CHIPPEWA COUNTY

EXECUTIVE COMMITTEE

REGULAR MEETING

MAY 20, 2025

CHIPPEWA COUNTY COURTHOUSE, RM 302

4:00 PM

1. CALL TO ORDER

Chair Hull called the meeting to order at 4:00 p.m.

2. ROLL CALL

Attendee Name	Organization	Title	Status	Arrived
Chuck Hull	Chippewa County	District 19, Chair	Present	
Peter Gehring	Chippewa County	District 4	Present	
Jason Bergeron	Chippewa County	District 7	Present	
Joel Seidlitz	Chippewa County	District 9	Present	

Others Present: Andy Albarado, Traci Bremness, Lori Zwiefelhofer, Melanie McManus, Todd Pauls, Rose Baier, Allyson Wisniewski, Brad Hentschel, Andy Bauer, Mike Sanders, Bob Krause, Patty Darley, Mickey Judkins, Bill Oemichen, Karl Greene (via phone)

3. MEMBERS OF THE PUBLIC WISHING TO BE HEARD

4. CONSENT AGENDA

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Jason Bergeron, District 7
SECONDER:	Joel Seidlitz, District 9
AYES:	Hull, Gehring, Bergeron, Seidlitz

1. Approve the Agenda

2. Approve the Minutes

   Executive Committee - Regular Meeting - May 6, 2025 4:00 PM

3. Schedule Next Meeting Date - June 3, 2025

5. REPORTS

1. Register of Deeds Annual Report - Melanie McManus
   McManus reviewed the annual report for the Register of Deeds Department.

RESULT:	**DISCUSSED**

6. UPDATES, ANNOUNCEMENTS, AND CORRESPONDENCE

A. County Board Chair Report

B. County Administrator Operation Report

7. BUSINESS ITEMS

1. Criminal Justice Services Division 2026 Opioid Fund Request - Rose Baier
   Baier reviewed the request to use opioid funds for the 2026 budget. This is the second year for this request for the re-entry program.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Peter Gehring, District 4
SECONDER:	Jason Bergeron, District 7
AYES:	Hull, Gehring, Bergeron, Seidlitz

2. Resolution Confirming and Ratifying the Authority of Counsel for Chippewa County to add Additional Defendants to Opioid Litigation, Including in MDL 2804 – Todd Pauls

RESULT:	**FORWARD TO COUNTY BOARD [UNANIMOUS]**	**Next: 6/10/2025 6:00 PM**
MOVER:	Joel Seidlitz, District 9	
SECONDER:	Jason Bergeron, District 7	
AYES:	Hull, Gehring, Bergeron, Seidlitz	

3. Chippewa Valley Health Cooperative Update on Community Hospital – Andy Albarado/Mike Sanders
   Albarado reminded the committee that the County Board provided funds for half of the feasibility study. The representatives gave a similar update to Eau Claire County. This report is strictly informational, and no action is being requested from the county at this meeting for financial commitment.

   Bob Krause explained since the last time they presented to Chippewa County, they have been approved for a non-profit status. They are also under contract for 20 acres to build a new hospital. They hired River Valley Architects to build that facility. They also have a contract to purchase St. Joseph's hospital. The goal is to sign it in late June and hope to have some final announcements in late June. They secured some financing for some remodeling. About a month ago they started a quiet campaign. So far, they raised $10.3 million from some businesses and individuals. They are referring to St. Joseph's as a temporary hospital.

   Mike Sanders is the Lead Advisor. He stated their goal is to raise $30-$40 million in equity capital. A hospital with 48 beds is financially feasible after one year of operation. The temporary hospital would allow them to open much sooner and start providing services again including cancer, delivery, etc. along with the use of the morgue. After about three years of operation, they anticipate having about 2,372 admissions, which is about half the amount of HSHS Sacred Heart and St. Joseph's. They have about 100 physicians ready to join to provide services. The total estimated cost is $158.4 million.

   Karl Greene reviewed options that counties have for debt including BCPL state trust fund loans, which are used to fund economic development loans. With that option the CVHC would use the County as a pass-through. The full payment, including principal and interest, would be paid 100% by the CVHC. The money would be paid back in 10 years. There would be no out of pocket cost to Chippewa County. However, if

the loan were to default, then the taxpayers would be on the hook to pay it back. If the County would agree to the $10 million loan request, that would add $33.21 to the median property impact.

Sanders stated with the St. Joseph's facility, they would like to start with some clinical services this fall (ER, OB, 6 bed ICU, surgical labs, imaging, cancer, morgue). The rest of the services would then be available in the fall of 2026. When the new hospital opens it will have over 300 positions. There are several doctors that lost their privileges when the old hospitals closed. They stayed in the area and want to provide services again at the new hospital.

Bergeron is not opposed to the concept, but he's concerned if the loan were to default it could impact our bond rating.

Albarado will put together a plan to assess the proposal and see what our options are and then bring that back to the committee and County Board for consideration.

RESULT:	**DISCUSSED**

4. The Executive Committee will convene in closed session pursuant to Wis. Stat. § 19.85(1)(e) – "Deliberating or negotiating the purchasing of public properties, the investing of public funds, or conducting other specified public business, whenever competitive or bargaining reasons require a closed session," (Considering future industrial/business park development)
The committee convened to closed session at 5:01 p.m.

The closed session included the following individuals: All Executive Committee members, Andy Albarado, Traci Bremness, Todd Pauls, Lori Zwiefelhofer, any other County Board Supervisors, and Brad Hentschel

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Jason Bergeron, District 7
SECONDER:	Peter Gehring, District 4
AYES:	Hull, Gehring, Bergeron, Seidlitz

The Executive Committee will reconvene to open session.

5. The committee reconvened to open session at 5:11 p.m.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Joel Seidlitz, District 9
SECONDER:	Jason Bergeron, District 7
AYES:	Hull, Gehring, Bergeron, Seidlitz

8. AGENDA ITEMS FOR FUTURE CONSIDERATION

9. ADJOURN

The meeting adjourned at 5:12 p.m.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Jason Bergeron, District 7
SECONDER:	Joel Seidlitz, District 9
AYES:	Hull, Gehring, Bergeron, Seidlitz

CHIPPEWA COUNTY

EXECUTIVE COMMITTEE

REGULAR MEETING

MAY 6, 2025

CHIPPEWA COUNTY COURTHOUSE, RM 302

4:00 PM

1. CALL TO ORDER

Chair Hull called the meeting to order at 4:00 p.m.

2. ROLL CALL

Attendee Name	Organization	Title	Status	Arrived
Chuck Hull	Chippewa County	District 19, Chair	Present	
Dean Mueller	Chippewa County	District 20, Vice-Chair	Present	
Peter Gehring	Chippewa County	District 4	Present	
Jason Bergeron	Chippewa County	District 7	Present	
Joel Seidlitz	Chippewa County	District 9	Present	

Others Present: Andy Albarado, Traci Bremness, Lori Zwiefelhofer, Jennifer Steinmetz, Toni Hohlfelder, Lee Hennick, Chuck Hassemer, Charlie Walker, Todd Pauls

3. MEMBERS OF THE PUBLIC WISHING TO BE HEARD

Chuck Hassemer expressed concerns over what farmers are doing to our ditches by planting about 18" from the edge of the road and not recognizing the right of ways. As a result some of the new shoulders are already giving away.

4. CONSENT AGENDA

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Jason Bergeron, District 7
SECONDER:	Peter Gehring, District 4
AYES:	Hull, Mueller, Gehring, Bergeron, Seidlitz

1. Approve the Agenda

2. Approve the Minutes

   Executive Committee - Regular Meeting - Mar 4, 2025 4:00 PM

3. Schedule Next Meeting Date - May 20, 2025

5. BUSINESS ITEMS

1. Resolution To Declare May 12-16, 2025 As Chippewa County Economic Development Week - Charlie Walker

   Walker explained since 2016 the county has been recognizing economic development week. He invited everyone to the CEDC Annual meeting on May 16th.

RESULT:	**FORWARD TO COUNTY BOARD [UNANIMOUS]**	**Next: 5/13/2025 6:00 PM**
MOVER:	Joel Seidlitz, District 9	
SECONDER:	Jason Bergeron, District 7	
AYES:	Hull, Mueller, Gehring, Bergeron, Seidlitz	

6. REPORTS

1. Financial Update - 2024 Pre-Audited and 1st Quarter 2025 - Lori Zwiefelhofer
   Zwiefelhofer gave an update on the 2024 pre-audited and the 1st quarter 2025 financials.

RESULT:	**REVIEWED**	**Next: 5/13/2025 6:00 PM**

2. 2026 Budget Process Review - Jennifer Steinmetz
   Steinmetz gave an overview of the 2026 budget process. The instructions will be distributed to Department Heads on May 14th so they can start preparing their budgets.

RESULT:	**REVIEWED**	**Next: 5/13/2025 6:00 PM**

3. Update on Print Management Project - Andy Bauer
   Bauer gave an overview of the print management program the County has been using for the last several years to manage all copy machines and printers. The program started in 2015 with a five-year replacement cycle.

RESULT:	**DISCUSSED**

4. Update on Self-Funded Health Insurance Program - Toni Hohlfelder
   Hohlfelder gave an update on the health insurance program from 2022 when we transitioned to a self-funded plan to current.

RESULT:	**REVIEWED**	**Next: 5/13/2025 6:00 PM**

7. UPDATES, ANNOUNCEMENTS, AND CORRESPONDENCE

A. County Board Chair Report

B. County Administrator Operation Report

8. AGENDA ITEMS FOR FUTURE CONSIDERATION

Seiditz would like the Executive Committee to discuss the ditch concern expressed by Chuck Hassemer. He would also like to have the County Board vote whether to allow Sheriff Hakes the ability to address the committee and County Board, as well as review the large assembly ordinance.

ADJOURN

The meeting adjourned at 5:21 p.m.

RESULT:	**APPROVED [UNANIMOUS]**
MOVER:	Jason Bergeron, District 7
SECONDER:	Joel Seidlitz, District 9
AYES:	Hull, Mueller, Gehring, Bergeron, Seidlitz

Register of Deeds

2024 Annual Report

Melanie McManus

May 20, 2025

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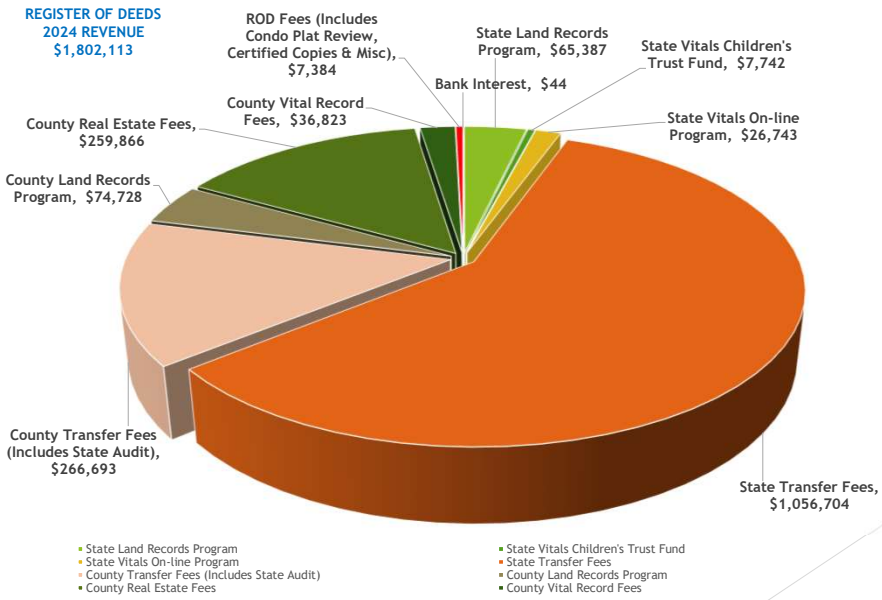
2024 Report

- During the period of January 1, 2024 to December 31, 2024, the Register of Deeds office collected the following fees, real estate transfer tax and state fees in the amount of $1,802,113.45, being paid into the County Treasurer's Office, of which $570,809.29 was retained by the County.

2024 ROD Budget Synopsis	
Total Revenue Budgeted:	$425,873.00
Actual Total Revenue:	$465,242.55
Total Expenses Budgeted:	$425,873.00
Actual Total Expenses:	$400,212.63
Surplus:	$65,029.92

2

Breakdown of 2024 Fees Collected



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5 Year Comparison of Fees Report

Year	Real Estate	Condo Plat Review	Vital Stats	Certified Copies	Misc	State Online Revenue	Children's Trust Fund	Land Records County	Land Records State	State Transfer fees	County Transfer Fees	State Audit County Share*	Bank Interest	Total
	$15/document, Laredo & Fidlar amounts	$100/Plat	$5/Birth, $7/Death, Divorce & Marriage, $3/Add'l Records, $10/Expedite	Copy fee plus $1.25/ document	Plain copies, misc prints, ORO service & delivery fees	$8/Birth, $13/Death, Divorce & Marriage, $10/Expedite	$7/Birth	$8/document	$7/document	80%	20%			
2020	$ 363,471.05	$ 500.00	$ 39,373.00	$ 32.00	$ 3,773.50	$ 31,978.00	$ 9,968.00	$120,464.00	$105,406.00	$ 955,971.84	$ 238,992.96			$1,869,930.35
2021	$ 387,776.85	$ 400.00	$ 39,000.00	$ 175.00	$ 4,335.70	$ 31,775.00	$ 10,423.00	$125,456.00	$109,774.00	$1,172,907.12	$ 293,226.78	$1,373.22	$ 49.31	$2,176,671.98
2022	$ 297,959.76	$ 200.00	$ 38,626.00	$ 43.00	$ 3,854.51	$ 29,502.00	$ 9,338.00	$ 87,360.00	$ 76,440.00	$1,030,963.68	$ 257,740.92	$ (55.47)	$ 41.02	$1,832,013.42
2023	$ 253,150.11	$ -	$ 38,604.00	$ 59.00	$ 4,699.75	$ 27,222.00	$ 8,246.00	$ 70,840.00	$ 61,985.00	$ 959,882.64	$ 240,096.71	$ -	$ 40.18	$1,664,825.39
2024	$ 259,865.72	$ -	$ 36,823.00	$ 124.00	$ 7,259.50	$ 26,743.00	$ 7,742.00	$ 74,728.00	$ 65,387.00	$1,056,704.16	$ 266,693.33	$ -	$ 43.74	$1,802,113.45
TOTAL	$1,049,207.66	$1,100.00	$116,999.00	$ 250.00	$11,963.71	$ 93,255.00	$ 29,729.00	$333,280.00	$291,620.00	$3,159,842.64	$ 789,960.66	$1,317.75	$ 90.33	$5,878,615.75

*If we receive a credit, it is now included in the County Transfer Fees column. If we owe the State, the debit will be shown here.

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5 Year Comparison of Statistical Report

Category	2020	2021	2022	2023	2024
Real Estate Doc. Recorded	15,097	15,686	10,976	8,848	9,363
Certified Copies of Real Estate Docs	20	130	27	41	76
Plain photo copies of Real Estate Docs	2,086	2,556	2,232	3,070	4,534
Copies of Vital Records	10,334	9,900	9,911	9,575	9,020
No. of Marriages Filed	420	519	512	454	476
No. of Births Filed	680	611	601	556	525
No. of Deaths Filed	711	640	615	626	608
Genealogists	23	43	42	49	44
Cert. Copies of Military Discharges	69	34	29	18	11
Vital Records for VA Benefits	173	187	171	174	168
New Filings of Discharges	17	8	5	7	5

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REAL ESTATE

	2020	2021	2022	2023	2024
Documents & UCC Real Estate Filings	15,097	15,686	10,976	8,848	9,363
Percentage Filed Electronically	56%	69%	68%	66%	68%
Plats (Condo, Subdivision & Transportation Project Plats)	20	15	18	12	8
Certified Survey Maps	194	186	161	186	183

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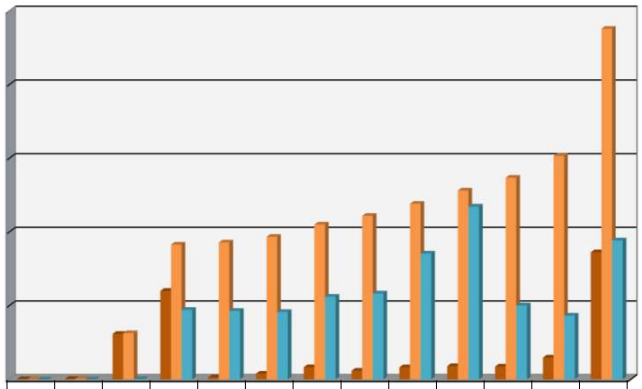
Property Fraud Alert Service

www.propertyfraudalert.com



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
New Subscribers	2	3	309	601	14	39	83	59	82	90	87	148	863
Total Subscribers	2	5	314	915	929	968	1051	1110	1192	1282	1369	1517	2380
Alerts	0	0	3	472	465	458	561	583	854	1173	502	433	943

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Fidlar Press Release

Area Registers of Deeds Team Up to Inform and Educate Professional Community

Upcoming state legislation will affect real estate professionals throughout Wisconsin

On April 23rd, Registers of Deeds from eight Wisconsin Counties came together to sponsor a learning opportunity for local real estate professionals. Barron County's Register, Margo Katterhagen, hosted the event, which was in turn sponsored by Jeanine Chell (Burnett), Jessica Hedinger (Washburn), Paula Chisser (Sawyer), Mary Berg (Rusk), Melanie McManus (Chippewa), Heather Kuhn (Dunn), and Sally Spanel (Polk).

All eight Registers of Deeds offer remote access to their official public record via a company called Fidlar Technologies out of Davenport, Iowa. This year marks the release of new and robust search tools called Laredo Anywhere (released January 16th) and Tapestry Eon (to be released this Fall). To foster networking and knowledge-sharing, these officials hosted an open house event. The event featured training sessions on the functionality of essential tools and updates on new legislation set to be enacted in 2025. The goal was to keep local real estate professionals well-informed and prepared for the future.

Beginning May 1st of 2025, Wisconsin will be implementing 2023 Wisconsin Act 235, commonly referred to as a "privacy shielding" bill. Under this new legislation, protected parties may have their records shielded from public access to provide additional protection from those who may target others through publicly accessible information. This means that real estate professionals and Registers of Deeds alike will have to implement new processes to ensure that their respective practices can proceed with minimal delays. This open house also spent time on how the tools used in the respective offices will handle this new legislative requirement.

For more information on Wisconsin County Register of Deeds Offices, visit https://www.wrdaonline.org/

For more information on Fidlar Technologies, visit https://fidlar.com/

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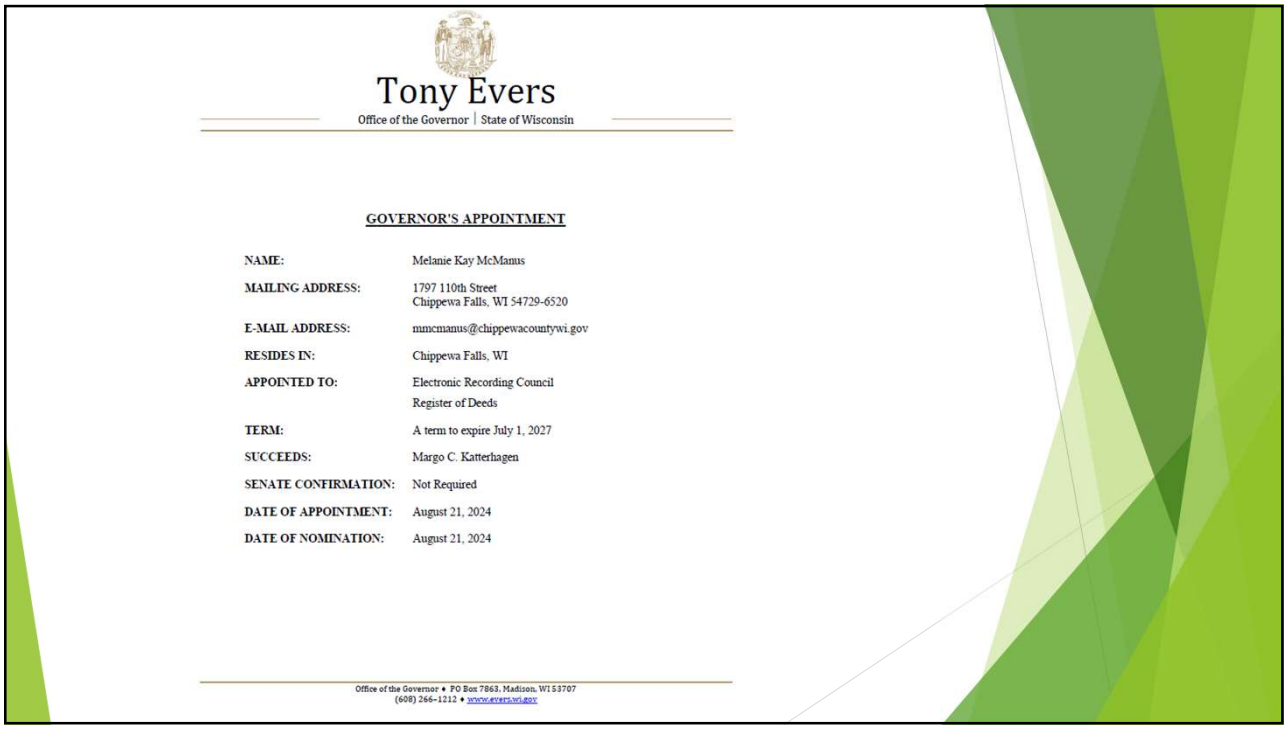

Tony Evers

Office of the Governor | State of Wisconsin

GOVERNOR'S APPOINTMENT

NAME:	Melanie Kay McManus
MAILING ADDRESS:	1797 110th Street Chippewa Falls, WI 54729-6520
E-MAIL ADDRESS:	mmcmanus@chippewacountywi.gov
RESIDES IN:	Chippewa Falls, WI
APPOINTED TO:	Electronic Recording Council Register of Deeds
TERM:	A term to expire July 1, 2027
SUCCEEDS:	Margo C. Katterhagen
SENATE CONFIRMATION:	Not Required
DATE OF APPOINTMENT:	August 21, 2024
DATE OF NOMINATION:	August 21, 2024

Office of the Governor • PO Box 7863, Madison, WI 53707
(608) 266-1212 • www.evers.wi.gov

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Office Project Updates/Goals

- Consolidation of our recorded document types was installed in March 2024. 1600 documents have been reviewed with approximately 970 documents remaining before final changes can be implemented.
- In the Fall of 2023, we had approximately 179,000 pages rescanned and all images are now in place. We have reviewed 16,581 documents to ensure proper social security redactions and have 13,458 documents remaining.
- Get our PINtegrity program going which will provide even more accurate indexing of documents. We have reviewed 490 documents and have 737 to complete to have more consistent address indexing.
- Now working on the Historical queue for back indexing (227,1116 documents as of 4/21/2025). This does not include documents with only Volume and Page assigned. Currently back indexed to 1954 and are now working on December 1953. I plan to utilize Fidlar's Condor service to back index using funds from our Land Information Plan with hopes to have 6+ years mass indexed. ROD staff will audit all documents indexed by Condor.
- Purchasing a book scanner for brittle vital records is cost prohibitive. ROD LTE is scanning and indexing vital records into Laserfiche for preservation/retention purposes.
- Citadel, a Fidlar application, has been installed and available which allows us to comply with judicial privacy requests.

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Questions or Comments?

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Opioid Fund Request Form

- **All programs/projects must be requested by April 15th each year** in order to be considered for an approved program/project for the following calendar/budget year.
- If the CA supports the project after the initial review, then DH have 60 days to complete Section 3 and review it with the policy committee to get their feedback. The completed Opioid Fund Request Form, with the committee feedback, is then submitted back to the CA to be incorporated into the next year's budget by June 15th.
- **All training requests may be requested throughout the year but must be approved by the CA**.
  * Each individual attending training must complete an Opioid Fund Request Form.
- The following documents are attached for reference when completing this form:
  * Exhibit E – List of Opioid Remediation Uses – Schedule A: Core Strategies
  * Exhibit E – List of Opioid Remediation Uses – Schedule B: Approved Uses

SECTION 1 – To Be Completed by DH Before Submitting to the CA for Initial Review

Project Requester/Department: Rose Baier- DOA-CJS Date: 3/12/2025

Identify the Budget Year Funds are Requested For: 2026

Name of Opioid Program/Project/Training: Reentry

☐ New Program ☒ Reoccurring Opioid Program *(identify below)* ☐ Expansion of Existing Program *(identify below)*

Identify: _____

Estimated Start Date of Project: 1/1/2026 Estimated Date of Completion: 12/31/2027

☐ Training Request Date of Training: _____ Location of Training: _____

Identify the Core Strategy from Schedule A: *(see Exhibit E – List of Opioid Remediation Uses)*

☐ Naloxone or Other FDA-Approved Drug to Reverse Opioid Overdoses
☒ Medication-Assisted Treatment ("MAT") Distribution and Other Opioid Related Treatment
☐ Pregnant & Postpartum Women
☐ Expanding Treatment for Neonatal Abstinence Syndrome ("NAS")
☐ Expansion of Warm Hands-Off Programs and Recovery Services
☒ Treatment for Incarcerated Population
☐ Prevention Programs
☐ Expanding Syringe Service Programs
☐ Evidence-Based Data Collection & Research Analyzing the Effectiveness of Abatement Strategies w/in the State

Identify the Approved Use from Schedule B: *(see Exhibit E – List of Opioid Remediation Uses)*

☐ Treat Opioid Use Disorder (OUD)
☐ Support People in Treatment and Recovery
☒ Connect People Who Need Help to the Help They Need (Connections to Care)
☒ Address the Needs of Criminal Justice-Involved Persons
☐ Address Needs of Pregnant/Parenting Women & Their Families, Including Babies with Neonatal Abstinence Syndrome
☐ Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids
☒ Prevent Misuse of Opioids
☒ Prevent Overdose Deaths and Other Harm (Harm Reduction)
☐ First Responders
☐ Leadership, Planning and Coordination
☐ Training
☐ Research

List the Subcategory as Shown in Exhibit E:
Note: The Subcategories are the numbered items listed under the Core Strategies from Schedule A or the Approved Uses from Schedule B

B. MEDICATION-ASSISTED TREATMENT ("MAT') DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT
B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY
D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS
G. PREVENT MISUSE OF OPIOIDS

Description – *Provide an explanation about what the program/project/training entails.*

CJS has been offering reentry services since the end of 2023. There have been numerous challenges for those reentering the community from jail. The majority of these individuals have a mental health or drug addiction and have been affected by Opioid use. The jail releases individuals between 5:30 and 6:00 a. m. when the majority of businesses are closed. Many of them do not have appropriate clothing for the weather. Along with these challenges, other identified needs include:
Lack of transportation, housing, telephone,basic needs, identification, birth certificates, or shelter. Funds will be used to support these. If there are additional funds, these will be used to help support the Take a Stand Against Meth (TASAM) campaign efforts for prevention. The TASAM has been meeting with youth in the middle schools to educate them on the harmful effects of drug use and vaping. Funds would be used for prevention materials for these events and community events.
Funds will also be used to purchase Evidence Based curriculum materials within the jail to support treatment programs for those with Opioid abuse disorders.

How does this program/project/training help with the Opioid use abatement efforts in Chippewa County?

By providing individuals supplies and services above and assuring they are set up for success, they will be more likely to succeed and not return to using drugs and alcohol. Since 2023 numerous individuals have reported that these services have assisted them with staying free from drugs and alcohol, gaining employment and getting proper medical care. These requests meet numerous criteria in the sub categories listed.

Has this program/project/training utilized Opioid funds in the previous year? ☒ Yes ☐ No
If yes, then identify some of the measurable impacts the program/project/training has had on abatement efforts.

With Opioid funds we were able to purchase and disburse 200 medication disposal kits, purchase prevention advertising in at the Cadott movie theatre, provided evidence based curriculum to the jail for prevention, education and treatment, and served over 136 people in reentry. Provided 56 with shelter, 70 clothing, 35 tra!1sportation, 24 birth certificates to get employment, 20 with phones, 8 bus and 28 transportation assistance.

Estimated Annual Cost of Program/Project/Training: $ 15,000

Amount of Annual Chippewa County Opioid Funds Requested: $ 7,000

Will matching funds be used by another organization/municipality? ☐ Yes ☒ No
If yes, identify who and amount: _____

Is there a current program/service that will no longer be offered? ☐ Yes ☒ No
If yes, please identify the program, costs and revenue source of the current program.

Are you able to manage and implement this new program/project/training with existing staff within your department?
☒ Yes ☐ No
If yes, how many staffing hours annually are anticipated? No additional hours than what we are currently doing

If no, are you able to contract with an organization/individual to provide the service? ☐ Yes ☐ No

Return completed form to the County Administrator

Rose Baier — Signature of Project Requester/Department Head

3/12/2025 — Date

SECTION 2 – To Be Completed by the County Administrator

☒ Approved for Committee Review and Feedback ☐ Denied ☐ More Information Needed
☐ Training Approved – Committee Review Not Needed

Total Amount of Chippewa County Opioid Funds Recommended by County Administrator: $ 7,000.00

Lori Zwiefelhofer (CA Vacancy) — County Administrator

4/10/2025 — Date

Comments:

SECTION 3 – Additional Action and/or Comments from Committee

Note: It should be emphasized to the Policy Committee that not all programs/projects may be approved due to the limited funds available in the Opioid Abatement Account.

Committee Meeting Date: _____ ☐ Approved ☐ Denied ☐ More Information Needed

Department Head Recommended Ranking: _____ Committee Approved Ranking: _____

Total Amount of Chippewa County Opioid Funds Approved by Committee: $_____

Comments:

- Submit completed form back to the County Administrator after policy committee has reviewed/approved by June 15th.

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.

STATEMENT OF EXPLANATION

Resolution No.

RESOLUTION CONFIRMING AND RATIFYING THE AUTHORITY OF COUNSEL FOR CHIPPEWA COUNTY TO ADD ADDITIONAL DEFENDANTS TO OPIOID LITIGATION, INCLUDING IN MDL 2804

Pursuant to Resolution 54-17, the Chippewa County Board of Supervisors previously authorized the County to enter into an engagement agreement with von Briesen & Roper, s.c., Crueger Dickinson LLC and Simmons Hanly Conroy LLC (the "Law Firms") to pursue litigation against manufacturers, distributors, and retailers, among others, of opioid pharmaceuticals (the "Opioid Defendants") in an effort to hold the Opioid Defendants responsible for the opioid epidemic in the County's community. The Law Firms filed similar lawsuits on behalf of 66 other Wisconsin counties and all Wisconsin cases were coordinated with thousands of other lawsuits filed against the same or substantially similar parties as the Opioid Defendants in the Northern District of Ohio, captioned *In re: Opioid Litigation,* MDL 2804 (the "Litigation") To date, through nationwide settlements, the Law Firms have achieved considerable success on behalf of the County in holding the Opioid Defendants responsible for their role in creating or maintaining the opioid epidemic.

Through the course of ongoing discovery and investigation concerning the opioid epidemic and parties potentially responsible therefor, it was determined that meritorious opioid-related claims exist against additional parties, including but not limited to the entities listed on Exhibit A hereto, and that they should be added as defendants in the Litigation. The engagement agreement with the Law Firms provides "depending upon the results of initial investigations of the facts and circumstances surrounding the potential claim(s), there may be additional parties sought to be made responsible …."

While the County believes the engagement agreement with the Law Firms provided the Law Firms with adequate authority to add additional parties to be held responsible, the County understands that recently those parties questioned that authority, and therefore, for the avoidance of doubt, the County is adopting this Resolution confirming and ratifying the Law Firms' authority to add additional parties, including but not limited to the entities listed on Exhibit A, as defendants in the Litigation.

Resolution No.

