



CLALLAM COUNTY BOARD OF HEALTH

AGENDA of September 20, 2022 @ 1:30 – 3:30 pm

Clallam County Courthouse

Board of Commissioners Meeting Room 160

223 E. 4th Street

Port Angeles, WA 98362

Board of Health meeting will also be available virtually at:

If you would like to participate in the meeting via Zoom audio only, call 253-215-8782 and join with Meeting ID: 935 7343 5754 and Passcode: 095863

If you would like to participate in the meeting via Zoom video conference, visit <https://zoom.us/j/93573435754> join with Meeting ID: 935 7343 5754 and Passcode: 095863

This meeting can be viewed on a live stream at this link: <http://www.clallam.net/features/meetings.html>

Public comment and questions can be directed to the Clerk of the Board at 360-417-2276 or cthompson@co.clallam.wa.us.

- Call to Order
- Roll Call
- Request for Modifications/Approval of Agenda
- Approval of Draft Meeting Minutes for July 19, 2022
- Public Comment for Agenda Items – *Please limit comments to three minutes*
- Presentations: Solid Waste in Clallam County – Eli Owens
- Board of Health Public Hearing: None
- Discussion Items:
 1. Opiate Litigation – Elizabeth Stanley
 2. Board of Health Bylaws – Kevin LoPiccolo
 3. Air monitoring (wildfire smoke) – Jennifer Garcelon and Dr. Berry
 4. Board of Health Conference – Mark Ozias and Jenny Oppelt
- Old Business and Information Items:
- Health Officer
 - COVID-19 Update
- Environmental Health Director
- HHS Director
- Future meeting agenda items:
 1. Early Childhood Court
 2. PIC (Pollution, Identification and Correction) Update
 3. Systemic Racism

4. Vaccination Rates
 5. Air Quality and Noise Ordinance
 6. Climate Change
 7. Update on Behavioral Health Organization (BHO)
 8. Olympic Peninsula Healthy Communities Coalition
- Public Comment – *Please limit comments to three minutes*
 - Adjournment

NEXT MEETING – October 18, 2022

INSTRUCTIONS FOR SPEAKING AT A BOARD OF HEALTH MEETING:

- Members of the public wishing to address the Board on general items may do so during the designated times on the agenda.
- Members of the public wishing to comment at the public hearing are asked to sign in on the sheet provided giving their name and place of residence.
- The Chair may limit the comment period to 3 minutes for each speaker subject to Board concurrence.
- Speakers, generally, will be heard in the order they signed up. All comments must be made from the speaker's rostrum and any individual making comments shall first state their name and address for the official record.
- General comments, applause, booing from members of the audience are inappropriate and may result in removal.

These guidelines are intended to promote an orderly system for conducting a public meeting/hearing so that each person has an opportunity to be heard and to ensure that exercising their right of free speech embarrasses no one.

Note: Written testimony presented by members of the public during the Board meeting is considered a public document and must be submitted to the Clerk of the Board. Copies of public documents from Board meetings are available by contacting the Public Records Department.

Members:

Chair, Shahida Shahrir; Vice-Chair, Navarra Carr; Dr. Gerald Stephanz; Helen Kenoyer; Mark Ozias;
Randy Johnson; Bill Peach

Health and Human Services Staff:

Dr. Allison Berry, Health Official; Kevin LoPiccolo, Director; Jenny Oppelt, Deputy Director;
Jennifer Garcelon, Environmental Health Director; Celia Thompson, Clerk of the Board

DRAFT MINUTES

JULY 19, 2022



CLALLAM COUNTY BOARD OF HEALTH

MINUTES of July 19, 2022 @ 1:30 pm – 3:30 pm

Clallam County Courthouse

Board of Commissioners Meeting Room 160

223 E. 4th Street Port Angeles, WA 98362

Meeting was held via Zoom (Video conference)

REGULAR MEETING OF THE CLALLAM COUNTY BOARD OF HEALTH

Call to Order: The meeting was called to order at 1:30 p.m.

