404416607%

State of Illinois
Counties Only Percentages

Putnam County	0.0452090528%
Randolph County	0.2879823727%
Richland County	0.1208518975%
Rock Island County	1.0782047657%
Saline County	0.2659477915%
Sangamon County	1.5850818631%
Schuyler County	0.0485294910%
Scott County	0.0349810216%
Shelby County	0.1586806535%
St Clair County	2.1366773448%
Stark County	0.0381570939%
Stephenson County	0.3550412743%
Tazewell County	1.1033013785%
Union County	0.1447352927%
Vermilion County	0.6907560341%
Wabash County	0.0923901750%
Warren County	0.1239679440%
Washington County	0.1076671021%
Wayne County	0.1225391595%
White County	0.1115911540%
Whiteside County	0.4275606484%
Will County	5.3461509816%
Williamson County	0.6715468751%
Winnebago County	2.7201669312%
Woodford County	0.3076824807%