RESOLUTION CONFIRMING AND RATIFYING THE AUTHORITY OF COUNSEL FOR CHIPPEWA COUNTY TO ADD ADDITIONAL DEFENDANTS TO OPIOID LITIGATION, INCLUDING IN MDL 2804

WHEREAS, pursuant to Resolution 54-17, the Chippewa County Board of Supervisors previously authorized the County to enter into an engagement agreement with von Briesen & Roper, s.c., Crueger Dickinson LLC and Simmons Hanly Conroy LLC (the "Law Firms") to pursue litigation against manufacturers, distributors, and retailers, among others, of opioid pharmaceuticals (the "Opioid Defendants") in an effort to hold the Opioid Defendants responsible for the opioid epidemic in the County's community; and

WHEREAS, on behalf of the County, the Law Firms filed a lawsuit against the Opioid Defendants; and

WHEREAS, the Law Firms filed similar lawsuits on behalf of 66 other Wisconsin counties and all Wisconsin cases were coordinated with thousands of other lawsuits filed against the same or substantially similar parties as the Opioid Defendants in the Northern District of Ohio, captioned *In re: Opioid Litigation,* MDL 2804 (the "Litigation"); and

WHEREAS, four (4) additional Wisconsin counties (Milwaukee, Dane, Waukesha, and Walworth) hired separate counsel and joined the Litigation; and

WHEREAS, since the inception of the Litigation, the Law Firms have coordinated with counsel from around the country (including counsel for Milwaukee, Dane, Waukesha, and Walworth Counties) to prepare the County's case for trial and engage in settlement discussions with the Opioid Defendants; and

WHEREAS, to date, through nationwide settlements, the Law Firms have achieved considerable success on behalf of the County in holding the Opioid Defendants responsible for their role in creating or maintaining the opioid epidemic; and

WHEREAS, through the course of ongoing discovery and investigation concerning the opioid epidemic and parties potentially responsible therefor, it was determined that meritorious opioid-related claims exist against additional parties, including but not limited to the entities listed on Exhibit A hereto, and that they should be added as defendants in the Litigation; and

WHEREAS, the engagement agreement with the Law Firms provides "depending upon the results of initial investigations of the facts and circumstances surrounding the potential claim(s), there may be additional parties sought to be made responsible ….;" and

WHEREAS, while the County believes the engagement agreement with the Law Firms

provided the Law Firms with adequate authority to add additional parties to be held responsible, the County understands that recently those parties questioned that authority, and therefore, for the avoidance of doubt, the County is adopting this Resolution confirming and ratifying the Law Firms' authority to add additional parties, including but not limited to the entities listed on Exhibit A, as defendants in the Litigation; and

WHEREAS, to avoid any confusion surrounding the County's authorization to the Law Firms to amend the pleadings in the Litigation to include additional parties, including but not limited to the entitles listed on Exhibit A as named defendants in MDL 2804, this Resolution is intended to serve as confirmation and ratification of such authorization; and

WHEREAS, the County, by this Resolution, intends to confirm and ratify the authority of the Law Firms to amend the pleadings in the Litigation to add additional parties, including but not limited to the entitles listed on Exhibit A as defendants in MDL 2804, or to commence appropriate federal or state court proceedings against such entities, and further intends to authorize Corporation Counsel to execute and deliver any and all other and further documents necessary to effectuate the intent of this Resolution; and

NOW, THEREFORE, BE IT RESOLVED**:** the County Board of Supervisors hereby confirms and ratifies the authority of:

1. The Law Firms to file appropriate pleadings in MDL 2804 or appropriate federal or state court proceedings to add additional parties, including but not limited to the entitles listed on Exhibit A as defendants.

2. The Corporation Counsel, Board Chair or other authorized official to execute and deliver any and all other and further documents necessary to effectuate the intent of this Resolution.

BE IT FURTHER RESOLVED, that all actions heretofore taken by the Board of Supervisors and other appropriate public officers and agents of the County with respect to the matters contemplated under this Resolution are hereby ratified, confirmed, and approved.

Forwarded to the County Board by the Executive Committee.

FINANCIAL IMPACT:

There is no fiscal impact to Chippewa County by passage of this resolution.

05/20/2025	**Executive Committee**
RESULT:	**FORWARD TO COUNTY BOARD [UNANIMOUS]** **Next: 6/10/2025 6:00 PM**
MOVER:	Joel Seidlitz, District 9
SECONDER:	Jason Bergeron, District 7
AYES:	Chuck Hull, Peter Gehring, Jason Bergeron, Joel Seidlitz

Approved as to Form:

Todd A. Pauls
Todd A. Pauls, Corporation Counsel 5/9/2025

Lori Zwiefelhofer
Lori Zwiefelhofer, Finance Director 5/9/2025

Andy J. Albarado
Andy J. Albarado, County Administrator 5/9/2025

Exhibit A – Non-Inclusive List of Potential Defendants
(Including all Related Entities of Each Listed)

Abbot Laboratories, Inc.
Albertsons LLC
Allergan, Inc.
Alvogen, Inc.
Amerisource Bergen
Amneal Pharmaceuticals, Inc.
Associated Pharmacies, Inc.
Auburn Pharmaceuticals
Aurolife Pharma LLC
Baker, Stuart
Cardinal Health
Costco Wholesale Corporation
CVS Health Corporation
Dakota Drug, Inc.
Discount Drug Mart
Eckerd Corp.
Eveready Wholesale Drugs
Express Scripts Inc.
Henry Shein, Inc.
Hy-Vee, Inc.
Indivior Inc.
Janssen Pharmaceuticals
K-VA-T/Ahold Delhaize
KVK-Tec, Inc.
Louisiana Wholesale Drug Co., Inc.
Lupin Pharmaceuticals, Inc.
McKesson
Miami-Luken, Inc.
Morris & Dickson Co., LLC
Mylan Pharmaceuticals, Inc.
North Carolina Mutual Wholesale Drug Co.
Omnicare Distribution Center
OptumRx, Inc.
Pharmacy Buying Association Inc.
Prescription Supply, Inc.
Publix Super Markets, Inc.
Purdue Pharma
Raymond Sacker Trust
RiteAid of Maryland, Inc.
Sacker, Kathe A.
Sacker, Richard S.
Sackler Defendants
Sackler Lefcourt, Ilene
Sackler, Beverly
Sackler, David A.
Sackler, Mortimer D.A.
Sackler, Theresa
Sandoz, Inc.
Smith Drug Company
Smith's Food & Drug Centers, Inc.
Sun Pharmaceutical
Supervalu, Inc. d/b/a Advantage Logistics
Target Corporation
Teva Pharmaceuticals
The Kroger Co.
Thrifty Payless, Inc.
Top Rx, Inc.
Tris Pharma, Inc.
Walgreens Boots Alliance
Walmart Inc.
Warner Chilcott Company, LLC
West-Ward Pharmaceuticals Corp. n/k/a
Hikma Pharmaceuticals, Inc.
Winn-Dixie
Zydus Pharmaceuticals (USA), Inc.

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STATEMENT OF EXPLANATION

Resolution No. 54 - 17

RESOLUTION TO APPROVE ENGAGEMENT LETTER TO ENTER INTO LITIGATION AGAINST PHARMACEUTICAL COMPANIES TO RECOVER FUNDS EXPENDED DUE TO THE OPIOID EPIDEMIC

Approval of this resolution will authorize Chippewa County to enter into an Engagement Letter with the law firms of von Briesen, Crueger Dickinson LLC, and Simons Hanly Conroy LLC to file a lawsuit as a plaintiff against certain pharmaceutical companies for their roles in causing the so-called "Opioid Epidemic". The goal of the litigation is to attempt to recoup funds that were expended by Chippewa County in addressing issues directly attributable to the Opioid Epidemic. The Departments most likely affected by the Opioid Epidemic are Human Services and Public Health. Other departments that may have recoverable costs that are attributable to opioid abuse, but to a lesser extent, are the Sheriff's Department, District Attorney's Office and the Courts.

The attached documents were provided by the WCA and the litigation team. Those documents include a presentation on the proposed opioid litigation, the proposed Engagement Letter, a sample complaint against pharmaceutical companies that was filed in New York, a Wall Street Journal article and a New York Times article on opioid addiction, and a listing of other lawsuits that are occurring across the country. These attachments provide further explanation as to the purpose and goals of the litigation.

Resolution No. 54 - 17

RESOLUTION TO APPROVE ENGAGEMENT LETTER TO ENTER INTO LITIGATION AGAINST PHARMACEUTICAL COMPANIES TO RECOVER FUNDS EXPENDED DUE TO THE OPIOID EPIDEMIC

WHEREAS, Chippewa County ("County") is concerned with the recent rapid rise in troubles among County citizens, residents, and visitors in relation to problems arising out of the use, abuse and overuse of opioid medications, which according to certain studies, impacts millions of people across the country; and

WHEREAS, issues and concerns surrounding opioid use, abuse and overuse by citizens, residents and visitors are not unique to County and are, in fact, issues and concerns shared by all other counties in Wisconsin and, for that matter, states and counties across the country, as has been well documented through various reports and publications, and is commonly referred to as the Opioid Epidemic ("Opioid Epidemic:); and

WHEREAS, the societal costs associated with the Opioid Epidemic are staggering and, according to the Centers for Disease Control and Prevention, amount to over $75 billion annually; and

WHEREAS, the National Institute for Health has identified the manufacturers of certain of the opioid medications as being directly responsible for the rapid rise of the Opioid Epidemic by virtue of their aggressive and, according to some, unlawful and unethical marketing practices; and

WHEREAS, certain of the opioid manufacturers have faced civil and criminal liability for their actions that relate directly to the rise of the Opioid Epidemic; and

WHEREAS, County has spent millions in unexpected and unbudgeted time and resources in its programs and services related to the Opioid Epidemic; and

WHEREAS, County is responsible for a multitude of programs and services, all of which require County to expend resources generated through state and federal aid, property tax levy, fees and other permissible revenue sources; and

WHEREAS, County's provision of programs and services becomes more and more difficult every year because the costs associated with providing the Opioid Epidemic programs and services continue to rise, yet County's ability to generate revenue is limited by strict levy limit caps and stagnant or declining state and federal aid to County; and

WHEREAS, all sums that County expends in addressing, combatting and otherwise dealing with the Opioid Epidemic are sums that cannot be used for other critical programs and services that County provides to County citizens, residents and visitors; and

WHEREAS, County has been informed that numerous counties and states across the country have filed or intend to file lawsuits against certain of the opioid manufacturers in an effort to force the persons and entities responsible for the Opioid Epidemic to assume financial responsibility for the costs associated with addressing, combatting and otherwise dealing with the Opioid Epidemic; and

WHEREAS, County has engaged in discussions with representatives of the law firms of von Briesen & Roper, s.c., Crueger Dickinson LLC and Simmons Hanly Conroy LLC (the "Law Firms") related to the potential for County to pursue certain legal claims against certain opioid manufacturers; and

WHEREAS, County has been informed that the Law Firms have the requisite skill, experience and wherewithal to prosecute legal claims against certain of the opioid manufacturers on behalf of public entities seeking to hold them responsible for the Opioid Epidemic; and

WHEREAS, the Law Firms have proposed that County engage the Law Firms to prosecute the aforementioned claims on a contingent fee basis whereby the Law Firms would not be compensated unless County receives a financial benefit as a result of the proposed claims and the Law Firms would advance all claim-related costs and expenses associated with the claims; and

WHEREAS, all of the costs and expenses associated with the claims against certain of the opioid manufacturers would be borne by the Law Firms; and

WHEREAS, the Law Firms have prepared an engagement letter, which is submitted as part of this Resolution ("Engagement Letter") specifying the terms and conditions under which the Law Firms would provide legal services to County and otherwise consistent with the terms of this Resolution; and

WHEREAS, County is informed that the Wisconsin Counties Association has engaged in extensive discussions with the Law Firms and has expressed a desire to assist the Law Firms, County and other counties in the prosecution of claims against certain of the opioid manufacturers; and

WHEREAS, County would participate in the prosecution of the claim(s) contemplated in this Resolution and the Engagement Letter by providing information and materials to the Law Firms and, as appropriate, the Wisconsin Counties Association as needed; and

WHEREAS, County believes it to be in the best interest of County, its citizens, residents, visitors and taxpayers to join with other counties in and outside Wisconsin in pursuit of claims against certain of the opioid manufacturers, all upon the terms and conditions set forth in the Engagement Letter; and

WHEREAS, by pursuing the claims against certain of the opioid manufacturers, County is

attempting to hold those persons and entities that had a significant role in the creation of the Opioid Epidemic responsible for the financial costs assumed by County and other public agencies across the country in dealing with the Opioid Epidemic;

NOW, THEREFORE BE IT RESOLVED, that the Chippewa County Board of Supervisors does hereby authorize and agrees to be bound by, the Engagement Letter and hereby directs the County Administrator to execute the Engagement Letter on behalf of the County; and

BE IT FURTHER RESOLVED, that Chippewa County shall endeavor to faithfully perform all actions required of the County in relation to the claims contemplated herein and in the Engagement Letter and hereby directs all County personnel to cooperate with and assist the Law Firms in relation thereto; and

BE IT FURTHER RESOLVED, that the County Clerk shall forward a copy of this Resolution, together with the signed Engagement Letter, to the Wisconsin Counties Association, 22 E. Mifflin Street, Suite 900, Madison, Wisconsin, 53703.

Forwarded to the County Board by the Executive Committee.

FINANCIAL IMPACT:

It is unclear what the fiscal impact will be to Chippewa County. The main cost will be staff time to gather records, comply with discovery requests, and to determine what costs were attributable to the opioid epidemic that were borne by Chippewa County.

11/7/2017	**County Board**
RESULT:	**APPROVED [9 TO 4]**
MOVER:	Florian Skwierczynski, (Vice-Chairman)
SECONDER:	Kari Ives, District 12
AYES:	Albarado, Skwierczynski, Steele, Sikorski, Zwiefelhofer, Bergeron, Gerrish, Ives, Hunt
NAYS:	Tom Thornton, Dean Gullickson, Lawrence J. Willkom, Leigh Darrow
ABSENT:	Matthew Hartman, Chuck Hull

History:

10/17/17 Executive Committee FORWARD TO COUNTY BOARD

Approved as to Form:

James B. Sherman
James B. Sherman, Deputy Corporation Counsel 10/12/2017

Melissa J. Roach
Melissa J. Roach, Finance Director 10/12/2017

Frank R. Pascarella

Frank R. Pascarella, County Administrator 10/12/2017

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Crueger Dickinson

von Briesen & Roper, s.c. | Attorneys at Law

October 11, 2017

VIA EMAIL

Chippewa County
c/o Anson Albarado, Board Chair

RE: ***Engagement of von Briesen & Roper, s.c., and Crueger Dickinson LLC, Together with Simmons Hanly Conroy LLC, as Counsel in Relation to Claims Against Opioid Manufacturers***

Dear Chippewa County Officials:

The purpose of this letter ("Engagement Letter") is to set out in writing the terms and conditions upon which the law firms of von Briesen & Roper, s.c., and Crueger Dickinson LLC (collectively "Counsel) will provide legal services to Chippewa County ("County") in relation to the investigation and prosecution of certain claims against the following manufacturers and other parties involved with the manufacture of opioid medications: Purdue Pharma L.P., Purdue Pharma Inc., The Purdue Frederick Company, Inc., Teva Pharmaceuticals USA, Inc., Cephalon, Inc., Johnson & Johnson, Janssen Pharmaceuticals, Inc., OrthoMcNeil-Janssen Pharmaceuticals, Inc. n/k/a Janssen Pharmaceuticals, Inc., Janssen Pharmaceutica, Inc. n/k/a Janssen Pharmaceuticals, Inc.; Endo Health Solutions Inc., Endo Pharmaceuticals, Inc., Russell Portenoy, Perry Fine, Scott Fishman and Lynn Webster (collectively "Opioid Manufacturers"). Depending upon the results of initial investigations of the facts and circumstances surrounding the potential claim(s), there may be additional parties sought to be made responsible and/or certain of the aforementioned parties may be removed from the potential claim.

This Engagement Letter shall apply solely and exclusively to the services set forth herein in relation to the investigation and Lawsuit, as defined below. This Engagement Letter does not govern, nor does it apply to, any services of either Counsel unrelated thereto.

SCOPE OF SERVICES

Counsel will work with County in the collection of information necessary to form a good faith basis for filing a claim against the Opioid Manufacturers. County hereby authorizes Counsel to file a lawsuit against one or all of the Opioid Manufacturers ("Lawsuit") upon the terms and conditions set forth herein.

RESPONSIBILITIES

Counsel will prosecute the Lawsuit with diligence and keep County reasonably informed of progress and developments, and respond to County's inquiries. County understands and agrees that Counsel, on behalf of County, will engage the services of the nationally-recognized law firm Simmons Hanly Conroy LLC, which has demonstrated experience prosecuting claims against Opioid Manufacturers ("National Law Firm") and which, in addition to Crueger Dickinson LLC, will serve as counsel of record for County in relation to the Lawsuit. County understands and agrees that all fees paid to Counsel and National Law Firm shall be as set forth in this Engagement Letter. County shall not be responsible for any fees and expenses of National Law Firm beyond the fees and expenses for which County has agreed to be responsible as set forth herein. County agrees to cooperate with Counsel and National Law Firm in the gathering of information necessary to investigate and prosecute the Lawsuit. County further understands and agrees that the law firm of von Briesen & Roper, s.c., shall

not be identified on any pleading as counsel of record for County in relation to the Lawsuit, but shall be available to assist County and Counsel and National Law Firm in relation to the Lawsuit.

The following additional terms apply to the relationship between County, Counsel and National Law Firm:

A. von Briesen & Roper, s.c., and Crueger Dickinson LLC shall remain sufficiently aware of the performance of one another and the performance of National Law Firm to ascertain if each firm's handling of the Lawsuit conforms to the Rules of Professional Conduct. Both von Briesen & Roper, s.c., and Crueger Dickinson LLC shall be available to County regarding any concerns on the part of County relating to the performance of Counsel and/or National Law Firm. Counsel shall at all times remain ethically and financially responsible to the County for the services of Counsel and National Law Firm set forth herein.

B. As set forth below, County's responsibility for attorney fees and expenses is contingent upon the successful outcome of the Lawsuit, as further defined below. Counsel and National Law Firm have agreed in writing as to the appropriate split of attorney fees and expenses upon the engagement of National Law Firm. Specifically, in the event of a Recovery (as defined below), the attorney fees will be split between the law firms as follows:

Firm Name	**Percentage of Fees if Successful**
von Briesen & Roper, s.c.	10%
Crueger Dickinson LLC	45%
Simmons Hanly Conroy LLC	45%

The split of attorneys' fees between Counsel and National Law Firm may be subject to change. In the event of such an amendment, the County will be notified in writing of that amendment.

C. Counsel and County understand and agree that Counsel and National Law Firm will all be considered attorneys for County. As such, each and all of Counsel and National Law Firm will adhere to the Rules of Professional Responsibility governing the relationship between attorney and client.

ACTUAL AND POTENTIAL CONFLICTS OF INTEREST AND WAIVER OF CONFLICT

As County is aware, Counsel and National Law Firm contemplate entering into the same arrangement as that set forth in this Engagement Letter with other counties and municipalities in Wisconsin and elsewhere. Counsel and National Law Firm believe that the goals and objectives of County are aligned with the goals and objectives of all other counties and municipalities with respect to the Lawsuit. Counsel and National Law Firm do not believe that to achieve the goals of the Lawsuit, either County or another county or municipality must take a position that is adverse to the interests of the other. However, to the extent any issue may arise in this matter about which County disagrees with another county or municipality, and one of you may wish to pursue a course that benefits one but is detrimental to the interest of the other, we cannot advise County or assist County or any other county or municipality in pursuing such a course. That is to say, Counsel and National

Law Firm cannot advocate for County's individual interests at the expense of the other counties or municipalities that Counsel and National Law Firm represent in a Lawsuit. Counsel and National Law Firm do not believe that this poses a problem because County's interests are currently aligned with the other counties and municipalities that are or may be in the Lawsuit. Counsel and National Law Firm are confident that their representation of County will not be limited in this matter by representation of any other county or municipality, but County should consider these consequences of joint representation in deciding whether to waive this conflict.

In addition to the material limitation discussed above, there are other consequences for County in agreeing to joint representation. Because each county or municipality would be a client of Counsel and National Law Firm, Counsel and National Law Firm owe equal duties of loyalty and communication to each client. As such, Counsel and National Law Firm must share all relevant information with all counties and municipalities who are clients in relation to the Lawsuit and Counsel and National Law Firm cannot, at the request of one county or municipality, withhold relevant information from the other client. That is to say, Counsel and National Law Firm cannot keep secrets about this matter among the counties and municipalities who are clients of Counsel and National Law Firm with respect to the Lawsuit. Also, lawyers normally cannot be forced to divulge information about communications with their clients because it is protected by the attorney-client privilege. However, because County would be a joint client in the same matter with other counties and municipalities, it is likely that were there to be a future legal dispute between County and other counties or municipalities that engage Counsel and National Law Firm about this matter, the attorney-client privilege would not apply, and each would not be able to invoke the privilege against the claims of the other.

Further, while County's position is in harmony with other counties and municipalities presently, and the conflict discussed above is waivable, facts and circumstances may change. For example, County may change its mind and wish to pursue a course that is adverse to the interests of another county or municipality and the conflict may become unwaivable. In that case, depending upon the circumstances, Counsel and National Law Firm may have to withdraw from representing either County or another county or municipality and County would have to bear the expense, if County chooses, of hiring new lawyers who would have to get up to speed on the matter.

County is not required to agree to waive this conflict, and County may, after considering the risks involved in joint representation, decline to sign this Engagement Letter. By signing this Engagement Letter, County is signifying its consent to waiving the conflict of interest discussed herein.

Other than the facts and circumstances related to the joint representation of numerous counties and municipalities, Counsel and National Law Firm are unaware of any facts or circumstances that would prohibit Counsel and/or National Law Firm from providing the services set forth in this Engagement Letter. However, it is important to note that the law firm of von Briesen & Roper, s.c., is a relatively large law firm based in Wisconsin and represents many companies and individuals. It is possible that some present and future clients of von Briesen & Roper, s.c., will have business relationships and potential or actual disputes with County. von Briesen & Roper, s.c., will not knowingly represent clients in matters that are actually adverse to the interests of County without County's permission and informed consent. von Briesen & Roper, s.c, respectfully requests that County consent, on a case by case basis, to von Briesen & Roper, s.c.'s representation of other clients whose interests are, or maybe adverse to, the interests of County in circumstances where County has selected other counsel and where von Briesen & Roper, s.c., has requested a written conflict waiver from County after being advised of the circumstances of the potential or actual conflict and County has provided informed consent.

FEES FOR LEGAL SERVICES AND RESPONSIBILITY FOR EXPENSES

A. Calculation of Contingent Fee

There is no fee for the services provided herein unless a monetary recovery acceptable to County is obtained by Counsel and National Law Firm in favor of County, whether by suit, settlement, or otherwise ("Recovery"). County understands and agrees that a Recovery may occur in any number of different fashions such as final judgment in the Lawsuit, settlement of the Lawsuit, or appropriation to County following a nationwide settlement or extinguishing of claims in lawsuits and matters similar to the Lawsuit. Counsel and National Law Firm agree to advance all costs and expenses of Counsel, National Law Firm and the Lawsuit associated with investigating and prosecuting the Lawsuit provided, however, that the costs and expenses associated with County cooperating with Counsel and National Law Firm in conjunction with the Lawsuit and otherwise performing its responsibilities under this Engagement Letter are the responsibility of County. In consideration of the legal services to be rendered by Counsel and National Law Firm, the contingent attorneys' fees for the services set forth in this Engagement Letter shall be a gross fee of 25% of the Recovery, which sum shall be divided among Counsel and National Law Firm as set forth in the above chart.

Upon the application of the applicable fee percentage to the gross Recovery, and that dollar amount set aside as attorneys' fees to Counsel and National Law Firm, the amount remaining shall first be reduced by the costs and disbursements that have been advanced by Counsel and National Law Firm, and that amount shall be remitted to Counsel and National Law Firm. By way of example only, if the gross amount of the Recovery is $1,000,000.00, and costs and disbursements are $100,000.00, then the fee to Counsel and National Law Firm shall be $250,000, the costs amount of $100,000 shall be deducted from the balance of $750,000.00, and the net balance owed to County shall be $650,000. The costs and disbursements which may be deducted from a Recovery include, but are not limited to, the following, without limitation: court fees, process server fees, transcript fees, expert witness fees and expenses, courier service fees, appellate printing fees, necessary travel expenses of attorneys to attend depositions, interview witnesses, attend meetings related to the scope of this Engagement Letter and the like, and other appropriate matter related out-of-pocket expenses. In the event that any Recovery results in a monetary payment to County that is less than the amount of the costs incurred and/or disbursements made by Counsel and National Law Firm, County shall not be required to pay Counsel and National Law Firm any more than the sum of the full Recovery.

B. Nature of Contingent Fee

No monies shall be paid to Counsel or National Law Firm for any work performed, costs incurred or disbursements made by Counsel or National Law Firm in the event no Recovery to County has been obtained. In the event of a loss at trial due to an adverse jury verdict or a dismissal of the Lawsuit by the court, no monies shall be paid to Counsel or National Law Firm for any work performed, costs incurred or disbursements made by Counsel or National Law Firm. In such an event, neither party shall have any further rights against the other.

C. Disbursement of Recovery Proceeds to County

The proceeds of any Recovery on County's behalf under the terms of this Engagement Letter shall be disbursed to County as soon as reasonably practicable after receipt by Counsel and National Law Firm. At the time of disbursement of any proceeds from a Recovery, County will be provided with a detailed disbursement sheet reflecting the method by which attorney's fees have been calculated and the expenses of litigation that are due to Counsel and National Law Firm from such proceeds. Counsel and National Law Firm are authorized to retain out of any moneys that may come into their

hands by reason of their representation of County the fees, costs, expenses and disbursements to which they are entitled as determined in this Engagement Letter.

TERMINATION OF REPRESENTATION

This Engagement Letter shall cover the period from the date first indicated below until the termination of the legal services rendered hereunder, unless earlier terminated as provided herein. This Engagement Letter may be terminated by County at any time, and in the event of such termination, neither party shall have any further rights against the other, except that in the event of a Recovery by County against the Opioid Manufacturers subsequent to termination, Counsel and National Law Firm shall have a statutory lien on any such recovery as provided by applicable law and further maintain rights in the nature of *quantum meruit* to recover fees, costs and expenses reasonably allocable to their work prior to termination. Counsel and National Law Firm may withdraw as County's attorneys at any time for the following reasons:

A. If Counsel and National Law Firm determine, in their sole discretion, that County's claim lacks merit or that it is not worthwhile to pursue the Lawsuit further; or

B. For Good Cause. For purposes of this Paragraph, Good Cause may include County's failure to honor the terms of the Engagement Letter, County's failure to follow Counsel or National Law Firm's advice on a material matter, or any fact or circumstance that would, in the view of Counsel or National Law Firm, impair an effective attorney-client relationship or would render continuing representation unlawful or unethical. If terminated for Good Cause, County will take all steps necessary to free Counsel and National Law Firm of any obligation to perform further, including the execution of any documents (including forms for substitution of counsel) necessary to complete withdrawal provided, however, that Counsel and National Law Firm shall have a statutory lien on any Recovery as provided by applicable law and further maintain rights in the nature of *quantum meruit* to recover fees, costs and expenses reasonably allocable to their work prior to termination.

SETTLEMENT

County has the authority to accept or reject any final settlement amount after receiving the advice of Counsel and National Law Firm. County understands settlements are a "compromise" of its claim(s), and that Counsel and National Law Firm's fee, as set forth above, applies to settlements also. For example, if a settlement is reached, and includes future or structured payments, Counsel and National Law Firm's fee shall include its contingent portion of those future or structured payments.

NO GUARANTEE OF RECOVERY

County understands and acknowledges that dispute resolution through litigation often takes years to achieve. County understands and acknowledges that there is no guarantee or assurances of any kind regarding the likelihood of success of the Lawsuit, but that Counsel and National Law Firm will use their skill, diligence, and experience to diligently pursue the Lawsuit.

LIMITED LIABILITY

von Briesen & Roper, s.c., and Crueger Dickinson LLC are limited liability entities under Wisconsin law. This means that if Counsel fails to perform duties in the representation of County and that failure causes County damages, the firms comprising Counsel and the shareholder(s) or principals directly involved in the representation may be responsible to County for those damages, but the

firm's other shareholders or principals will not be personally responsible. Counsel's professional liability insurance exceeds the minimum amounts required by the Wisconsin Supreme Court for limited liability entities of similar size.

COMMUNICATION BY E-MAIL

Counsel and National Law Firm primarily communicate with their clients via unencrypted internet e-mail, and this will be the way in which communications occur with County. While unencrypted e-mail is convenient and fast, there is risk of interception, not only within internal networks and the systems used by internet service providers, but elsewhere on the internet and in the systems of our clients and their internet service providers.

FILE RETENTION AND DESTRUCTION

In accordance with Counsel and National Law Firm's records retention policy, most paper and electronic records maintained are subject to a 10-year retention period from the last matter activity date or whatever date deemed appropriate. Extended retention periods may apply to certain types of matters or pursuant to County's specific directives.

After the expiration of the applicable retention period, Counsel and National Law Firm will destroy records without further notice to County, unless County otherwise notifies in writing.

MISCELLANEOUS

This Engagement Letter shall be governed by and construed in accordance with the laws of the State of Wisconsin, without regard to conflicts of law rules. In the event of any dispute arising out of the terms of this Engagement Letter, venue for any such dispute shall be exclusively designated in the State of Wisconsin Circuit Court for Milwaukee County, Wisconsin, or in the United States District Court for the Eastern District of Wisconsin.

It is expressly agreed that this Engagement Letter represents the entire agreement of the parties, that all previous understandings are merged in this Engagement Letter, and that no modification of this Engagement Letter shall be valid unless written and executed by all parties.

It is expressly agreed that if any term or provision of this Engagement Letter, or the application thereof to any person or circumstance, shall be held invalid or unenforceable to any extent, the remainder of this Engagement Letter, or the application of such term or provision to persons or circumstances other than those to which it is held invalid or unenforceable, shall not be affected thereby; and every other term and provision of this Engagement Letter shall be valid and shall be enforced to the fullest extent permitted by law.

The parties acknowledge that they have carefully read and fully understand all of the provisions of this Engagement Letter, and that they have the capacity to enter into this Engagement Letter. Each party and the person signing on behalf of each party, represents that the person signing this Engagement Letter has the authority to execute this document and thereby bind the party hereto on whose behalf the person is signing. Specifically, County acknowledges that it is bound by this Engagement Letter, has satisfied all conditions precedent to execution of this Engagement Letter and will execute all the necessary documents that may be required by its governing statutes and/or code.

CONCLUSION

Counsel and National Law Firm are pleased to have this opportunity to be of service to County. If at any time during the course of representation you have any questions or comments about our services

or any aspect of how we provide services, please don't hesitate to call one or all of the individuals listed below.

Very truly yours,

von BRIESEN & ROPER, s.c.

Andrew T. Phillips

CRUEGER DICKINSON LLC

Erin K. Dickinson

SIMONS HANLY CONROY LLC (Acknowledged)

Paul J. Hanly, Jr.

CHIPPEWA COUNTY agrees to retain the services of Counsel and National Law Firm all upon the terms and conditions specified above.