Roll Call: Members present were Commissioner Johnson; Commissioner Ozias; Commissioner Peach; At Large representative, Dr. Gerald Stephanz; Chair, Shahida Shahrir; Vice-Chair, Navarra Carr; Helen Kenoyer, Health and Human Services represented by Dr. Alison Berry, Health Officer; HHS Director, Kevin LoPiccolo; Jennifer Oppelt, Deputy Director.

Members excused: Environmental Health Director, Jennifer Garcelon.

Request for Modifications/Approval of Agenda

Kevin requested that 'Election of Board Chair' be added in after 'Modify Board of Health Bylaws', Dr. Berry requested that 'Clallam County Overdose Trends' be moved to after 'Board of Health Membership'.

Commissioner Johnson made a motion to approve the agenda modifications, Helen Kenoyer second.

ACTION TAKEN: There was unanimous consent to modify the agenda.

Approval of Draft Meeting Minutes for June 21, 2022

Commissioner Ozias made a motion to approve the draft minutes, Commissioner Peach second.

ACTION TAKEN: The Board had unanimous consent to approve the meeting minutes from the June 21, 2022 meeting.

Public Comment for Agenda Items: None

Presentations: None

Public Hearing: None

Discussion items

Board of Health Membership Bylaws-Kevin LoPiccolo

Discussion on Membership and the Bylaws. Navarra Carr made a motion to modify the Clallam County Board of Health Bylaws; Article III. Representation- Membership. New language will include: The Board of Health shall consist of at least 8 members, and at least one tribal representative selected by the American Indian Health Commission.

Commissioner Peach second.

ACTION TAKEN: There was unanimous consent to amend the Membership of the Board of Health Bylaws.

Mark Ozias nominated Navarra Carr as Vice Chair, Dr. Gerald Stephanz second.

ACTION TAKEN: There was unanimous consent to elect Navarra Carr as Vice-Chair.

At the September 20, 2022 meeting, the amended Bylaws will be approved.

Board of Health Membership – Tribal Representatives that have submitted applications for Board of Health membership. Once selected by the American Indian Health Commission, the BOCC will review and approve/appoint members to BOH. Two applications have been submitted:

Tia Skerbeck – LEKT Tribal Representative

Paul Cunningham – Jamestown Tribal Representative

Overdose Trends/Harm Reduction – Dr. Berry

Dr. Berry gave a presentation on Overdose Trends/Harm Reduction, discussion followed.

August Board of Health meeting recess

Kevin Lopiccolo asked the Board if they would like to take a recess on the August meeting. Commissioner Peach made a motion to take August off. Navara Carr second. 6 members voted yes, Commissioner Johnson abstained, Commissioner Ozias voted no. Motion carried.

Old Business and Information Items

None

Health Officer - Covid 19 update – Dr. Berry

Dr. Berry reported that there is still a high rate of transmission in our community: Covid cases to date 14,243; case rate 567/100K; two hospitalizations currently, no new deaths. The dominant variant is BA.5., and it is very transmissible. She continues to encourage masking, particularly in indoor settings, and keeping up to date on vaccines. She also touched on treatments options available in the community, and the state tele health program. Links are available on the CCHHS website. Discussion followed.

Environmental Health Director

None

HHS Director

Kevin LoPiccolo – HHS Director

Kevin introduced new board member Helen Kenoyer, Consumer of Public Health position.

He also discussed the Rapid Rehousing grant and the RFP process.

6 agencies applied and will be awarded funds to help individuals, and families with rental assistance, utilities, hotel/motel rooms, and support services.

Public Comment

None

Adjournment

Meeting was adjourned at 3:17 p.m.

