GLADSTONE CITY COUNCIL WORK SESSION
CIVIC CENTER COUNCIL CHAMBERS
August 23, 2022 - 5:30 PM

5:30 p.m.
CALL TO ORDER
ROLL CALL
FLAG SALUTE

The City of Gladstone is abiding by guidelines set forth in House Bill 2560, which requires the governing body of the public body, to extent reasonably possible, to make all meetings accessible remotely through technological means and provide opportunity for members of general public to remotely submit oral and written testimony during meetings to extent in-person oral and written testimony is allowed. Therefore, this meeting will be open to the public both in person and virtually using the Zoom platform.

Please click the link below to join the webinar:
https://us06web.zoom.us/j/83318580465?pwd=S1N5MjhVTHJUV1I4dXhQU3RLcVJTQT09

Passcode: 157425

Or One tap mobile :
US: +12532158782,,83318580465#,,,,*157425# or +13462487799,,83318580465#,,,,*157425#

Or Telephone:
Dial(for higher quality, dial a number based on your current location):
US: +1 253 215 8782 or +1 346 248 7799 or +1 669 444 9171 or +1 719 359 4580 or +1 720 707 2699 or +1 646 931 3860 or +1 301 715 8592 or +1 309 205 3325 or +1 312 626 6799 or +1 386 347 5053 or +1 564 217 2000 or +1 646 558 8656

Webinar ID: 833 1858 0465
Passcode: 157425

The public is welcome to attend the Work Session in person, or on-line however, no public comment will be allowed.

REGULAR WORK SESSION

1. **CHILD CARE FOR ALL (CC4A) TASK FORCE PRESENTATION**
   Bridget Dazey, Clackamas Workforce and Dani-Stamm-Thomas, Clackamas Early Learning Hub will provide a presentation on the Task Force's work.

2. **NATIONAL OPIOID SETTLEMENT AGREEMENT- SUBSTANCE USE AND OVERDOSE PREVENTION INITIATIVE**
   Apryl Herron and Elizabeth White with Clackamas County Public Health Division's Substance Use and Overdose Prevention Initiative will present the City Council an overview on the County's initiatives to address the opioid crisis with the national opioid settlement funds.

ADJOURN

Upcoming Meeting Dates:

- September 13, 2022 - Regular City Council Meeting - 6:30 p.m.
- September 27, 2022 – City Volunteer Celebration at the Senior Center - 5:30-6:30 pm

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MEETING ACCESSIBILITY SERVICES AND AMERICANS WITH DISABILITIES ACT (ADA) NOTICE

The Civic Center is ADA accessible. Hearing devices may be requested from the City Recorder at least 48 hours prior to the meeting. Individuals requiring other assistance must make their request know 48 hours preceding the meeting by contacting the City Recorder at bannick@ci.gladstone.or.us. Staff will do their best to respond in a timely manner and to accommodate requests.

WORK SESSION #1

City of Gladstone
Staff Report

Report Date: August 16, 2022
Meeting Date: August 23, 2022
To: Gladstone City Council
Via:
From: Jacque M. Betz, City Administrator

AGENDA ITEM
Child Care for All (CC4A) *Task Force* Update to the Gladstone City Council

History/Background/Proposal

CC4A is a consortium which comprises local business and industry leaders, elected officials, community-based organizations, social service providers, educators and working parents. The goal is to resolve the local (or regional) childcare crisis through effective public/private sector partnerships that address the key elements of this issue; raising public awareness; growing the childcare workforce; and strengthening the infrastructure for the child care industry.CC4A will present an update to the Gladstone City Council on their program.

Recommended Staff Action

This item is for informational purposes only and there is no staff recommendation.