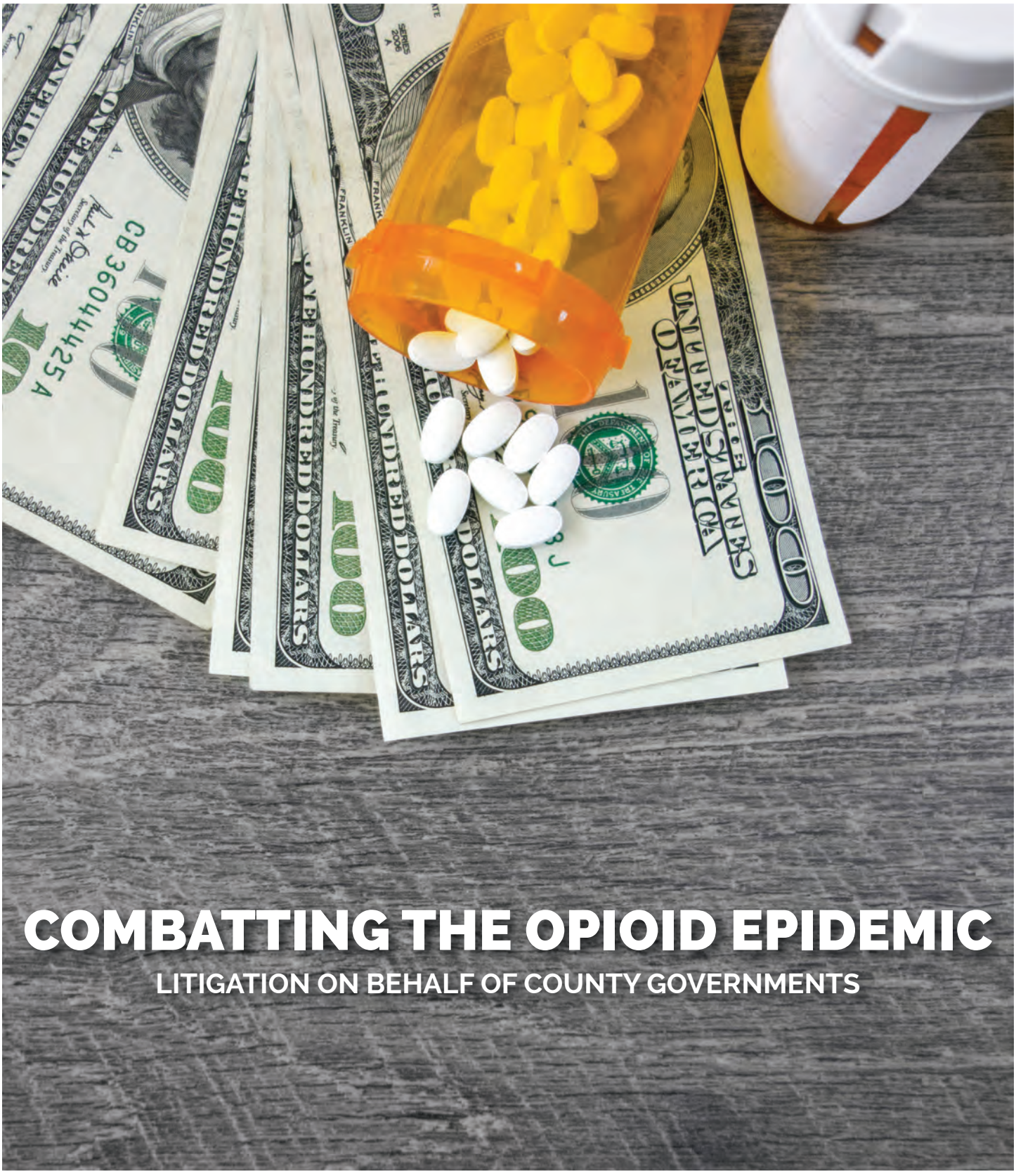
By: _____ Date: _____

Title: _____

cc: Corporation Counsel

29243067_1.DOCX

Crueger Dickinson | von Briesen
von Briesen & Roper, s.c. | Attorneys at Law



COMBATTING THE OPIOID EPIDEMIC

LITIGATION ON BEHALF OF COUNTY GOVERNMENTS

Crueger Dickinson | von Briesen
von Briesen & Roper, s.c. | Attorneys at Law

THE OPIOID EPIDEMIC: A PUBLIC HEALTH CRISIS

Opioid addiction and abuse have reached epidemic levels over the past decade. Indeed, on March 22, 2016, the FDA recognized opioid abuse as a "public health crisis" that has a "profound impact on individuals, families and communities across our country."[1]

In the last decade, the epidemic has exploded. From 1999 to 2013 the amount of opioids dispensed in the United States quadrupled.

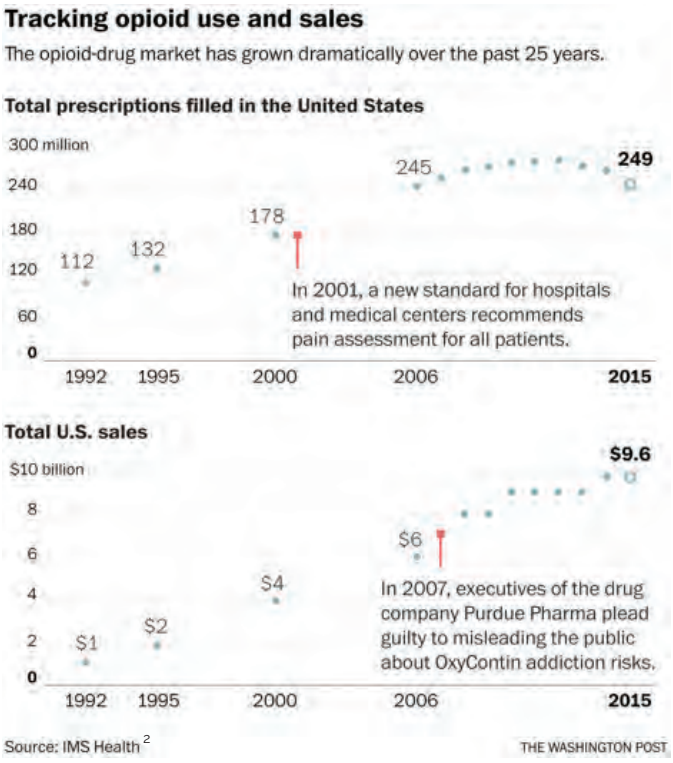
In 2013, nearly 207 million opioid prescriptions were written. A year later, that number grew to 259 million.

Those sales are big business for the pharmaceutical companies that manufacture and sell opioids including Purdue, Teva, Janssen, Cephalon and Endo (referred to as "Pharma"). In 2015 alone, the sale of opioids generated nearly $10 Billion in revenue for Pharma.

Sales and profits have grown dramatically over the past several decades.

4X

From 1999 to 2013, the amount of prescription opioids dispensed in the U.S. nearly **quadrupled.**



1 http://www.fda.gov/newsevents/newsroom/pressannouncements/ucm491739.htm

2 https://www.washingtonpost.com/national/the-drug-industrys-answer-to-opioid-addiction-more-pills/2016/10/15/181a529c-8ae4-11e6-bff0-d53f592f176e_story.html?utm_term=.2d1327bf59ae

Crueger Dickinson | von Briesen
von Briesen & Roper, s.c. | Attorneys at Law

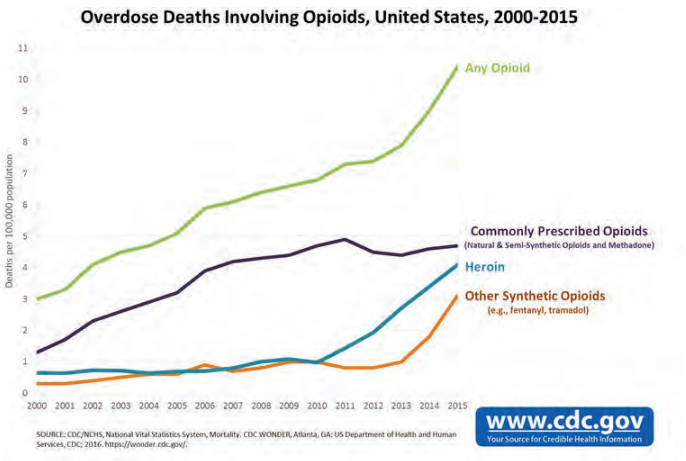
This spike in sales has had devastating and catastrophic effects. 2015 Data from the National Survey on Drug Use and Health showed that in the year 2013 over a third of the people in the United States had used prescription opioids with a significant number suffering from addiction as a result.

37.8% Americans used prescription opioids
(91.8 MILLION PEOPLE)

4.7% misused them
(11.5 MILLION PEOPLE)

.8% had a use disorder
(1.9 MILLION PEOPLE)

Additionally, deaths from opioids dramatically spiked with increased sales:



As described below, these dramatically increased sales and the spike in abuse and resultant deaths directly corresponds to Pharma's decision to market opioids for long-term use despite their known addictive effects.

PHARMA'S ROLE IN CREATING THE OPIOID EPIDEMIC

Opioids were historically used to provide effective treatment for short-term pain management. Controlled studies of the safety and efficacy of opioids were limited to short-term use. Pharma knew the limitations of the controlled studies. However, Pharma knew that profits could sky rocket if they were able to market and sell opioids for long-term use, including to treat chronic pain. In order to expand their market and achieve a dramatic increase in profits, Pharma decided to create a false marketing campaign designed to give the medical community and the public the false impression that opioids were safe and efficacious for long-term use. This false marketing campaign began in the late 90s, but exponentially increased starting in about 2006 and continues to the present.

Pharma was successful.

SINCE 1999
Prescription sales of opioids have **quadrupled**

IN 2010
254 million opioid prescriptions were written

IN 2013
37.4% of the population had been prescribed Opioids

Crueger Dickinson | von Briesen & Roper, s.c. | Attorneys at Law

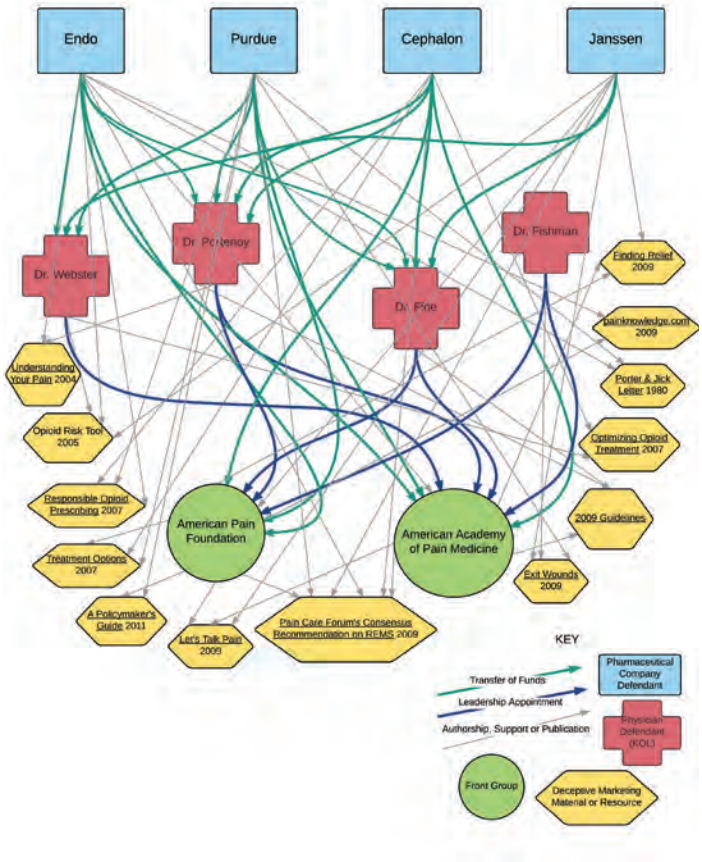
The result was a public health crisis that has had a profound impact on individuals, families and communities across the country.

The National Institute for Health ("NIH") identified Pharma as directly responsible for this crisis. In 2015, the NIH found that "several factors are likely to have contributed to the current prescription drug abuse problem. They include drastic increases in the number of prescriptions written and dispensed, greater social acceptability for using medications for different purposes, and *aggressive marketing by pharmaceutical companies.*"[3]

That "aggressive marketing campaign" included distorting medical and public perception of existing scientific data to create the false impression that opioids were safe and efficacious for long-term use. To accomplish this, Pharma poured money into generating articles, continuing education courses, sales groups and advocacy groups to create a phony "consensus" supporting the long-term use of opioids. Pharma and a select group of doctors and "front groups" banded together to create false legitimacy and the impression that these drugs were safe and efficacious for long-term use.

91 91 Americans die every day from an **opioid overdose** (that includes prescription opioids and heroin).

The following graphic depicts how this worked:



County of Suffolk v. Purdue Pharm L.P. et al., Case No. NYSCEF 613760/2016, Doc. No. 2, Ex. A.

WHY DID PHARMA DO THIS?

The answer is simple. Pharma made blockbuster profits. In 2012 alone, Pharma raked in $8 Billion from the sale of opioids. Purdue alone made $3.1 Billion from the sale of the opioid Oxycontin.

3 https://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2016/americas-addiction-to-opioids-heroin-prescription-drug-abuse

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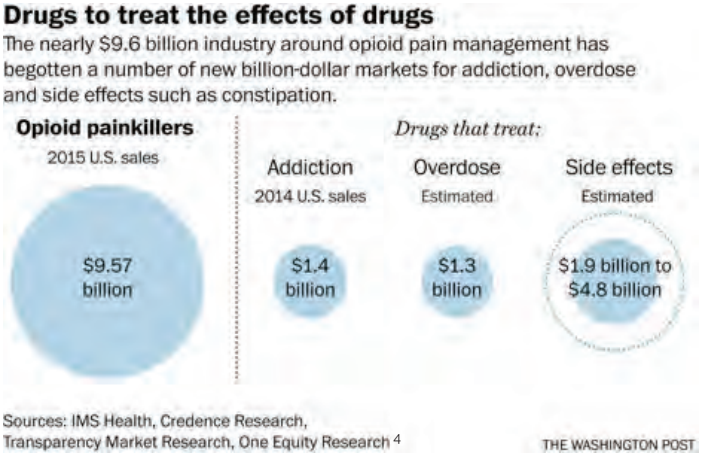
Not only has the Pharma industry profited from selling opioids but companies have also profited from treating the effects. As illustrated in a recent Washington Post article, the profits have been enormous:



COUNTIES BEAR THE COSTS

While Pharma was raking in profits, county governments have been forced to spend a significant amount of money combatting this epidemic. Costs to counties include health care costs, addiction and treatment costs, social costs, programming, training and education costs, criminal justice and victimization costs and lost productivity.

COUNTIES AND STATES FILE LAWSUITS

A number of government entities have brought litigation against the Pharma companies for their role in creating the Opioid Epidemic. This includes the State of Kentucky, the State of Ohio, the City of Chicago and counties in New York, West Virginia and Illinois. More and more cases are filed every week. Additionally, major news outlets have been covering the opioid epidemic and resulting litigation.

HOLDING PHARMA ACCOUNTABLE: CLAIMS

Lawsuits seek to hold opioid manufacturers accountable for the costs communities incur as a result of the opioid epidemic.

Lawsuits have alleged that Pharma and a select group of doctors worked together to create a false impression of the safety and efficacy of opioids for long term use. Allegations are that Pharma and the doctors misled the medical community and consumers into believing that opioids were non-addictive and were a viable option for treatment of chronic pain. Legal claims have included:

- Misrepresentation
- Consumer Fraud/Violation of Consumer Protection Statutes
- False Advertising
- Nuisance
- Civil RICO

Different cases have taken different approaches, but the facts and allegations are similar.

4 https://www.washingtonpost.com/national/the-drug-industrys-answer-to-opioid-addiction-more-pills/2016/10/15/181a529c-8ae4-11e6-bff0-d53f592f176e_story.html?utm_term=.2d1327bf59ae

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WHAT ARE THE DOLLAR FIGURES?

While it is still early in the investigation into the exact costs to counties, states and municipalities, costs of the Opioid Epidemic are staggering. Indeed, in 2016 researchers from the CDC estimated the annual economic burden of prescription opioid abuse in the U.S. at $78.4 Billion. The study further broke down this cost as follows:

LOST PRODUCTIVITY
$42 Billion (53.3%)

HEALTH INSURANCE
$26.1 Billion (33.3%)

CRIMINAL JUSTICE
$7.6 Billion (9.7%)

SUBSTANCE ABUSE TREATMENT
$2.8 Billion (3.6%)

[5]

While the CDC study did not attempt to estimate damages to county governments, the economic impact is significant and, to date, unreimbursed by Pharma.

5 Florence CS, Zhou C, Luo F, Xu L. The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013. *Medical Care*, October 2016, 54(10): 901 – 906.

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FREQUENTLY ASKED QUESTIONS

WHAT IS THE OPIOID LITIGATION AND WHY DOES IT AFFECT COUNTIES?

State and local governments around the country have begun to file lawsuits against several major manufacturers (Purdue, Janssen, Endo, Cephalon and others)(referred to as "Pharma") for their role in creating the Opioid Epidemic. These manufacturers flooded the market with highly addictive drugs, claiming they were safe and efficacious for long term use, manufactured studies to support these false claims and knowingly misrepresented the addictive nature of these drugs. As a result of these misrepresentations, millions of Americans lives have been impacted or destroyed (commonly referred to as the "Opioid Epidemic"). The Opioid Epidemic has in turn imposed huge costs on both county and state governments around the country including health care costs, substance abuse, treatment and prevention costs, criminal justice costs and productivity costs.

WHAT IS THE ECONOMIC IMPACT OF THE OPIOID EPIDEMIC?

While it is still early in the investigation, studies have analyzed the economic impact of the Opioid Epidemic. In the most recent major study, published in 2016 by CDC researchers, the annual estimated economic burden of prescription opioid abuse in the United States was determined to be $78.4 Billion. Of that number the economic impact broke down as follows:

LOST PRODUCTIVITY
$42 Billion (53.3%)

HEALTH INSURANCE
$26.1 Billion (33.3%)

CRIMINAL JUSTICE
$7.6 Billion (9.7%)

SUBSTANCE ABUSE TREATMENT
$2.8 Billion (3.6%)

Predictably, as the epidemic has worsened, so has the economic burden. Indeed, a similar study in 2007 found the annual economic impact was $55.7 Billion. And a recent 2017 study funded by the U.S. Department of Health and Human Services found that more than one third of U.S. civilian, noninstitutionalized adults reported prescription opioid use, with substantial numbers reporting misuse and use disorders. As the problem has worsened since 2013, it is expected that the impact has correspondingly worsened.

6 Florence CS, Zhou C, Luo F, Xu L. The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013. *Medical Care*, October 2016, 54(10): 901 – 906.

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WHAT IS THE GOAL OF THE OPIOID LITIGATION?

To hold Pharma responsible for their role in creating the Opioid Epidemic and to return to the counties the money spent battling the epidemic and the expense of other critical programming. While it is unrealistic to think that the lawsuit will solve the problem, Pharma should be responsible for funding solutions to a problem they created.

WHAT KINDS OF COSTS WOULD A LAWSUIT SEEK TO RECOVER?

The counties would seek repayment for the costs they have expended related to the Opioid Epidemic. Those costs include but are not limited to:

- County funded healthcare costs for employees and dependents related to opioid addiction, substance abuse treatment, hospitalizations, etc.
- County funded programs for residents for prevention, treatment, health visits, substance abuse programs etc.
- Criminal Justice and law enforcement costs associated with opioids
- Loss of county employee productivity related to opioid abuse and addiction
- General societal mayhem and opioid related death costs

WHAT IS THE REASON THE COUNTIES SHOULD GET INVOLVED IN THE OPIOID LITIGATION?

The only way to recover any of the significant costs the counties have faced as a result of Pharma's role in the Opioid Epidemic is to bring suit. Any county that does not get involved risks receiving no recovery. While recovery in this type of litigation is not certain, one certain way to get nothing is to stay out of the litigation.

WHAT IF THE COUNTIES DO NOT GET INVOLVED?

Counties who do not get involved will not get a recovery in the event that there is one.

WHO WILL PAY FOR THE LITIGATION?

The counties will not be asked to bear the costs of the Opioid Litigation. The law firms proposing to represent the counties will work on a contingent fee basis (only getting paid out of a portion of the recovery if there is one) and bearing all costs of the litigation.

WHAT WILL BE EXPECTED OF A COUNTY BRINGING SUIT?

Counties bringing suit will be expected to participate in some significant ways, the most major of which is document collecting and information gathering to support the county's claim for costs associated with the Opioid Epidemic. The team of private attorneys will work on site with county employees to help identify, gather and assemble this information; however, county employee time will also be necessary. Affected departments will likely be Health and Human Services, Human Resources, Medical Examiner/Coroner, District Attorney's Office, Office of the Sheriff, Circuit Courts, Department of Administration.

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WHAT IS THE REASON TO COORDINATE EFFORTS ACROSS COUNTIES IN THE LITIGATION?

It will be very important to coordinate efforts both among counties in each state and between counties nationally. Government entities will face a well-financed, well-funded and coordinated defense from Pharma. Unless a critical mass of counties not only file suit and coordinate efforts, it is a safe bet that Pharma will simply continue to fight each individual case without contemplating a resolution.

WILL THE STATE BE INVOLVED AND HOW WILL THAT IMPACT THE COUNTIES AND THEIR ABILITY TO RECOVER?

The State of Ohio has brought suit and other states are contemplating suit. It is safe to assume that state governments will bring similar suits. The states and counties will have separate damages, however, and the counties should be able to recover even if the states bring suit. As the tobacco litigation demonstrated, there is no reason to expect that the counties can simply let the states file suit and wait for their portion of the states' recovery. The best way for the counties to protect their interests is to pursue their own litigation.

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CATEGORIES OF INFORMATION SUPPORTING COUNTY COSTS

COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES/SOCIAL SERVICES/COMMUNITY PROGRAMS	Information regarding child welfare costs; out of home placements; community education; outreach and prevention; opioid abuse treatment; education of medical professionals; and costs associated with such programs. Information regarding county funded (for residents/indigents) opioid-related office visits, toxicology screenings, inpatient therapy, medical claims, medical diagnosis, pharmacy claims, emergency department visits, emergency department claims, opioid treatment programs; days missed from work for opiate treatment or offenses, prescription drug plans, mental health screenings, mental health hospital visits, mental health diagnosis and Medicaid claims. Information regarding opiate treatment programs, funding for opiate treatment programs, inpatient and outpatient treatment data, cost of drugs for opiate treatment programs, insurance information for treatment and relapse information. Information from delinquency and court services regarding opioid-related interventions and programs designed to curb or prevent opioid use.
DEPARTMENT OF HUMAN RESOURCES	Information regarding county funded employee opioid-related office visits, toxicology screenings, inpatient therapy, medical claims, medical diagnosis, pharmacy claims, emergency department visits, emergency department claims, opioid treatment programs; days missed from work for opiate treatment or offenses, prescription drug plans, mental health screenings, mental health hospital visits, mental health diagnosis Information regarding county employees' opioid-related disability claims, funding used for substance abuse, workers compensation claims, and mental health treatment.
MEDICAL EXAMINER/ CORONER	Information regarding the number of opioid overdose deaths, costs associated with those deaths.
JUSTICE SYSTEM IMPACTS	Information regarding the prosecution of opioid-related crimes committed within the county and the impacts on the justice system.

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OFFICE OF THE SHERIFF/ COUNTY JAIL	Information regarding opioid-related arrests and charges, illegal trafficking data, prescription-related DWI's, incarceration records, probation records, drug court data, sheriff/deputy overtime data regarding opioid-related offenses, data from Narcan program, sheriff/data resources data dedicated to heroin epidemic including prevention, emergency dispatch data, repeat offender data, involuntary treatment programs, emergency dispatch data. Information regarding costs associated with housing inmates with addiction arrests, requiring addiction treatment programs.
DEPARTMENT OF ADMINISTRATION	Information regarding costs associated with expenditures incurred, or resources allocated, to combat opioid addiction or abuse.
COUNTY-OWNED HOSPITALS/NURSING HOMES	Information regarding costs of opioid treatment at county-owned hospitals and nursing homes.

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RESOLUTION NO. _____

TO THE HONORABLE BOARD OF SUPERVISORS OF _____ COUNTY, WISCONSIN

MEMBERS,

WHEREAS, _____ County ("County") is concerned with the recent rapid rise in troubles among County citizens, residents, and visitors in relation to problems arising out of the use, abuse and overuse of opioid medications, which according to certain studies, impacts millions of people across the country; and

WHEREAS, issues and concerns surrounding opioid use, abuse and overuse by citizens, residents and visitors are not unique to County and are, in fact, issues and concerns shared by all other counties in Wisconsin and, for that matter, states and counties across the country, as has been well documented through various reports and publications, and is commonly referred to as the Opioid Epidemic ("Opioid Epidemic:); and

WHEREAS, the societal costs associated with the Opioid Epidemic are staggering and, according to the Centers for Disease Control and Prevention, amount to over $75 billion annually; and

WHEREAS, the National Institute for Health has identified the manufacturers of certain of the opioid medications as being directly responsible for the rapid rise of the Opioid Epidemic by virtue of their aggressive and, according to some, unlawful and unethical marketing practices; and

WHEREAS, certain of the opioid manufacturers have faced civil and criminal liability for their actions that relate directly to the rise of the Opioid Epidemic; and

WHEREAS, County has spent millions in unexpected and unbudgeted time and resources in its programs and services related to the Opioid Epidemic; and

WHEREAS, County is responsible for a multitude of programs and services, all of which require County to expend resources generated through state and federal aid, property tax levy, fees and other permissible revenue sources; and

WHEREAS, County's provision of programs and services becomes more and more difficult every year because the costs associated with providing the Opioid Epidemic programs and services continue to rise, yet County's ability to generate revenue is limited by strict levy limit caps and stagnant or declining state and federal aid to County; and

WHEREAS, all sums that County expends in addressing, combatting and otherwise dealing with the Opioid Epidemic are sums that cannot be used for other critical programs and services that County provides to County citizens, residents and visitors; and

WHEREAS, County has been informed that numerous counties and states across the country have filed or intend to file lawsuits against certain of the opioid manufacturers in an effort to force the persons and entities responsible for the Opioid Epidemic to assume financial responsibility for the costs associated with addressing, combatting and otherwise dealing with the Opioid Epidemic; and

WHEREAS, County has engaged in discussions with representatives of the law firms of von Briesen & Roper, s.c., Crueger Dickinson LLC and Simmons Hanly Conroy LLC (the "Law Firms") related to the potential for County to pursue certain legal claims against certain opioid manufacturers; and

WHEREAS, County has been informed that the Law Firms have the requisite skill, experience and wherewithal to prosecute legal claims against certain of the opioid manufacturers on behalf of public entities seeking to hold them responsible for the Opioid Epidemic; and

WHEREAS, the Law Firms have proposed that County engage the Law Firms to prosecute the aforementioned claims on a contingent fee basis whereby the Law Firms would not be compensated unless County receives a financial benefit as a result of the proposed claims and the Law Firms would advance all claim-related costs and expenses associated with the claims; and

WHEREAS, all of the costs and expenses associated with the claims against certain of the opioid manufacturers would be borne by the Law Firms; and

WHEREAS, the Law Firms have prepared an engagement letter, which is submitted as part of this Resolution ("Engagement Letter") specifying the terms and conditions under which the Law Firms would provide legal services to County and otherwise consistent with the terms of this Resolution; and

WHEREAS, County is informed that the Wisconsin Counties Association has engaged in extensive discussions with the Law Firms and has expressed a desire to assist the Law Firms, County and other counties in the prosecution of claims against certain of the opioid manufacturers; and

WHEREAS, County would participate in the prosecution of the claim(s) contemplated in this Resolution and the Engagement Letter by providing information and materials to the Law Firms and, as appropriate, the Wisconsin Counties Association as needed; and

WHEREAS, County believes it to be in the best interest of County, its citizens, residents, visitors and taxpayers to join with other counties in and outside Wisconsin in pursuit of claims against certain of the opioid manufacturers, all upon the terms and conditions set forth in the Engagement Letter; and

WHEREAS, by pursuing the claims against certain of the opioid manufacturers, County is attempting to hold those persons and entities that had a significant role in the creation of the Opioid Epidemic responsible for the financial costs assumed by County and other public agencies across the country in dealing with the Opioid Epidemic.

NOW, THEREFORE, BE IT RESOLVED:

County authorizes, and agrees to be bound by, the Engagement Letter and hereby directs the appropriate officer of the County to execute the Engagement Letter on behalf of the County; and

BE IT FURTHER RESOLVED:

County shall endeavor to faithfully perform all actions required of County in relation to the claims contemplated herein and in the Engagement Letter and hereby directs all County personnel to cooperate with and assist the Law Firms in relation thereto.

Respectfully submitted this _____ day of _____, 2016.

[COMMITTEE]

**[FISCAL NOTE]

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TAB 2

U.S.

Opioid-Addiction Diagnoses Up Nearly 500% in Past Seven Years, Study Shows

Analysis of insurance claims illustrates the growing epidemic in the U.S.

Opioid-use disorder is the clinical term for addiction to opioids, which include prescription painkillers and illicit narcotics such as heroin. PHOTO: MICHAEL BRYANT/THE PHILADELPHIA INQUIRER/ASSOCIATED PRESS

By Anne Steele

June 29, 2017 8:00 a.m. ET

An analysis of millions of Americans' medical claims showed diagnoses of opioid-use disorder surged nearly 500% over the past seven years, according to a review by the Blue Cross Blue Shield Association.

The analysis, which examined the claims of over 30 million people with commercial insurance provided by Blue Cross Blue Shield insurers between 2010 and 2016, underscores the rising tide of addiction in the U.S. Opioid-use disorder is the clinical term for addiction to opioids, which include prescription painkillers and illicit narcotics such as heroin.

Twenty-one percent of the people reviewed in the analysis filled at least one opioid prescription in 2015, according to BCBSA, with higher doses and longer-duration prescriptions associated with higher addiction rates.

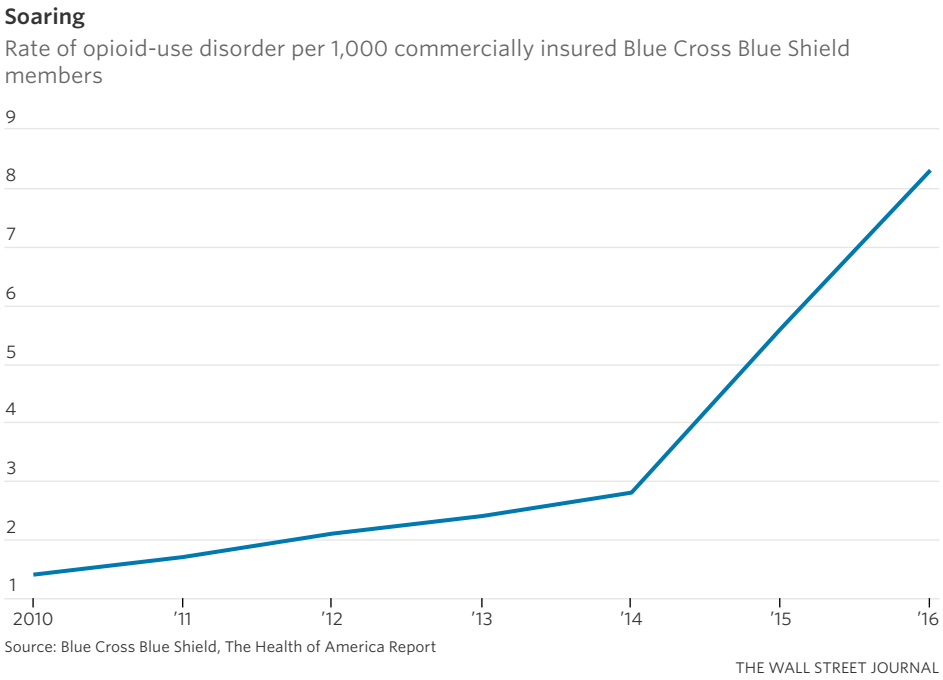
RELATED

- The Victims of the Opioid Crisis
- When the Mailman Unwittingly Becomes a Drug Dealer
- Fatal Student Opioid Overdoses Prompt Colleges to Action
- States Launch Bipartisan Probe of Opioid Marketing and Addiction
- Opioid Use Soars Among Middle Aged and Elderly

Opioid-use disorder was 40 times more likely in patients prescribed high doses for a short duration, compared with low doses for a short duration. And the disorder was seven times more likely when patients were prescribed a high dose for a long duration than a low dose for a long duration.

"You have to be concerned not just how long the script goes but how high a dose you're prescribing," says David Pizza, BCBSA's managing director of strategy and data analytics. "The way in which they're provided is key to addressing the dependency issue."

John Kelly, an associate professor of psychiatry in addiction medicine at Harvard Medical School, who wasn't involved in the study, said the results show "we are now at



the public health equivalent of 'DEFCON 5' with this opioid crisis."

"High-dose, long-duration prescribing practices, which can drive up rates of opioid-use disorder, are still too common. This needs much closer attention and monitoring to curb the onset of new cases of opioid-use disorder," he said.

The analysis also showed that use of medications to treat opioid addiction, such as buprenorphine or methadone, grew by 65% over the period of the study—a rate dwarfed by the 493% increase in opioid-use disorder diagnoses.

Kim Holland, vice president for state affairs at BCBSA, said the necessary infrastructure to support people getting the treatment they need to address substance abuse effectively is lacking.

The analysis found more people with opioid-use disorder are treated with medication in New England than in the South and parts of the Midwest.

"It tells us there's work to do," says Ms. Holland. "Not everyone is getting the treatment they need."

She said opioids are an important part of a physician's ammunition to help alleviate pain.

"But to recognize potential dangers it's important to understand the extent to which they are prescribed," she said.

Ninety-one Americans die each day from an opioid overdose, according to the Centers for Disease Control and Prevention.

The amount of prescription opioids sold in the U.S. has nearly quadrupled since 1999 even though there has been no change in the amount of pain reported by Americans, the CDC says. Meanwhile, deaths from prescription opioids have more than quadrupled over the same period.

Write to Anne Steele at Anne.Steele@wsj.com

https://www.wsj.com/articles/oklahoma-sues-opioid-painkiller-makers-1498848561

U.S.

Oklahoma Sues Opioid Painkiller Makers

State alleges Purdue Pharma, Teva, Johnson & Johnson and Allergan misrepresented addictive risks of drugs

Oklahoma is suing Purdue, which sells the painkiller OxyContin, among other pharmaceutical companies . PHOTO: GEORGE FREY/REUTERS

By Jeanne Whalen

Updated June 30, 2017 4:35 p.m. ET

Oklahoma became the latest state to file a lawsuit against opioid painkiller makers, alleging they caused widespread addiction by misrepresenting the benefits and addictive risks of their drugs.