Next Meeting – September 20, 2022

PASSED AND ADOPTED this ____ day of _____, 2022

CLALLAM COUNTY BOARD OF HEALTH

Shahida Shahrir, Chair

Allison Berry, MD, MPH, Health Officer

ATTEST:

Celia Thompson, Clerk of the Board

MOU - OPIATE SETTLEMENT

ONE WASHINGTON MEMORANDUM OF UNDERSTANDING BETWEEN WASHINGTON MUNICIPALITIES

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

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

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

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

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

A. Definitions

As used in this MOU:

1. “Allocation Regions” are the same geographic areas as the existing nine (9) Washington State Accountable Community of Health (ACH) Regions and have the purpose described in Section C below.
2. “Approved Purpose(s)” shall mean the strategies specified and set forth in the Opioid Abatement Strategies attached as Exhibit A.
3. “Effective Date” shall mean the date on which a court of competent jurisdiction enters the first Settlement by order or consent decree. The Parties anticipate that more than one Settlement will be administered according to the terms of this MOU, but that the first entered Settlement will trigger allocation of Opioid Funds in accordance with Section B herein, and the formation of the Opioid Abatement Councils in Section C.
4. “Litigating Local Government(s)” shall mean Local Governments that filed suit against any Pharmaceutical Supply Chain Participant pertaining to the Opioid epidemic prior to September 1, 2020.

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

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

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

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

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

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

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

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

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

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

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

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

B. Allocation of Settlement Proceeds for Approved Purposes

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

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

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

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

C. Regional Agreements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- i. Developing a methodology for obtaining proposals for use of Opioid Funds.
- ii. Ensuring there is opportunity for community-based input on priorities for Opioid Fund programs and services.
- iii. Receiving and reviewing proposals for use of Opioid Funds for Approved Purposes.
- iv. Approving or denying proposals for use of Opioid Funds for Approved Purposes.
- v. Receiving funds from the Trustee for approved proposals and distributing the Opioid Funds to the recipient.
- vi. Reporting to the OAC and making publicly available all decisions on Opioid Fund allocation applications, distributions and expenditures.

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

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

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

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

- ii. Annual review of expenditure reports from Participating Local Jurisdictions within the Allocation Region for compliance with Approved Purposes and the terms of this MOU and any Settlement.
- iii. In the case where Participating Local Governments chose to forego their allocation of Opioid Funds:
 - (i) Approving or denying proposals by Participating Local Governments or community groups to the OAC for use of Opioid Funds within the Allocation Region.
 - (ii) Directing the Trustee to distribute Opioid Funds for use by Participating Local Governments or community groups whose proposals are approved by the OAC.
 - (iii) Administrating and maintaining records of all OAC decisions and distributions of Opioid Funds.
- iv. Reporting and making publicly available all decisions on Opioid Fund allocation applications, distributions and expenditures by the OAC or directly by Participating Local Governments.
- v. Developing and maintaining a centralized public dashboard or other repository for the publication of expenditure data from any Participating Local Government that receives Opioid Funds, and for expenditures by the OAC in that Allocation Region, which it shall update at least annually.
- vi. If necessary, requiring and collecting additional outcome-related data from Participating Local Governments to evaluate the use of Opioid Funds, and all Participating Local Governments shall comply with such requirements.
- vii. Hearing complaints by Participating Local Governments within the Allocation Region regarding alleged failure to (1) use Opioid Funds for Approved Purposes or (2) comply with reporting requirements.

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

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

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

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

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

D. Payment of Counsel and Litigation Expenses

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

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

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

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

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

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

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

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

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

E. General Terms

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

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

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

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

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

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

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

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

Name & Title _____

On behalf of _____

4894-0031-1574, v. 2

EXHIBIT A

OPIOID ABATEMENT STRATEGIES

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

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

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.
2. Support and reimburse services that include the full American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including but not limited to:
 - a. Medication-Assisted Treatment (MAT);
 - b. Abstinence-based treatment;
 - c. Treatment, recovery, or other services provided by states, subdivisions, community health centers; non-for-profit providers; or for-profit providers;
 - d. Treatment by providers that focus on OUD treatment as well as treatment by providers that offer OUD treatment along with treatment for other SUD/MH conditions, co-usage, and/or co-addiction; or
 - e. Evidence-informed residential services programs, as noted below.
3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.
4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based, evidence-informed, or promising practices such as adequate methadone dosing.
5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction and for persons who have experienced an opioid overdose.
6. Support treatment of mental health trauma resulting from the traumatic experiences of the opioid user (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose

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

7. Support detoxification (detox) and withdrawal management services for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including medical detox, referral to treatment, or connections to other services or supports.
8. Support training on MAT for health care providers, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.
9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.
10. Provide fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
11. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.
12. Support the dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.
13. Support the development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

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

3. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including supportive housing, recovery housing, housing assistance programs, or training for housing providers.
4. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.
5. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.
6. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.
7. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.
8. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to manage the opioid user in the family.
9. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to current and recovering opioid users, including reducing stigma.
10. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

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

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

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.
2. Support Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders.
3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.
5. Support training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.
6. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, or persons who have experienced an opioid overdose, into community treatment or recovery services through a bridge clinic or similar approach.
7. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction or persons that have experienced an opioid overdose.
8. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.
9. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction or to persons who have experienced an opioid overdose.
10. Provide funding for peer navigators, recovery coaches, care coordinators, or care managers that offer assistance to persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction or to persons who have experienced an opioid overdose.
11. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.
12. Develop and support best practices on addressing OUD in the workplace.
13. Support assistance programs for health care providers with OUD.
14. Engage non-profits and the faith community as a system to support outreach for treatment.
15. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.
16. Create or support intake and call centers to facilitate education and access to treatment, prevention, and recovery services for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.

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

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

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

1. Support pre-arrest or post-arrest diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including established strategies such as:
 - a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);
 - b. Active outreach strategies such as the Drug Abuse Response Team (DART) model;
 - c. “Naloxone Plus” strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;
 - d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;
 - e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative;
 - f. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise and to reduce perceived barriers associated with law enforcement 911 responses; or
 - g. County prosecution diversion programs, including diversion officer salary, only for counties with a population of 50,000 or less. Any diversion services in matters involving opioids must include drug testing, monitoring, or treatment.
2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction to evidence-informed treatment, including MAT, and related services.
3. Support treatment and recovery courts for persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, but only if these courts provide referrals to evidence-informed treatment, including MAT.

4. Provide evidence-informed treatment, including MAT, recovery support, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction who are incarcerated in jail or prison.
5. Provide evidence-informed treatment, including MAT, recovery support, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction who are leaving jail or prison have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.
6. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.
7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, case management, or other services offered in connection with any of the strategies described in this section.

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

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

1. Support evidence-based, evidence-informed, or promising treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.
2. Provide training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.
3. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.
4. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

5. Offer enhanced family supports and home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, including but not limited to parent skills training.
6. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

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

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

1. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.
2. Academic counter-detailing to educate prescribers on appropriate opioid prescribing.
3. Continuing Medical Education (CME) on appropriate prescribing of opioids.
4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.
5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:
 - a. Increase the number of prescribers using PDMPs;
 - b. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs or by improving the interface that prescribers use to access PDMP data, or both; or
 - c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD.
6. Development and implementation of a national PDMP – Fund development of a multistate/national PDMP that permits information sharing while providing appropriate safeguards on sharing of private health information, including but not limited to:
 - a. Integration of PDMP data with electronic health records, overdose episodes, and decision support tools for health care providers relating to OUD.

- b. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database.
7. Increase electronic prescribing to prevent diversion or forgery.
8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Corrective advertising or affirmative public education campaigns based on evidence.
2. Public education relating to drug disposal.
3. Drug take-back disposal or destruction programs.
4. Fund community anti-drug coalitions that engage in drug prevention efforts.
5. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).
6. Engage non-profits and faith-based communities as systems to support prevention.
7. Support evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.
8. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.
9. Support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.
10. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.
11. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses or other school staff, to

