

**GOODHUE COUNTY
HEALTH & HUMAN SERVICES (GCHHS)**



REQUEST FOR BOARD ACTION

Requested Board Date:	August 12, 2025	Staff Lead:	Sarah Matzek
Consent Agenda:	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Attachments:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Action Requested:	Approve Opioid Settlement Budget for 2026-2028		

BACKGROUND:

In October 2023, Goodhue County contracted with Sand Prink Consulting, led by Laura Sand Prink, to establish and facilitate the Opioid Settlement Advisory Committee (OSAC). The committee's role is to guide the use of settlement funds based on the county's needs assessment. OSAC began meeting in May 2024 and, as the first year was considered a pilot, opted for a one-year RFP cycle. Using a participatory grantmaking process, OSAC allocated funds to projects aligned with priorities identified through the community engagement process and the Community Health Improvement Plan. By late 2025, OSAC awarded \$200,035 in grants to eight applicants, as outlined below.

Organization	Program	Investment Strategy	Grant Amount
Common Ground	Peer Recovery Specialist	Peer Recovery Specialist/Sober Navigator	\$ 65,000.00
RIPple Drug Education & Awareness	Education, Awareness and Harm Reduction in Goodhue County	Harm Reduction Access and Education	\$ 5,405.00
Goodhue County Sheriff's Office	Goodhue County Adult Detention Center Guardian RFID	Harm Reduction Access and Education	\$ 18,217.00
Hiawatha Valley Mental Health Center	Save A Life: Naloxone Training & Awareness	Harm Reduction Access and Education	\$ 6,063.00
CARE Clinic	Improve Chemical Health through Access to Mental Health and Harm Reduction Care/Resources	Increasing Mental Health Treatment for Youth AND Harm Reduction Access and Education	\$ 30,000.00
International Fellowship of Chaplains	SOS	Increasing Mental Health Treatment for Youth AND Increasing Protective Factors for At-Risk Youth	\$ 8,750.00
International Fellowship of Chaplains	ADC Inmate Mentoring	Peer Recovery Specialist/Sober Navigator AND Harm Reduction Access and Education	\$ 1,600.00
RiseUp Red Wing	Rising Above	Peer Recovery Specialist/sober Navigator, Increasing Protective Factors for At-Risk Youth AND Harm Reduction Access and Education	\$ 65,000.00
			\$ 200,035.00

CURRENT REQUEST:

Looking ahead, OSAC has elected to transition to a three-year RFP cycle for 2026–2028, following a grantmaking process similar to that used in the pilot year. This approach will allow for longer-term project planning and more sustained impact, while maintaining the participatory framework OSAC members engaged in last year.

OSAC is co-facilitated by Laura Sand Prink and GCHHS Supervisor Sarah Matzek, who, in collaboration with HHS Accounting, have developed the proposed budget for 2026–2028 (see below).

The budget allocates \$200,000 annually for community grant projects in 2026, 2027, and 2028. Per the Memorandum of Understanding (MOU) regarding the opioid settlement, board approval is required for the use of settlement funds, along with an explanation of how the funds will be used under one of the categories in MOU Attachment A. While specific grant applications are not yet known, OSAC will ensure all funded projects meet these criteria.

Goodhue County Opioid Settlement	Budget CY 2026 January- December 2026	Budget CY 2027 January- December 2027	Budget CY 28 January- December 2028	Total Budget 3 years
<u>Budget</u>				
Sand Prink Consulting	\$ 20,000.00	\$ 20,000.00	\$ 20,000.00	\$ 60,000.00
Conference				\$ -
Travel				\$ -
OSAC Members	\$ 5,750.00	\$ 5,750.00	\$ 5,750.00	\$ 17,250.00
OSAC Contracts	\$ 200,000.00	\$ 200,000.00	\$ 200,000.00	\$ 600,000.00
Noelle Harden				\$ -
OSNAConsult				\$ -
Grants/Impact				\$ -
Meeting Supplies				\$ -
Boots on the Ground (originally 2024 - 4 or 5 activities - maybe only 1)				\$ -
HHS Fiscal Fee (3% of budgeted expenditures)	\$ 6,772.50	\$ 6,772.50	\$ 6,772.50	\$ 20,317.50

RECOMMENDATION: Goodhue County HHS recommends approval of the Opioid Settlement Budget as presented.

EXHIBIT A

List of Opioid Remediation Uses

Settlement fund recipients shall choose from among abatement strategies, including but not limited to those listed in this Exhibit. The programs and strategies listed in this Exhibit are not exclusive, and fund recipients shall have flexibility to modify their abatement approach as needed and as new uses are discovered.