The lawsuit filed in state court by Oklahoma's Republican Attorney General, Mike Hunter, targets the parent companies and subsidiaries of Purdue Pharma L.P., Johnson & Johnson , Teva Pharmaceutical Industries Ltd. and Allergan PLC.

"Over a period of several years, defendants executed massive and unprecedented marketing campaigns through which they misrepresented the risks of addiction from their opioids and touted unsubstantiated benefits," the lawsuit alleges. "The damage defendants' false and deceptive marketing campaigns caused to the state of Oklahoma is catastrophic." The state is seeking damages and penalties to compensate it for costs related to addiction.

RELATED

- Ohio Sues Five Drugmakers, Saying They Fueled Opioid Crisis (May 31)
- Overdose Fatalities From Opioids Hit New Peaks (Jan. 6, 2017)
- Opioid-Addiction Diagnoses Up Nearly 500% in Past Seven Years, Study Shows (June 29)
- The Children of the Opioid Crisis (Dec. 15, 2016)

Purdue, which sells the painkiller OxyContin, said: "While we vigorously deny the allegations in the complaint, we share the attorney general's concerns about the opioid crisis and we are committed to working collaboratively to find solutions."

Johnson & Johnson, whose subsidiary Janssen sells the opioid drug Duragesic, said: "We recognize opioid abuse is a serious public health issue that must be addressed. At the

same time, we firmly believe Janssen has acted responsibly and in the best interests of patients and physicians."

Allergan, which sells the painkillers Kadian and Norco, said "it has a history of supporting—and continues to support—the safe, responsible use of prescription medications," including opioids and said the drugs "play an appropriate role in pain relief for millions of Americans" when used correctly.

Teva, which sells the opioid drugs Actiq and Fentora, said it is "committed to the appropriate promotion and use of opioids."

Oklahoma's lawsuit follows similar suits filed by Mississippi, Ohio and Missouri.

The state lawsuits come amid mounting public concern over opioid addiction, which has helped drive U.S. overdose rates to all-time highs.

Many people became addicted by taking powerful opioid painkillers and often progressed to heroin if they couldn't get access to pills. Public-health officials have long blamed aggressive company marketing and lax prescribing for sparking the crisis.

Write to Jeanne Whalen at jeanne.whalen@wsj.com

The New York Times | https://nyti.ms/2rqd6fm

U.S.

Ohio Sues Drug Makers, Saying They Aided Opioid Epidemic

By RICHARD PÉREZ-PEÑA MAY 31, 2017

The State of Ohio filed a lawsuit on Wednesday against the pharmaceutical industry over the opioid epidemic, accusing several drug companies of conducting marketing campaigns that misled doctors and patients about the danger of addiction and overdose.

Ohio's attorney general, Mike DeWine, sued the drug makers in a case similar to one that was filed by Mississippi in 2015 and is still pending. In another case, West Virginia went after major drug distributors and has reached settlements that will pay the state tens of millions of dollars. The City of Chicago, and counties in New York, California and West Virginia, have all started litigation.

Complaints like these are being closely watched by state and local governments around the country that are trying to decide how to proceed — decisions that are complicated by differences in state laws.

"We are in ongoing discussions with attorneys general about what can only be described as a national epidemic," said Michael P. Canty, a lawyer in New York whose firm, Labaton Sucharow, is advising states on possible opioid litigation.

In 2015, more than 25,000 people in the United States died in 2015 from overdosing on opioids like fentanyl, oxycodone and hydrocodone, more than twice as

those narcotics, now kill more Americans than homicide, and are approaching traffic accidents as a cause of death.

Middle-aged white men suffer disproportionately from opioid abuse, and the states with the highest overdose tolls are Ohio, Kentucky, New Hampshire and West Virginia.

The drugs were once used primarily for acute, or short-term pain, but over the last two decades, doctors have increasingly prescribed them to treat chronic pain, giving them to patients for months or years at a stretch. Drug makers promoted that change, Mr. DeWine charged in his suit, spending "millions of dollars on promotional activities and materials that falsely deny or trivialize the risks of opioids while overstating the benefits of using them for chronic pain."

In addition, he said, the companies provided funding to prominent doctors, medical societies and patient advocacy groups to win their support for the drugs' use. By 2012, the suit says, opioid prescriptions in Ohio equaled 68 pills a year for every resident of the state, including children.

Defendants in the case include Purdue Pharma, Teva Pharmaceutical Industries, Johnson & Johnson, Endo Pharmaceuticals, Allergan and others.

Purdue, the maker of OxyContin, a time-release opioid, released a statement saying, "We share the attorney general's concerns about the opioid crisis and we are committed to working collaboratively to find solutions," and calling the company "an industry leader in the development of abuse-deterrent technology."

Pharmaceutical Research and Manufacturers of America, the leading industry group, said it would not comment on litigation involving specific companies.

Ohio's lawsuit seeks to recover money the state has spent on the drugs themselves, through programs like Medicaid, and on addiction treatment. States took a similar approach in suing the tobacco industry in the 1990s, which eventually led to settlements worth more than $200 billion.

A version of this article appears in print on June 1, 2017, on Page A17 of the New York edition with the headline: Ohio Sues Drug Makers Over Opioid Crisis.

TAB 3

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK

THE COUNTY OF SUFFOLK,

Plaintiff,

v.

PURDUE PHARMA L.P.; PURDUE PHARMA INC.; THE PURDUE FREDERICK COMPANY, INC.; TEVA PHARMACEUTICALS USA, INC.; CEPHALON, INC.; JOHNSON & JOHNSON; JANSSEN PHARMACEUTICALS, INC.; ORTHO-MCNEIL-JANSSEN PHARMACEUTICALS, INC. N/K/A JANSSEN PHARMACEUTICALS, INC.; JANSSEN PHARMACEUTICA, INC. N/K/A JANSSEN PHARMACEUTICALS, INC.; ENDO HEALTH SOLUTIONS INC.; ENDO PHARMACEUTICALS, INC.; RUSSELL PORTENOY; PERRY FINE; SCOTT FISHMAN; and LYNN WEBSTER,

Defendants.

Index No.

COMPLAINT

Plaintiff, the County of Suffolk, New York ("Plaintiff"), by and through the undersigned attorneys, for its Complaint against Defendants Purdue Pharma L.P., Purdue Pharma Inc., The Purdue Frederick Company, Inc., Teva Pharmaceuticals USA, Inc., Cephalon, Inc., Johnson & Johnson, Janssen Pharmaceuticals, Inc., Ortho-McNeil-Janssen Pharmaceuticals, Inc. n/k/a Janssen Pharmaceuticals Inc., Janssen Pharmaceutica, Inc. n/k/a Janssen Pharmaceuticals, Endo Health Solutions Inc., Endo Pharmaceuticals, Inc., Russell Portenoy, Perry Fine, Scott Fishman, and Lynn Webster (collectively, "Defendants") alleges as follows:

INTRODUCTION

1. Plaintiff spends millions of dollars each year to provide or pay for the health care, pharmaceutical care, and other necessary services and programs on behalf of indigents and otherwise eligible residents, including payments for prescription opium-like painkillers ("opioids"), which are manufactured, marketed, promoted, sold, and/or distributed by the Defendants.

2. Plaintiff also provides a wide range of other services on behalf of its residents, including services for families and children, public assistance, and law enforcement.

3. Plaintiff is one of the largest employers on Long Island, employing approximately 10,000 people in 22 departments. Plaintiff funds its own health insurance plan for the benefit of its employees, through which it pays part or all of its employees' health care costs, including the cost of prescription drugs, including opioids.

4. Opioids include brand-name drugs like OxyContin and Percocet and generics like oxycodone and hydrocodone. They are derived from or possess properties similar to opium and heroin, and, as such, they are highly addictive and dangerous and therefore are regulated by the United States Food and Drug Administration ("FDA") as controlled substances.

5. Opioids provide effective treatment for short-term post-surgical and trauma-related pain, and for palliative end-of-life care. They are approved by the FDA for use in the management of moderate to severe pain where use of an opioid analgesic is appropriate for more than a few days. Defendants, however, have manufactured,

promoted, and marketed opioids for the management of pain by misleading consumers and medical providers through misrepresentations or omissions regarding the appropriate uses, risks, and safety of opioids.

6. Addiction is a spectrum of substance use disorders that range from misuse and abuse of drugs to addiction.[1] Throughout this Complaint, "addiction" refers to the entire range of substance abuse disorders. Individuals suffer negative consequences wherever they fall on the substance use disorder continuum.

7. Defendants knew that, barring exceptional circumstances, opioids are too addictive and too debilitating for long-term use for chronic non-cancer pain lasting three months or longer ("chronic pain").

8. Defendants knew that, with prolonged use, the effectiveness of opioids wanes, requiring increases in doses to achieve pain relief and markedly increasing the risk of significant side effects and addiction.[2]

9. Defendants knew that controlled studies of the safety and efficacy of opioids were limited to short-term use (*i.e.*, not longer than 90 days) in managed settings (*e.g.*, hospitals) where the risk of addiction and other adverse outcomes was significantly minimized.

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[1] Diagnostic and Statistical Manual of Mental Disorders (5th ed. 2013) ("DSM-V").

[2] *See, e.g.*, Russell K. Portenoy, *Opioid Therapy for Chronic Nonmalignant Pain: Current Status*, 1 Progress in Pain Res. & Mgmt., 247-287 (H.L. Fields and J.C. Liebeskind eds., 1994).

10. To date, there have been no long-term studies demonstrating the safety and efficacy of opioids for long-term use.

11. Despite the foregoing knowledge, in order to expand the market for opioids and realize blockbuster profits, Defendants sought to create a false perception of the safety and efficacy of opioids in the minds of medical professionals and members of the public that would encourage the use of opioids for longer periods of time and to treat a wider range of problems, including such common aches and pains as lower back pain, arthritis, and headaches.

12. Defendants accomplished that false perception through a coordinated, sophisticated, and highly deceptive marketing campaign that began in the late 1990s, became more aggressive in or about 2006, and continues to the present.

13. Defendants accomplished their marketing campaign goal by convincing doctors, patients, and others that the benefits of using opioids to treat chronic pain outweighed the risks, and that opioids could be safely used by most patients.

14. Defendants, individually and collectively, knowing that long-term opioid use causes addiction, misrepresented the dangers of long-term opioid use to physicians, pharmacists, and patients by engaging in a campaign to minimize the risks of, and to encourage, long-term opioid use.

15. Defendants' marketing campaign has been extremely successful in expanding opioid use. Since 1999, the amount of prescription opioids sold in the U.S.

nearly quadrupled.[3] In 2010, 254 million prescriptions for opioids were filled in the U.S. – enough to medicate every adult in America around the clock for a month. In that year, 20% of all doctors' visits resulted in the prescription of an opioid (nearly double the rate in 2000).[4] While Americans represent only 4.6% of the world's population, they consume 80% of the opioids supplied around the world and 99% of the global hydrocodone supply.[5] By 2014, nearly two million Americans either abused or were dependent on opioids.[6]

16. Defendants' campaign has been extremely profitable for them. In 2012 alone, opioids generated $8 billion in revenue for drug companies.[7] Of that amount, $3.1 billion went to Purdue for its OxyContin sales.[8]

17. Defendants' marketing campaign has been extremely harmful to Americans. Overdoses from prescription pain relievers are a driving factor in a 15-year increase in opioid overdose deaths. Deaths from prescription opioids have also

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[3] CDC, Injury Prevention & Control: Opioid Overdose, Understanding the Epidemic. Available at: http://www.cdc.gov/drugoverdose/epidemic/index.html (accessed March 31, 2016) (internal footnotes omitted).

[4] M. Daubresse, et al., Ambulatory Diagnosis and Treatment of Nonmalignant Pain in the United States, 2000-2010, 51(10) Med. Care 870-78 (2013).

[5] L. Manchikanti, et al., Therapeutic Use, Abuse, and Nonmedical Use of Opioids: A Ten-Year Perspective, 13 Pain Physician 401-435 (2010).

[6] CDC, Injury Prevention & Control: Opioid Overdose, Prescription Opioids. Available at: http://www.cdc.gov/drugoverdose/opioids/prescribed.html (accessed March 31, 2016).

[7] B. Meier & B. Marsh, *The Soaring Cost of the Opioid Economy*, N.Y. Times (June 22, 2013).

[8] K. Eban, *Purdue Pharma's Painful Medicine*, Fortune Magazine (Nov. 9, 2011).

quadrupled since 1999. From 2000 to 2014 nearly half a million people died from such overdoses. Seventy-eight Americans die every day from an opioid overdose.[9]

18. In 2012, an estimated 2.1 million people in the United States suffered from substance use disorders related to prescription opioid pain relievers.[10] Between 30% and 40% of long-term users of opioids experience problems with opioid use disorders.[11]

19. Opioid addiction and overdose have reached epidemic levels over the past decade. On March 22, 2016, the FDA recognized opioid abuse as a "public health crisis" that has a "profound impact on individuals, families and communities across our country."[12]

[9] CDC, Injury Prevention & Control: Opioid Overdose, Understanding the Epidemic, *supra*.

[10] Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

[11] J. Boscarino et al., Risk factors for drug dependence among out-patients on opioid therapy in a large US health-care system, 105(10) Addiction 1776 (2010); J. Boscarino et al., Prevalence of Prescription Opioid-Use Disorder Among Chronic Pain Patients: Comparison of the DSM-5 vs. DSM-4 Diagnostic Criteria, 30(3) Journal of Addictive Diseases 185 (2011).

[12] FDA announces enhanced warnings for immediate-release opioid pain medications related to risks of misuse, abuse, addiction, overdose and death. Available at http://www.fda.gov/newsevents/newsroom/pressannouncements/ucm491739.htm (accessed March 31, 2016).

20. Defendants' marketing campaign has failed to achieve any material health care benefits. Since 1999, there has been no overall change in the amount of pain that Americans report.[13]

21. The National Institutes of Health ("NIH") not only recognizes the opioid abuse problem, but also identifies Defendants' "aggressive marketing" as a major cause: "Several factors are likely to have contributed to the severity of the current prescription drug abuse problem. They include drastic increases in the number of prescriptions written and dispensed, greater social acceptability for using medications for different purposes, and *aggressive marketing by pharmaceutical companies*."[14] As shown below, the "drastic increases in the number of prescriptions written and dispensed" and the "greater social acceptability for using medications for different purposes " are not really independent causative factors but are in fact the direct result of "the aggressive marketing by pharmaceutical companies."

22. The rising numbers of persons addicted to opioids have led to significantly increased health care costs as well as a dramatic increase of social problems, including drug abuse and diversion[15] and the commission of criminal acts to obtain opioids

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[13] CDC, Injury Prevention & Control: Opioid Overdose, Understanding the Epidemic, *supra*.

[14] America's Addiction to Opioids: Heroin and Prescription Drug Abuse. Available at http://www.drugabuse.gov/about-nida/legislative-activities/testimony-to-congress/2015/americas-addiction-to-opioids-heroin-prescription-drug-abuse#_ftn2 (accessed March 31, 2016) (emphasis added).

[15] According to the CDC, when prescription medicines are obtained or used illegally, it is called "drug diversion."

throughout the United States, including New York State and Suffolk County. Consequently, public health and safety throughout the United States, including Suffolk County, has been significantly and negatively impacted due to the misrepresentations and omissions by Defendants regarding the appropriate uses and risks of opioids, ultimately leading to widespread inappropriate use of the drug.

23. Between 1996 and 2006, the New York State consumption of hydrocodone increased from approximately 2,000 milligrams (mgs) per person to 12,000 mgs per person. Oxycodone consumption increased from approximately 1,000 mgs per person to 16,000 mgs per person. At the same time, health care admissions for opioid analgesic abuse have risen both nationally and in New York State at rates of greater than 300%.

24. In Suffolk County in 2012, there were 8,271 emergency room visits due to opiate use. Substance abuse programs in Suffolk County served 18,724 people for opioid abuse. Deaths from prescription opioids have also quadrupled since 1999. From 2000 to 2014 nearly half a million people died from such overdoses. In 2012 there were 214 overdose deaths related to opioids.

25. The commission of criminal acts to obtain opioids is an inevitable consequence of opioid addiction. For example, on June 19, 2011, David Laffer and his wife, prescription opioid abusers desperately seeking opioids, robbed the Haven Pharmacy in Medford, New York. During the robbery, Laffer brutally executed four unarmed, unsuspecting customers and employees.[16]

[16] *Id*.

26. As a direct and foreseeable consequence of Defendants' wrongful conduct, Plaintiff has been required to spend millions of dollars each year in its efforts to combat the public nuisance created by Defendants' deceptive marketing campaign. Plaintiff has incurred and continues to incur costs related to opioid addiction and abuse, including, but not limited to, health care costs, criminal justice and victimization costs, social costs, and lost productivity costs. Defendants' misrepresentations regarding the safety and efficacy of long-term opioid use proximately caused injury to Plaintiff and its residents.

JURISDICTION AND VENUE

27. This Court has jurisdiction over this action pursuant to New York Constitution, article VI, § 7(a) and CPLR 301 and 302.

28. Venue is proper in Suffolk County pursuant to CPLR 503(a).

29. This action is non-removable because there is incomplete diversity of residents and no substantial federal question is presented.

PARTIES

30. Suffolk County comprises ten towns in eastern Long Island, New York. Plaintiff provides a wide range of services on behalf of its residents, including services for families and children, public health, public assistance, law enforcement, and emergency care. As mentioned above, Plaintiff also funds its own health insurance plan for its approximately 10,000 employees.

31. Plaintiff brings this action on its own behalf and also as subrogee of its employees and residents and, as such, Plaintiff stands in the shoes of its subrogors, and is entitled to all the rights of its subrogors. In making the payments it has made on behalf

of its employees and residents, Plaintiff did not act as a volunteer but rather acted under compulsion, for the protection of its interests, or as *parens patriae.*

32. Defendant Purdue Pharma L.P. ("PPL") is a limited partnership organized under the laws of Delaware with its principal place of business in Stamford, Connecticut.

33. Defendant Purdue Pharma Inc. ("PPI") is a New York corporation with its principal place of business in Stamford, Connecticut.

34. Defendant The Purdue Frederick Company, Inc. ("PFC") is a New York corporation with its principal place of business in Stamford, Connecticut.

35. PPL, PPI, and PFC (collectively, "Purdue") are engaged in the manufacture, promotion, distribution, and sale of opioids nationally and in Suffolk County, including the following:

Table 1. Purdue Opioids

Drug Name	**Chemical Name**	**Schedule**[17]
OxyContin	Oxycodone hydrochloride extended release	Schedule II
MS Contin	Morphine sulfate extended release	Schedule II
Dilaudid	Hydromorphone hydrochloride	Schedule II
Dilaudid-HP	Hydromorphone hydrochloride	Schedule II
Butrans	Byprenorpine	Schedule III
Hysingla ER	Hydrocodone bitrate	Schedule II

[17] Since passage of the Controlled Substances Act ("CSA") in 1970, opioids have been regulated as controlled substances. As controlled substances, they are categorized in five schedules, ranked in order of their potential for abuse, with Schedule I being the most dangerous. The CSA imposes a hierarchy of restrictions on prescribing and dispensing drugs based on their medicinal value, likelihood of addiction or abuse, and safety. Opioids generally had been categorized as Schedule II or Schedule III drugs. Schedule II drugs have a high potential for abuse, have a currently accepted medical use, and may lead to severe psychological or physical dependence. Schedule III drugs are deemed to have a lower potential for abuse, but their abuse still may lead to moderate or low physical dependence or high psychological dependence.

Targiniq ER	Oxycodone hydrochloride and naloxone hydrochloride	Schedule II

36. OxyContin is Purdue's largest-selling opioid. Since 2009, Purdue's national annual sales of OxyContin have fluctuated between $2.47 billion and $2.99 billion, up four-fold from 2006 sales of $800 million. OxyContin constitutes roughly 30% of the entire market for analgesic drugs (*i.e.*, painkillers).

37. Defendant Teva Pharmaceuticals USA, Inc. ("Teva USA") is a Delaware corporation with its principal place of business in North Whales, Pennsylvania. Teva USA is a wholly owned subsidiary of Teva Pharmaceutical Industries, Ltd. ("Teva Ltd."), an Israeli corporation.

38. Defendant Cephalon, Inc. is a Delaware corporation with its principal place of business in Frazer, Pennsylvania. In 2011, Teva Ltd. acquired Cephalon, Inc.

39. Teva USA and Cephalon, Inc. (collectively, "Cephalon") work together to manufacture, promote, distribute and sell both brand name and generic versions of the opioids nationally and in Suffolk County, including the following:

Table 2. Cephalon Opioids

Drug Name	**Chemical Name**	**Schedule**
Actiq	Fentanyl citrate	Schedule II
Fentora	Fentanyl citrate	Schedule II

40. Teva USA was in the business of selling generic opioids, including a generic form of OxyContin from 2005 to 2009 nationally and in Suffolk County.

41. Defendant Johnson & Johnson ("J&J") is a New Jersey corporation with its principal place of business in New Brunswick, New Jersey.

42. Defendant Janssen Pharmaceuticals, Inc. ("Janssen Pharmaceuticals") is a Pennsylvania corporation with is principal place of business in Titusville, New Jersey, and is a wholly owned subsidiary of J&J.

43. Janssen Pharmaceuticals, Inc. was formerly known as Ortho-McNeil-Janssen Pharmaceuticals, Inc., which in turn was formerly known as Janssen Pharmaceutica, Inc.

44. Defendant Ortho-McNeil-Janssen Pharmaceuticals, Inc. ("OMP"), now known as Janssen Pharmaceuticals, Inc., is a Pennsylvania corporation with its principal place of business in Titusville, New Jersey.

45. Janssen Pharmaceutica, Inc. ("Janssen Pharmaceutica"), now known as Janssen Pharmaceuticals, Inc., is a Pennsylvania corporation with its principal place of business in Titusville, New Jersey.

46. J&J is the only company that owns more than 10% of Janssen Pharmaceuticals stock. Upon information and belief, J&J controls the sale and development of Janssen Pharmaceuticals drugs and Janssen Pharmaceuticals profits inure to J&J's benefit.

47. J&J, Janssen Pharmaceuticals, OMP, and Janssen Pharmaceutica (collectively, "Janssen") are or have been engaged in the manufacture, promotion, distribution, and sale of opioids nationally and in Suffolk County, including the following:

Table 3. Janssen Opioids

Drug Name	Chemical Name	Schedule
Duragesic	Fentanyl	Schedule II
Nucynta[18]	Tapentadol extended release	Schedule II
Nucynta ER	Tapentadol	Schedule II

48. Together, Nucynta and Nucynta ER accounted for $172 million in sales in 2014. Prior to 2009, Duragesic accounted for at least $1 billion in annual sales.

49. Defendant Endo Health Solutions Inc. ("EHS") is a Delaware corporation with its principal place of business in Malvern, Pennsylvania.

50. Defendant Endo Pharmaceuticals, Inc. ("EPI") is a wholly owned subsidiary of EHS and is a Delaware corporation with its principal place of business in Malvern, Pennsylvania.

51. EHS and EPU (collectively, "Endo") manufacture, promote, distribute and sell opioids nationally and in Suffolk County, including the following:

Table 4. Endo Opioids

Drug Name	Chemical Name	Schedule
Opana ER	Oxymorphone hydrochloride extended release	Schedule II
Opana	Oxymorphone hydrochloride	Schedule II
Percodan	Oxymorphone hydrochloride and aspirin	Schedule II
Percocet	Oxymorphone hydrochloride and acetaminophen	Schedule II

52. Opioids made up roughly $403 million of Endo's overall revenues of $3 billion in 2012. Opana ER yielded revenue of $1.15 billion from 2010 to 2013, and it

[18] Depomed, Inc. acquired the rights to Nucynta and Nucynta ER from Janssen in 2015.

accounted for 10% of Endo's total revenue in 2012. Endo also manufactures and sells generic opioids, both directly and through its subsidiary, Qualitest Pharmaceuticals, Inc., including generic oxycodone, oxymorphone, hydromorphone, and hydrocodone products.

53. Russell Portenoy, M.D., is an individual residing in New York. Dr. Portenoy was instrumental in promoting opioids for sale and distribution nationally and in Suffolk County.

54. Perry Fine, M.D., is an individual residing in Utah. Dr. Fine was instrumental in promoting opioids for sale and distribution nationally and in Suffolk County.

55. Scott Fishman, M.D., is an individual residing in California. Dr. Fishman was instrumental in promoting opioids for sale and distribution nationally and in Suffolk County.

56. Lynn Webster, M.D., is an individual residing in Utah. Dr. Webster was instrumental in promoting opioids for sale and distribution nationally and in Suffolk County.

FACTS RELEVANT TO ALL CAUSES OF ACTION

A. The Pain-Relieving and Addictive Properties of Opioids

57. The pain-relieving properties of opium have been recognized for millennia. So has the magnitude of its potential for abuse and addiction. Opioids are related to illegal drugs like opium and heroin.

58. During the Civil War, opioids, then known as "tinctures of laudanum," gained popularity among doctors and pharmacists for their ability to reduce anxiety and relieve pain – particularly on the battlefield – and they were popularly used in a wide variety of commercial products ranging from pain elixirs to cough suppressants to beverages. By 1900, an estimated 300,000 people were addicted to opioids in the United States,[19] and many doctors prescribed opioids solely to avoid patients' withdrawal. Both the numbers of opioid addicts and the difficulty in weaning patients from opioids made clear their highly addictive nature.

59. Due to concerns about their addictive properties, opioids have been regulated at the federal level as controlled substances by the U.S. Drug Enforcement Administration ("DEA") since 1970. The labels for scheduled opioid drugs carry black box warnings of potential addiction and "[s]erious, life-threatening, or fatal respiratory depression," as the result of an excessive dose.

60. Studies and articles from the 1970s and 1980s also made clear the reasons to avoid opioids. Scientists observed negative outcomes from long-term opioid therapy in pain management programs; opioids' mixed record in reducing pain long-term and failure to improve patients' function; greater pain complaints as most patients developed tolerance to opioids; opioid patients' diminished ability to perform basic tasks; their inability to make use of complementary treatments like physical therapy due to the side

[19] Substance Abuse and Mental Health Services Administration, Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, Treatment Improvement Protocol (TIP Services), No. 43 (2005).

effects of opioids; and addiction. Leading authorities discouraged, or even prohibited, the use of opioid therapy for chronic pain.

61. In 1986, Dr. Portenoy, who later became Chairman of the Department of Pain Medicine and Palliative Care at Beth Israel Medical Center in New York while at the same time serving as a top spokesperson for drug companies, published an article reporting that "[f]ew substantial gains in employment or social function could be attributed to the institution of opioid therapy."[20]

62. Writing in 1994, Dr. Portenoy described the prevailing attitudes regarding the dangers of long-term use of opioids:

> *The traditional approach to chronic non-malignant pain does not accept the long-term administration of opioid drugs.* This perspective has been justified by the perceived likelihood of tolerance, which would attenuate any beneficial effects over time, and the potential for side effects, worsening disability, and addiction. According to conventional thinking, the initial response to an opioid drug may appear favorable, with partial analgesia and salutary mood changes, but adverse effects inevitably occur thereafter. It is assumed that the motivation to improve function will cease as mental clouding occurs and the belief takes hold that the drug can, by itself, return the patient to a normal life. *Serious management problems are anticipated, including difficulty in discontinuing a problematic therapy and the development of drug seeking behavior induced by the desire to maintain analgesic effects, avoid withdrawal, and perpetuate reinforcing psychic effects. There is an implicit assumption that little separates these outcomes from the highly aberrant behaviors associated with addiction.*[21]

[20] R. Portenoy & K. Foley, Chronic Use of Opioid Analgesics in Non-Malignant Pain: Report of 38 cases, 25(2) Pain 171 (1986).

[21] R. Portenoy, *Opioid Therapy for Chronic Nonmalignant Pain: Current Status*, 1 Progress in Pain Res. & Mgmt., 247-287 (H.L. Fields and J.C. Liebeskind eds., 1994) (emphasis added).

According to Dr. Portenoy, the foregoing problems could constitute "compelling reasons to reject long-term opioid administration as a therapeutic strategy in all but the most desperate cases of chronic nonmalignant pain."[22]

63. For all the reasons outlined by Dr. Portenoy, and in the words of one researcher from the University of Washington in 2012, and quoted by a Harvard researcher the same year, "it did not enter [doctors'] minds that there could be a significant number of chronic pain patients who were successfully managed with opioids, because if there were any, we almost never saw them."[23]

64. Discontinuing opioids after more than just a few weeks of therapy will cause most patients to experience withdrawal symptoms. These withdrawal symptoms include: severe anxiety, nausea, vomiting, headaches, agitation, insomnia, tremors, hallucinations, delirium, pain, and other serious symptoms, which may persist for months after a complete withdrawal from opioids, depending on how long the opioids were used.

65. When under the continuous influence of opioids over time, patients grow tolerant to their analgesic effects. As tolerance increases, a patient typically requires progressively higher doses in order to obtain the same levels of pain reduction to which

[22] *Id*.

[23] J. Loeser. Five crises in pain management, Pain Clinical Updates. 2012;20 (1):1–4(cited by I. Kissin, Long-term opioid treatment of chronic nonmalignant pain: unproven efficacy and neglected safety?, 6 J. Pain Research 513, 514 (2013)).

he has become accustomed – up to and including doses that are "frighteningly high."[24] At higher doses, the effects of withdrawal are more substantial, thus leaving a patient at a much higher risk of addiction. A patient can take the opioids at the continuously escalating dosages to match pain tolerance and still overdose at recommended levels.

66. Opioids vary by duration. Long-acting opioids, such as Purdue's OxyContin and MS Contin, Janssen's Nucynta ER and Duragesic, Endo's Opana ER, and Actavis's Kadian, are designed to be taken once or twice daily and are purported to provide continuous opioid therapy for, in general, 12 hours. Short-acting opioids, such as Cephalon's Actiq and Fentora, are designed to be taken in addition to long-acting opioids to address "episodic pain" and provide fast-acting, supplemental opioid therapy lasting approximately 4 to 6 hours.

67. Defendants promoted the idea that pain should be treated by taking long-acting opioids continuously and supplementing them by also taking short-acting, rapid-onset opioids for episodic pain.

68. In 2013, in response to a petition to require manufacturers to strengthen warnings on the labels of long-acting opioid products, the FDA warned of the "grave risks" of opioids, including "addiction, overdose, and even death." The FDA further warned, "[e]ven proper use of opioids under medical supervision can result in life-threatening respiratory depression, coma, and death." Because of those grave risks, the FDA said that long-acting or extended release opioids "should be used only when

[24] M. Katz, Long-term Opioid Treatment of Nonmalignant Pain: A Believer Loses His Faith, 170(16) Archives of Internal Med. 1422 (2010).

alternative treatments are inadequate."[25] The FDA required that – going forward – opioid makers of long-acting formulations clearly communicate these risks in their labels.

69. In 2016, the FDA expanded its warnings for immediate-release opioid pain medications, requiring similar changes to the labeling of immediate-release opioid pain medications as it had for extended release opioids in 2013. The FDA also required several additional safety-labeling changes across all prescription opioid products to include additional information on the risk of these medications.[26]

70. The facts on which the FDA relied in 2013 and 2016 were well known to Defendants in the 1990s when their deceptive marketing began.

B. Opioid Therapy Makes Patients Sicker Without Long Term Benefits

71. There is no scientific evidence supporting the safety or efficacy of opioids for long-term use. Defendants are well aware of the lack of such scientific evidence. While promoting opioids to treat chronic pain, Defendants failed to disclose the lack of evidence to support their use long-term and have failed to disclose the substantial scientific evidence that chronic opioid therapy actually makes patients sicker.

72. There are no controlled studies of the use of opioids beyond 16 weeks, and no evidence that opioids improve patients' pain and function long-term. For example, a

[25] Letter from Janet Woodcock, M.D., Dir., Ctr. For Drug Eval. & Res., to Andrew Kolodny, M.D., Pres. *Physicians for Responsible Opioid Prescribing,* Re Docket No. FDA-2012-P-0818 (Sept. 10, 2013) (emphasis in original).

[26] FDA announces enhanced warnings for immediate-release opioid pain medications related to risks of misuse, abuse, addiction, overdose and death. Available at http://www.fda.gov/newsevents/newsroom/pressannouncements/ucm491739.htm (accessed March 31, 2016).

2007 systematic review of opioids for back pain concluded that opioids have limited, if any, efficacy for back pain and that evidence did not allow judgments regarding long-term use.

73. Substantial evidence exists that opioid drugs are ineffective to treat chronic pain, and actually worsen patients' health. For example, a 2006 study-of-studies found that opioids as a class did not demonstrate improvement in functional outcomes over other non-addicting treatments.[27]

74. Increasing duration of opioid use is strongly associated with an increasing prevalence of mental health conditions (including depression, anxiety, post-traumatic stress disorder, or substance abuse), increased psychological distress, and greater health care utilization.