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

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS

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

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, opioid users, families and friends of opioid users, schools, community navigators and outreach workers, drug offenders upon release from jail/prison, or other members of the general public.
2. Provision by public health entities of free naloxone to anyone in the community, including but not limited to provision of intra-nasal naloxone in settings where other options are not available or allowed.
3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, and other members of the general public.
4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.
5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.
6. Public education relating to emergency responses to overdoses.
7. Public education relating to immunity and Good Samaritan laws.
8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.
9. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.
10. Support mobile units that offer or provide referrals to treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.
11. Provide training in treatment and recovery strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction.
12. Support screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

1. Current and future law enforcement expenditures relating to the opioid epidemic.
2. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

J. LEADERSHIP, PLANNING AND COORDINATION

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

1. Community regional planning to identify goals for reducing harms related to the opioid epidemic, to identify areas and populations with the greatest needs for treatment intervention services, or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
2. A government dashboard to track key opioid-related indicators and supports as identified through collaborative community processes.
3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

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

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.
2. Invest in infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, co-usage, and/or co-addiction, or implement other

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

L. RESEARCH

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

1. Monitoring, surveillance, and evaluation of programs and strategies described in this opioid abatement strategy list.
2. Research non-opioid treatment of chronic pain.
3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.
4. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.
5. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).
6. Research on expanded modalities such as prescription methadone that can expand access to MAT.

EXHIBIT B

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

EXHIBIT B

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

EXHIBIT B

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

EXHIBIT B

County	Local Government	% Allocation
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Grays Harbor County

Grays Harbor County	0.9992429138%
Aberdeen	0.2491525333%
Cosmopolis	
Elma	
Hoquiam	
McCleary	
Montesano	
Oakville	
Ocean Shores	
Westport	
County Total:	1.2483954471%

Island County

Island County	0.6820422610%
Coupeville	
Langley	
Oak Harbor	0.2511550431%
County Total:	0.9331973041%

Jefferson County

Jefferson County	0.4417137380%
Port Townsend	
County Total:	0.4417137380%

EXHIBIT B

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

EXHIBIT B

County	Local Government	% Allocation
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Kitsap County

Kitsap County	2.6294133668%
Bainbridge Island	0.1364686014%
Bremerton	0.6193374389%
Port Orchard	0.1009497162%
Poulsbo	0.0773748246%
County Total:	3.5635439479%

Kittitas County

Kittitas County	0.3855704683%
Cle Elum	
Ellensburg	0.0955824915%
Kittitas	
Roslyn	
South Cle Elum	
County Total:	0.4811529598%

Klickitat County

Klickitat County	0.2211673457%
Bingen	
Goldendale	
White Salmon	
County Total:	0.2211673457%

Lewis County

Lewis County	1.0777377479%
Centralia	0.1909990353%
Chehalis	
Morton	
Mossyrock	
Napavine	
Pe Ell	
Toledo	
Vader	
Winlock	
County Total:	1.2687367832%

EXHIBIT B

County	Local Government	% Allocation
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Lincoln County

Lincoln County	0.1712669645%
Almira	
Creston	
Davenport	
Harrington	
Odessa	
Reardan	
Sprague	
Wilbur	
County Total:	0.1712669645%

Mason County

Mason County	0.8089918012%
Shelton	0.1239179888%
County Total:	0.9329097900%

Okanogan County

Okanogan County	0.6145043345%
Brewster	
Conconully	
Coulee Dam***	
Elmer City	
Nespelem	
Okanogan	
Omak	
Oroville	
Pateros	
Riverside	
Tonasket	
Twisp	
Winthrop	
County Total:	0.6145043345%

Pacific County

Pacific County	0.4895416466%
Ilwaco	
Long Beach	
Raymond	
South Bend	
County Total:	0.4895416466%

EXHIBIT B

County	Local Government	% Allocation
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Pend Oreille County

Pend Oreille County	0.2566374940%
Cusick	
Ione	
Metaline	
Metaline Falls	
Newport	
County Total:	0.2566374940%

