

**ADVISORY PANEL TO THE ATTORNEY GENERAL ON DISTRIBUTION AND ALLOCATION OF
OPIOID SETTLEMENT FUNDS**

STATE-SUBDIVISION AGREEMENT RECOMMENDATIONS

Summary of the Panel's Work

The Attorney General convened the *Advisory Panel to the Attorney General on Distribution and Allocation of Opioid Settlement Funds* (Panel) in October 2021 in order to solicit feedback from state, county, and city public health experts, members of the state's Opioid Epidemic Response Advisory Council (OERAC), and community service providers on how best to distribute opioid settlement money throughout Minnesota. The panelists were:

Advisory Panel to the Attorney General on Distribution and Allocation of Opioid Settlement Funds

First Name	Last Name	Organization	Role
Nina	Arneson	Goodhue County Human Services	Panelist
Suzanne	Arntson	Scott County Human Services	Panelist
Rep. Dave	Baker	Opioid Epidemic Response Advisory Council (OERAC)	Panelist
Anne	Barry	Ramsey County Human Services	Panelist
Julie	Bauch	Hennepin County Public Health	Panelist
Dr. Heather	Bell	OERAC	Panelist
Matthew	Durose	Coalition of Greater MN Cities-Mankato Public Safety	Panelist
Sarah	Grosshuesch	OERAC	Panelist
Dr. Peter	Hayden	Turning Point	Panelist
Marc	Johnigan	Twin Cities Recovery	Panelist
Mark	Kinde	MN Dept. of Health (MDH)	Panelist
Larry	Kleindl	Kandiyohi County	Panelist
Dave	Lee	Carlton County Human Services	Panelist
Mary	Manning	MN Dept. of Health (MDH)	Panelist
Gertrude	Matemba-Mutasa	Dept. of Human Services (DHS)	Panelist
Gretchen	Musicant	City of Minneapolis	Panelist
Kathy	Nevins	OERAC	Panelist
Sarah	Reese	Polk County Public Health	Panelist
Linnea	Mirsch	St. Louis County Public Health & Human Services	Panelist
Jamie	Verbrugge	League of MN Cities/City of Bloomington	Panelist

The Panel also had several *ex officio* attendees, including:

Patricia	Beety	League of Minnesota Cities	Ex Officio
Dana	Farley	MDH/OERAC	Ex Officio
Shannon	Geshick	MN Indian Affairs Council	Ex Officio
Kristy	Graume	DHS	Ex Officio
Carly	Melin	AGO	Ex Officio
Julie	Ring	AMC	Ex Officio
Angie	Thies	AMC	Alternate
Elizabeth	Wefel	Coalition of Greater MN Cities	Ex Officio

Over the course of six weeks, the Panel met seven times to hear presentations from stakeholders, discuss concepts to incorporate into a State-Subdivision Agreement, and decide on recommendations to make to the Attorney General’s Office and local governments regarding distribution and allocation of the settlement funds.

I. ALLOCATION RECOMMENDATIONS

The Panel met on October 27, November 1, and November 3 to review allocation models from the settlements and from other states, and to hear allocation proposals and feedback from the Association of Minnesota Counties, the League of Minnesota Cities, the Coalition of Greater Minnesota Cities, and state agency representatives.

On the issue of the appropriate allocation between state government and local governments, a straw poll was conducted and the panel was evenly split between the following two proposals:

- (1) A proposal made by the counties to direct 80% of the settlement funds flow directly to counties¹ and 20% to state government. State law requires the state’s share of settlement funds to be split 50% to county and tribal social service agencies for child

¹ The counties have stated that they are willing to consider an allocation that would allow some cities to receive a direct share from the 80%. There was no consensus achieved regarding which municipalities will be eligible for the local government share, though preliminary discussions focused on the following categories of municipalities: (a) those that meet a certain population threshold, (b) those that have funded or otherwise managed an established health care or treatment infrastructure (e.g., health department or similar agency), or (c) those that have initiated litigation against opioid defendants as of January 1, 2021.

protection services, and 50% for grants determined by OERAC, after certain appropriations are made. Minn. Stat. § 256.043, subd. 3. The counties' proposal is predicated on amending the statute to ensure that the 20% state government share is not further subdivided and distributed to the counties. The counties have stated that they will work toward achieving that legislative change.

- (2) A proposal made by Minnesota state agencies to direct 50% of the settlement funds to local governments and 50% to state government. The state's proposal assumes no state law change and therefore actually resembles something closer to a split of 75% to local governments and 25% to state governments since the 50% share to state government would be divided and distributed pursuant to Minn. Stat. § 256.043, subd. 3, as explained above.

The following list reflects recommendations of the allocation concepts agreed upon by the Panel.

RECOMMENDATION #1: Public health departments as Chief Strategists

For the Participating Counties and those Participating Cities that have public health departments, the public health departments shall serve as the lead agency and Chief Strategist to identify, collaborate and respond to local issues as local governments decide how to leverage and disperse the national opioid settlement dollars. In their role as Chief Strategist, public health departments will convene and lead efforts that build upon local efforts like Community Health Assessments and Community Health Improvement Plans, while fostering community focused and collaborative approaches that prevent and address addiction across the areas of public health, human services and public safety.

RECOMMENDATION #2: Regions allowed but not required

Two or more Participating Local Governments may at their discretion form a group ("Region") to pool their respective shares of settlement funds and make joint spending decisions. Participating Local Governments may choose to create a Region through a joint exercise of powers under Minn. Stat. § 471.59.