75. While opioids may work acceptably well for a while, when they are used on a long term basis, function generally declines, as does general health, mental health, and social function. Over time, even high doses of potent opioids often fail to control pain, and patients exposed to such doses are unable to function normally.[28]

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[27] A. Furlan *et al.*, *Opioids for chronic noncancer pain: a meta-analysis of effectiveness and side effects*, 174(11) Can. Med. Ass'n J. 1589 (2006). This same study revealed that efficacy studies do not typically include data on opioid addiction. In many cases, patients who may be more prone to addiction are pre-screened out of the study pool. This does not reflect how doctors actually prescribe the drugs, because even patients who have past or active substance use disorders tend to receive higher doses of opioids. K. Seal, *Association of Mental Health Disorders With Prescription Opioids and High- Risk Opioids in US Veterans of Iraq and Afghanistan*, 307(9) J. Am. Med. Ass'n 940 (2012).

[28] *See* A. Rubenstein, *Are we making pain patients worse?* Sonoma Medicine (Fall 2009).

76. The foregoing is true both generally and for specific pain-related conditions. Studies of the use of opioids long-term for chronic lower back pain have been unable to demonstrate an improvement in patients' function. Instead, research consistently shows that long-term opioid therapy for patients who have lower back injuries does not cause patients to return to work or physical activity. This is due partly to addiction and other side effects.

77. For example, as many as 30% of patients who suffer from migraines have been prescribed opioids to treat their headaches. Users of opioids had the highest increase in the number of headache days per month, scored significantly higher on the Migraine Disability Assessment, and had higher rates of depression, compared to non-opioid users. A survey by the National Headache Foundation found that migraine patients who used opioids were more likely to experience sleepiness, confusion, and rebound headaches, and reported a lower quality of life than patients taking other medications.

C. Defendants' Scheme to Change Prescriber Habits and Public Perception

78. Before Defendants began the marketing campaign complained of herein, generally accepted standards of medical practice dictated that opioids should only be used short-term, for instance, for acute pain, pain relating to recovery from surgery, or for cancer or palliative care. In those instances, the risks of addiction are low or of little significance.

79. The market for short-term pain relief is significantly more limited than the market for long-term chronic pain relief. Defendants recognized that if they could sell opioids not just for short term pain relief but also for long-term chronic pain relief, they

could achieve blockbuster levels of sales and their profits. Further, they recognized that if they could cause their customers to become physically addicted to their drugs, they would increase the likelihood that their blockbuster profits would continue indefinitely.

80. Defendants knew that in order to increase their profits from the sale of opioids they would need to convince doctors and patients that long-term opioid therapy was safe and effective. Defendants needed, in other words, to persuade physicians to abandon their long-held apprehensions about prescribing opioids, and instead to prescribe opioids for durations previously understood to be unsafe.

81. Defendants knew that their goal of increasing profits by promoting the prescription of opioids for chronic pain would lead directly to an increase in health care costs for patients, health care insurers, and health care payors such as Plaintiff.

82. Marshalling help from consultants and public relations firms, Defendants developed and executed a common strategy to reverse the long-settled understanding of the relative risks and benefits of chronic opioid therapy. Rather than add to the collective body of medical knowledge concerning the best ways to treat pain and improve patient quality of life, however, Defendants instead sought to distort medical and public perception of existing scientific data.

83. As explained more fully herein and illustrated in Exhibit A, Defendants, collectively and individually, poured vast sums of money into generating articles, continuing medical education courses ("CMEs"), and other "educational" materials, conducting sales visits to individual doctors, and supporting a network of professional

societies and advocacy groups, which was intended to, and which did, create a new but phony "consensus" supporting the long-term use of opioids.

D. Defendants Used "Unbranded" Marketing to Evade Regulations and Consumer Protection Laws

84. Drug companies' promotional activity can be branded or unbranded; unbranded marketing refers not to a specific drug, but more generally to a disease state or treatment. By using unbranded communications, drug companies can evade the extensive regulatory framework governing branded communications.

85. A drug company's branded marketing, which identifies and promotes a specific drug, must: (a) be consistent with its label and supported by substantial scientific evidence; (b) not include false or misleading statements or material omissions; and (c) fairly balance the drug's benefits and risks. The regulatory framework governing the marketing of specific drugs reflects a public policy designed to ensure that drug companies, which are best suited to understand the properties and effects of their drugs, are responsible for providing prescribers with the information they need to assess accurately the risks and benefits of drugs for their patients.

86. Further, the Federal Food, Drug, and Cosmetic Act ("FDCA") places further restrictions on branded marketing. It prohibits the sale in interstate commerce of drugs that are "misbranded." A drug is "misbranded" if it lacks "adequate directions for use" or if the label is false or misleading "in any particular." "Labeling" includes more than the drug's physical label; it also includes "all … other written, printed, or graphic matter … accompanying" the drug, including promotional material. The term "accompanying"

is interpreted broadly to include promotional materials – posters, websites, brochures, books, and the like – disseminated by or on behalf of the manufacturer of the drug. Thus, Defendants' promotional materials are part of their drugs' labels and required to be accurate, balanced, and not misleading.

87. Branded promotional materials for prescription drugs must be submitted to the FDA when they are first used or disseminated. If, upon review, the FDA determines that materials marketing a drug are misleading, it can issue an untitled letter or warning letter. The FDA uses untitled letters for violations such as overstating the effectiveness of the drug or making claims without context or balanced information. Warning letters address promotions involving safety or health risks and indicate the FDA may take further enforcement action.

88. Defendants generally avoided using branded advertisements to spread their deceptive messages and claims regarding opioids. Defendants did so in order to evade regulatory review.

89. Instead, Defendants disseminated much of their false, misleading, imbalanced, and unsupported statements through unregulated unbranded marketing materials – materials that generally promoted opioid use but did not name a specific opioid while doing so. Through these unbranded materials, Defendants presented information and instructions concerning opioids generally that were false and misleading.

90. By acting through third parties, Defendants were able to give the false appearance that their messages reflected the views of independent third parties. Later,

Defendants would cite to these sources as "independent" corroboration of their own statements. Further, as one physician adviser to Defendants noted, third-party documents had not only greater credibility, but also broader distribution, as doctors did not "push back" at having materials, for example, from the non-profit American Pain Foundation ("APF") on display in their offices, as they would with drug company pieces.

91. As part of their marketing scheme, Defendants spread and validated their deceptive messages through the following unbranded vehicles ("the Vehicles"): (i) so-called "key opinion leaders" (*i.e.*, physicians who influence their peers' medical practice, including but not limited to prescribing behavior) ("KOLs"), who wrote favorable journal articles and delivered supportive CMEs; (ii) a body of biased and unsupported scientific literature; (iii) treatment guidelines; (iv) CMEs; and (v) unbranded patient education materials disseminated through groups purporting to be patient-advocacy and professional organizations ("Front Groups"), which exercised their influence both directly and indirectly through Defendant-controlled KOLs who served in leadership roles in these organizations.

92. Defendants disseminated many of their false, misleading, imbalanced and unsupported messages through the Vehicles because they appeared to uninformed observers to be independent. Through unbranded materials, Defendants presented information and instructions concerning opioids generally that were false and misleading.

93. Even where such unbranded messages were disseminated through third-party vehicles, Defendants adopted these messages as their own when they cited to,

edited, approved, and distributed such materials knowing they were false, misleading, unsubstantiated, unbalanced, and incomplete. As described herein, Defendants' sales representatives distributed third-party marketing material to Defendants' target audience that was deceptive.

94. Defendants took an active role in guiding, reviewing, and approving many of the misleading statements issued by third parties, ensuring that Defendants were consistently in control of their content. By funding, directing, editing, and distributing these materials, Defendants exercised control over their deceptive messages and acted in concert with these third parties fraudulently to promote the use of opioids for the treatment of chronic pain.

95. The unbranded marketing materials that Defendants assisted in creating and distributing either did not disclose the risks of addiction, abuse, misuse, and overdose, or affirmatively denied or minimized those risks.

i. Defendants' KOLs

96. Defendants cultivated a select circle of doctors who were chosen and sponsored by Defendants solely because they favored the aggressive treatment of chronic pain with opioids. As set forth herein and as depicted in Exhibit A, pro-opioid doctors have been at the hub of Defendants' promotional efforts, presenting the appearance of unbiased and reliable medical research supporting the broad use of opioid therapy for chronic pain. These pro-opioid doctors have written, consulted on, edited, and lent their names to books and articles, and given speeches and CMEs supportive of opioid therapy for chronic pain. They have served on committees that developed treatment guidelines

that strongly encouraged the use of opioids to treat chronic pain and on the boards of pro-opioid advocacy groups and professional societies that develop, select, and present CMEs. Defendants were able to exert control of each of these modalities through their KOLs.

97. In return for their pro-opioid advocacy, Defendants' KOLs received money, prestige, recognition, research funding, and avenues to publish.

98. Defendants cited and promoted their KOLs and studies or articles by their KOLs to broaden the chronic opioid therapy market. By contrast, Defendants did not support, acknowledge, or disseminate the publications of doctors critical of the use of chronic opioid therapy.

99. Defendants carefully vetted their KOLs to ensure that they were likely to remain on-message and supportive of their agenda. Defendants also kept close tabs on the content of the materials published by these KOLs.

100. In their promotion of the use of opioids to treat chronic pain, Defendants' KOLs knew that their statements were false and misleading, or they recklessly disregarded the truth in doing so, but they continued to publish their misstatements to benefit themselves and Defendants.

ii. Defendants' Corruption of Scientific Literature

101. Rather than actually test the safety and efficacy of opioids for long- term use, Defendants led physicians, patients, and health care payors to believe that such tests had already been done. As set forth herein and as depicted in Exhibit A, Defendants created a body of false, misleading, and unsupported medical and popular literature

about opioids that (a) understated the risks and overstated the benefits of long-term use; (b) appeared to be the result of independent, objective research; and (c) was likely to shape the perceptions of prescribers, patients, and payors. This literature was, in fact, marketing material intended to persuade doctors and consumers that the benefits of long-term opioid use outweighed the risks.

102. To accomplish their goal, Defendants – sometimes through third-party consultants and/or front groups – commissioned, edited, and arranged for the placement of favorable articles in academic journals.

103. Defendants' plans for these materials did not originate in the departments within the Defendant organizations that were responsible for research, development, or any other area that would have specialized knowledge about the drugs and their effects on patients; rather, they originated in Defendants' marketing departments and with Defendants' marketing and public relations consultants.

104. In these materials, Defendants (or their surrogates) often claimed to rely on "data on file" or presented posters, neither of which are subject to peer review. Still, Defendants presented these materials to the medical community as scientific articles or studies, despite the fact that Defendants' materials were not based on reliable data and subject to the scrutiny of others who are experts in the same field.

105. Defendants also made sure that favorable articles were disseminated and cited widely in the medical literature, even when Defendants knew that the articles distorted the significance or meaning of the underlying study. Most notably, Purdue frequently cited a 1980 item in the well-respected New England Journal of Medicine, J.

Porter & H. Jick, *Addiction Rare in Patients Treated with Narcotics*, 302 (2) New Eng. J. Med. 123 (1980) ("Porter & Jick Letter"), in a manner that makes it appear that the item reported the results of a peer reviewed study. It is also cited in two CME programs sponsored by Endo. Defendants and those acting on their behalf failed to reveal that this "article" is actually a letter-to-the-editor, not a study, much less a peer-reviewed study. The letter, reproduced in full below, states that the authors examined their files of hospitalized patients who had received opioids.

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER
HERSHEL JICK, M.D.
Boston Collaborative Drug Surveillance Program
Boston University Medical Center
Waltham, MA 02154

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

106. The patients referred to in the letter were all treated prior to the letter, which was published in 1980. Because of standards of care prior to 1980, the treatment of those

patients with opioids would have been limited to acute or end-of-life situations, not chronic pain. The letter notes that, when these patients' records were reviewed, the authors found almost no references to signs of addiction, though there is no indication that caregivers were instructed to look for, assess, or document signs of addiction. Nor, indeed, is there any indication whether the patients were followed after they were discharged from the hospital or, if they were, for how long. None of these serious limitations was disclosed when Defendants and those acting on their behalf cited the letter, typically as the sole scientific support for the proposition that opioids are rarely addictive.

107. Dr. Jick has complained that his letter has been distorted and misused – as indeed it has.

108. Defendants worked to not only create and promote favorable studies in the literature, but to discredit or suppress negative information. Defendants' studies and articles often targeted articles that contradicted Defendants' claims or raised concerns about chronic opioid therapy. In order to do so, Defendants – often with the help of third-party consultants – used a broad range of media to get their message out, including negative review articles, letters to the editor, commentaries, case-study reports, and newsletters.

109. Defendants' strategy – to plant and promote supportive literature and then to cite the pro-opioid evidence in their promotional materials, while failing to disclose evidence that contradicted those claims – was flatly inconsistent with their legal

obligations. The strategy was intended to, and did, distort prescribing patterns by distorting the truth regarding the risks and benefits of opioids for chronic pain relief.

iii. Defendants' Misuse of Treatment Guidelines

110. Treatment guidelines have been particularly important in securing acceptance for chronic opioid therapy. They are relied upon by doctors, especially the general practitioners and family doctors targeted by Defendants, who are generally not experts, and who generally have no special training, in the treatment of chronic pain. Treatment guidelines not only directly inform doctors' prescribing practices, but also are cited throughout scientific literature and relied on by third-party payors in determining whether they should pay for treatments for specific indications.

a. FSMB

111. The Federation of State Medical Boards ("FSMB") is a trade organization representing the various state medical boards in the United States. The state boards that comprise the FSMB membership have the power to license doctors, investigate complaints, and discipline physicians. The FSMB finances opioid- and pain-specific programs through grants from Defendants.

112. Since 1998, the FSMB has been developing treatment guidelines for the use of opioids for the treatment of pain. The 1998 version, Model Guidelines for the Use of Controlled Substances for the Treatment of Pain ("1998 Guidelines") was produced "in collaboration with pharmaceutical companies" and taught not that opioids could be appropriate in limited cases after other treatments had failed, but that opioids were "essential" for treatment of chronic pain, including as a first prescription option.

113. A 2004 iteration of the 1998 Guidelines and the 2007 book, Responsible Opioid Prescribing, also made the same claims as the 1998 Guidelines. These guidelines were posted online and were available to and intended to reach physicians nationwide, including in Suffolk County.

114. The publication of Responsible Opioid Prescribing was backed largely by drug manufacturers. In all, 163,131 copies of Responsible Opioid Prescribing were distributed by state medical boards (and through the boards, to practicing doctors). The FSMB website describes the book as the "leading continuing medication (CME) activity for prescribers of opioid medications."

115. Defendants relied on 1998 Guidelines to convey the alarming message that "under-treatment of pain" would result in official discipline, but no discipline would result if opioids were prescribed as part of an ongoing patient relationship and prescription decisions were documented. FSMB turned doctors' fear of discipline on its head: doctors, who used to believe that they would be disciplined if their patients became addicted to opioids, were taught instead that they would be punished if they failed to prescribe opioids to their patients with chronic pain.

b. AAPM/APS Guidelines

116. American Academy of Pain Medicine ("AAPM") and the American Pain Society ("APS") are professional medical societies, each of which received substantial funding from Defendants from 2009 to 2013. In 1997, AAPM issued a "consensus" statement that endorsed opioids to treat chronic pain and claimed that the risk that

patients would become addicted to opioids was low.[29] The Chair of the committee that issued the statement, Dr. J. David Haddox, was at the time a paid speaker for Purdue. The sole consultant to the committee was Defendant Portenoy. The consensus statement, which also formed the foundation of the 1998 Guidelines, was published on the AAPM's website.

117. AAPM and APS issued their own guidelines in 2009 ("2009 Guidelines") and continued to recommend the use of opioids to treat chronic pain. Fourteen of the 21 panel members who drafted the 2009 Guidelines, including KOLs Defendant Dr. Portenoy and Defendant Dr. Fine, received support from Defendants Janssen, Cephalon, Endo, and Purdue.

118. The 2009 Guidelines promote opioids as "safe and effective" for treating chronic pain and conclude that the risk of addiction is manageable for patients regardless of past abuse histories. The 2009 Guidelines have been a particularly effective channel of deception and have influenced not only treating physicians, but also the body of scientific evidence on opioids; they were reprinted in the *Journal of Pain*, have been cited hundreds of times in academic literature, were disseminated in Suffolk County during the relevant time period, and were and are available online.

119. Defendants widely cited and promoted the 2009 Guidelines without disclosing the lack of evidence to support their conclusions.

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[29] The Use of Opioids for the Treatment of Chronic Pain, APS & AAPM (1997). Available at http://opi.areastematicas.com/generalidades/OPIOIDES.DOLORCRONICO.pdf (as viewed 3/31/2016).

c. Guidelines that Did Not Receive Defendants' Support

120. The extent of Defendants' influence on treatment guidelines is demonstrated by the fact that independent guidelines – the authors of which did not accept drug company funding – reached very different conclusions.

121. The 2012 Guidelines for Responsible Opioid Prescribing in Chronic Non-Cancer Pain, issued by the American Society of Interventional Pain Physicians ("ASIPP"), warned that "[t]he recent revelation that the pharmaceutical industry was involved in the development of opioid guidelines as well as the bias observed in the development of many of these guidelines illustrate that the model guidelines are not a model for curtailing controlled substance abuse and may, in fact, be facilitating it." ASIPP's Guidelines further advise that "therapeutic opioid use, specifically in high doses over long periods of time in chronic non-cancer pain starting with acute pain, not only lacks scientific evidence, but is in fact associated with serious health risks including multiple fatalities, and is based on emotional and political propaganda under the guise of improving the treatment of chronic pain." ASIPP recommends long-acting opioids in high doses only "in specific circumstances with severe intractable pain" and only when coupled with "continuous adherence monitoring, in well-selected populations, in conjunction with or after failure of other modalities of treatments with improvements in physical and functional status and minimal adverse effects."[30]

[30] Laxmaiah Manchikanti, et al., American Society of Interventional Pain Physicians (ASIPP) *Guidelines for Responsible Opioid Prescribing in Chronic Non-Cancer Pain: Part 1, Evidence Assessment*, 15 Pain Physician (Special Issue) S1-S66; *Part 2 – Guidance*, 15 Pain Physician (Special Issue) S67-S116 (2012).

122. Similarly, the 2011 Guidelines for the Chronic Use of Opioids, issued by the American College of Occupational and Environmental Medicine, recommend against the "routine use of opioids in the management of patients with chronic pain," finding "at least moderate evidence that harms and costs exceed benefits based on limited evidence."[31]

123. The Clinical Guidelines on Management of Opioid Therapy for Chronic Pain, issued by the U.S. Department of Veterans Affairs ("VA") and Department of Defense ("DOD") in 2010, notes that their review revealed a lack of solid evidence-based research on the efficacy of long-term opioid therapy.[32]

iv. Defendants' Misuse of CMEs

124. A CME (an acronym for "Continuing Medical Education") is a professional education program provided to doctors. Doctors are required to attend a certain number and, often, type of CME programs each year as a condition of their licensure. These programs are delivered in person, often in connection with professional organizations' conferences, and online, or through written publications. Doctors rely on CMEs not only to satisfy licensing requirements, but also to get information on new developments in medicine or to deepen their knowledge in specific areas of practice. Because CMEs

[31] *American College of Occupational and Environmental Medicine's Guidelines for the Chronic Use of Opioids* (2011).
[32] Management of Opioid Therapy for Chronic Pain Working Group, VA/DoD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain (May 2010). Available at http://www.healthquality.va.gov/guidelines/Pain/cot/COT_312_Full-er.pdf (accessed March 31, 2016).

typically are taught by KOLs who are highly respected in their fields, and are thought to reflect these physicians' medical expertise, they can be especially influential with doctors.

125. The countless doctors and other health care professionals who participate in accredited CMEs constitute an enormously important audience for opioid reeducation. As one target, Defendants aimed to reach general practitioners, whose broad area of practice and lack of expertise and specialized training in pain management made them particularly dependent upon CMEs and, as a result, especially susceptible to Defendants' deceptions.

126. Defendants sponsored CMEs that were delivered thousands of times, promoting chronic opioid therapy and supporting and disseminating the deceptive and biased messages described in this Complaint. These CMEs, while often generically titled to relate to the treatment of chronic pain, focus on opioids to the exclusion of alternative treatments, inflate the benefits of opioids, and frequently omit or downplay their risks and adverse effects.

127. The American Medical Association ("AMA") has recognized that support from drug companies with a financial interest in the content being promoted "creates conditions in which external interests could influence the availability and/or content" of the programs and urges that "[w]hen possible, CME[s] should be provided without such support or the participation of individuals who have financial interests in the education subject matter."[33]

[33] Opinion 9.0115, *Financial Relationships with Industry in CME*, Am. Med. Ass'n (Nov. 2011).

128. Suffolk County physicians attended or reviewed Defendants' sponsored CMEs during the relevant time period and were misled by them.

129. By sponsoring CME programs put on by Front Groups like APF, AAPM and others, Defendants could expect instructors to deliver messages favorable to them, as these organizations were dependent on Defendants for other projects. The sponsoring organizations honored this principle by hiring pro-opioid KOLs to give talks that supported chronic opioid therapy. Defendant-driven content in these CMEs had a direct and immediate effect on prescribers' views on opioids. Producers of CMEs and Defendants measure the effects of CMEs on prescribers' views on opioids and their absorption of specific messages, confirming the strategic marketing purpose in supporting them.

v. Defendants' Misuse of Patient Education Materials and Front Groups

130. Pharmaceutical industry marketing experts see patient-focused advertising, including direct-to-consumer marketing, as particularly valuable in "increas[ing] market share . . . by bringing awareness to a particular disease that the drug treats."[34] Physicians are more likely to prescribe a drug if a patient specifically requests it, and physicians' willingness to acquiesce to such patient requests holds true even for opioids and for conditions for which they are not approved.[35] Recognizing this

[34] Kanika Johar, An Insider's Perspective: Defense of the Pharmaceutical Industry's Marketing Practices, 76 Albany L. Rev. 299, 308 (2013).

[35] In one study, for example, nearly 20% of sciatica patients requesting oxycodone received a prescription for it, compared with 1% of those making no specific request. J.B.

phenomenon, Defendants put their relationships with Front Groups to work to engage in largely unbranded patient education about opioid treatment for chronic pain.

131. Defendants entered into arrangements with numerous Front Groups (*i.e.*, groups purporting to be patient-advocacy and professional organizations) to promote opioids. These organizations depend upon Defendants for significant funding and, in some cases, for their survival. They were involved not only in generating materials and programs for doctors and patients that supported chronic opioid therapy, but also in assisting Defendants' marketing in other ways—for example, responding to negative articles and advocating against regulatory changes that would constrain opioid prescribing. They developed and disseminated pro-opioid treatment guidelines; conducted outreach to groups targeted by Defendants, such as veterans and the elderly; and developed and sponsored CMEs that focused exclusively on use of opioids to treat chronic pain. Defendants funded these Front Groups in order to ensure supportive messages from these seemingly neutral and credible third parties, and their funding did, in fact, ensure such supportive messages.

d. American Pain Foundation

132. The most prominent of Defendants' Front Groups was the American Pain Foundation ("APF"), which received more than $10 million in funding from opioid manufacturers from 2007 until it closed its doors in May 2012.

McKinlay *et al.*, *Effects of Patient Medication Requests on Physician Prescribing Behavior*, 52(2) Med. Care 294 (2014).

133. APF issued purported "education guides" for patients, the news media, and policymakers that touted the benefits of opioids for chronic pain and trivialized their risks, particularly the risk of addiction. APF also engaged in a significant multimedia campaign – through radio, television and the internet – to "educate" patients about their "right" to pain treatment with opioids. All of the programs and materials were intended to, and did, reach a national audience, including residents of Suffolk County.

134. By 2011, APF was entirely dependent on incoming grants from defendants Purdue, Cephalon, Endo, and others to avoid using its line of credit. APF board member, Dr. Portenoy, explained the lack of funding diversity was one of the biggest problems at APF.

135. APF held itself out as an independent patient advocacy organization, yet engaged in grassroots lobbying against various legislative initiatives that might limit opioid prescribing. In reality, APF functioned largely as an advocate for the interests of Defendants, not patients.

136. In practice, APF operated in close collaboration with Defendants. APF submitted grant proposals seeking to fund activities and publications suggested by Defendants. APF also assisted in marketing projects for Defendants.

137. The close relationship between APF and Defendants demonstrates APF's clear lack of independence, in its finances, management, and mission, and its willingness to allow Defendants to control its activities and messages supports an inference that each Defendant that worked with it was able to exercise editorial control over its publications.

138. In May 2012, the U.S. Senate Finance Committee began looking into APF to determine the links, financial and otherwise, between the organization and the manufacturers of opioid painkillers. Within days of being targeted by the Senate investigation, APF's board voted to dissolve the organization "due to irreparable economic circumstances." APF then "cease[d] to exist, effective immediately."[36]

e. The American Academy of Pain Medicine

139. The American Academy of Pain Medicine ("AAPM"), with the assistance, prompting, involvement, and funding of Defendants, issued the treatment guidelines discussed herein, and sponsored and hosted CMEs essential to Defendants' deceptive marketing scheme.

140. AAPM received over $2.2 million in funding since 2009 from opioid manufacturers. AAPM maintained a corporate relations council, whose members paid $25,000 per year (on top of other funding) to participate. The benefits included allowing members to present educational programs at off-site dinner symposia in connection with AAPM's marquee event – its annual meeting held in Palm Springs, California, or other resort locations. AAPM describes the annual event as an "exclusive venue" for offering CMEs to doctors. Membership in the corporate relations council also allows drug company executives and marketing staff to meet with AAPM executive committee members in small settings. Defendants Endo, Purdue, and Cephalon were members of the council and presented deceptive programs to doctors who attended this annual event.

[36] American Pain Foundation Website. Available at http://www.painfoundation.org (accessed March 31, 2016).

141. The conferences sponsored by AAPM heavily emphasized CME sessions on opioids – 37 out of roughly 40 at one conference alone. AAPM's presidents have included top industry-supported KOLs and Defendants, Dr. Fine, Dr. Portenoy, and Dr. Webster. Dr. Webster was elected president of AAPM while under a DEA investigation. Another past AAPM president, Defendant Dr. Scott Fishman, stated that he would place the organization "at the forefront" of teaching that "the risks of addiction are … small and can be managed."[37]

142. AAPM's staff understood that they and their industry funders were engaged in a common task. Defendants were able to influence AAPM through both their significant and regular funding and the leadership of pro-opioid KOLs within the organization.

E. Defendants Acted in Concert with KOLs and Front Groups in the Creation, Promotion, and Control of Unbranded Marketing.

143. Like cigarette makers, which engaged in an industry-wide effort to misrepresent the safety and risks of smoking, Defendants worked with each other and with the Front Groups and KOLs they funded and directed to carry out a common scheme to deceptively market opioids by misrepresenting the risks, benefits, and superiority of opioids to treat chronic pain.

[37] *Interview by Paula Moyer with Scott M. Fishman, M.D., Professor of Anesthesiology and Pain Medicine, Chief of the Division of Pain Medicine*, Univ. of Cal., Davis (2005), http://www.medscape.org/ viewarticle/500829 (accessed March 31, 2016).

144. Defendants acted through and with the same network of Front Groups, funded the same KOLs, and often used the very same language and format to disseminate the same deceptive messages regarding the appropriate use of opioids to treat chronic pain. Although participants knew this information was false and misleading, these misstatements were nevertheless disseminated nationwide, including to Suffolk County prescribers and patients.

145. One Vehicle for Defendants' marketing collaboration was Pain Care Forum ("PCF"). PCF began in 2004 as an APF project with the stated goals of offering "a setting where multiple organizations can share information" and "promote and support taking collaborative action regarding federal pain policy issues." APF President Will Rowe described the forum as "a deliberate effort to positively merge the capacities of industry, professional associations, and patient organizations."

146. PCF is comprised of representatives from opioid manufacturers and distributors (including Cephalon, Endo, Janssen, and Purdue); doctors and nurses in the field of pain care; professional organizations (including AAPM, APS, and American Society of Pain Educators); patient advocacy groups (including APF and American Chronic Pain Association ("ACPA")); and other like-minded organizations, almost all of which received substantial funding from Defendants.

147. PCF, for example, developed and disseminated "consensus recommendations" for a Risk Evaluation and Mitigation Strategy ("REMS") for long-acting opioids that the FDA mandated in 2009 to communicate the risks of opioids to

prescribers and patients.[38] This was critical because a REMS that went too far in narrowing the uses or benefits or highlighting the risks of chronic opioid therapy would undermine Defendants' marketing efforts. The recommendations claimed that opioids were "essential" to the management of pain, and that the REMS "should acknowledge the importance of opioids in the management of pain and should not introduce new barriers." Defendants worked with PCF members to limit the reach and manage the message of the REMS, which enabled them to maintain, not undermine, their deceptive marketing of opioids for chronic pain.

F. Defendants' Misrepresentations

148. Defendants, through their own marketing efforts and publications and through their sponsorship and control of patient advocacy and medical societies and projects, caused deceptive materials and information to be placed into the marketplace, including to prescribers, patients, and payors in Suffolk County. These promotional messages were intended to and did encourage patients to ask for, doctors to prescribe, and payors to pay for chronic opioid therapy.

149. Doctors are the gatekeepers for all prescription drugs so, not surprisingly, Defendants focused the bulk of their marketing efforts, and their multi-million dollar budgets, on the professional medical community. Particularly because of barriers to prescribing opioids, which are regulated as controlled substances, Defendants knew

[38] The FDA can require a drug maker to develop a REMS—which could entail (as in this case) an education requirement or distribution limitation—to manage serious risks associated with a drug.

doctors would not treat patients with common chronic pain complaints with opioids unless doctors were persuaded that opioids had real benefits and minimal risks. Accordingly, Defendants did not disclose to prescribers, patients or the public that evidence in support of their promotional claims was inconclusive, non-existent or unavailable. Rather, each Defendant disseminated misleading and unsupported messages that caused the target audience to believe those messages were corroborated by scientific evidence. As a result, Suffolk County doctors began prescribing opioids long-term to treat chronic pain – something that most never would have considered prior to Defendants' campaign.

150. Drug company marketing materially impacts doctors' prescribing behavior.[39] Doctors rely on drug companies to provide them with truthful information about the risks and benefits of their products, and they are influenced by their patients' requests for particular drugs and payors' willingness to pay for those drugs.

151. Defendants spent millions of dollars to market their drugs to prescribers and patients and meticulously tracked their return on that investment. In one recent

[39] See, e.g., P. Manchanda & P. Chintagunta, *Responsiveness of Physician Prescription Behavior to Salesforce Effort: An Individual Level Analysis*, 15 (2-3) Mktg. Letters 129 (2004) (detailing has a positive impact on prescriptions written); I. Larkin, *Restrictions on Pharmaceutical Detailing Reduced Off-Label Prescribing of Antidepressants and Antipsychotics in Children*, 33(6) Health Affairs 1014 (2014) (finding academic medical centers that restricted direct promotion by pharmaceutical sales representatives resulted in a 34% decline in on-label use of promoted drugs); *see also* A. Van Zee, *The Promotion and Marketing of OxyContin: Commercial Triumph, Public Health Tragedy*, 99(2) Am J. Pub. Health 221 (2009) (correlating an increase of OxyContin prescriptions from 670,000 annually in 1997to 6.2 million in 2002 to a doubling of Purdue's sales force and trebling of annual sales calls).

survey published by the AMA, even though nine in ten general practitioners reported prescription drug abuse to be a moderate to large problem in their communities, 88% of the respondents said they were confident in their prescribing skills, and nearly half were comfortable using opioids for chronic non-cancer pain.[40] These results are directly due to Defendants' fraudulent marketing campaign.

152. As described in detail below, Defendants:

- misrepresented the truth about how opioids lead to addiction;
- misrepresented that opioids improve function;
- misrepresented that addiction risk can be managed;
- misled doctors, patients, and payors through the use of misleading terms like "pseudoaddiction;"
- falsely claimed that withdrawal is simply managed;
- misrepresented that increased doses pose no significant additional risks;
- falsely omitted or minimized the adverse effects of opioids and overstated the risks of alternative forms of pain treatment.

153. Defendants' misrepresentations were aimed at doctors, patients, and payors.

154. Underlying each of Defendants' misrepresentations and deceptions in promoting the long-term continuous use of opioids to treat chronic pain was Defendants'

[40] Research Letter, Prescription Drug Abuse: A National Survey of Primary Care Physicians, JAMA Intern. Med. (Dec. 8, 2014), E1-E3.

collective effort to hide from the medical community the fact that there exist no adequate and well-controlled studies of opioid use longer than 12 weeks.[41]

i. Defendants, acting individually and collectively, misrepresented the truth about how opioids lead to addiction.