Pierce County

Pierce County	7.2310164020%
Auburn***	0.0628522112%
Bonney Lake	0.1190773864%
Buckley	
Carbonado	
DuPont	
Eatonville	
Edgewood	0.0048016791%
Enumclaw***	0.0000000000%
Fife	0.1955185481%
Fircrest	
Gig Harbor	0.0859963345%
Lakewood	0.5253640894%
Milton***	
Orting	
Pacific***	
Puyallup	0.3845704814%
Roy	
Ruston	
South Prairie	
Steilacoom	
Sumner	0.1083157569%
Tacoma	3.2816374617%
University Place	0.0353733363%
Wilkeson	
County Total:	12.0345236870%

San Juan County

San Juan County	0.2101495171%
Friday Harbor	
County Total:	0.2101495171%

EXHIBIT B

County	Local Government	% Allocation
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Skagit County

Skagit County	1.0526023961%
Anacortes	0.1774962906%
Burlington	0.1146861661%
Concrete	
Hamilton	
La Conner	
Lyman	
Mount Vernon	0.2801063665%
Sedro-Woolley	0.0661146351%
County Total:	1.6910058544%

Skamania County

Skamania County	0.1631931925%
North Bonneville	
Stevenson	
County Total:	0.1631931925%

Snohomish County

Snohomish County	6.9054415622%
Arlington	0.2620524080%
Bothell***	0.2654558588%
Brier	
Darrington	
Edmonds	0.3058936009%
Everett	1.9258363241%
Gold Bar	
Granite Falls	
Index	
Lake Stevens	0.1385202891%
Lynnwood	0.7704629214%
Marysville	0.3945067827%
Mill Creek	0.1227939546%
Monroe	0.1771621898%
Mountlake Terrace	0.2108935805%
Mukilteo	0.2561790702%
Snohomish	0.0861097964%
Stanwood	
Sultan	
Woodway	
County Total:	11.8213083387%

EXHIBIT B

County	Local Government	% Allocation
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Spokane County

Spokane County	5.5623859292%
Airway Heights	
Cheney	0.1238454349%
Deer Park	
Fairfield	
Latah	
Liberty Lake	0.0389636519%
Medical Lake	
Millwood	
Rockford	
Spangle	
Spokane	3.0872078287%
Spokane Valley	0.0684217500%
Waverly	
County Total:	8.8808245947%

Stevens County

Stevens County	0.7479240179%
Chewelah	
Colville	
Kettle Falls	
Marcus	
Northport	
Springdale	
County Total:	0.7479240179%

Thurston County

Thurston County	2.3258492094%
Bucoda	
Lacey	0.2348627221%
Olympia	0.6039423385%
Rainier	
Tenino	
Tumwater	0.2065982350%
Yelm	
County Total:	3.3712525050%

Wahkiakum County

Wahkiakum County	0.0596582197%
Cathlamet	
County Total:	0.0596582197%

EXHIBIT B

County	Local Government	% Allocation
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Walla Walla County

Walla Walla County	0.5543870294%
College Place	
Prescott	
Waitsburg	
Walla Walla	0.3140768654%
County Total:	0.8684638948%

Whatcom County

Whatcom County	1.3452637306%
Bellingham	0.8978614577%
Blaine	
Everson	
Ferndale	0.0646101891%
Lynden	0.0827115612%
Nooksack	
Sumas	
County Total:	2.3904469386%

Whitman County

Whitman County	0.2626805837%
Albion	
Colfax	
Colton	
Endicott	
Farmington	
Garfield	
LaCrosse	
Lamont	
Malden	
Oakesdale	
Palouse	
Pullman	0.2214837491%
Rosalia	
St. John	
Tekoa	
Uniontown	
County Total:	0.4841643328%

EXHIBIT B

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

DRAFT BOH BYLAWS

**BYLAWS
OF THE
CLALLAM COUNTY BOARD OF HEALTH**

ARTICLE I. NAME

The name of this organization shall be the Clallam County Board of Health.