Department Head Signature Date

Jacque M. Betz 8/17/22
City Administrator Signature Date

Clackamas County
Child Care For All

CC4A

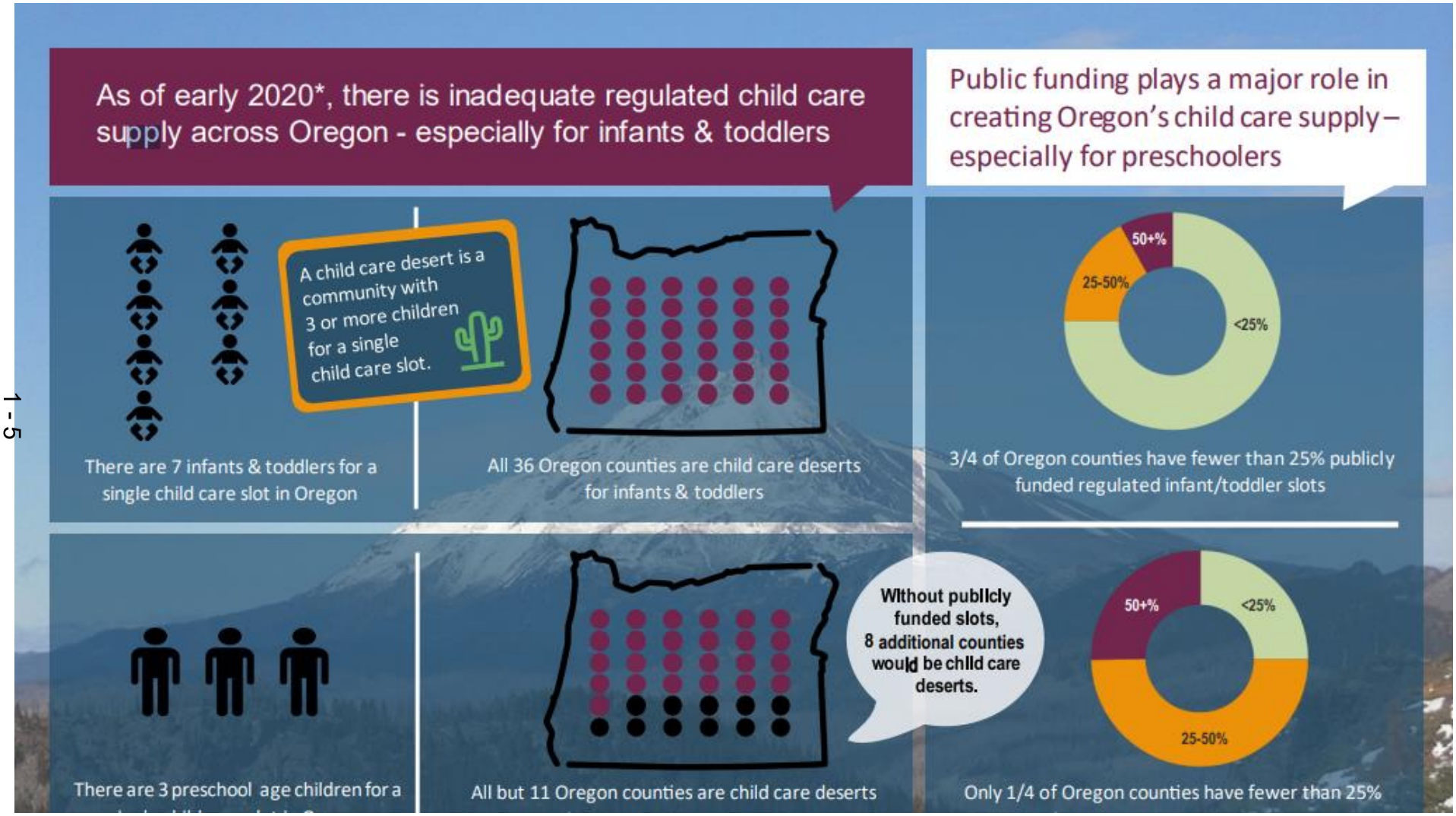
CC4A Presentation

to: Gladstone City Council, August 23


Chris
JORDAN

This impacts ALL of us – women are important and bear the brunt of the impacts.

- Burnout & mental health
- Standing at the intersections of challenge and opportunity
- Childcare and Early Learning and Education NOW – determines our collective future


As of early 2020*, there is inadequate regulated child care supply across Oregon - especially for infants & toddlers
A child care desert is a community with 3 or more children for a single child care slot.
There are 7 infants & toddlers for a single child care slot in Oregon
All 36 Oregon counties are child care deserts for infants & toddlers
There are 3 preschool age children for a
All but 11 Oregon counties are child care deserts
Without publicly funded slots, 8 additional counties would be child care deserts.
Public funding plays a major role in creating Oregon's child care supply – especially for preschoolers
50+%
25-50%
<25%
3/4 of Oregon counties have fewer than 25% publicly funded regulated infant/toddler slots
50+%
<25%
25-50%
Only 1/4 of Oregon counties have fewer than 25%

Pre-pandemic & Current Early Learning Profile, Clackamas

End of 2020

- Children under the age 13: 61,346
- Family childcare slots: 1,849
- Center childcare slots: 8,029
- **16% of children have access to viable childcare**
- 57% of a minimum wage workers annual earnings would be needed to pay the price of childcare for a toddler

Currently

- Updated Census not available
- Family childcare slots: 1,574*
- Center childcare slots: 7,089*
- Lost childcare slots since 2020: 1,215
- Percent of childcare lost since 2020: 10.2%

Something we can all agree on – this is an important issue

On October 6, 2021, Clackamas County Board of County Commissioners held a Town Hall on Child Care attended by 60+.

The Commissioners heard from child care providers, families, nonprofits, and the business sector.

01. **6 in 10** American parents say that there is a serious problem finding quality, affordable childcare in their community

02. **60%** of voters agree with the following statement: "Government should take a more active role in ensuring all families have access to reliable, affordable childcare because we will not be able to fully recover from the current coronavirus pandemic unless parents are able to return to work

03. **7 in 10** voters support increased congressional funding for childcare and early childhood education

04. **8 in 10 voters** back a proposal to offer options public pre-K to all 3 and 4 year old children in the county

*National Survey of Registered Voters, American Progress Report Sept. 2020

Child Care Access is Multidimensional

- ***Access*** *to early care & education means that parents, with reasonable effort and affordability, can enroll their child in an arrangement that supports child's development and meets the parents' needs.*

- **Reasonable Effort:** supply, parents can access information
- **Affordability:** price of care, cost of operations, public funding
- **Supports Child Development:** quality, specialized services
- **Meets Parents Needs:** match with parent job schedule
- **Equity:** disproportionate access to by certain populations

Child Care for All in Clackamas County

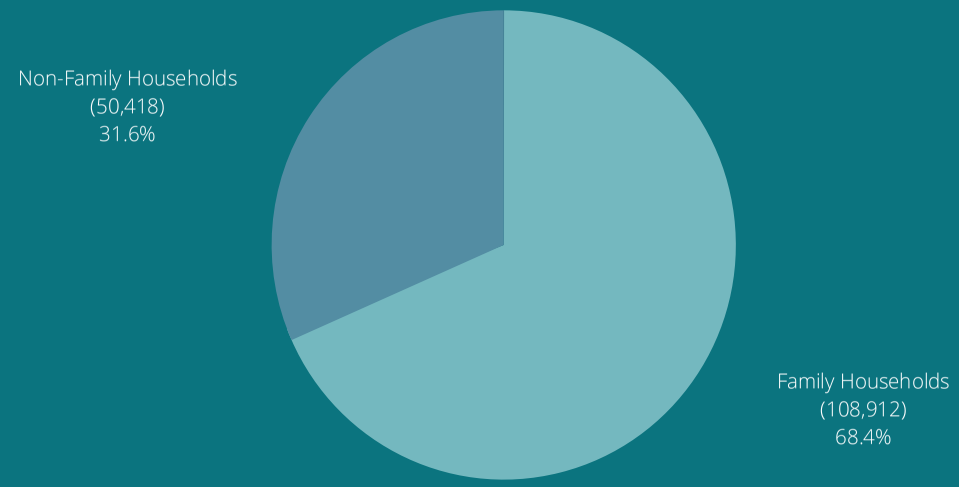
Childcare for All is Our Goal

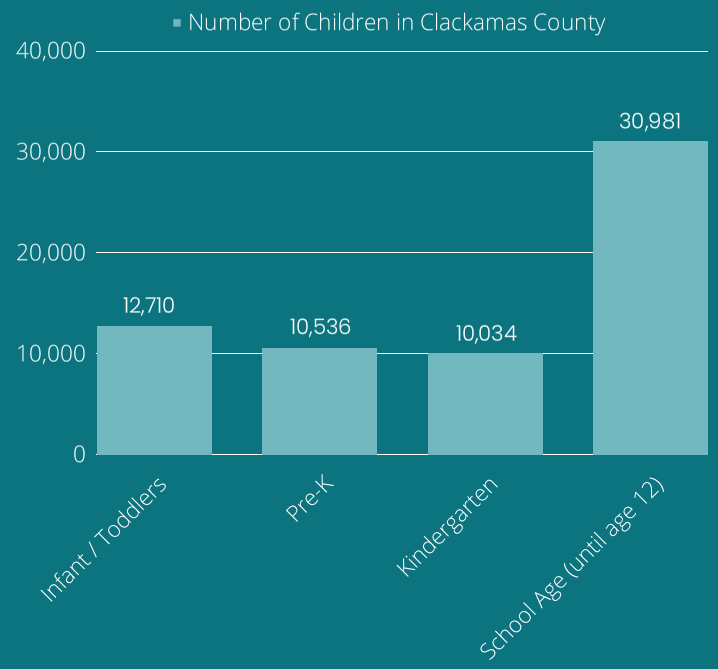
We can do this by:

1. Elevating the issue
2. Identifying solutions
3. Creating committees based on prioritized solutions
4. Developing an action plan & set of strategies by Summer of 2022
5. Creating the largest network for early learning & childcare advocates
6. **Collective Impacts!**

422,537 Residents in Clackamas Co

The child care for all market size encompasses care for 64,261 children between ages 6 weeks to 12 years of age; living in 108,912 households.