155. Defendants' fraudulent representation that opioids are rarely addictive is central to Defendants' scheme. Through their well-funded, comprehensive, aggressive marketing efforts, Defendants succeeded in changing the perceptions of many physicians, patients, and health care payors and in getting them to accept that addiction rates are low and that addiction is unlikely to develop when opioids are prescribed for pain. That, in turn, directly led to the expected, intended, and foreseeable result that doctors prescribed more opioids to more patients – thereby enriching Defendants.

156. Each of the Defendants claimed that the potential for addiction from its drugs was relatively small or non-existent, even though there was no scientific evidence to support those claims.

157. For example, Cephalon and Purdue sponsored APF's *Treatment Options: A Guide for People Living with Pain* (2007), which taught that addiction is rare and limited to extreme cases of unauthorized dose escalations, obtaining opioids from multiple sources, or theft.

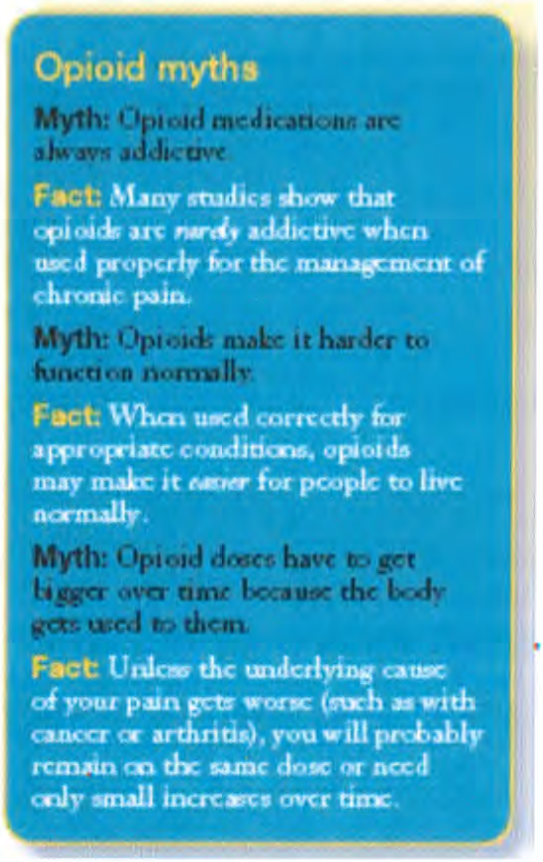
158. For another example, Endo sponsored a website, painknowledge.com, through APF, which claimed that: "[p]eople who take opioids as prescribed usually do

[41] Letter from Janet Woodcock, M.D., Dir., Ctr. For Drug Eval. & Res., to Andrew Kolodny, M.D., Pres. *Physicians for Responsible Opioid Prescribing*, Re Docket No. FDA-2012-P-0818 (Sept. 10, 2013).

not become addicted." Although the term "usually" is not defined, the overall presentation suggests that the rate is so low as to be immaterial. The language also implies that as long as a prescription is given, opioid use will not become problematic.

159. For another example, Endo distributed a patient education pamphlet edited by KOL Defendant Dr. Portenoy entitled *Understanding Your Pain: Taking Oral Opioid Analgesics*. It claimed that "[a]ddicts take opioids for other reasons [than pain relief], such as unbearable emotional problems." This implies that patients prescribed opioids for *genuine* pain will not become addicted, which is unsupported and untrue.

160. For another example, Janssen sponsored a patient education guide entitled *Finding Relief: Pain Management for Older Adults* (2009) in conjunction with the AAPM, ACPA and APF, which, as set forth in the excerpt below, described as a "myth" the fact that opioids are addictive, and asserts as fact that "[m]any studies show that opioids are rarely addictive when used properly for the management of chronic pain."



Opioid myths

Myth: Opioid medications are always addictive.

Fact: Many studies show that opioids are *rarely* addictive when used properly for the management of chronic pain.

Myth: Opioids make it harder to function normally.

Fact: When used correctly for appropriate conditions, opioids may make it *easier* for people to live normally.

Myth: Opioid doses have to get bigger over time because the body gets used to them.

Fact: Unless the underlying cause of your pain gets worse (such as with cancer or arthritis), you will probably remain on the same dose or need only small increases over time.

Although the term "rarely" is not defined, the overall presentation suggests that the rate is so low as to be immaterial. The language also implies that as long as a prescription is given, opioid use is unlikely to lead to addition, which is untrue.

161. The guide states as a "fact" that "Many studies" show that opioids are *rarely* addictive when used for chronic pain. In fact, no such studies exist.

162. For another example, Purdue sponsored and Janssen provided grants to APF to distribute *Exit Wounds* (2009) to veterans, which taught, "[l]ong experience with opioids shows that people who are not predisposed to addiction are very unlikely to become addicted to opioid pain medications." Although the term "very unlikely" is not defined, the overall presentation suggests that the rate is so low as to be immaterial.

163. For another example, Purdue sponsored APF's *A Policymaker's Guide to Understanding Pain & Its Management*, which inaccurately claimed that less than 1% of children prescribed opioids would become addicted.[42] This publication also falsely asserted that pain is undertreated due to "misconceptions about opioid addiction."

164. For another example, in the 1990s, Purdue amplified the pro-opioid message with promotional videos and featuring Dr. Portnoy and other doctors in which it was claimed, "the likelihood that treatment of pain using an opioid drug which is prescribed by a doctor will lead to addiction is extremely low."[43]

165. Rather than honestly disclose the risk of addiction, Defendants attempted to portray those who were concerned about addiction as callously denying treatment to suffering patients. To increase pressure on doctors to prescribe chronic opioid therapy, Defendants turned the tables: they suggested that doctors who *failed* to treat their patients' chronic pains with opioids were failing their patients and risking professional discipline, while doctors who relieved their pain using long-term opioid therapy were following the compassionate (and professionally less risky) approach. Defendants claimed that purportedly overblown worries about addiction cause pain to be under-treated and opioids to be over-regulated and under-prescribed. The Treatment Options guide funded by Purdue and Cephalon states "[d]espite the great benefits of opioids, they

[42] In support of this contention, it misleadingly cites a 1996 article by Dr. Kathleen Foley concerning cancer pain.

[43] Excerpts from one such video, including the statement quoted here, may be viewed at http://www.wsj.com/articles/SB10001424127887324478304578173342657044604.

are often underused." The APF publication funded by Purdue, *A Policymaker's Guide to Understanding Pain & Its Management*, laments that: "Unfortunately, too many Americans are not getting the pain care they need and deserve. Some common reasons for difficulty in obtaining adequate care include … misconceptions about opioid addiction."[44]

166. *Let's Talk Pain*, sponsored by APF, AAPM and Janssen, likewise warns, "strict regulatory control has made many physicians reluctant to prescribe opioids. The unfortunate casualty in all of this is the patient, who is often undertreated and forced to suffer in silence." The program goes on to say, "[b]ecause of the potential for abusive and/or addictive behavior, many health care professionals have been reluctant to prescribe opioids for their patients…. This prescribing environment is one of many barriers that may contribute to the undertreatment of pain, a serious problem in the United States."

ii. Defendants, acting individually and collectively, misrepresented that opioids improve function

167. Defendants produced, sponsored, or controlled materials with the expectation that, by instructing patients and prescribers that opioids would improve patient functioning and quality of life, patients would demand opioids and doctors would prescribe them. These claims also encouraged doctors to continue opioid therapy for patients in the belief that lack of improvement in quality of life could be alleviated by increasing doses or prescribing supplemental short-acting opioids to take on an as-needed basis for breakthrough pain.

[44] This claim also appeared in a 2009 publication by APF, *A Reporter's Guide*.

168. Although opioids may initially improve patients' function by providing pain relief in the short term, there exist no controlled studies of the use of opioids beyond 12 weeks and no evidence that opioids improve patients' function in the long-term. Indeed, research such as a 2008 study in the journal *Spine* has shown that pain sufferers prescribed opioids long-term suffered addiction that made them more likely to be disabled and unable to work.[45] Despite this lack of evidence of improved function, and the existence of evidence to the contrary, Defendants consistently promoted opioids as capable of improving patients' function and quality of life without disclosing the lack of evidence for this claim.

169. Claims that opioids improve patients' function are misleading because such claims have "not been demonstrated by substantial evidence or substantial clinical experience."[46]

170. The Federation of State Medical Boards' Responsible Opioid Prescribing (2007), sponsored by drug companies including Cephalon, Endo and Purdue, taught that relief of pain itself improved patients' function: "While significant pain worsens function, relieving pain should reverse that effect and improve function."

171. Cephalon and Purdue sponsored the APF's *Treatment Options: A Guide for People Living with Pain* (2007), which taught patients that opioids, when used properly

[45] Jeffrey Dersh, et al., Prescription opioid dependence is associated with poorer outcomes in disabling spinal disorders, 33(20) Spine 2219-27 (Sept. 15, 2008).

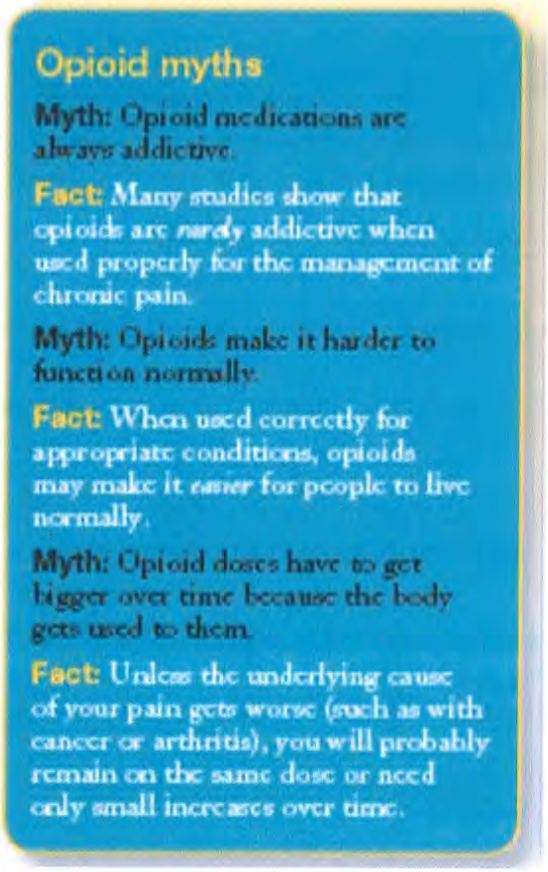
[46] Letter from Thomas W. Abrams, RPh., MBA, Dir., Div. of Marketing, Advertising and Communications to Brian A. Markison, Chairman, *King Pharmaceuticals*, Re: NDA 21-260 (March 24, 2008).

"give [pain patients] a quality of life we deserve." The Treatment Options guide notes that non-steroidal anti-inflammatory drugs (*e.g.*, Aspirin or Ibuprofen) have greater risks with prolonged duration of use, but there was no similar warning for opioids. The APF distributed 17,200 copies of this guide in one year alone, according to its 2007 annual report, and it is currently available online.

172. Endo sponsored a website, painknowledge.com, through the APF, which claimed in 2009 that with opioids, "your level of function should improve; you may find you are now able to participate in activities of daily living, such as work and hobbies, that you were not able to enjoy when your pain was worse." Elsewhere, the website touted improved quality of life as well as "improved function" as benefits of opioid therapy.

173. Janssen sponsored a patient education guide entitled *Finding Relief: Pain Management for Older Adults* (2009) in conjunction with the AAPM, ACPA and APF. This guide features a man playing golf on the cover and lists examples of expected functional improvement from opioids like sleeping through the night, returning to work, recreation, sex, walking, and climbing stairs.

174. As set forth in the excerpt below, the guide states as a "fact" that "opioids may make it *easier* for people to live normally" (emphasis in the original). The myth/fact structure implies authoritative support for the claim that does not exist. The targeting of older adults also ignored heightened opioid risks in this population.



Opioid myths

Myth: Opioid medications are always addictive.

Fact: Many studies show that opioids are *rarely* addictive when used properly for the management of chronic pain.

Myth: Opioids make it harder to function normally.

Fact: When used correctly for appropriate conditions, opioids may make it *easier* for people to live normally.

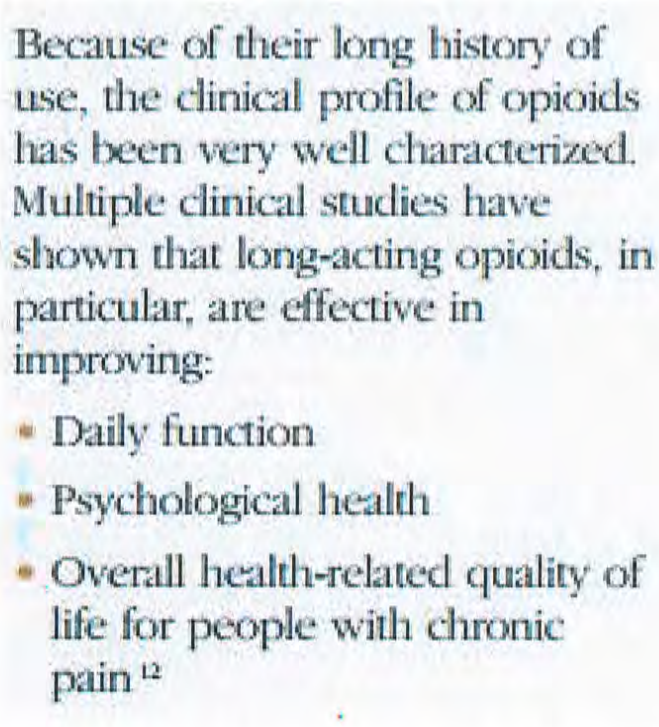
Myth: Opioid doses have to get bigger over time because the body gets used to them.

Fact: Unless the underlying cause of your pain gets worse (such as with cancer or arthritis), you will probably remain on the same dose or need only small increases over time.

175. Janssen sponsored a website, *Let's Talk Pain* in 2009, acting in conjunction with the APF, AAPM, and American Society for Pain Management Nursing whose participation in *Let's Talk Pain* Janssen financed and orchestrated. This website featured a video interview, which was edited by Janssen personnel, claiming that opioids were what allowed a patient to "continue to function," falsely implying that her experience would be representative.

176. Purdue sponsored APF's *A Policymaker's Guide to Understanding Pain & Its Management* (2011), which inaccurately claimed that "multiple clinical studies" have shown that opioids are effective in improving daily function, psychological health, and

health-related quality of life for chronic pain patients," with the implication these studies presented claims of long-term improvement.



Because of their long history of use, the clinical profile of opioids has been very well characterized. Multiple clinical studies have shown that long-acting opioids, in particular, are effective in improving:

- Daily function
- Psychological health
- Overall health-related quality of life for people with chronic pain [12]

The sole reference for the functional improvement claim (i) noted the absence of long-term studies and (ii) actually stated, "For functional outcomes, the other analgesics were significantly more effective than were opioids."

177. Purdue sponsored and Janssen provided grants to APF to distribute *Exit Wounds* to veterans, which taught that opioid medications "increase your level of functioning" (emphasis in the original).

iii. Defendants, acting individually and collectively, misrepresented that addiction risk can be effectively managed

178. Defendants each continue to maintain to this day that most patients safely can take opioids long-term for chronic pain without becoming addicted. Presumably to explain why doctors encounter so many patients addicted to opioids, Defendants have

come to admit that some patients could become addicted, but that doctors can effectively avoid or manage that risk by using screening tools or questionnaires. These tools, they say, identify those with higher addiction risks (stemming from personal or family histories of substance abuse, mental illness, or abuse) so that doctors can more closely monitor patients at greater risk of addiction.

179. There are three fundamental flaws in Defendants' representations that doctors can consistently identify and manage the risk of addiction. First, there is no reliable scientific evidence that doctors can depend on the screening tools currently available to materially limit the risk of addiction. Even if the tools are effective, they may not always be applied correctly, and are subject to manipulation by patients. Second, there is no reliable scientific evidence that high-risk or addicted patients identified through screening can take opioids long-term without triggering or worsening addiction, even with enhanced monitoring. Third, there is no reliable scientific evidence that patients who are not identified through such screening can take opioids long-term without significant danger of addiction.

180. Addiction is difficult to predict on a patient-by-patient basis, and there are no reliable, validated tools to do so. An Evidence Report by the Agency for Healthcare Research and Quality ("AHRQ"), which "systematically review[ed] the current evidence on long-term opioid therapy for chronic pain" identified "[n]o study" that had "evaluated the effectiveness of risk mitigation strategies, such as use of risk assessment instruments, opioid management plans, patient education, urine drug screening, prescription drug monitoring program data, monitoring instruments, more frequent

monitoring intervals, pill counts, or abuse-deterrent formulations on outcomes related to overdose, addiction, abuse or misuse."[47] Furthermore, attempts to treat high-risk patients, like those who have a documented predisposition to substance abuse, by resorting to patient contracts, more frequent refills, or urine drug screening are not proven to work in the real world, even when well meaning, but doctors were misled to employ them.[48]

181. Defendants' misrepresentations regarding the risk of addiction from chronic opioid therapy were particularly dangerous because they were aimed at general practitioners or family doctors (collectively "GPs"), who treat many chronic conditions but lack the time and expertise to closely manage patients on opioids by reviewing urine screens, counting pills, or conducting detailed interviews to identify other signs or risks of addiction. One study conducted by pharmacy benefits manager Express Scripts concluded, after analyzing 2011-2012 narcotic prescription data of the type regularly used by Defendants to market their drugs, that, of the more than half million prescribers of opioids during that time period, only 385 were identified as pain specialists.[49]

[47] The Effectiveness and Risks of Long-term Opioid Treatment of Chronic Pain, Agency for Healthcare Res. & Quality (Sept. 19, 2014).

[48] M. Von Korff, et al., *Long-term opioid therapy reconsidered*, 15595, Annals Internal Med. 325 (Sept. 2011); L. Manchikanti, et al., American Society of Interventional Pain Physicians (ASIPP) *Guidelines for Responsible Opioid Prescribing in Chronic Non-Cancer Pain: Part I – Evidence Assessment*, 15 Pain Physician S1 (2012).

[49] Express Scripts Lab, A Nation in Pain: Focusing on U.S. Opioid Trends for Treatment of Short-Term and Longer-Term Pain (December 2014).

182. In materials they produced, sponsored, or controlled, Defendants instructed patients and prescribers that screening tools can identify patients predisposed to addiction, thus making doctors feel more comfortable prescribing opioids to their patients and patients more comfortable starting on opioid therapy for chronic pain. Defendants' marketing scheme contemplated a "heads we win; tails we win" outcome: patients deemed low risk were to receive opioids on a long-term basis without enhanced monitoring, while and patients deemed high risk were also to receive opioids on a long-term basis but with more frequent visits, tests and monitoring – with those added visits, tests, and monitoring to be paid for or reimbursed by payors, including Plaintiff. This, of course, led to a "heads you lose; tails you lose" outcome for patients – all of whom are subjected to an unacceptable risk of addition – and for payors, including Plaintiff.

183. Cephalon and Purdue sponsored APF's *Treatment Options: A Guide for People Living with Pain* (2007), which falsely reassured patients that "opioid agreements" between doctors and patients can "ensure that you take the opioid as prescribed."

184. Endo paid for a 2007 supplement available for continuing education credit in the Journal of Family Practice written by a doctor who became a member of Endo's speaker's bureau in 2010. This publication, entitled *Pain Management Dilemmas in Primary Care: Use of Opioids*, (i) recommended screening patients using tools like (a) the *Opioid Risk Tool* created by Defendant Dr. Webster and linked to Janssen or (b) the *Screener and Opioid Assessment for Patients with Pain*, and (ii) taught that patients at high risk of addiction could safely receive chronic opioid therapy using a "maximally structured approach" involving toxicology screens and pill counts.

185. Purdue sponsored a 2011 webinar taught by Defendant Dr. Webster, entitled *Managing Patient's Opioid Use: Balancing the Need and Risk*. This publication misleadingly taught prescribers that screening tools, urine tests, and patient agreements have the effect of preventing "overuse of prescriptions" and "overdose deaths."

iv. Defendants, acting individually and collectively, misled physicians, patients, and payors through the use of misleading pseudowords like "pseudoaddiction."

186. Defendants instructed patients and prescribers that signs of addiction are actually the product of untreated pain, thereby causing doctors to prescribe ever more opioids despite signs that the patient was addicted. The word "pseudoaddiction" was concocted by Dr. J. David Haddox, who later went to work for Purdue, and was popularized in opioid therapy for chronic pain by Defendant Dr. Portenoy, who consulted for Defendants Cephalon, Endo, Janssen, and Purdue. Much of the same language appears in other Defendants' treatment of this issue, highlighting the contrast between "undertreated pain" and "true addiction" – as if patients could not experience both.

187. In the materials they produced, sponsored, or controlled, Defendants misrepresented that the concept of "pseudoaddiction" is substantiated by scientific evidence.

188. Cephalon and Purdue sponsored the Federation of State Medical Boards' Responsible Opioid Prescribing (2007), which taught that behaviors such as "requesting drugs by name," "demanding or manipulative behavior," seeing more than one doctor

to obtain opioids, and hoarding, which are in fact signs of genuine addiction, are all really signs of "pseudoaddiction."

189. Purdue did not mention that the author who concocted both the word and the phenomenon it purported to describe became a Purdue Vice President; nor did Purdue disclose the lack of scientific evidence to support the existence of "pseudoaddiction."[50]

190. Purdue posted an unbranded pamphlet entitled *Clinical Issues in Opioid Prescribing* on its unbranded website, PartnersAgainstPain.com, in 2005, and upon information and belief circulated this pamphlet after 2007. The pamphlet listed conduct including "illicit drug use and deception" that it claimed was not evidence of true addiction but rather was indicative of "pseudoaddiction" caused by untreated pain. It also stated, "Pseudoaddiction is a term which has been used to describe patient behaviors that may occur when pain is untreated … . Even such behaviors as illicit drug use and deception can occur in the patient's efforts to obtain relief. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when the pain is effectively treated."

v. Defendants, acting individually and collectively, claimed withdrawal is simply managed.

191. In an effort to underplay the risk and impact of addiction, Defendants claimed that, while patients become physically "dependent" on opioids, physical

[50] J. David Haddox & David E. Weissman, *Opioid pseudoaddiction – an iatrogenic syndrome*, 36(3) Pain 363 (Mar. 1989).

dependence is not the same as addiction and can be addressed, if an when pain relief is no longer desired, by gradually tapering patients' dosage to avoid the adverse effects of withdrawal. Defendants fail to disclose the extremely difficult and painful effects that patients can experience when they are removed from opioids – an adverse effect that also makes it less likely that patients will be able to stop using the drugs.

192. In materials Defendants produced, sponsored, and/or controlled, Defendants made misrepresentations to persuade doctors and patients that withdrawal from their opioids was not a problem and they should not be hesitant about prescribing or using opioids. These claims were not supported by scientific evidence.

193. A CME sponsored by Endo entitled *Persistent Pain in the Older Adult*, taught that withdrawal symptoms can be avoided entirely by tapering a patient's opioid dose by 10% to 20% per day for ten days. This claim was misleading because withdrawal in a patient already physically dependent would take longer than ten days – when it is successful at all.[51]

194. Purdue sponsored APF's *A Policymaker's Guide to Understanding Pain & Its Management*, which taught that "Symptoms of physical dependence can often be ameliorated by gradually decreasing the dose of medication during discontinuation," but the guide did not disclose the significant hardships that often accompany cessation of use.

[51] See Jane Ballantyne, New Addiction Criteria: Diagnostic Challenges Persist in Treating Pain With Opioids, 21(5) Pain Clinical Updates (Dec. 2013).

vi. Defendants, acting individually and collectively, misrepresented that increased doses pose no significant additional risks.

195. Defendants claimed that patients and prescribers could increase doses of opioids indefinitely without added risk, even when pain was not decreasing or when doses had reached levels that were "frighteningly high," suggesting that patients would eventually reach a stable, effective dose. Each of Defendants' claims was deceptive in that it omitted warnings of increased adverse effects that occur at higher doses.

196. In materials Defendants produced, sponsored or controlled, Defendants instructed patients and prescribers that patients could remain on the same dose indefinitely, assuaging doctors' concerns about starting patients on opioids or increasing their doses during treatment, or about discontinuing their patients' treatment as doses escalated. These claims were not supported by scientific evidence.

197. Cephalon and Purdue sponsored APF's *Treatment Options: A Guide for People Living with Pain* (2007), which claims that some patients "need" a larger dose of an opioid, regardless of the dose currently prescribed. The guide taught that opioids differ from NSAIDs in that they have "no ceiling dose" and are therefore the most appropriate treatment for severe pain. The publication attributes 10,000 to 20,000 deaths annually to NSAID overdose when the true figure was closer to 3,200 at the time.[52]

198. Cephalon sponsored a CME written by KOL Defendant Dr. Webster, *Optimizing Opioid Treatment for Breakthrough Pain*, offered by Medscape, LLC from

[52] Robert E. Tarone, et al., Nonselective Nonaspirin Nonsteroidal Anti-Inflammatory Drugs and Gastrointestinal Bleeding: Relative and Absolute Risk Estimates from Recent Epidemiologic Studies, 11 Am. J. of Therapeutics 17-25 (2004).

September 28, 2007 through December 15, 2008. The CME taught that non-opioid analgesics and combination opioids containing non-opioids such as aspirin and acetaminophen are less effective at treating breakthrough pain because of dose limitations on the non-opioid component.

199. Endo sponsored a website, *painknowledge.com*, through APF, which claimed in 2009 that opioids may be increased until "you are on the right dose of medication for your pain," at which point further dose increases would not be required.

200. Endo distributed a patient education pamphlet edited by KOL Defendant Dr. Portenoy entitled *Understanding Your Pain: Taking Oral Opioid Analgesics*, which was published on Endo's website. In Q&A format, it asked, "If I take the opioid now, will it work later when I really need it?" The response is, "The dose can be increased. … You won't 'run out' of pain relief."

201. Purdue sponsored APF's *A Policymaker's Guide to Understanding Pain & Its Management*, which taught that dose escalations are "sometimes necessary," even indefinite ones, but did not disclose the risks from high-dose opioids. This publication is still available online.

202. Purdue sponsored *Overview of Management Options*, a CME issued by the AMA in 2003, 2007, 2010, and 2013. The 2013 version remains available for CME credit. The CME was edited by KOL Defendant Dr. Portenoy, among others, and taught that NSAIDs and other drugs, but not opioids, are unsafe at high doses.

vii. Defendants, acting individually and collectively, deceptively omitted or minimized the adverse effects of opioids and overstated the risks of alternative forms of pain treatment.

203. In materials they produced, sponsored or controlled, Defendants omitted known risks of chronic opioid therapy and emphasized or exaggerated risks of competing products so that prescribers and patients would be more likely to choose opioids and would favor opioids over other therapies such as over-the-counter acetaminophen or over-the-counter or prescription NSAIDs. None of these claims was supported by scientific evidence.

204. In addition to failing to disclose in promotional materials the risks of addiction, abuse, overdose, and respiratory depression, Defendants routinely ignored the risks of hyperalgesia, a "known serious risk associated with chronic opioid analgesic therapy in which the patient becomes more sensitive to certain painful stimuli over time;"[53] hormonal dysfunction;[54] decline in immune function; mental clouding, confusion, and dizziness; increased falls and fractures in the elderly;[55] neonatal abstinence syndrome (when an infant exposed to opioids prenatally suffers withdrawal after birth), and potentially fatal interactions with alcohol or benzodiazepines, which are

[53] Letter from Janet Woodcock, M.D., Dir., Ctr. For Drug Eval. & Res., to Andrew Kolodny, M.D., Pres. *Physicians for Responsible Opioid Prescribing,* Re Docket No. FDA-2012-P-0818 (Sept. 10, 2013).

[54] H.W. Daniell, Hypogonadism in men consuming sustained-action oral opioids, 3(5) J. Pain 377-84 (2001).

[55] See Bernhard M. Kuschel, The risk of fall injury in relation to commonly prescribed medications among older people – a Swedish case-control study, Eur. J. Pub. H. (July 31, 2014).

used to treat post-traumatic stress disorder and anxiety. Post-traumatic stress disorder and anxiety also often accompany chronic pain symptoms.[56]

205. Cephalon and Purdue sponsored APF's *Treatment Options: A Guide for People Living with Pain* (2007), which taught patients that opioids differ from NSAIDs in that they have "no ceiling dose" and are therefore the most appropriate treatment for severe pain. The publication attributes 10,000 to 20,000 deaths annually to NSAID overdose when the figure is closer to 3,200.[57] *Treatment Options* also warned that risks of NSAIDS increase if "taken for more than a period of months," with no corresponding warning about opioids.

206. Endo sponsored a website, painknowledge.com, through APF, which contained a flyer called "Pain: Opioid Therapy." This publication included a list of adverse effects that omitted significant adverse effects including hyperalgesia, immune and hormone dysfunction, cognitive impairment, tolerance, dependence, addiction, and death.

207. Janssen and Purdue sponsored and Endo provided grants to APF to distribute *Exit Wounds* (2009), which omits warnings of the risk of potentially fatal

[56] Karen H. Seal, Association of Mental Health Disorders With Prescription Opioids and High-Risk Opioids in US Veterans of Iraq and Afghanistan, 307(9) J. Am. Med. Ass'n 940-47 (2012).

[57] Robert E. Tarone, et al., Nonselective Nonaspirin Nonsteroidal Anti-Inflammatory Drugs and Gastrointestinal Bleeding: Relative and Absolute Risk Estimates from Recent Epidemiologic Studies, 11 Am. J. of Therapeutics 17-25 (2004).

interactions between opioids and certain anti-anxiety medicines called benzodiazepines, commonly prescribed to veterans with post-traumatic stress disorder.

208. As a result of Defendants' campaign of deception, promoting opioids over safer and more effective drugs, opioid prescriptions increased even as the percentage of patients visiting a doctor for pain remained constant. A study of 7.8 million doctor visits between 2000 and 2010 found that opioid prescriptions increased from 11.3% to 19.6% of visits, as NSAID and acetaminophen prescriptions fell from 38% to 29%, driven primarily by the decline in NSAID prescribing.[58]

G. Defendants' Promotion of Their Branded Drugs Was Also Deceptive

209. While Defendants worked in concert to expand the market for opioids, they also worked to maximize their individual shares of that market. Each Defendant promoted opioids for chronic pain through sales representatives (which Defendants called "detailers" to deemphasize their primary sales role) and small group speaker programs to reach out to individual prescribers nationwide and in Suffolk County. By establishing close relationships with doctors, Defendants were able to disseminate their misrepresentations in targeted, one-on-one settings that allowed them to differentiate

[58] M. Daubresse, *et al.*, *Ambulatory Diagnosis and Treatment of Nonmalignant Pain in the United States, 2000-2010,* 51(*10)* Med. Care, 870-878 (2013). For back pain alone, the percentage of patients prescribed opioids increased from 19% to 29% between 1999 and 2010, even as the use of NSAIDs or acetaminophen declined from 39.9% to 24.5% of these visits; and referrals to physical therapy remained steady. *See also* J. Mafi, *et al.*, *Worsening Trends in the Management and Treatment of Back Pain*, 173(17) J. of the Am Med. Ass'n Internal Med. 1573, 1573 (2013).

their opioids and to allay individual prescribers' concerns about prescribing opioids for chronic pain.

210. Defendants developed sophisticated methods for selecting doctors for sales visits based on the doctors' prescribing habits. In accordance with common industry practice, Defendants purchase and closely analyze prescription sales data from IMS Health, a healthcare data collection, management and analytics corporation. This data allows them to track precisely the rates of initial and renewal prescribing by individual doctors, which allows them to target and tailor their appeals. Sales representatives visited hundreds of thousands of doctors and disseminated the misinformation and materials described above throughout the United States, including doctors in Suffolk County.

H. Defendants Knew That Their Marketing of Chronic Opioid Therapy Was False, Unfounded, and Dangerous and Would Harm Plaintiff and its Residents

211. Defendants made, promoted, and profited from their misrepresentations – individually and collectively – knowing that their statements regarding the risks, benefits, and superiority of opioids for chronic pain were false and misleading. Cephalon and Purdue entered into settlements in the hundreds of millions of dollars to resolve criminal and federal charges involving nearly identical conduct. Defendants had access to scientific studies, detailed prescription data, and reports of adverse events, including reports of addiction, hospitalization, and deaths – all of which made clear the significant adverse outcomes from opioids and that patients were suffering from addiction, overdoses, and death in alarming numbers.

212. Defendants expected and intended that their misrepresentations would induce doctors to prescribe, patients to use, and payors to pay for their opioids for chronic pain.