ARTICLE II. PURPOSE

The purpose of the Clallam County Board of Health is to supervise all matters pertaining to the preservation of the life and health of the people of Clallam County and to comply fully with the requirements of all applicable chapters of Title 70, Revised Code of Washington. The Board of Health shall:

- Collect, analyze and disseminate to the community in a timely manner, through the Clallam County Health & Human Services Department, information about community health conditions, risks and resources, and the availability of resources to address identified problems.
- Enact such rules, regulations and policies as are necessary to preserve, promote and improve the health and behavioral health status of Clallam County residents, and guide the allocation of appropriate and necessary public health resources.
- Assure that necessary, high quality, effective foundational public health services are available for the protection of the people of Clallam County, including the control and prevention of any dangerous, contagious or infectious disease within the county.
- Provide for the prevention, control and abatement of nuisances detrimental to public health.
- Enforce, through the Health Officer, the public health statutes of the state and county.
- Establish fee schedules for issuing and renewing licenses and permits, or for such other services, as are authorized by the law and rules of the State of Board of Health.
- Assure that environmental health issues address clean water, septic's, and clean air.

ARTICLE III. REPRESENTATION

Membership: The Board of Health shall consist of ~~8~~ 11 members, selected as follows:

- Each member of the Clallam County Board of County Commissioners shall serve as a member of the Board of Health for the duration of their elected term of office.
- Eight members of the Board of Health shall be appointed by the County Commissioners. Appointed members shall include one elected city council member, ~~one Clallam County Public Hospital District Commissioner nominated by their respective organizations~~, one public health, health care facilities, and providers, one consumers of public health, ~~one~~ four tribal representatives, one from each federally recognized Tribe in Clallam County, selected by the American Indian Health Commission, and one community stakeholder, as described in RCW70.05.035.

- Terms: Initial appointments to the Board will be divided between two and three year terms. Following initial appointments to the Board, reappointments and future new appointments will be for 3 year terms. Board of Health members may serve more than one term, including consecutive terms.

Vacancies: In the event that a vacancy occurs for the City Council Member, Tribal Representative, ~~or Clallam County Public Hospital District Commissioner~~, the City ~~ies, and the~~ American Indian Health Commission, ~~or Hospital Districts~~ shall nominate another representative ~~from their membership~~ within thirty (30) days and the Board of County Commissioners shall appoint another City Council Member, Tribal Representative, ~~or Public Hospital District Commissioner~~ within thirty (30) days of the date of nomination.

Participation: Board members may participate in meetings in person or via conference call or video conferencing.

Absences: Board members shall notify the Chairperson in advance if unable to attend any regular meeting of the Board of Health. Appointed Board members may be removed from Board membership by action of the Clallam County Board of Commissioners for lack of attendance. Three or more unexcused absences from regular Board of Health meetings in one calendar year may be considered cause for removal.

ARTICLE IV. OFFICERS

Chairperson: The presiding officer of the Board of Health shall be the Chairperson, who shall serve for a term of at least one (1) year, and may be reelected as Chairperson as ~~The Chairperson shall be~~ selected by a majority vote of the Board members present at the first regular meeting of each year. The Chairperson shall direct preparation of the meeting agenda, conduct meetings, and act on behalf of the Board between regularly scheduled meetings.

Vice-Chairperson: At the same meeting, a Vice-Chairperson ~~also~~ shall be selected for a term of at least one (1) year, and may be reelected as Vice-Chairperson as selected by a majority of the Board members present at the first regular meeting of each year. The Vice-Chairperson ~~who~~ shall preside over all proceedings of the Board in the absence of the Chairperson.

Vacancies: In the event of a vacancy in the office of Chairperson, the Vice-Chairperson shall immediately assume the duties of the Chairperson for the remainder of the year. Another representative shall be selected to serve as Vice-Chairperson at the next regular or special meeting of the Board.

Consecutive Terms: Board members ~~shall not~~ may serve consecutive terms as Chairperson and Vice-Chairperson.

ARTICLE V. RULES OF BUSINESS

Business shall be conducted in accordance with the generally accepted Robert's Rules of Order, so long as they are consistent with these Bylaws or amendments thereto.