Residents and household data: US Census Bureau, 2020 (Resident estimate updated 2021)
Demographic data: Estimated from US Census Bureau, 2020

Overview of Process

Round 1

Initial Findings & Early Recommendations

Workgroups will develop initial recommendations for the Steering Committee

Status: In Progress

Round 2

Interim Recommendations

Workgroup will revise recommendations or further validate for final recommendations to the Steering Committee

Status: Upcoming

Round 3

Final Recommendations

Final sets of recommendations will go to the Steering Committee

Status: Upcoming


Clackamas Community College
worksource | OREGON
Clackamas Parenting Together
All Families Need Strong Roots
DHS
Oregon Department of Human Services
Clackamas Education Service District
Morant McLeod
City of Canby
Clackamas County Children's Commission
headstart
earlyheadstart
Family Forward
Oregon
Early Learning Hub
of Clackamas County
Oregon ASK
Afterschool & Summer for Kids Network
Todos Juntos
Clackamas County
CITY OF
ESTACADA
unexpected / untamed / unforgettable
Oregon City
Clackamas County Children's Commission
A few partners of our partners in Childcare for All...and still growing!

Finance & Strategy	Supply & Demand (current, potential)
	Expenditures, Revenue options
	Projections
Infrastructure	Geography
	Current Facilities & Future Facilities
	Zoning/Regulations
Program & Policy	Alignments
	Implementation Pathways
	Quality
Workforce	Equity
	Culture
	Wages

CC4A Workgroups

Current Focal Points

Data Overview

	To: Finance & Strategy	To: Infrastructure	To: Program & Policy	To: Workforce
From: Finance Strategy	**Supply / Demand Exp / Revenues**	Geography Implications	Time of day, age implications	Livable wages, License costs
From: Infrastructure	Expenditures	**Facilities Inventory**	Availability	Availability
From: Program & Policy	Subsidies & Rates	Location Requirements	**Equity & Values**	Wage Basis
From: Workforce	Wage bounds	Geographies	Equity, Wage Bounds	**Culture**

Insights on the Sustainable Wages

Employees working for childcare providers experience hardships when they have children of their own or do not have another adult to provide support.

Current hourly wages for child care provider employees

- Average $17.54 per hour for employees
- Average $36,483 annual income for employees

One Adult Household Living Expenditures

- One child: $72,681
  - $34.94 wage required
- Two children: $89,314
  - $42.94 wage required
- Three children: $120,382
  - $57.88 wage required

Two Adult Household Living Expenditures (both working)

- One child: $79,552
  - $19.12 wage required
- Two children: $100,740
  - $24.22 wage required
- Three children: $122,289
  - $29.40 wage required

Employment data: Oregon Employment Department, 2021. US Census Bureau, 2020.
Household expenditures: US Census Bureau, 2020; Glasmeier, Amy K. Living Wage Calculator. 2020. Massachusetts Institute of Technology. livingwage.mit.edu.

Return on Investment – It will payoff!

- Each dollar spent on early childhood education programs returns more than $6 in benefits
- Good for kids. Good for parents. Good for the economy
- "There's clear evidence that kids develop better and stronger essential skills," he said, "and we can basically show that this does act to reduce income inequality.“ -CBS News

A Future with Child Care for All Looks Bright

→ Less likely to need special education services

→ More likely to be literate by the sixth grade

→ Fosters greater Labor Force Participation

→ High school completion

→ Reduces duration on Unemployment

→ Reduces employee turnover (Patagonia shared stat that it costs the equivalent of 1.5FTE to replace a 1.0 FTE who left)

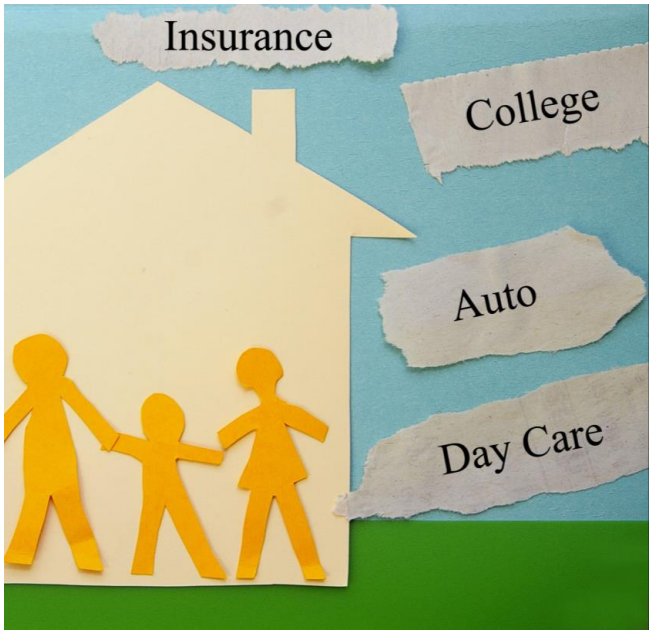
→ Better trained workforce

→ Four times as likely to graduate college

→ Stronger safety net (or trampoline)

→ 50% less likely to commit a crime

Recommendations



- Sign onto the Child Care for All initiative
- Follow on social media
- Guest write a blog entry / article
- Help spread the word
- Believe this is possible and will happen

WHAT QUESTIONS DO YOU HAVE FOR US?