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 programs⁵ or strategies that may include, but are not limited to, those that:⁶

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication for Opioid Use Disorder (“*MOUD*”)⁷ 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 *MOUD*, 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 Use of the terms “evidence-based,” “evidence-informed,” or “best practices” shall not limit the ability of recipients to fund innovative services or those built on culturally specific needs. Rather, recipients are encouraged to support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions.

⁶ As used in this Exhibit, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs.

⁷ Historically, pharmacological treatment for opioid use disorder was referred to as “Medication-Assisted Treatment” (“*MAT*”). It has recently been determined that the better term is “Medication for Opioid Use Disorder” (“*MOUD*”). This Exhibit will use “*MOUD*” going forward. Use of the term *MOUD* is not intended to and shall in no way limit abatement programs or strategies now or into the future as new strategies and terminology evolve.

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 detoxification (detox) and withdrawal management services for people with OUD and any co-occurring SUD/MH conditions, including but not limited to medical detox, referral to treatment, or connections to other services or supports.
8. Provide training on MOUD 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 or mental health conditions.
10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
11. Offer scholarships and supports for certified addiction counselors, licensed alcohol and drug counselors, licensed clinical social workers, licensed mental health counselors, and other mental and behavioral health practitioners or workers, including peer recovery coaches, peer recovery supports, and treatment coordinators, 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, continuing education, licensing fees, 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 MOUD for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.
13. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry’s Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.
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 medication 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 but not limited to new Americans, African Americans, and American Indians.
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 Screening, Brief Intervention and Referral to Treatment (“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 MOUD in hospital emergency departments.
6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MOUD, 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 (“*PAARP*”);
 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 MOUD, 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 MOUD, 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 MOUD, 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 (“*CTP*”), 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 THE PERINATAL POPULATION, CAREGIVERS, AND FAMILIES, INCLUDING BABIES WITH NEONATAL OPIOID WITHDRAWAL SYNDROME.

Address the needs of the perinatal population and caregivers with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with

neonatal opioid withdrawal syndrome (“*NOWS*”), 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 MOUD, recovery services and supports, and prevention services for the perinatal population—or individuals who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to caregivers and families affected by Neonatal Opioid Withdrawal Syndrome.
2. Expand comprehensive evidence-based treatment and recovery services, including MOUD, for uninsured individuals 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 the perinatal population and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.
4. Expand comprehensive evidence-based treatment and recovery support for *NOWS* babies; expand services for better continuum of care with infant-caregiver dyad; and expand long-term treatment and services for medical monitoring of *NOWS* babies and their caregivers and families.
5. Provide training to health care providers who work with the perinatal population and caregivers on best practices for compliance with federal requirements that children born with *NOWS* get referred to appropriate services and receive a plan of safe care.
6. Provide child and family supports for caregivers with OUD and any co-occurring SUD/MH conditions, emphasizing the desire to keep families together.
7. 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.
8. 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.
9. 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 MOUD 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, including but not limited to focusing on risk factors and early interventions.
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. Law enforcement expenditures related to the opioid epidemic.
2. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.
3. 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.
5. Support multidisciplinary collaborative approaches consisting of, but not limited to, public health, public safety, behavioral health, harm reduction, and others at the state, regional, local, nonprofit, and community level to maximize collective impact.

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 MOUD and their association with treatment engagement and treatment outcomes.

M. POST-MORTEM

1. Toxicology tests for the range of opioids, including synthetic opioids, seen in overdose deaths as well as newly evolving synthetic opioids infiltrating the drug supply.
2. Toxicology method development and method validation for the range of synthetic opioids observed now and in the future, including the cost of installation, maintenance, repairs and training of capital equipment.
3. Autopsies in cases of overdose deaths resulting from opioids and synthetic opioids.
4. Additional storage space/facilities for bodies directly related to opioid or synthetic opioid related deaths.
5. Comprehensive death investigations for individuals where a death is caused by or suspected to have been caused by an opioid or synthetic opioid overdose, whether intentional or accidental (overdose fatality reviews).
6. Indigent burial for unclaimed remains resulting from overdose deaths.
7. Navigation-to-care services for individuals with opioid use disorder who are encountered by the medical examiner’s office as either family and/or social network members of decedents dying of opioid overdose.
8. Epidemiologic data management and reporting to public health and public safety stakeholders regarding opioid overdose fatalities.