213. When they began their deceptive marketing practices, Defendants recklessly disregarded the harm that their practices were likely to cause. As their scheme was implemented, and as reasonably foreseeable harm began to occur, Defendants were well aware that it was occurring. Defendants closely monitored their own sales and the habits of prescribing doctors, which allowed them to see sales balloon – overall, in individual practices, and for specific indications. Their sales representatives, who visited doctors and attended CME programs, knew what types of doctors were receiving their messages and how they were responding. Moreover, Defendants had access to, and carefully monitored government and other data that tracked the explosive rise in opioid use, addiction, injury, and death.

I. Defendants Fraudulently Concealed their Misrepresentations

214. Defendants took steps to avoid detection of, and to fraudulently conceal, their deceptive marketing and conspiratorial behavior.

215. Defendants disguised their own roles in the deceptive marketing by funding and working through Front Groups purporting to be patient advocacy and professional organizations and through paid KOLs. Defendants purposefully hid behind the assumed credibility of the front organizations and KOLs and relied on them to vouch for the accuracy and integrity of Defendants' false and misleading statements about opioid use for chronic pain.

216. While Defendants were listed as sponsors of many of the publications described in this Complaint, they never disclosed their role in shaping, editing, and approving their content. Defendants exerted their considerable influence on these purportedly "educational" or "scientific" materials in emails, correspondence, and meetings with KOLs, Front Groups, and public relations companies that were not public.

217. In addition to hiding their own role in generating the deceptive content, Defendants manipulated their promotional materials and the scientific literature to make it appear these items were accurate, truthful, and supported by substantial scientific evidence. Defendants distorted the meaning or import of materials they cited and offered them as evidence for propositions the materials did no support. The true lack of support for Defendants' deceptive messages was not apparent to the medical professionals who relied upon them in making treatment decisions. The false and misleading nature of Defendants' marketing was not known to, nor could it reasonably have been discovered by, Plaintiff or its residents.

218. Defendants also concealed their participation by extensively using the public relations companies they hired to work with Front Groups to produce and disseminate deceptive materials.

219. Defendants concealed from the medical community, patients, and health care payors facts sufficient to arouse suspicion of the existence of claims that Plaintiff now asserts. Plaintiff did not discover the existence and scope of Defendants' industry-wide fraud and could not have acquired such knowledge earlier through the exercise of reasonable diligence.

220. Through the public statements, marketing, and advertising, Defendants' deceptions deprived Plaintiff of actual or implied knowledge of facts sufficient to put them on notice of potential claims.

J. Defendants Entered into and Engaged in a Civil Conspiracy

221. Defendants entered into a conspiracy to engage in the wrongful conduct complained of herein, and intended to benefit both independently and jointly from their conspiratorial enterprise.

222. Defendants reached an agreement between themselves to set up, develop, and fund an unbranded promotion and marketing network to promote the use of opioids for the management of pain in order to mislead physicians, patients, health care providers, and health care payors through misrepresentations or omissions regarding the appropriate uses, risks and safety of opioids.

223. This network is interconnected and interrelated, as demonstrated by Exhibit A, which is incorporated herein, and relied upon Defendants' collective use of and reliance upon unbranded marketing materials, such as KOLs, scientific literature, CMEs, patient education materials, and Front Groups. These materials were developed and funded collectively by Defendants, and Defendants relied upon the materials to intentionally mislead consumers and medical providers of the appropriate uses, risks and safety of opioids.

224. By knowingly misrepresenting the appropriate uses, risks, and safety of opioids, Defendants committed overt acts in furtherance of their conspiracy.

FIRST CAUSE OF ACTION
DECEPTIVE ACTS AND PRACTICES – NEW YORK GENERAL BUSINESS LAW § 349
(AGAINST ALL DEFENDANTS)

225. Plaintiff incorporates the allegations within all prior paragraphs within this Complaint as if they were fully set forth herein.

226. Defendants violated New York General Business Law § 349, because they engaged in deceptive acts or practices in the conduct of business, trade or commerce in this state.

227. Plaintiff and its residents have been injured by reason of Defendants' violation of § 349.

SECOND CAUSE OF ACTION
FALSE ADVERTISING – NEW YORK GENERAL BUSINESS LAW § 350
(AGAINST ALL DEFENDANTS)

228. Plaintiff incorporates the allegations within all prior paragraphs within this Complaint as if they were fully set forth herein.

229. Defendants violated New York General Business Law § 350, because they engaged in false advertising in the conduct of a business, trade or commerce in this state.

230. Plaintiff and its residents have been injured by reason of Defendants' violation of § 350.

THIRD CAUSE OF ACTION
PUBLIC NUISANCE
(AGAINST ALL DEFENDANTS)

231. Plaintiff incorporates the allegations within all prior paragraphs within this Complaint as if they were fully set forth herein.

232. Defendants, individually and acting through their employees and agents, and in concert with each other, have intentionally, recklessly, or negligently engaged in conduct or omissions which endanger or injure the property, health, safety or comfort of a considerable number of persons in Suffolk County by their production, promotion, and marketing of opioids for use by residents of Suffolk County.

233. Defendants' conduct is unreasonable.

234. Defendants' conduct is not insubstantial or fleeting. It has caused deaths, serious injuries, and a severe disruption of public peace, order and safety; it is ongoing, and it is producing permanent and long-lasting damage.

235. Defendants' conduct constitutes a public nuisance.

236. Defendants' conduct directly and proximately caused injury to Plaintiff and its residents.

237. Plaintiff and its residents suffered special injuries distinguishable from those suffered by the general public.

FOURTH CAUSE OF ACTION
VIOLATION OF NEW YORK SOCIAL SERVICES LAW § 145-B
(AGAINST ALL DEFENDANTS)

238. Plaintiff incorporates the allegations within all prior paragraphs within this Complaint as if they were fully set forth herein.

239. Defendants violated Social Services Law § 145-b, because they knowingly, by means of a false statement or representation, or by deliberate concealment of any material fact, or other fraudulent scheme or device, on behalf of themselves or others, attempted to obtain or obtained payment from public funds for services or supplies

furnished or purportedly furnished pursuant to Chapter 55 of the Social Services Law. Plaintiff is a "political subdivision" of the State of New York as that term is used in § 145-b (1) (b) and a "local social services district" as that term is used in § 145-b (2).

240. By reason of Defendants' violation of § 145-b, Plaintiff has been damaged.

FIFTH CAUSE OF ACTION
FRAUD
(AGAINST ALL DEFENDANTS)

241. Plaintiff incorporates the allegations within all prior paragraphs within this Complaint as if they were fully set forth herein.

242. Defendants, individually and acting through their employees and agents, and in concert with each other, made misrepresentations and omissions of facts material to Plaintiff and its residents to induce them to purchase, administer, and consume opioids as set forth in detail above.

243. Defendants knew at the time that they made their misrepresentations and omissions that they were false.

244. Defendants intended that Plaintiff and its residents would rely on their misrepresentations and omissions.

245. Plaintiff and its residents reasonably relied upon Defendants' misrepresentations and omissions.

246. By reason of their reliance on Defendants' misrepresentations and omissions of material fact Plaintiff and its residents suffered actual pecuniary damage.

247. Defendants' conduct was willful, wanton, and malicious and was directed at the public generally.

SIXTHCAUSE OF ACTION
UNJUST ENRICHMENT
(AGAINST ALL DEFENDANTS)

248. Plaintiff incorporates the allegations within all prior paragraphs within this Complaint as if they were fully set forth herein.

249. As an expected and intended result of their conscious wrongdoing as set forth in this Complaint, Defendants have profited and benefited from opioid purchases made by Plaintiff and its residents.

250. In exchange for the opioid purchases, and at the time Plaintiff and its residents made these payments, Plaintiff and its residents expected that Defendants had provided all of the necessary and accurate information regarding those risks and had not misrepresented any material facts regarding those risks.

251. Defendants have been unjustly enriched at the expense of Plaintiff.

PRAYER FOR RELIEF

WHEREFORE Plaintiff demands judgment against Defendants, jointly and severally, awarding Plaintiff:

i. compensatory damages in an amount sufficient to fairly and completely compensate Plaintiff for all damages;

ii. treble damages, penalties, and costs pursuant to Social Services Law § 145-b;

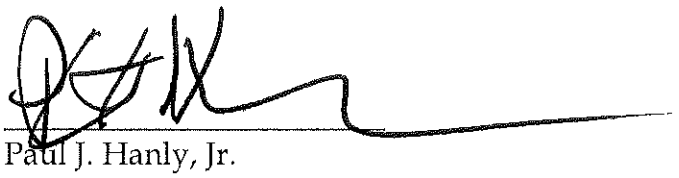
iii. Treble damages and attorney's fees pursuant to General Business Law §§ 349(h) and 350-3(3);

iv. punitive damages;

v. interest, costs, and disbursements; and

vi. such other and further relief as this Court deems just and proper.

Dated: August 31, 2016



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Attorneys for Plaintiff

TAB 1

Court	Case No.	Plaintiff(s)	Defendant(s)	Date Filed	Firms Representing
Cleveland County, OK	CJ-2017-816	State of Oklahoma; AG Mike Hunter	Purdue Pharma LP; Purdue Pharma Inc; The Purdue Frederick Company Inc,; Teva Pharmaceuticals USA Inc.; Cephalon Inc; Johnson & Johnson; Janssen Pharmaceuticals Inc; Ortho-McNeil-Janssen Pharmaceuticals Inc; Jansen pharmaceceutica, Inc.; Allergan PLC; Watson Laboratories Inc; Actavis LLC; Actavis Pharma, Inc.	6/30/2017	Whitten Burrage; Nix Patterson & Roach LLP; Glenn Coffee & Associates, PLLC
CNDC	17-CV-203	Cherokee Nation	McKesson Corp., Cardinal Health, Inc., Amerisourcebergen, CVS Health, Walgreens Boots Alliance, Inc., Wal-Mart Stored, Inc.	4/20/2017	Filed in Tribal Ct.
EDCA	17-CV-1485	County of San Joaquin; City of Stockton; Montezuma Fire Protection District	Purdue Pharma, L.P.; Purdue Pharma, Inc.; Purdue Frederick Company, Inc.; Teva Pharmaceuticals USA, Inc.; Cephalon, Inc.; Johnson & Johnson; Janssen Pharmaceuticals, Inc.; Ortho-McNeil-Janssen Pharmaceuticals, Inc.; Janssen Phamaceutica, Inc.; Endo Health Solutions, Inc.; Endo Pharmaceuticals, Inc.; McKesson Corporation	7/17/2017	Law Offices Of Francis O. Scarpulla; Parish Guy Castillo, PLC;
EDTN	17-CV-122	Barry Staubus, Tony Clark, Dan Armstrong and Baby Doe	Purdue Pharma LP, Purdue Pharma, Inc., The Purdue Frederick Company, Mallinckrodt PLC, Endo Health Solutions, Inc., Endo Pharmaceuticals, Inc., Center Pointe Medical Clinic, LLC, Elizabeth Ann Bowers Campbell, Pamela Moore and Abdelrahman Hassabu Mohamed	7/27/2017	
Montgomery County, Ohio	17-CV-2647	The City of Dayton	Purdue Pharma L.P.; Purdue Pharma Inc.; The Purdue Frederick Co., Inc.; Teva Pharm. USA, Inc.; Cephalon, Inc.; Johnson & Johnson; Janssen Pharm., Inc.; Ortho-McNeil-Janssen Pharm., Inc.; Janssen Pharmaceutica, Inc.; Endo Pharm., Inc.; Allergan PLC; Actavis, Inc.; Watson Lab., Inc.; Actavis LLC; Actavis Pharma, Inc.; Endo Health Solutions Inc.; McKesson Corp.; Cardinal Health, Inc.; AmerisourceBergen Corp.; Russell Portenoy; Perry Fine; Scott Fishman; and Lynn Webster.	6/5/2017	Napoli Shkolnik, PLLC; Climaco, Wildcox, Peca, & Garofoli, C.O., L.P.A.
NDIL	1:14-cv-04361	City of Chicago	Purdue Pharma L.P.; Purdue Pharma Inc.; The Purdue Frederick Company, Inc.; Teva Pharmaceuticals USA, Inc.; Cephalon, Inc.; Johnson & Johnson; Janssen Pharmaceuticals, Inc.; Ortho-McNeil-Janssen Pharmaceuticals, Inc. n/k/a Janssen Pharmaceuticals, Inc.; Janssen Pharmaceutica, Inc. n/k/a Janssen Pharmaceuticals, Inc.; Depomed, Inc.; Endo Health Solutions, Inc., Endo Pharmaceuticals, Inc.; Allergan PLC, f/k/a Actavis PLC; Actavis, Inc. f/k/a Watson Pharmaceuticals, Inc.; Watson Laboratories, Inc.; Actavis LLC; and Actavis Pharma, Inc. f/k/a Watson Pharma, Inc.	2015	Motley Rice/Wexler Wallace
NY State Court	EFCA2017-252	Broome County NY	Purdue Pharma L.P.; Purdue Pharma Inc.; The Purdue Frederick Company, Inc.; Teva Pharmaceuticals USA, Inc.; Cephalon, Inc.; Johnson & Johnson; Janssen Pharmaceuticals, Inc.; Ortho-McNeil-Janssen Pharmaceuticals, Inc. n/k/a Janssen Pharmaceuticals, Inc.; Janssen Pharmaceutica, Inc. n/k/a Janssen Pharmaceuticals, Inc.; Endo Health Solutions, Inc., Endo Pharmaceuticals, Inc.; Russell Portenoy; Perry Fine; Scott Fishman; Lynn Webster	2/1/2017	Simmons Hanly

NY State Court	Dutchess County NY	Purdue Pharma LP; Purdue Pharma Inc.; The Purdue Frederick Company, Inc.; Teva Pharmaceuticals USA, Inc.; Cephalon, Inc.; Johnson & Johnson; Janssen Pharmaceuticals, Inc.; Ortho-McNeil-Janssen Pharmaceuticals, Inc. n/k/a Janssen Pharmaceuticals Inc.; Janssen Pharmaceutical, Inc. n/k/a Janssen Pharmaceuticals; Endo Health Solutions Inc.; and Endo Pharmaceuticals, Inc.; as well as physicians Russell Portenoy, Perry Fine, Scott Fishman and Lynn Webster	6/6/2017	Simmons Hanly
NY State Court	Erie County NY	Purdue Pharma LP; Purdue Pharma Inc.; The Purdue Frederick Company, Inc.; Teva Pharmaceuticals USA, Inc.; Cephalon, Inc.; Johnson & Johnson; Janssen Pharmaceuticals, Inc.; Ortho-McNeil-Janssen Pharmaceuticals, Inc. n/k/a Janssen Pharmaceuticals Inc.; Janssen Pharmaceutical, Inc. n/k/a Janssen Pharmaceuticals; Endo Health Solutions Inc.; and Endo Pharmaceuticals, Inc.; as well as physicians Russell Portenoy, Perry Fine, Scott Fishman and Lynn Webster	2/1/2017	Simmons Hanly
NY State Court	Orange County NY	Purdue Pharma LP; Purdue Pharma Inc.; The Purdue Frederick Company, Inc.; Teva Pharmaceuticals USA, Inc.; Cephalon, Inc.; Johnson & Johnson; Janssen Pharmaceuticals, Inc.; Ortho-McNeil-Janssen Pharmaceuticals, Inc. n/k/a Janssen Pharmaceuticals Inc.; Janssen Pharmaceutical, Inc. n/k/a Janssen Pharmaceuticals; Endo Health Solutions Inc.; and Endo Pharmaceuticals, Inc.; as well as physicians Russell Portenoy, Perry Fine, Scott Fishman and Lynn Webster	5/11/2017	Simmons Hanly
NY State Court	Nassau County NY	Purdue Pharma LP; Purdue Pharma Inc.; The Purdue Frederick Company, Inc.; Teva Pharmaceuticals USA, Inc.; et al.	6/12/2017	Napoli Shkolnik
NY State Court	Schenectady County NY	Purdue Pharma LP; Purdue Pharma Inc.; The Purdue Frederick Company, Inc.; Teva Pharmaceuticals USA, Inc.; Cephalon, Inc.; Johnson & Johnson; Janssen Pharmaceuticals, Inc.; Ortho-McNeil-Janssen Pharmaceuticals, Inc. n/k/a Janssen Pharmaceuticals Inc.; Janssen Pharmaceutical, Inc. n/k/a Janssen Pharmaceuticals; Endo Health Solutions Inc.; and Endo Pharmaceuticals, Inc.; as well as physicians Russell Portenoy, Perry Fine, Scott Fishman and Lynn Webster	6/15/2017	Simmons Hanly
NY State Court	Seneca County NY	Purdue Pharma LP; Purdue Pharma Inc.; The Purdue Frederick Company, Inc.; Teva Pharmaceuticals USA, Inc.; Cephalon, Inc.; Johnson & Johnson; Janssen Pharmaceuticals, Inc.; Ortho-McNeil-Janssen Pharmaceuticals, Inc. n/k/a Janssen Pharmaceuticals Inc.; Janssen Pharmaceutical, Inc. n/k/a Janssen Pharmaceuticals; Endo Health Solutions Inc.; and Endo Pharmaceuticals, Inc.; as well as physicians Russell Portenoy, Perry Fine, Scott Fishman and Lynn Webster	6/7/2017	Simmons Hanly

NY State Court		Suffolk County NY	Purdue Pharma LP; Purdue Pharma Inc.; The Purdue Frederick Company, Inc.; Teva Pharmaceuticals USA, Inc.; Cephalon, Inc.; Johnson & Johnson; Janssen Pharmaceuticals, Inc.; Ortho-McNeil-Janssen Pharmaceuticals, Inc. n/k/a Janssen Pharmaceuticals Inc.; Janssen Pharmaceutical, Inc. n/k/a Janssen Pharmaceuticals; Endo Health Solutions Inc.; and Endo Pharmaceuticals, Inc.; as well as physicians Russell Portenoy, Perry Fine, Scott Fishman and Lynn Webster	8/31/2016	Simmons Hanly
NY State Court	2017-961	Sullivan County NY	Purdue Pharma LP; Purdue Pharma Inc.; The Purdue Frederick Company, Inc.; Teva Pharmaceuticals USA, Inc.; Cephalon, Inc.; Johnson & Johnson; Janssen Pharmaceuticals, Inc.; Ortho-McNeil-Janssen Pharmaceuticals, Inc. n/k/a Janssen Pharmaceuticals Inc.; Janssen Pharmaceutical, Inc. n/k/a Janssen Pharmaceuticals; Endo Health Solutions Inc.; and Endo Pharmaceuticals, Inc.; as well as physicians Russell Portenoy, Perry Fine, Scott Fishman and Lynn Webster	6/7/2017	Simmons Hanly
Ross County, Ohio		State of Ohio & Mike DeWine	Purdue Pharma LP; Purdue Pharma Inc; The Purdue Frederick Company Inc, Teva Pharmaceutical Industries LTD; Teva Pharmaceuticals USA Inc.; Cephalon Inc; Johnson & Johnson; Janssen Pharmaceuticals Inc; Ortho-McNeil-Janssen Pharmaceuticals Inc; Jansen pharmaceuticals Inc; Endo Health Solutions; Endo Pharmaceuticals Inc; Allergan PLC; Watson Pharmaceuticals Inc; Watson Laboratories Inc; Actavis LLC	5/31/2017	Hagen Berman Sobol Shapiro
SDIL	17-CV-616	People of the State of Illinois; St. Clair County, Illinois	Purdue Pharma L.P.; Purdue Pharma Inc.; The Purdue Frederick Company, Inc.; Abbott Laboratories; Abbott Laboratories, Inc.	6/9/2017	Cates Mahoney, LLC; Law Office of Christopher Cueto , LTD; Holland, Groves, et al.; Goldenberg Heller & Antognoli PC
SDOH	17-CV-663	Belmont County Board of County Commissioners	AmerisourceBergen Drug Corporation, Cardinal Health, Inc., McKesson Corporation	7/28/2017	Hill, Peterson, Carper, Bee & Deitzler, PLLC
SDOH	17-CV-664	Brown County Board of County Commissioners	AmerisourceBergen Drug Corporation, Cardinal Health, Inc., McKesson Corporation	7/28/2017	Hill, Peterson, Carper, Bee & Deitzler, PLLC
SDOH	17-CV-662	Clermont County Board Of County Commissioners	AmerisourceBergen Drug Corporation, Cardinal Health, Inc., McKesson Corporation	7/28/2017	Hill, Peterson, Carper, Bee & Deitzler, PLLC
St. Louis, MO County Court		The State of Missouri; Joshua D. Hawley	Purdue Pharma, L.P.; Purdue Pharma, Inc.; Purdue Prederick Company; Endo Health Solutions, Inc.; Endo Pharmaceuticals, Inc.; Janssen Pharmaceuticals, Inc.; Johnson & Johnson	6/21/2017	
The Superior Court of Orange County, CA	30-2014-00725287	The People of the State of California	Actavis LLC; Actavis Pharma, Inc.; Actavis, Inc.; Actavis, PLC; Cephalon, Inc.; Endo Health Solutions, Inc.; Endo Pharmaceuticals, Inc.; Janssen Pharmaceutica, Inc.; Janssen Pharmaceuticals, Inc.; Johnson & Johnson; Ortho-McNeil-Janssen Pharmaceuticals; Purdue Pharma, LP; Purdue Pharma Inc.; Purdue, Inc.; Teva Pharmaceutical Industries, Ltd.; Teva Pharmaceuticals USA, Inc.' The Purdue Frederick Company, Inc.; Watson Laboratories, Inc.; Watson Pharmaceuticals, Inc.	5/21/2014	

WDWA	17-CV-209	Snohomish County	Purdue Pharma L.P.; Purdue Pharma Inc.; The Purdue Frederick Company, Inc.; John and Jane Does 1 through 10	2/10/2017	Kelley, Goldfarb; Huck; Roth; & Riojas, PLLC
WDWA	17-CV-209	The City of Everett	Purdue Pharma, L.P.; Purdue Pharma, Inc.; The Purdue Frederick Co., Inc.; John and Jane Does 1 through 10, individuals who are executives, officers, and/or directors of Purdue.		Kelley, Goldfarb, Huck, Roth & Riojas, PLLC
WVSD	17-CV-2028	Boone County Commission	AmerisourceBergen Drug Corporation, Rite Aid of Maryland, Inc., Kroger Limited Partnership II, Cardinal Health, Inc., McKesson Corporation, Kroger Limited Partnership I, H.D. Smith Wholesale Drug Co., Anda, Inc., Generics Bidco I, LLC, Anda Pharmaceuticals, Inc., Bellco Drug Corp. and Qualitest Pharmaceuticals, Inc.	3/27/2017	Hendrickson & Long/Powell & Majestro (WV firms)
WVSD	17-CV-1665	Cabell County Commission	AmerisourceBergen Drug Corporation, CVS Indiana, L.L.C., Cardinal Health, Inc., Rite Aid of Maryland, Inc., Wal-Mart Stores East, LP, Kroger Limited Partnership II, McKesson Corporation, Walgreen Eastern Co., Inc., Kroger Limited Partnership I and H.D. Smith Wholesale Drug Co.	3/9/2017	Hendrickson & Long/Powell & Majestro (WV firms)
WVSD	17-CV-1957	Fayette County Commission	Cardinal Health, Inc., CVS Indiana, L.L.C., AmerisourceBergen Drug Corporation, Rite Aid of Maryland, Inc., Wal-Mart Stores East, LP, Kroger Limited Partnership I, Kroger Limited Partnership II, McKesson Corporation and Top Rx, LLC	3/21/2017	Hendrickson & Long/Powell & Majestro (WV firms)
WVSD	17-CV-1666	Kanawha County Commission	AmerisourceBergen Drug Corporation, Rite Aid of Maryland, Inc., Cardinal Health, Inc., Kroger Limited Partnership II, CVS Indiana, L.L.C., Omnicare Distribution Center LLC, McKesson Corporation, Wal-Mart Stores East, LP, Miami-Luken, Inc., Kroger Limited Partnership I, The Harvard Drug Group, L.L.C., Walgreen Eastern Co., Inc., Anda, Inc., Anda Pharmaceuticals, Inc., Masters Pharmaceutical, Inc. and Keysource Medical, Inc.	3/9/2017	Hendrickson & Long/Powell & Majestro (WV firms)
WVSD	17-CV-2296	Logan County Commission	Cardinal Health, Inc., McKesson Corporation, AmerisourceBergen Drug Corporation, Rite Aid of Maryland, Inc., Wal-Mart Stores East, LP, Kroger Limited Partnership II, H. D. Smith Wholesale Drug Co., The Harvard Drug Group, L.L.C., Kroger Limited Partnership I, Miami-Luken, Inc., Anda Pharmaceuticals, Inc., Cedardale Distributors LLC, Anda, Inc., Bellco Drug Corp., SAJ Distributors and Masters Pharmaceutical, Inc.	4/11/2017	Hendrickson & Long/Powell & Majestro (WV firms)
WVSD	17-CV-1362	The City of Huntington	AmerisourceBergen Drug Corporation, Cardinal Health, Inc., McKesson Corporation and Gregory Donald Chaney	2/23/2017	Hendrickson & Long/Powell & Majestro (WV firms)
WVSD	17-CV-946	The County Commission of McDowell County	AmerisourceBergen Drug Corporation, Cardinal Health, Inc., McKesson Corporation, Harold Anthony Cofer, Jr., & Cardinal Health 110, LLC	1/25/2017	The Bell Law Firm, Morgan & Morgan Complex Litigation Group, and Troy Law Firm
WVSD	17-CV-1962	Wayne County Commission	Rite Aid of Maryland, Inc., CVS Indiana, L.L.C., McKesson Corporation, Cardinal Health, Inc., SAJ Distributors, Wal-Mart Stores East, LP, AmerisourceBergen Drug Corporation and Top Rx, LLC	3/21/2017	Hendrickson & Long/Powell & Majestro (WV firms)
WVSD	17-CV-2311	Wyoming County Commission	AmerisourceBergen Drug Corporation, Rite Aid of Maryland, Inc., McKesson Corporation, H. D. Smith Wholesale Drug Co., Miami-Luken, Inc., J M Smith Corporation, Anda, Inc. and The Harvard Drug Group, L.L.C.	4/12/2017	Hendrickson & Long/Powell & Majestro (WV firms)

Mississippi

Department of Administration

Andy Albarado, County Administrator

May 14, 2025

TO: Executive Committee

FR: Andy Albarado

RE: Chippewa Valley Health Cooperative Update Regarding the Community Hospital

On 07/09/2024, the County Board approved Resolution 29-24 to support the location of a community hospital in Chippewa County and to authorize $70,000 to be used by the Chippewa Valley Health Cooperative to complete a financial feasibility study. The funding came from the Land Development Fund. The proposed community hospital will include a morgue, and the Chippewa Valley Health Cooperative has agreed to allow the County to use it at little or no cost, but for the cost of supplies.

The Chippewa Valley Health Cooperative has an executed purchase agreement for the HSHS St. Joseph's Hospital in Chippewa Falls. Their goal is to use that facility until the new hospital is built. They are currently in the process of a capital campaign to raise between $30-$40 million in equity capital so they can then borrow the remainder of the total $170 million project cost.

As a reminder the Chippewa County Board approved Resolution 21-24 to allocate $750,000 of sales tax funds to construct a new County Morgue as a result of the hospital closures. Chippewa County is currently using the Stokes, Proct & Mundt Funeral Chapel & Crematory in Altoona as our morgue until we can secure a permanent facility. If the Chippewa Valley Health Cooperative is able to open the HSHS St. Joseph's Hospital until the new hospital is constructed, that would allow us to use the existing morgue like we did before the hospital closure.

Representatives from the Chippewa Valley Health Cooperative provided an update to Eau Claire County and they now want to provide a similar update to Chippewa County. The report will provide an overview of the findings from the feasibility study along with an update on the project and a request for Chippewa County to contribute financially to the project.

The goal of this agenda item is to provide you with information. Chippewa County is not being asked to financially commit to anything at this time. The only potential action request would be to direct the County Administrator to do further due diligence on the matter.

Sincerely,

Andy Albarado
County Administrator

711 N. Bridge Street, Room 106
Chippewa Falls, WI 54729
aalbarado@chippewacountywi.gov
Ph: (715)
Fx: (715)

Raising Capital for the Chippewa Valley Health Cooperative

Chippewa Valley Health Cooperative

05/20/2025

1

Chippewa Valley Health Cooperative needs to raise $30-$40 million in equity capital to borrow the remainder of the total $170 million project cost

Philanthropy	Federal earmarks	Federal grants
State appropriations	Corporate contributions	Revenue Bonds
Appeal to community benefactors	Members (currently ~$8.5 M)	Ask Counties to partner....

2

Wipfli Financial Proforma Demonstrates CVHC's Financial Feasibility/Sustainability

- Wipfli Financial Proforma
  - Nationally Recognized Healthcare Financial experts
  - Conducted detailed study analyzing:
    - Local healthcare market needs
    - Financial performance of comparable hospitals
    - Potential staffing availability
  - Demonstrates CVHC's proposed hospital with 48 beds is financially feasible after one year of operation
  - Interim hospital impact
    - Serve a vitally important community healthcare need
    - Restore Chippewa County morgue
    - Employ 400+ medical professionals and supporting staff at estimated annual payroll of $40 million
    - Create CVHC financial performance history for new hospital in Lake Hallie

3

Key Statistics from Proforma

- Hospital Statistics (year 3)
  - 2372 admissions
  - 531 births
  - Average census – 33.4 patients
  - 10,406 ER visits
  - 3587 surgical procedures
  - Payor mix comparable to Sacred Heart Hospital

4

Financial Statistics from Proforma

- Sources of Funds:
  - USDA financing - $125.5m
  - Equity Contribution - $32.9m
  - Total - $158.4m
- Uses of Funds:
  - Land/Construction - $101m
  - Architectural and Engineering - $5m
  - Furniture, fixtures, and equipment - $20.5m
  - Interest during construction - $5.8m
  - Start up capital and financing costs - $26.1m
  - Total - $158.4m

5

Financial Statistics from Proforma

- Annual Debt Service - $7.1m
- EBIDA Needed for 1.25x Debt Service Coverage - $8.9m
- Projected EBIDA –
  - Year 3 - $11.8m
  - Year 4 - $12.5m
  - Year 5 - $13.1m
- Note: Interim Hospital would have similar EBIDA with little or no Debt Service

6

Types of Debt tools for Local Governments

GENERAL OBLIGATION DEBT

- Used for general municipal borrowing
- Maximum debt capacity is 5% municipal/county equalized value
- Debt default risk shared by county taxpayer

REVENUE-BACKED DEBT INSTRUMENT

- Used for enterprise funding, utility or revenue-backed project funding (Ex. landfill, nursing home, civic center, etc)
- ***Need history of revenue to show ability to generate revenue, risk potential***
- Higher interest rate than G.O debt
- Risk default only carried by enterprise fund/utility, not county taxpayer

7

BCPL STATE TRUST FUND LOAN PROGRAM

Within our diversified investment portfolio, the BCPL State Trust Fund Loan Program provides an important amount of distributable income for our beneficiaries. The program allows us to invest our Trust Funds in direct loans to municipalities and school districts throughout the State. These loans provide the Trust Funds with a good rate of return at a very low risk. Since 1871, throughout the ebbs and flows of economic cycles and the course of history, we have been investing in these loans and have never had a default. We are proud to be able to contribute to building Wisconsin's public infrastructure by financing community and school projects as one of the largest government lenders in Wisconsin.

BCPL State Trust Fund loans can be used by local governments, school districts, and special districts to finance virtually any project in the State of Wisconsin. While these loans can be used for any public purpose, they are typically used for financing:

- Economic Development – Loans to fund acquisition and development of land for business and industrial parks, provide incentives to private companies, fund municipal TIF District projects including street and utility work, and environmental remediation.
- Local Infrastructure – Loans to fund construction or repair of municipal buildings, schools, streets, and utilities.
- Capital Equipment and Vehicles – Loans to fund the purchase of capital assets including public safety vehicles, telephone and computer systems, and road and snow equipment.

Borrowers appreciate that the BCPL application process is extremely simple and there are no application fees, prepayment penalties, or any other fees. Our interest rates are competitive with the bond market and other financial institutions. But what really makes our program special is that all of the interest paid on State Trust Fund loans is returned to Wisconsin communities in the form of aid to public school libraries. That's why we like to think of ourselves as **'The Statewide Lender That Pays Local Dividends!'**

During the 2021-23 biennium, BCPL disbursed a total of 229 loans totaling more than $151million.

A complete listing of BCPL State Trust Fund Loan activity during the biennium is included in the appendix.