Bridget Dazey | Bridget.Dazey@clackamasworkforce.org

Dani Stamm-Thomas | DStammThomas@clackamas.us

@CLACKAMASWORKFORCE (FACEBOOK)
@_C_W_P (TWITTER)
@CLACKAMASWORKFORCEPARTNERSHIP (INSTAGRAM)

@CLACKAMASCC4A (FACEBOOK)
@CLACKAMASCC4A (TWITTER)
@CLACKAMAS CHILD CARE 4 ALL (LINKEDIN)

86%	Support for making childcare more affordable by providing financial support to help working families pay some or all the cost of quality care
88%	Support for attracting, retaining, and supporting quality early childhood educators and caregivers by paying them better salaries and providing them with opportunities to increase their skills through ongoing training, education, and certification, which would improve the instruction and care that children receive.
85%	Support for making childcare more affordable by providing parents with a tax credit to help pay for childcare.
84%	Support for making preschool more available by providing it to all three- and four-year-olds whose parents want to send them.
87%	Support for increasing the availability of quality childcare for families by providing a tax credit to businesses that help their employees access and afford quality childcare.
74%	Voters nationwide say elected leaders should make childcare and early learning a priority in 2021

WORK SESSION #2

City of Gladstone
Staff Report

Report Date:	August 16, 2022
Meeting Date:	August 23, 2022
To:	Gladstone City Council
Via:	
From:	Jacque M. Betz, City Administrator

AGENDA ITEM
National Opioid Settlement Agreement- Substance Use and Overdose Prevention Initiative Prevention.

History/Background/Proposal
In December of 2021, the City Council gave staff direction to participate in the proposed settlement agreement with opioid distributors as well as one manufacturer, Janssen (Johnson & Johnson). As you recall, local governments throughout the country have filed lawsuits against various opioid manufacturers and distributors due to their actions that resulted in an uncontrolled and misleading distribution of millions of addicting opioid pills. The lawsuits allege that these actions have directly resulted in and caused an epidemic level crisis in cities and counties. In Oregon, ten counties and one city filed suit and are part of the national Multi-District Litigation (MDL), which include the combination of over 3,000 federal court cases.

The proposed settlements are based off an incentive based model and the City of Gladstone will receive approximately $7,000 in the first installment. It is expected the funds will be paid over 7 years as provided in the Settlement Agreements. The funds come with strict restrictions that require to be spent on purposes related to alleviating the impacts of the opioid epidemic and that there are ongoing reporting requirements for how the money is used. There are 9 core abatement strategies being elevated (included in this packet)- many of them will be hard to do with limited funding.

Clackamas County is also a recipient of these funds, specifically the Clackamas County Public Health Division has a Substance Use and Overdose Prevention Initiative Program. This summer they presented their proposed use of funds framework to the Board of County Commissioners. I reached out to the County and asked that they also attend a future Gladstone City Council meeting to present their proposed use of funds to determine whether the City would like to work with the County on a coordinated use of funds.

Recommended Staff Action
No decision will be made at the work session however, if it is the consensus of the City Council to work with Clackamas County staff will draft and intergovernmental agreement with Clackamas County and bring it back at a future Council meeting for consideration.

Department Head Signature — Date

Jacque M. Betz 8/17/22
City Administrator Signature — Date

Opioid Litigation Settlement: *Using Evidence to Lead Action*

August 23, 2022

Apryl Herron, MPH
Clackamas County Public Health Division

Elizabeth White, MPA
Clackamas County Children, Family & Community Connections

Health, Housing & Human Services
CLACKAMAS COUNTY

Agenda

- Impact of the Opioid Crisis
- Community Response
- Settlement Agreement Background
- Allowable Uses of Funding
- Guiding Principles
- Using Data to Inform Decisions
- County Framework
- Support to Cities
- Questions

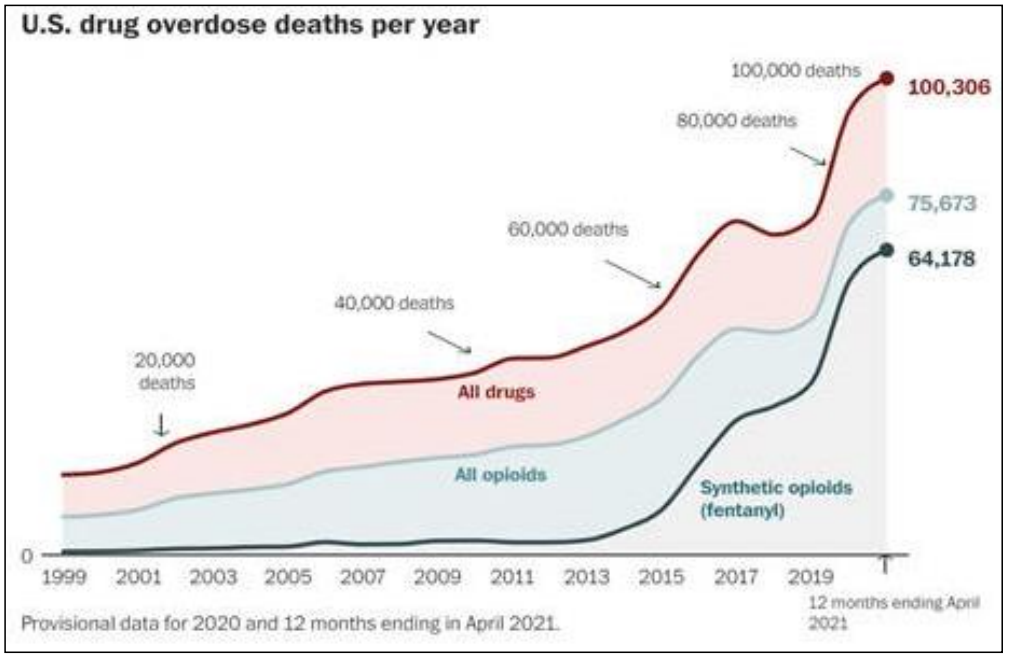
Lifting Up Our Community

- Clackamas County and Cities will receive funding from the National Opioid Settlement to mitigate harms associated with the opioid and other drug crisis.
- New funding provides an opportunity to make strategic investments in evidence-based approaches that **strengthen our communities, prevent opioid misuse and stem the rising number of overdose deaths.**

National Opioid Crisis

- Over **100,000** people died as a result of the overdose epidemic from April 2020 to April 2021.