RECOMMENDATION #3: Regional advisory councils

For each group of Participating Local Governments that choose to form a Region, they shall form an advisory council that will decide how to distribute and spend their collective settlement

shares within the Region. Each advisory council must include at least three representatives appointed by the Participating Local Governments. Such representatives are not limited to government employees and may include interested community members. Each advisory council must consult with the Participating Local Governments in the Region regarding future use of the settlement funds within the Region.

RECOMMENDATION #4: Cities can redirect shares to county

Any municipality allocated a share may elect to have its share of current or future annual distributions of settlement funds instead directed to the Participating County or Participating Counties in which it is located. Such an election may be made by January 1 each year to apply to the following fiscal year. If a municipality is located in more than one county, the municipality's funds will be directed based on the intra-county allocation model.

RECOMMENDATION #5: Counties must partner with local communities

Participating Counties must form partnerships at the local level whereby Participating Counties dedicate a portion of their settlement funds to support city- or community-based work with local stakeholders and partners, including healthcare providers, within the Approved Uses, including support of culturally specific services.

RECOMMENDATION #6: Consultation

Participating Counties must consult annually with the municipalities in the county regarding future use of the settlement funds in the county. Each Participating County and any Participating Municipalities within that County have a duty to regularly consult with each other to coordinate spending priorities.

RECOMMENDATION #7: Regional administrative fund

Reserve a very small portion of the settlement funds (1%–2%) to help cover the administrative costs of the Participating Local Governments that choose to form Regions.

II. REPORTING RECOMMENDATIONS

The Panel met on October 20 to review reporting requirements in the national settlements and reporting structures put in place by other State-Subdivision Agreements. The following list reflects recommendations of reporting concepts agreed upon by the Panel.

RECOMMENDATION #1: Settlement funds must be spent on future remediation

Opioid settlement funds can only be spent within the definition of “opioid remediation” on forward-looking spending on the approved uses recommended by this panel and cannot be used to reimburse past spending or past programs.

RECOMMENDATION #2: Reporting to statewide entity

Direct recipients of settlement funds must provide annual financial and impact reports to the state, covering both funds received/spent and plans for future spending.

RECOMMENDATION #3: Tailored impact reporting

Any governmental entity that receives settlement funds is required to track the impact and outcomes of its use of the funds. The required reporting will differ depending on the program being tracked (treatment vs. prevention).

RECOMMENDATION #4: Direct recipients are responsible for monitoring grant recipients

Any governmental entity that receives settlement funds and grants those funds to subrecipients/grantees is responsible for monitoring and tracking the distribution and use of those funds to satisfy the entity's reporting obligations as if the entity had spent the money itself.

RECOMMENDATION #5: Statewide Opioid Settlement Dashboard

Reporting from all recipients of settlement funds collected by the state should be published on a statewide opioid settlement dashboard that is accessible to the public.

RECOMMENDATION #6: Tiered reporting requirements

The financial and impact reporting required of local governments should be flexible, depending on the size and sophistication of the entity and how much settlement money the entity is receiving. This includes allowing reporting by a region covering spending by local governments in that region (if regions are included in final allocation model).

RECOMMENDATION #7: Special revenue funds

Any governmental entity that receives settlement funds is required to deposit and maintain those funds in a separate account from other government funds and cannot commingle opioid settlement monies with other funds. This would also prohibit governmental entities from assigning their payment streams or funding decision responsibilities to another entity.

RECOMMENDATION #8: Cap administrative expenses at 10%

Settlement fund recipients (including governmental entities and grant recipients) may use up to 10% of the funds to reimburse reasonable administrative expenses related to administering and overseeing the settlement funds.

RECOMMENDATION #9: Coordinate accountability across the state

State agencies (including MMB, DHS, and MDH) work together with the Office of the State Auditor to build out uniform measurement and reporting measures. Stakeholders will continue to work together to identify a statewide entity to coordinate reporting intake and a statewide opioid settlement dashboard. All interested persons, including communities and clinical providers, can participate in the construction of reporting mechanisms, like the statewide opioid settlement dashboard and other measures.

RECOMMENDATION #10: Avoid duplicative and burdensome requirements

Reporting requirements should bolster existing infrastructure while addressing any shortcomings. To the greatest extent possible, reporting requirements should not require duplicate systems or that staff manually track data. Existing data systems must be used to report on performance or outcome measures.

RECOMMENDATION #11: Importance of evaluation

Reporting requirements should allow for and foster evaluating program and service practice so as to inform future practice and access additional state and federal funding streams. Stakeholders will explore whether funding recipients could access the same evaluation structure at the state through MMB or other entities, if feasible under current state law and within state budgetary constraints.

RECOMMENDATION #12: Reporting should capture impact of work with disproportionately affected communities

Reporting outcomes should capture collaboration and partnership and specifically highlight the important work with communities that have been disproportionately impacted by addiction, including African American and Native American populations among others.

III. APPROVED USES RECOMMENDATIONS

The Panel met on October 13 to review Exhibit E to the national settlement documents, review other states' approved opioid remediation uses, and discuss what programs or strategies should be permitted in Minnesota. The following list of approved uses reflects the consensus of the Panel and is intended to be attached as an exhibit to a Minnesota State-Subdivision settlement agreement.

EXHIBIT []

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 programs² or strategies that may include, but are not limited to, those that:³

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication for Opioid Use Disorder (“*MOUD*”)⁴ 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.

² 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.

³ As used in this Exhibit, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs.

⁴ 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.