8

9

BOARD OF COMMISSIONERS OF PUBLIC LANDS
1849

Managing Wisconsin's trust assets for public education

Sarah Godlewski, *Secretary of State*
John Leiber, *State Treasurer*
Joshua L. Kaul, *Attorney General*

101 E. Wilson Street
2nd Floor
PO Box 8943
Madison, WI 53708-8943

(608) 266-1370 INFORMATION
(608) 266-0034 LOANS
(608) 267-2787 FAX
bcpl.wisconsin.gov

Thomas P. German, *Executive Secretary*

Fact Sheet - General Obligation Loans

Eligible Borrowers:	Wisconsin towns, villages, cities, counties, school districts, technical college districts, public inland lake protection and rehabilitation districts, town sanitary districts, metropolitan sewerage districts, metropolitan sewerage systems, joint sewerage systems, consortiums, cooperative educational service agencies (CESAs), federated public library systems, and drainage districts.
Loan Process:	Simple and transparent, with funds available 30-45 days from initial application request.
Loan Security:	Loans become a general obligation of the borrower and require the borrower to levy a tax sufficient to make annual principal and interest payments when due.
Loan Purpose:	Loans of 10 years or less may be made to facilitate the performance of any power or duty of the borrowing municipality, including operations and maintenance. Loans greater than 10 years are restricted to the financing or refinancing of public purpose projects including "the acquisition, leasing, planning, design, construction, development, extension, enlargement, renovation, rebuilding, repair or improvement of land, waters, property, highways, buildings, equipment, or facilities", or any purpose otherwise allowed by law.
Economic Development Lending:	BCPL is a major source of funding for economic development projects including pass-through loans or grants made for private development, funding development incentives, TID infrastructure loans, land acquisition and development of business parks, and similar projects. Upon request, BCPL is able to provide critical flexibility in the repayment schedule if and when expected revenues are delayed.
Payments:	Annual payments are due March 15 each year and are exempt from State of Wisconsin municipal levy limit calculations. Loans funded between September 1 and March 14 do not have a required payment the following March 15. BCPL can provide custom amortization schedules to coordinate payments with future budgeted items. Upon request, we can allow a few years of interest-only payments to provide sufficient time for the project to generate expected revenues.
Prepayment:	Prepayments are allowed without penalty between January 1 and August 31 each year, upon 30 days prior written notice. This flexibility can be extremely valuable for our customers when compared to the rigid payment structure required after selling bonds. Tired of waiting for a call date? Call BCPL!
Terms:	2-year to 20-year fixed rate loans.
Current Rates:	Loan Term: 2 years 5.75%; 3-5 years 5.75%; 6-10 years 5.75%; 11-20 years 5.75%
Rate Lock:	Market-based interest rates are locked for 60 days following BCPL receipt of the loan application request form. If the completed application is received by BCPL within 60 days, the rate lock remains in place through final loan approval, the 4-month draw period, and the full term of the loan.
Fees:	No application fees, origination fees or prepayment fees. **No fees period!**
Best Part:	100% of interest earned by BCPL is distributed to provide the sole state aid for public school library media and resources. This payment effectively reduces local real estate taxes by providing schools with another source of funding. See our website for the annual contribution BCPL made to your local school district. You might be surprised!

Rev. 06/27/2023

Board of Commissioners of Public Lands:

https://bcpl.wisconsin.gov/bcpl.wisconsin.gov%20Shared%20Documents/Loans/FactSheet_GOLoans.pdf

Easy source for G.O. debt access

Quick (30-45 day turn around)

No application fees

Levy requirements for repayment are not subject to Levy Limits

Interest revenues BCPL receives goes to fund public school library resources

Extension
UNIVERSITY OF WISCONSIN–MADISON
LOCAL GOVERNMENT EDUCATION PROGRAM

10

Debt capacity of Chippewa County

County	Full Value (2023)	Allowable Debt	Actual Debt	Margin (add. debt capacity)
Chippewa	$9,298,786,200	$464,939,310	$8,450,000	$456,489,310

- **Chippewa Valley Health Cooperative would pay 100% of principal and interest !!!**
- $10 Million loan request still provides Chippewa County plenty of G.O. debt capacity for future debt needs

11

Example: La Crosse County

- La Crosse County
  - City Brewery following closure of G.Heilemen/Strohs brewery
  - Since 1999 La Crosse County has used STFL in 9 separate occasions

LA CROSSE COUNTY'S USE OF THE BCPL STATE TRUST FUND LOAN PROGRAM

–Steve O'Malley, La Crosse County Administrator

Steve O'Malley, La Crosse County Administrator

My responsibilities as county administrator includes working with the finance department and an independent financial advisor to evaluate the most advantageous method for financing long-term debt. In my experience, the most appropriate means for debt financing is the sale of promissory notes or bonds in a competitive sale. Bonds or notes sold in this manner for a term of 10 or 20 years, likely provides a lower true interest cost than can be realized by using the BCPL State Trust Fund Loan (STFL) Program.

However, depending upon the circumstances, there can be advantages to using STFL, including a simplified application process, no pre-payment penalty, and no cost of issuance. Since 1999, La Crosse County has used the STFL program on nine different occasions.

In 1999, La Crosse County borrowed $1.5 million to assist a group of local investors to purchase the assets of Heileman Brewery – one of the area's iconic employers – in order to create the City Brewery Company. At the time, it seemed unlikely that the bond market would offer a favorable rate for such a venture and the debt might require a penalty for early payment. As it turned out, the county only needed to lend $616,000 to the brewery and the entire loan was fully repaid by 2003 without risk to the county. This employer is still in business today.

In 2004, the county chose to use STFL to refinance its outstanding pension liability to the Wisconsin Retirement System at a 5.25% instead

The most innovative use of the STFL program was in 2015 and 2016 when La Crosse County converted two General Obligation debt issues to Revenue Debt ($7.8 million and $5.475 million) for the county's solid waste enterprise. The debt was originally incurred mainly to install environmental improvements to reduce air pollution from the Waste-To-Energy plant operated by Xcel energy. The plant burns refuse-derived fuel (municipal solid waste) generating electricity for about 20% of the homes in the City of La Crosse, while reducing the amount of waste buried in the landfill.

The original debt was required to be a taxable issue with much higher rates of up to 4.5% and 5.95% as General Obligation Debt. BCPL agreed to refinance these two issues as Revenue Debt at a fixed rate of 3.75% and 4%, lowering the cost of debt service. Because the solid waste enterprise has always been able to cover debt obligations from tipping fees, the county felt this use of Revenue Debt presented a better picture to Moody's Investor Service when conducting their annual rating review. La Crosse County's long-term debt has been rated at Aa1 since 2010, only one step below the highest rating of Aaa.

It is always best to use an independent financial advisor to help each local government consider the pros and cons of the best means of financing. A financial advisor has a fiduciary responsibility to

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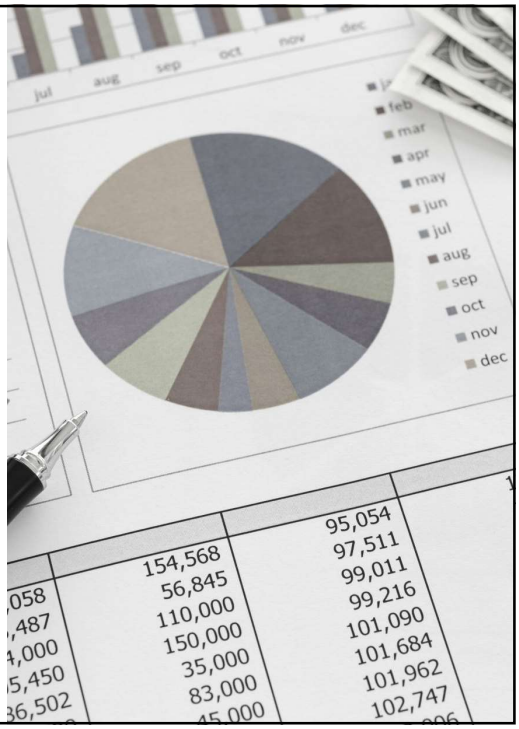
Specific Ask:

- Is Chippewa County willing to allow a small portion of their General Obligation (G.O.) Debt to secure a community-owned Health Care Facility in the Chippewa Valley?
  - ALL the borrowed money (Principal & Interest) to be paid back (in 10 years or less) – **no out of pocket cost to Chippewa County**
  - ALL the borrowed money invested in the local area (Chippewa Valley)
  - ALL employees of CHVC are local residents and taxpayers
  - ANY Chippewa County resident will be eligible for care through the Chippewa Valley Health Cooperative?
  - G.O. debt may be converted to a revenue debt instrument in future (once revenue stream established)?
- $10 Million Loan from BCPL for CVHC
  Payments from hospital revenues (Wipfli Proforma)
- Will help with CVHC Federal/State grant requests if local municipalities are involved with funding!!!



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Worst Case Scenario - Impact to Chippewa County

Equalized Value	Debt Risk	Default annual impact	Median Property Value	Median Property Impact (Annual)
$9,536,158,100.00	$10,000,000.00	(1,332,246.02)	$237,700.00	$33.21

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Debt issuance conditions:

- **(1)** The governing body of a county may not issue bonds under s. 67.05 or promissory notes under s. 67.12 (12) unless one or more of the following apply:
- **(a)** A referendum is held, following the procedures in s. 67.05 (3), that approves the debt issuance.
- **(b)** The governing body of the county adopts a resolution that sets forth its reasonable expectations that issuance of the debt will not cause the county to increase the debt levy rate, as defined in s. 59.605 (1) (b).
- **(c)** Issuance of the debt was authorized by an initial resolution adopted by the governing body of the county prior to August 12, 1993.
- **(d)** The debt is issued for the purposes under s. 67.05 (7) (c), (cc), (f), (h) or (i).
- **(e)** The debt is issued to fund or refund outstanding municipal obligations, interest on outstanding municipal obligations, or the payment of related issuance costs or redemption premiums.
- **(f)** The governing body adopts a resolution to issue the debt by a vote of at least three-fourths of the members-elect, as defined in s. 59.001 (2m).
- **(g)** The debt is issued by a county having a population of 750,000 or more to pay unfunded prior service liability with respect to an employee retirement system.
- **(h)** The debt is issued for the purpose of acquiring or installing energy efficient equipment.
- **(2)**
- **(a)** The department of revenue shall promulgate rules that set forth the standards to be used by the governing body of a county in adopting a resolution under sub. (1) (b). The rules shall permit the reasonable exercise of local self-determination and debt management and prohibit the consideration of unreasonable assumptions that may cause an increase in the debt levy rate, as defined in s. 59.605 (1) (b).
- **(b)** The standards in the rules under par. (a) shall address issues including all of the following:
- **1.** The equalized value of taxable property in the county.
- **2.** The annual debt service on the debt being issued.
- **3.** The treatment of anticipated refunding of balloon payments.
- **4.** Variable rate obligations.
- **5.** Past and anticipated revenues that may abate a debt levy.
- **6.** The amount of state aid that may be received in future years.

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Questions

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Chippewa Valley

Health Cooperative

TRANSFORMING THE HEALTHCARE LANDSCAPE IN THE CHIPPEWA VALLEY TO HELP OUR COMMUNITY

THRIVE

chippewavalleyhealthcooperative.org

HEALTH CARE FOR THE CHIPPEWA VALLEY

The Chippewa Valley faces an unprecedented healthcare crisis. For over a decade, access to affordable, timely, exceptional healthcare and hospital services has been an increasing issue throughout our region. As our community has grown, our local healthcare ecosystem has struggled to keep pace and was further challenged as we weathered the pandemic together.

And then Illinois-based HSHS closed Sacred Heart and St. Joseph's hospitals and their 19 Prevea clinics in Western Wisconsin. After a surprise announcement on January 22, 2024, HSHS exited the region in March 2024, the fastest market exit of a hospital system ever in the United States.

What was a challenge for a smaller portion of our community has now become a crisis for us all. Despite the best efforts of the remaining healthcare systems to accommodate the over 70,000 patients displaced by the hospital and clinic closures, critical services such as labor & delivery, cancer treatment, critical care, cardiology, and surgery are maxed out. Emergency Room wait times have soared. The result? More and more of our family members and neighbors travel at least 95 miles, and often up to 250 miles each way outside our region to get the care they need.

Healthcare costs have also surged, with local businesses reporting significant, double-digit increases in employee healthcare expenses across the board in the last year.

The Chippewa Valley Health Cooperative was formed six weeks after HSHS's announcement to solve the healthcare crisis in our region. **Our goal is bold yet simple:** find a BETTER WAY to provide healthcare here that lowers costs, increases access to care, keeps care close to home, and delivers exceptional experiences and outcomes from physicians and other medical professionals we know and trust.

We seek not to replace what has been lost **but to transform the healthcare landscape in the Chippewa Valley so that our community can thrive for generations to come.**

The Cooperative's Way

- **Accountable Governance:** Our Cooperative is governed by local members, ensuring that every decision reflects and meets the needs of **our community.**
- **Reinvestment in the Region:** Cooperative investments in infrastructure and services benefit the community directly, with reinvestment staying **here**, where it belongs.
- **Prioritizing Local Partners:** Our Cooperative prioritizes working with local partners to provide the equipment, resources, services, and materials we need to succeed. We make purchasing decisions **here** for our members and our community.
- **Efficient and Independent:** Our Cooperative is local and lean, free from the burdens of excessive bureaucracy that weighs down the bottom line and complicates and delays decision-making, so we can focus on delivering innovative, high-quality care.

The Cooperative will deliver what our community wants and needs: modern, innovative, and exceptional healthcare delivered by excellent local physicians and medical professionals we know, who are free to care for patients throughout their entire healthcare journey, and who are unburdened by corporate standards that dictate time spent, tests ordered, and treatment plans prescribed. We will always prioritize medicine over unrelated metrics.

We are breaking the mold to help fix the healthcare crisis we are in. It's about building something better, not just to replace but to improve. If any community can revolutionize local healthcare delivery, it's the Chippewa Valley.

We hope you join us in creating a healthier future for our community.

Robert Krause
Chair

Patti Darley
Vice Chair

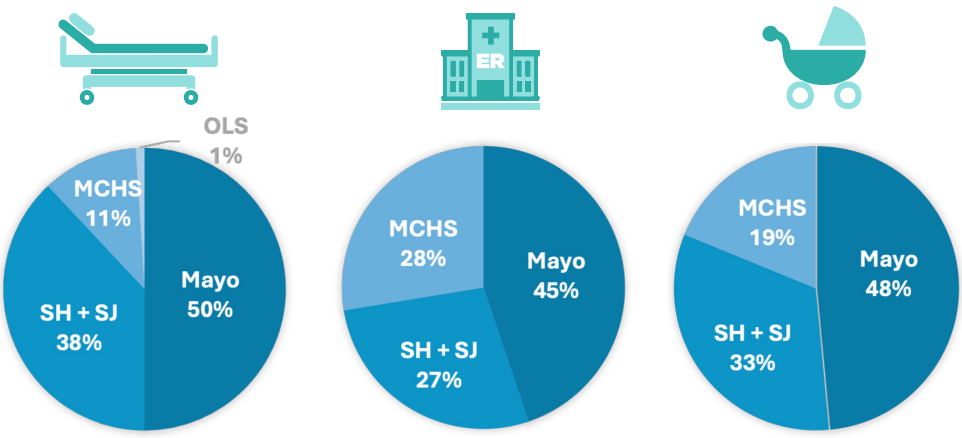
Board of Organizers

THE NEED

Since HSHS closed its hospitals, cancer center, and the rest of its Prevea healthcare clinics, local physicians, providers, clinics, and hospitals have been scrambling to provide the healthcare services the community needs.

While the two other local hospitals have done what they can to accommodate the influx of patients previously cared for at St. Joseph's, Sacred Heart, and Prevea's specialty clinics, they **simply do not have enough capacity or the physicians and other trained medical staff to do so.**

2023



Avg Hospital Inpatient Census

SH + SJ

Avg 112 daily inpatients

40,880 hospital night stays yearly

Emergency Room Visits

SH + SJ

22,875 visits

Newborn Deliveries

SH

763 newborns

* Source, Wisconsin Hospital Association, Information Center, FY 2023

"Before Prevea Cancer Clinic closed, we used to be able to just run into the clinic if there was an issue or Donnie needed anything. Now, everything we have to do for him is in Lacrosse, so everything is a 4-hour round trip, no matter if it's an appointment, a lab or scans. It's incredibly stressful knowing it's such a long drive if anything goes south."

Glenda Nelson, who cares for her husband Donnie

300 cancer patients were moved from Eau Claire to other facilities in Wisconsin and Minnesota in March, 2024

NEW INDEPENDENT COMMUNITY HOSPITAL

The Chippewa Valley Health Cooperative is building a new modern, independent hospital to help close the significant capacity gap HSHS's withdrawal from the region created. Our goal is not to just replace what was lost, but to improve hospital services in the region.

The new nonprofit hospital will be approximately 144,000 square feet and employ over 410 full-time employees, not including the medical staff.

Concept Rendering

Inpatient Care:

- 48 total beds, including a 12-bed ICU
- Average daily census: 33 patients
- Medical-surgical, labor and delivery, and critical care units

Emergency Department:

- Will handle more than 10,400 visits annually

Cancer Care:

- Comprehensive Cancer Center with radiation therapy and chemotherapy to serve oncology patients in the community

Surgical & Procedural Services:

- 4 operating rooms, 2 GI rooms
- Projected volume of 1,750 surgeries and 1,800 GI scopes per year
- Full pre- and post-surgical care

Therapy Services:

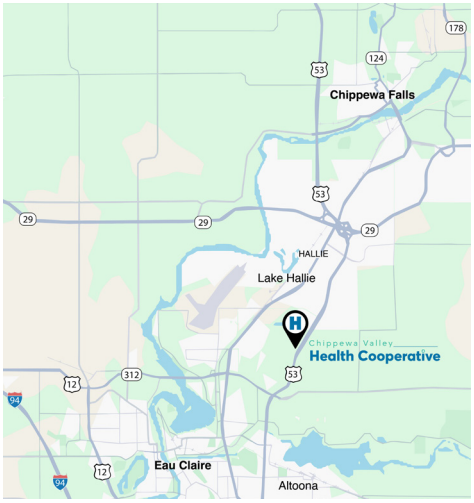
- Physical Therapy: 19,000 procedures annually
- Occupational Therapy: 2,300 visits annually
- Speech Therapy: 650 visits annually

Diagnostic Services:

- Comprehensive Laboratory and Radiology facilities
- Cardiology services for advanced heart care

Strategically Located For Growth and Access:

- New facility built for the future; efficient, right-sized, low maintenance
- Easy access for Emergency Services across counties
- Location allows for flexible, strategic growth
- Central to largest population centers
- Easy rural community access



THE COOPERATIVE'S WAY

The Chippewa Valley Community Hospital will stand as a beacon of exceptional healthcare, dedicated to elevating the health and well-being of our community through unparalleled quality, patient-centered care, and innovative hospital practices. Our nonprofit hospital is committed to achieving the highest standards of excellence and setting a new benchmark for healthcare in the region.

PHYSICIAN-CENTERED

Physicians and the medical staff are the heart of any great hospital. The Cooperative is in the unique and unprecedented position to have an excellent medical staff already identified and in the community. Unlike any other hospital in the region, The Cooperative will not need to recruit new physicians to move to our community to create the hospital bed and service capacity the region so desperately needs.

The Chippewa Valley is home to an extraordinary, long-standing network of independent physicians and healthcare providers who have already pledged to care for their current and future patients who need hospital services at the Cooperative's new community hospital.

Many of these physicians are the same doctors who staffed Sacred Heart and St. Joseph's hospitals and accounted for the overwhelming majority of hospital referral admissions. These independent physicians care for more than 60,000 patients throughout the Chippewa Valley today.

"Building a new, modern independent hospital will help ensure that the Chippewa Valley is a desirable location for exceptional physicians and healthcare providers to come, build fulfilling careers, and become strong members of our communities."

Kyle Dettbarn, MD

Our Goals

- **Exceptional, Accessible Patient Care:** We will create an environment where patient experience is paramount
- **Excellent Medical Staff** in place and pledged to support the new hospital
- **Local Control** is guaranteed by our Cooperative Model that mandates local control for the benefit of our local members
- **Built for the Future:** designed for best practices and the flexibility to evolve with healthcare technologies; no compromises due to aging buildings and overwhelming infrastructure costs
- **Sustainable:** Financial stability and excellence will be at the core of our operations

OUR GOAL: BRING PATIENTS BACK TO THE CHIPPEWA VALLEY

The Chippewa Valley is home to a wide range of leading businesses across many different industries – many of which self-fund their health insurance. Offering competitive healthcare benefits to employees is a strategic imperative for local businesses to attract and retain great talent. This means ensuring their employees have both access to high-quality healthcare and reasonable costs for healthy outcomes.

For a variety of reasons, Eau Claire is one of the most expensive cities for healthcare costs in the country. **In the year since HSHS exited the region, local businesses have seen their healthcare costs increase dramatically while access to the care they need has shrunk.**

Self-funded employers have increasingly sent their employees out of the area for the healthcare their employees need so their employees can be cared for faster and at much less cost than local providers can offer.

One large local company recently had an employee who required much-needed surgery. After comparing costs and services, the employee had his surgery in a top hospital, along with two weeks in a rehabilitative facility, in Minneapolis for about half the cost of the same surgery in the Eau Claire area. The cost savings meant that the company could provide more healthcare services for their employees.

Building a modern, independent community hospital will increase access to and the affordability of healthcare here.

"Every time a local patient needs to travel outside the area for healthcare services, they contribute to the economy of a different region. When care is local, local businesses help those patients, and our local economy benefits."

Eric Rygg,
Silver Spring Foods

HOW WILL WE INCREASE ACCESS AND LOWER COSTS?

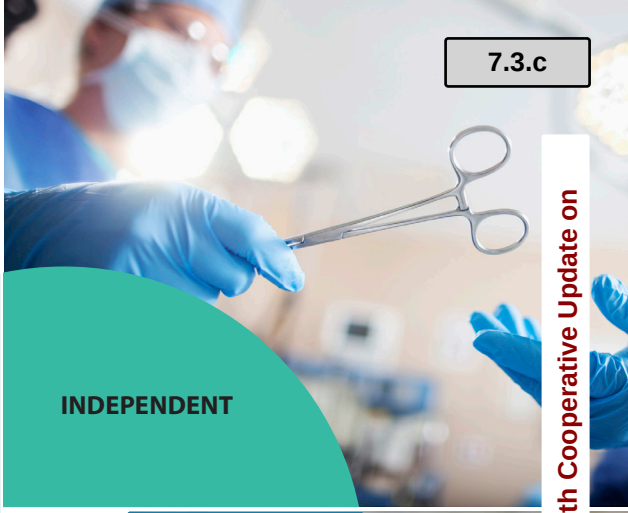
We know our bold vision begs the question, "if HSHS and Prevea couldn't do it, how can you?" The answer lies in a combination of factors that work together, and help us change the healthcare landscape here, and be a model for other communities facing similar crises.

- **We are Independent**
  Independent hospitals (over 1,500 across the United States) run without being part of a larger hospital system, healthcare network, or corporate holding company. Unlike hospitals that are part of a larger system, the Cooperative's hospital and other facilities will not need to support any other hospitals, clinics, or operations.

- **We are a Cooperative**
  We are a Cooperative, accountable to our members, all residents of the Chippewa Valley. All decisions will be made here by our local physicians, medical staff, and lean hospital management.

- **A Community Hospital**
  The Cooperative does not employ physicians beyond a few key positions. Unlike hospital systems that employ primary care and specialist physicians who work in their clinics and admit patients to their facilities, the Cooperative's hospital model will not have the expensive salaries and associated costs for physicians.

- **Sustainable**
  Financial stability and excellence are paramount to our operations. Given our focus on quality, patient experience, and cost-effective health care, we are establishing sustainable contracts with third-party payors and will become the preferred community hospital for local employers. In addition, by building an efficient, modern, flexible and right-sized hospital, the Cooperative will not be saddled with overwhelming legacy maintenance costs that are required in the two closed hospitals.



INDEPENDENT

SUSTAINABLE

COOPERATIVE

COMMUNITY HOSPITAL

"The Cooperative is breaking the mold to help fix the healthcare crisis we are in. We've started from a bold vision, and every step of the way, we have examined how we can do things better and avoid the pitfalls other hospitals and hospital systems have to ensure we can deliver exceptional healthcare in the most cost-effective way possible. It's about building something better, not just to replace but to improve what is available, and setting us up for a sustainable, successful future. If any community can revolutionize local healthcare delivery, it's the Chippewa Valley."

Kamal Thapar, MD, PhD

BRIDGE TO THE FUTURE 2025 - 2027

What the new hospital will cost?

The projected construction cost for the 144,000-square-foot state-of-the-art independent hospital is $120 million. Total project cost is $158 million. We expect to be open by late 2027.

Financing for the hospital will be supported through community philanthropy, grants, and loans.

We seek to raise $55 million from community gifts, pledges, and grants towards the overall goal, which will, in turn, help us secure more favorable financing and additional grants.

The Proforma, completed by WIPFLI, an expert in hospital financial operations, conservatively projects positive cash flow three years after opening our doors.

Reopening St. Joseph's Hospital as Interim Facility

Our goal is to start taking care of patients as fast as possible while we build for the future. To that end, the Cooperative has signed a letter of intent with HSHS to purchase St. Joseph's and reopen the building as an interim facility.

The Cooperative has until early June 2025 to determine if opening St. Joseph's is financially possible. We've fast-tracked due diligence and are hopeful that we can reopen the facility in late 2025.

"Fortunately, most of the costs required to reopen St. Joseph's as an interim facility can be applied to the new hospital. Not only will running the older facility for two years while we are building the new hospital allow us to care for patients faster and create more than 400 jobs this year, it will establish our operating contracts faster, generate cash flow, and build our credit. All of these factors will position the Cooperative for even more favorable financing options."

Lori Geissler, Board of Organizers

WHY A COOPERATIVE?

The Board of Organizers chose the Cooperative business structure to ensure that the new hospital and any other services we ultimately offer will be **governed by and accountable to the people of the Chippewa Valley.**

With this structure, the Board of Organizers is ensuring both prioritizing local interests and local control so that **decisions for the hospital will always be made by people here, not by people or organizations located out of state or outside our region.**

Cooperatives help ensure local economic development, keeping money in the region and reinvesting in the community.

Members

The Cooperative has three different memberships:

- **Community Members** must be residents of the 18-county greater Chippewa Valley region, at least 18 years old, and intend to use the Cooperative services if needed. Community Members annually elect seven of the Board of Directors, all of whom must be members of the Cooperative and residents of one of the 18 counties. Lifetime membership fee: $25.
- **Medical Professional Members** are qualified licensed medical professionals who hold a valid license to practice medicine in the state of Wisconsin. Medical Professional Members intend to provide medical services at Cooperative facilities. They elect the three medical professional designated members of the Board of Directors. Lifetime membership fee: $100.
- **Patient Members** are any person who has received medical services at a Cooperative facility. Patient Members do not have voting rights in the Cooperative. Fee: $0.

As of January 2025, the Cooperative has over 1,000 community and medical professional members, people who believe in our mission and who are invested in helping bring our vision to life.

INVITATION TO SUPPORT OUR MISSION

The Chippewa Valley Health Cooperative, a 501c3 nonprofit organization dedicated to patient-centered care, will have a positive, long-lasting impact on our community's health for generations to come.

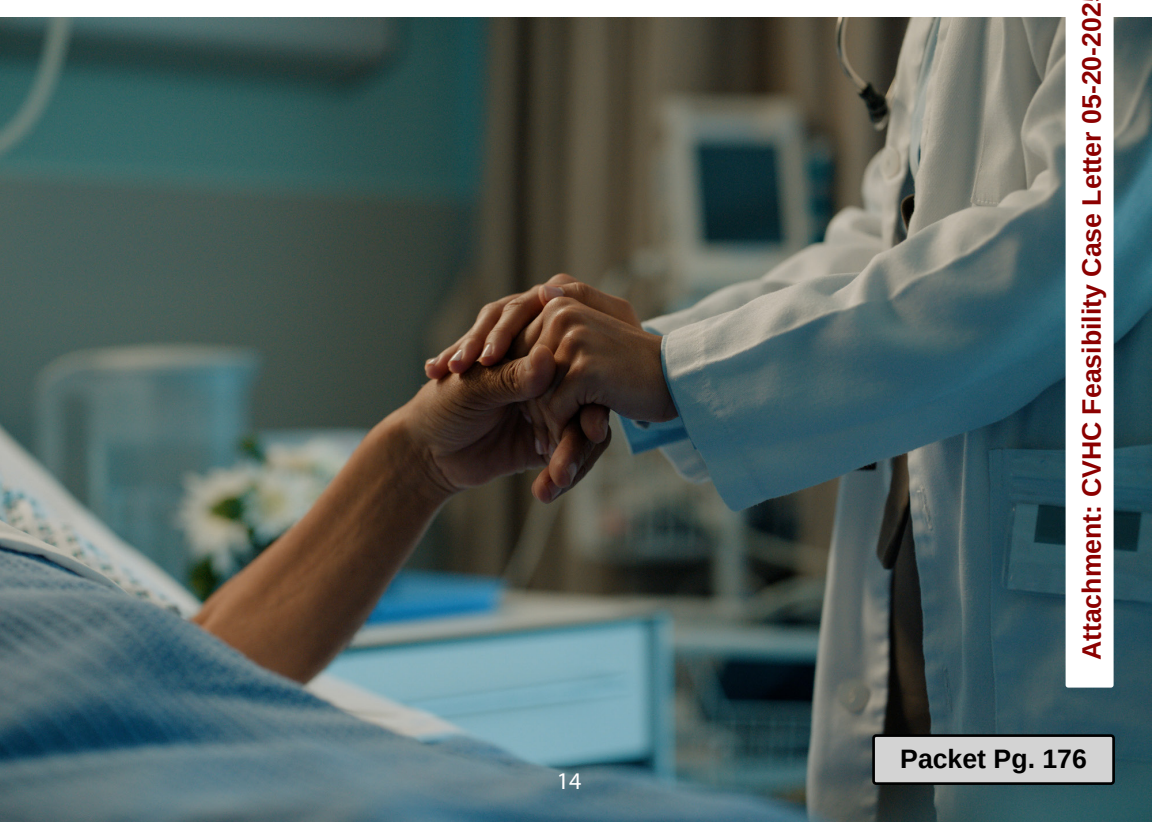
We are committed to making high-quality healthcare accessible and affordable for the residents of the Chippewa Valley region. Independently governed and locally rooted, we strive to make a lasting difference in our community's health and well-being long into the future.

Board of Organizers

Robert Krause, Chair
Patti Darley, Vice Chair
Lori Geissler
Peter Hoeft
Mickey Judkins
Thomas Larson
Eric Rygg

Physician Advisory Council

Rick Daniels, MD
Rima DeFatta, MD
Kyle Dettbarn, MD
Erik Dickson, MD
Chris Longbella, MD
Paul Ruh, MD
Kamal Thapar, MD



An Invitation

We are working to transform and improve the healthcare landscape in the Chippewa Valley so our region can thrive for generations to come. Our goal: to create an organization that can provide affordable access to exceptional healthcare here for our greater community. And to ensure that our community is always the first priority in every decision we make. As a cooperative we are accountable only to our members, people from the 18-county Chippewa Valley region.

We are breaking the mold to help fix the healthcare crisis we are experiencing now. We are focused on building something better, not just replacing what was lost.

If any community can revolutionize local healthcare delivery, we know it's the Chippewa Valley.

This is where YOU come in

Become a Member Today!

Show your support by becoming a member of the Cooperative.

Community Members: Residents of the 18-county Chippewa Valley region, who are at least 18 years old are eligible to become Community Members.

Medical Professional Members: Licensed medical professionals who hold a valid license to practice medicine in the state of Wisconsin are eligible to become Medical Professional Members.

Members elect the Board of Directors

Become a member at **chippewavalleyhealthcooperative.org/members/**

Make a Donation

A donation made to the Chippewa Valley Health Cooperative will go directly to providing critical healthcare services to our community lacks and building the new hospital.

Make a donation at **chippewavalleyhealthcooperative.org/donate/**

Please join us in our Bold Mission to ensure that our community has a say in the healthcare services available in our region.

The Chippewa Valley is known for its resilience, ingenuity, community spirit, and problem-solving ability. The Chippewa Valley Health Cooperative was founded in this spirit.

We know that we can, with your help, build a Better Way forward to provide excellent, accessible, and more affordable healthcare for our whole community.

We are determined to be a big part of what will ensure the Chippewa Valley thrives for generations to come.

We are breaking the mold to improve our future.
If anyone can do it, the people of the Chippewa Valley can.

Chippewa Valley
Health Cooperative

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rkrause@invisibleinc.com

chippewavalleyhealthcooperative.org