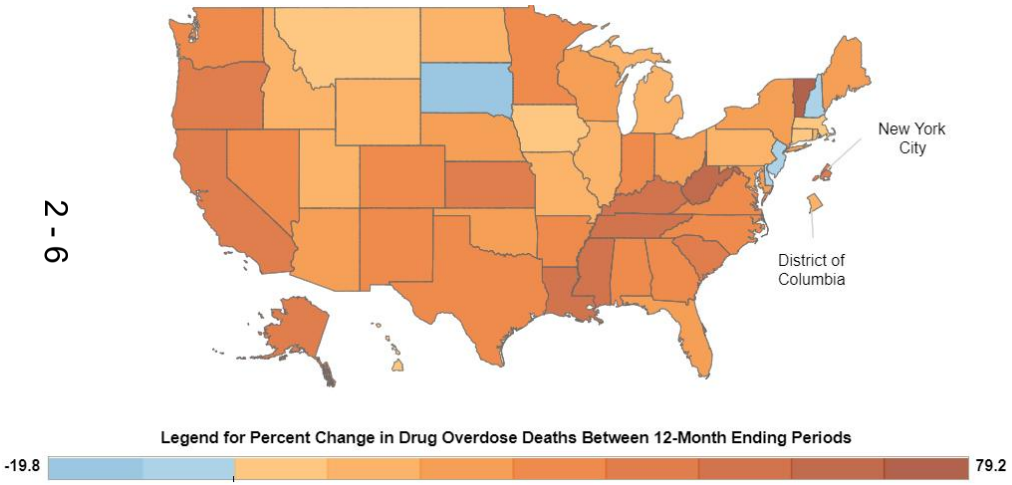
- Approximately **75,000** of those deaths involved opioids, most of which were due to synthetic opioids such as fentanyl.



Source: Centers for Disease Control and Prevention, National Center for Health Statistics

Local Impact

Oregon saw a **45.1% increase** in ALL overdose deaths- Apr 2020-Apr 2021.



Alcohol and Drug Addiction Worsens in Oregon- Deaths soar during pandemic

- Oregon now ranks 2nd in the country for substance use disorders
- Oregon fell to 50th in access to treatment,
- Oregon ranks 1st in prescription opioid misuse
- Oregon ranks 1st in methamphetamine use

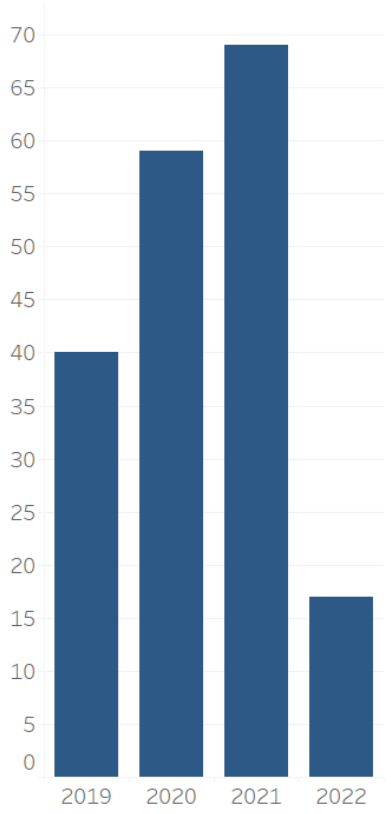
CDC, Center for Health Statistics, Vital Statistics Rapid Release (VSRR) program: https://emergency.cdc.gov/han/2020/han00438.asp

National Survey on Drug Use and Health, conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), 2020

Local Impact

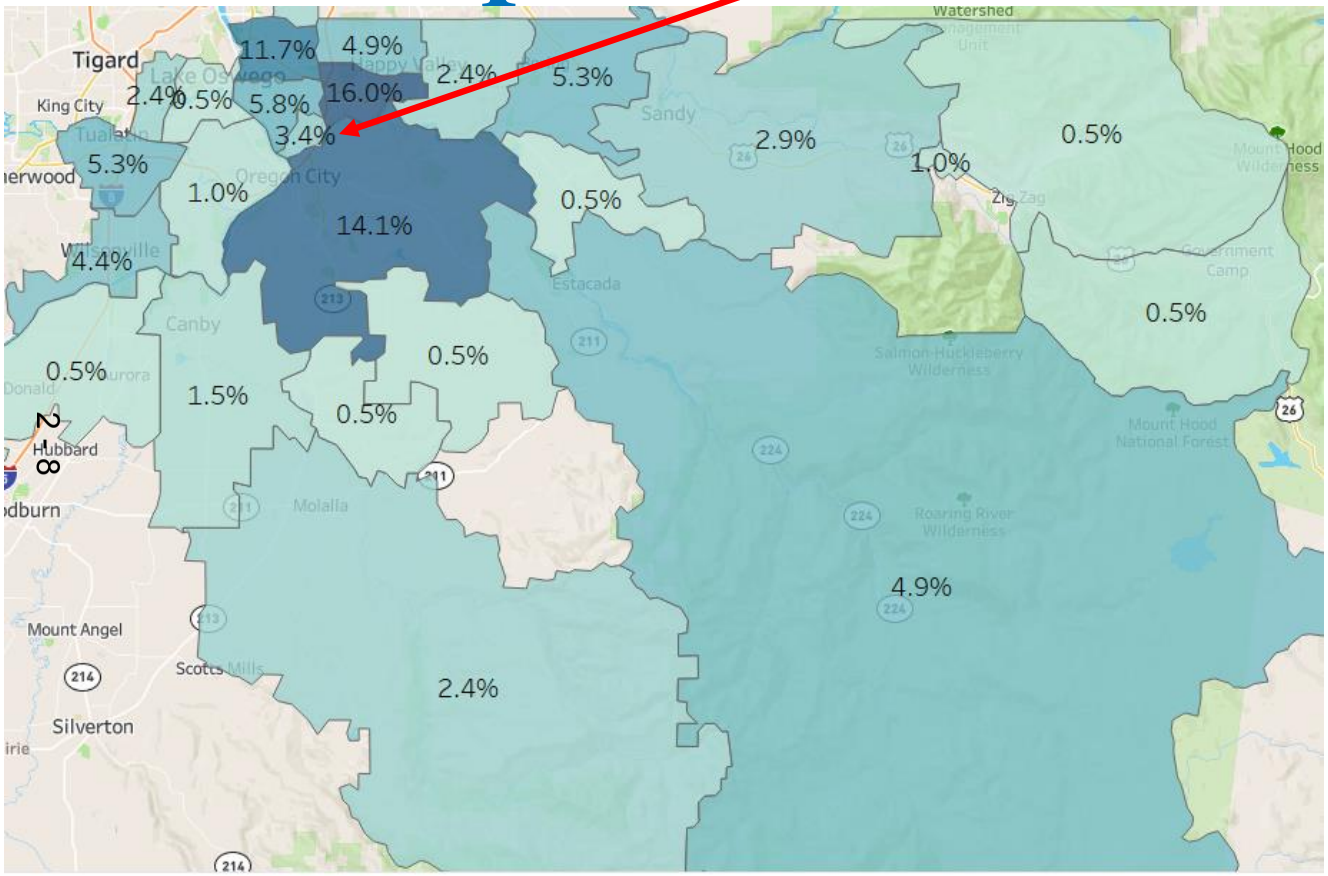
- Clackamas County saw a 68% increase in drug-related deaths from 2019 (41) to 2021 (69).
- The presence of opioids in the results of people who died in association with substance use has increased 168% from 2019 (19) to 2021 (51) in Clackamas County.
- Deaths related to fentanyl have increased more than 5 fold from 2019 (5) to 2021 (40).