ARTICLE VI. SUBCOMMITTEES

The Chairperson shall appoint subcommittees from the Board of Health or members of the community from time to time as the Chairperson shall deem necessary. The Chairperson shall be an ex-officio member of all subcommittees.

ARTICLE VII. HEALTH OFFICER

The Board of Health shall appoint a County Health Officer who shall be a qualified physician trained and experienced in public health and qualified according to standards set forth in RCW 70.05.051 through 70.05.055. The health officer shall serve as staff to the Board of Health, exercise the powers, and perform the duties prescribed in RCW 70.05.070. No term of office shall be established for the health officer, but the local health officer shall not be removed until after notice is given and an opportunity for a hearing before the Board as to the reason for his or her removal as prescribed in RCW 70.05.050.

ARTICLE VIII. OPERATING RULES

Section 1. Meetings

Regular Meeting: Regular meetings of the Board of Health shall be held on the third Tuesday of each month beginning at 1:30 pm. If the third Tuesday is a legal holiday, an alternate day may be selected by the Chairperson. Any regular meeting of the Board of Health may be cancelled with the concurrence of a majority of the Board. The location of the meetings shall be within Clallam County.

Special Meeting: The Chairperson or a majority of the Board that includes at least two County Commissioners may call a special meeting of the Board consistent with RCW 42.30.080.

Executive Session: The Board may hold executive sessions from which the public may be excluded for the purposes set forth in RCW 42.30.110.

Quorum: A majority of all Board members present shall constitute a quorum, including at least two Clallam County Commissioners. ~~shall constitute a quorum for Board meetings.~~

Recordings: The proceedings of all Board meetings shall be recorded. Minutes of the meeting shall be posted on the Board of Health website after approval.

Minutes: The Clerk of the Board or designee shall attend all Board of Health meetings to record, prepare, and maintain meeting minutes and perform other duties as requested. Written minutes of each Board meeting shall be prepared and approved by the Board at the subsequent regular meeting. Minutes shall be signed by the Chairperson and Health Officer at the time of their approval by the Board.

Meetings Open to Public: Regular and special meetings of the Board and Board committees shall be open to the public, in accordance with RCW 42.30.

Materials to Board Members: Whenever possible, the agenda and materials related to action items shall be sent to the Board members at least 5 days in advance of the meeting at which the items will be considered.

Section 2. Voting

Actions Requiring a Vote: Each member of the Board shall be entitled to one vote on all actions of the Board that require a vote. An affirmative vote of a majority of Board members shall be required to pass an action of the Board, provided that a quorum of the Board is present.

Tie Vote: In the event of a tie vote, the action does not pass.

Voting By Proxy: There will not be voting by proxy on any question before the Board.

Section 3. Ethics

Conflict of Interest: Members of the Board of Health having personal or professional interest on an action item that may be deemed conflicting or infringe upon the appearance of fairness shall declare the conflict and refrain from discussing or voting on such matters.

Section 4. Public Testimony

Public Comments: At each meeting, according to the usual order of business, the Chairperson shall call for public comments. Persons wishing to comment shall give their name and address (or place of residence, and business or organizational affiliation). The Chairperson may establish time limits for individuals who wish to speak.

Public Hearings: The Board may call for a public hearing to receive comments by persons interested in or affected by the matter under consideration before the Board. A hearing date and time will be set and persons wishing to comment on the items may give comment and the Chairperson may establish time limits for individuals who wish to speak. Upon closure of the hearing, the Board of Health will take action on the item.

ARTICLE IX. MISCELLANEOUS

Reimbursement of Expenses: Board of Health members may receive reimbursement for approved expenses related to completion of their responsibilities.

ARTICLE X. AMENDMENTS TO BYLAWS

These Bylaws can be amended at any regular meeting of the Board by a majority of the Board, provided that a quorum of the Board is present, and provided that the amendment has been submitted in writing to the Board of Health at least ten (10) days prior to the said meeting.