Confirmed and Suspect Drug-Related Deaths 2019-July 2022



Source: Clackamas County Medical Examiner
Created by: Clackamas County Public Health Division
Data are preliminary and subject to change

Local Impact



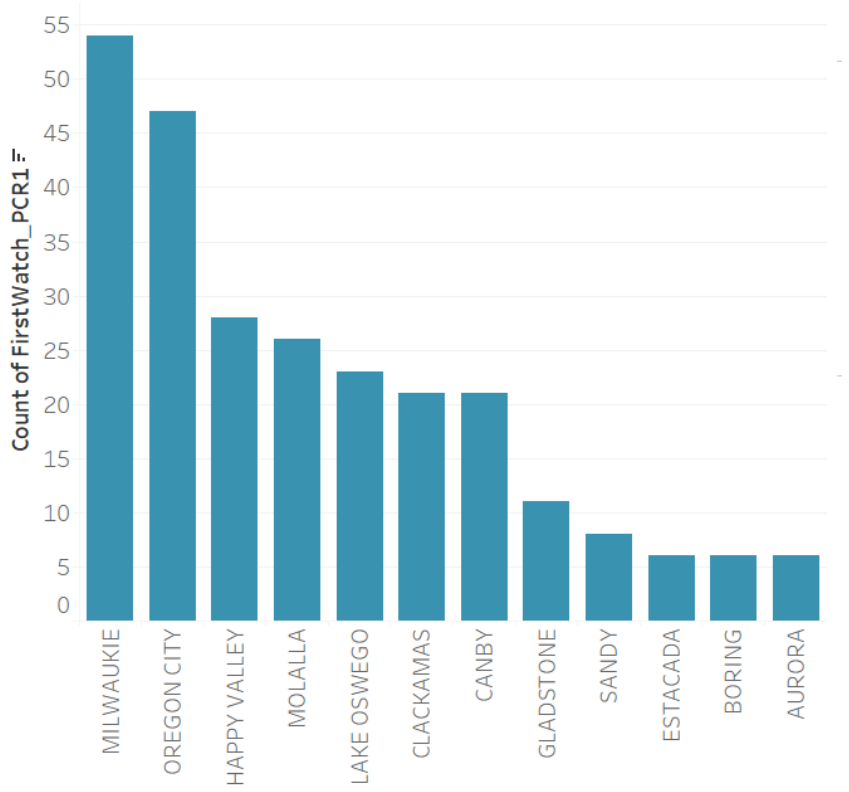
Drug-Related Deaths by Location of Death (zip code)
2019-July 2020
*Data are preliminary and subject to change
Source: Clackamas County Medical Examiner
Created by Clackamas County Public Health Division

Local Impact

# of Calls by Drug (Drugs appearing less than 5 times suppressed)

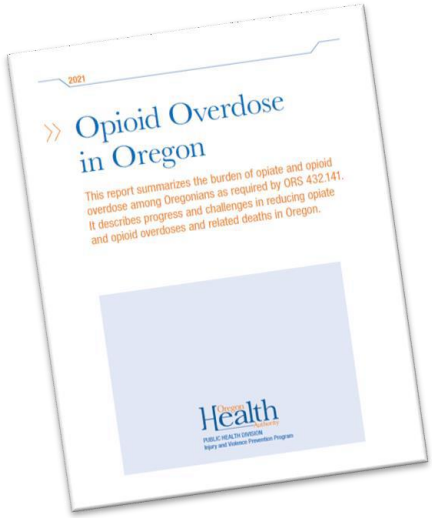
UNKNOWN	127
fentanyl	39
oxy	21
meth	19
heroin	19
antidepressant	15
acetaminophen	9
opioid	7
antihistamine	6
cocaine	5
antianxiety	5

Overdose-Related 911 Calls via FirstWatch
By Week and By City February 1– July 30, 2022
Source: FirstWatch
Created by Clackamas County Public Health Division



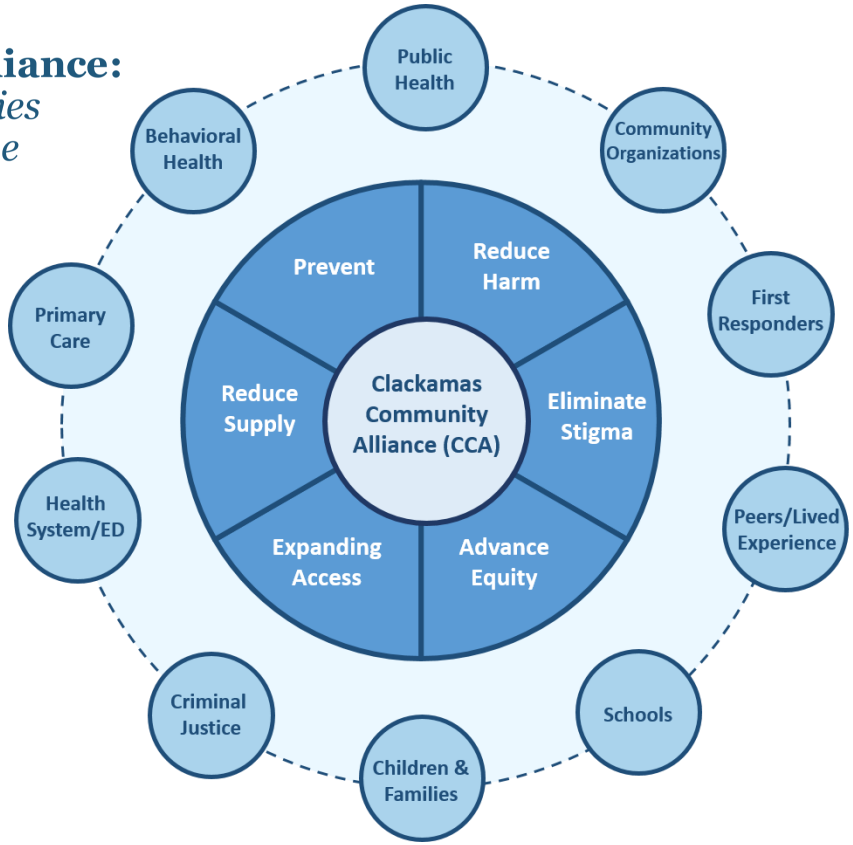
Key Take-Aways from OR Overdose Report:

- Many people who overdosed never touched the health care system
- 70% of people who overdosed were not administered naloxone
- Root causes: lack of community cohesion, mental health issues, and absence of basic needs
- Stigma associated with substance use
- Lack of access to shelters, detox facilities, and treatment centers
- Many don't know what community resources exist



Community Response

Clackamas Community Alliance:
Strengthening communities affected by substance use



Settlement Agreement Background

- **Oregon will receive $333 million** as part of two settlements, including Johnson & Johnson ($5 billion) and the 3 distributors ($21 billion).
  - Defendants have **up to 18 years** to complete payments.
  - State funding: 45%
  - Local funding: 55% to counties and cities who signed onto the agreement

- **Clackamas County will receive approximately $13.7 million**.
  - Cities will receive lesser amounts depending on population.
  - Expect that payments will be front-loaded with 40% distributed in the first 2-3 years.
  - First payment expected July 2022
  - County Attorney fees paid by national settlement, not county funds

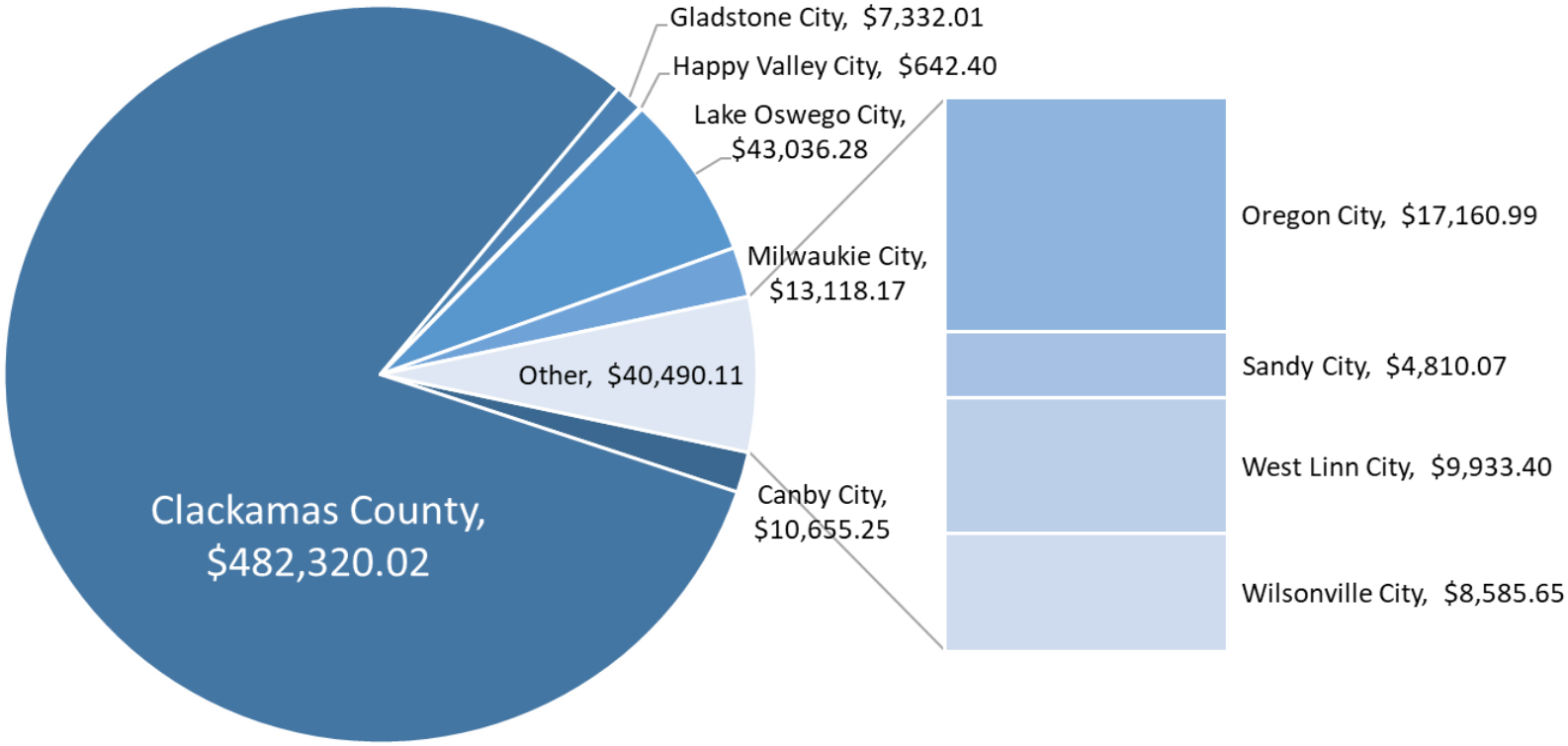
Allowable Uses of Settlement Funding

The Exhibit E of the Settlement Agreement identifies **nine core abatement strategies:**

1) Targeted naloxone distribution
2) Criminal justice interventions
3) Medication for Opioid Use Disorder
4) Enrich prevention strategies
5) Linkage to Syringe Exchange programs
6) Healthcare system interventions
7) Warm hand-off program and recovery support
8) Data collection and research
9) Treatment during pregnancy & postpartum period

Settlement Funding for Cities

Year 1 Abatement Allocation



Guiding Principles

1) Spend Money to save lives
2) Use evidence to guide spending
3) Invest in youth prevention
4) Focus on racial equity
5) Develop a fair & transparent process

Source: Principles For the Use of Funds from the Opioid Litigation, Johns Hopkins Bloomberg School of Public Health, opioidprinciples.jhsph.edu

Using Data to Inform Decisions

Public Health staff maintain a substance use data dashboard that includes key indicators of opioid harm. These numbers describe some, but not all, of the impact of opioids on the people of our county.

Data can be used to identify populations and areas of the county most impacted. Data collected includes:

- **Overdose deaths** involving opioids
- **Emergency Department (ED) visits** for overdose
- Non-fatal overdoses that involve **illicit drugs, such as heroin, fentanyl and meth**
- The rate of **prescriptions for opioids**

Opioid Settlement Framework

Evidence	• Assess gaps in prevention, treatment, harm reduction and recovery.
Equity	• Identify populations and those most generally impacted including our communities of color.
Collaboration	• Engage communities to identify priorities and need to inform funding allocations. • Bring together multi-disciplinary representation including those with lived experience to advise the process.
Transparency	• Provide annual report on investments and lives saved.

Support to Cities

- **Inform investments**
  - Assessment findings & data
    - **Identify gap & needs**
  - Share evidence-based programs/practices

- **Maximize investments**
  - Coordinate aligned activities to build economies of scale
  - Strengthen local response through **collaborative investments**

Questions?

Health, Housing & Human Services
CLACKAMAS COUNTY

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

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

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

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

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

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

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

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

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

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

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

C. **PREGNANT & POSTPARTUM WOMEN**

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

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

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

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

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

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

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

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

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

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

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

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

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

F. **TREATMENT FOR INCARCERATED POPULATION**

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

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

G. **PREVENTION PROGRAMS**

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

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

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

4. Funding for community drug disposal programs; and

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

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

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

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

Schedule B
Approved Uses

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

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Create and/or support recovery high schools.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PART TWO: PREVENTION

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

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

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

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

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

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

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

1. Increase the number of prescribers using PDMPs;

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

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

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

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Funding media campaigns to prevent opioid misuse.

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

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Public education relating to emergency responses to overdoses.

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

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

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

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

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

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

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

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

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

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

J. LEADERSHIP, PLANNING AND COORDINATION

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

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

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

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

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

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

K. TRAINING

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

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

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

L. RESEARCH

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

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

2. Research non-opioid treatment of chronic pain.

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

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

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

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

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

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

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

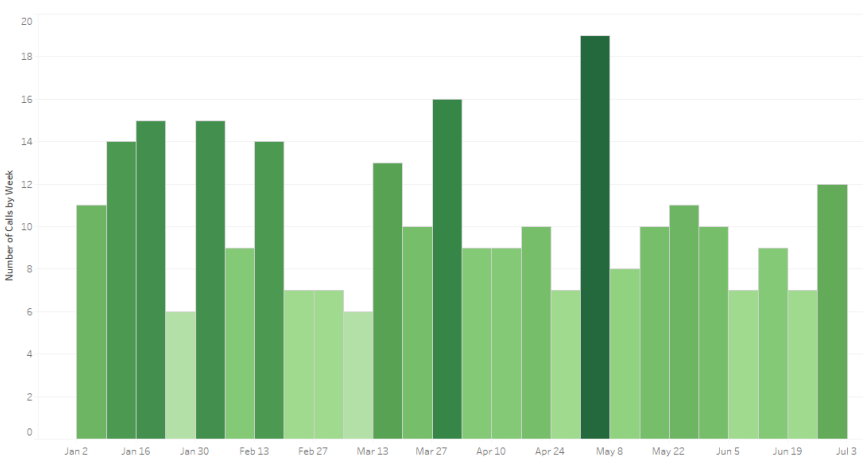
Drug Overdose Data

Clackamas County Public Health Division

Health, Housing & Human Services
CLACKAMAS COUNTY

911 Calls for Drug Overdoses January – June 2022

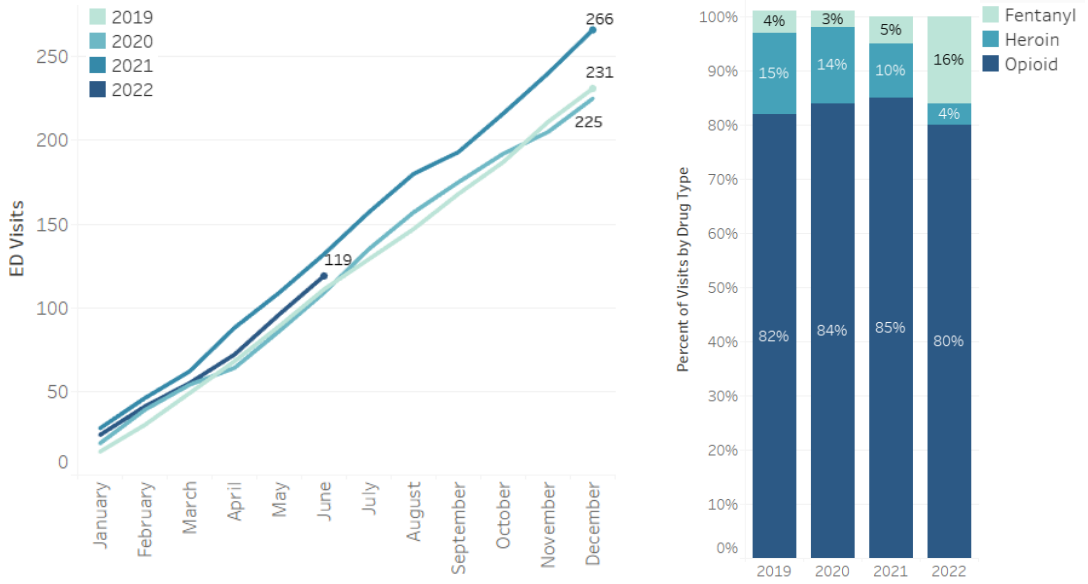
Source: FirstWatch



CITY	
MILWAUKIE	51
OREGON CITY	46
HAPPY VALLEY	26
MOLALLA	25
LAKE OSWEGO	23
CLACKAMAS	20
CANBY	20
GLADSTONE	11
SANDY	8
BORING	6
AURORA	6
ESTACADA	5

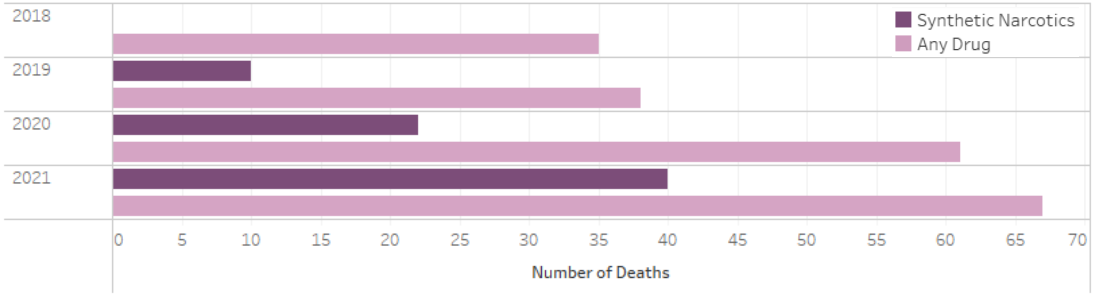
Opioid-Related Emergency Department Visits 2019 – 2022

Source: Oregon ESSENCE – OHA Opioid Overdose Query & Tri-County Drug Overdose Query



Fatalities Due to Drug Poisoning – Any Drug vs. Synthetic Narcotics 2018 – 2021

Source: CDC WONDER Database



*2021 fatality data are provisional and subject to change. Counts of synthetic narcotics too low to report for 2018

** "Any drug" category includes but is not limited to opioids, heroin, methamphetamines, fentanyl, prescriptions drugs, over-the-counter drugs; "synthetic narcotics" is a subset of "any drug" and includes fentanyl, which contributes to the majority of the growth in that category over the last three years