



AGENDA

EMERGENCY MEETING OF
THE GOVERNING BODY
MARCH 07, 2022
2:00 PM
ATTEND VIRTUALLY

SPECIAL PROCEDURES FOR EMERGENCY GOVERNING BODY MEETING

Attendance: In response to the State's declaration of a Public Health Emergency, the Mayor's Proclamation of Emergency, and the ban on public gatherings in excess of those permitted in the current Public Health Order, the Governing Body meeting will be conducted virtually.

Viewing: Members of the public may view the meeting through the Government Channel on Comcast Channel 28 and Comcast HD928 or may stream the meeting live on the City of Santa Fe's YouTube channel at <https://www.youtube.com/user/cityofsantafe>. The YouTube live stream can be accessed at this address from most smartphones, tablets, or computers.

The video recording of this and all past meetings of the Governing Body will also remain available for viewing at any time on the City's YouTube channel at <https://www.youtube.com/user/cityofsantafe>. Staff is available to help members of the public access pre-recorded Governing Body meetings on-line at any time during normal business hours. Please call 955-6521 for assistance.

Radio Broadcast: The meeting can be heard on radio station KSFR 101.1.

Agenda: The agenda for the meeting will be posted at <https://www.santafenm.gov>.

Written Comments: The public may submit written comments on any of the legislative items to be considered on the *Consent Agenda*, *Discussion Agenda*, *Public Hearings* or *Petitions From the Floor* through 1:00 p.m. the day of the meeting, via the virtual comment "button" at <https://santafe.primegov.com/public/portal>.

Public Comment: To provide live public comment during *Petitions from the Floor* or *Public Hearings*, you must join the Zoom meeting by internet or phone, as follows:

Internet: To join the Zoom meeting on the internet using a computer, laptop, smartphone, or tablet, use the following link: <https://santafenm-gov.zoom.us/j/84816340225?pwd=VE0vQlZpdzVBQUVPMc82YVRZSDBFZz09>. **Passcode: 433361**



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Attendees should use the “Raise Hand” function to be recognized by the Mayor to speak at the appropriate time.

Phone: To join the Zoom meeting using a phone, use the following phone numbers and Webinar ID: **US: 1 (346) 248-7799 - Webinar ID: 945 9904 5794 - Passcode: 433361**

Phone attendees should press *9 to use the “Raise Hand” function to be recognized by the Mayor to speak at the appropriate time.

1. **CALL TO ORDER**
2. **ROLL CALL**
3. **APPROVAL OF AGENDA**
4. **MATTERS FROM THE CITY ATTORNEY**

Executive Session

In Accordance with the New Mexico Open Meetings Act, NMSA 1978, Section 10-15-1, Part (H)(7), Attorney-Client Privileged Discussion of Litigation, Specifically *City of Santa Fe v. Purdue Pharma, et al.*, DNM No. 1:19-CV-01105. (Erin K. McSherry, City Attorney: ekmcsberry@santafenm.gov, 955-6512).

5. **EXECUTIVE SESSION ACTION ITEMS**
 - a. Approval of a New Mexico Opioid Allocation Agreement Between the State of New Mexico, City of Santa Fe, and Other Local Governments, in Relation of Distribution of Funds in Two, State-Wide Settlement Agreements, Removing Certain Defendants from *City of Santa Fe v. Purdue Pharma, et al.* DNM No. 1:19-CV-01105. (Erin K. McSherry, City Attorney: ekmcsberry@santafenm.gov, 955-6512).
6. **ADJOURN**

NEW MEXICO OPIOID ALLOCATION AGREEMENT

A. Definitions

As used in this Memorandum of Understanding (“MOU”):

1. “Local Government” shall mean every litigating county and city, each county regardless of population, each city with a population exceeding 10,000, and any Special District as that term is defined in the Master Settlement Agreements within the geographic boundaries of the State of New Mexico.¹ For avoidance of doubt, Local Governments within this definition are identified on Exhibit A hereto.
2. “Opioid Funds” shall mean monetary amounts obtained through a Settlement as defined in this MOU.
3. “Opioid Related Expenditure” shall mean an expenditure consistent with the categories enumerated in Exhibit E to the Distributor Master Settlement Agreement and the J&J Master Settlement Agreement found at <https://nationalopioidsettlement.com/> and attached hereto as Exhibit B.
4. “Parties” shall mean the State of New Mexico and Participating Local Governments.
5. “Pharmaceutical Supply Chain Participant” shall mean any entity that engages in or has engaged in the manufacture, marketing, promotion, distribution or dispensing of an opioid analgesic, including but not limited to those persons or entities identified as Defendants in the matter captioned *In re: Opioid Litigation*, MDL 2804 pending in the United States District Court for the Northern District of Ohio.
6. “Participating Local Government” is any Local Government that agrees to be bound by a Settlement by Participation Agreement necessary to effectuate that Settlement or other similar document.
7. “Settlement” shall mean the settlement reached with the Distributor Opioid Defendants, namely McKesson Corporation, AmerisourceBergen Corporation, and Cardinal Health, Inc. (each a “Settling Distributor”) and the settlement reached with Janssen (“J&J”)² (referenced as “National Distributor Settlement” and “J&J Settlement”) with certain states and local government entities that the State of New Mexico and its Local Governments have the option to join. For avoidance of doubt, a Settlement shall not include the resolution of any other legal or equitable claims alleged against any other Supply Chain Participant other than the Settling Distributors and J&J.

¹ The population figures contained in this MOU shall be derived from the published U.S. Census Bureau’s population estimates for July 1, 2019, released May 2020 as set forth in the Distributor Master Settlement Agreement and the J&J Master Settlement Agreement.

² “Janssen” means Johnson & Johnson, Janssen Pharmaceuticals, Inc., OrthoMcNeil-Janssen Pharmaceuticals, Inc., and Janssen Pharmaceuticals, Inc.

8. “Master Settlement Agreement” shall mean the agreements documenting a Settlement. For the purposes of this MOU the Distributor Master Settlement Agreement and the J&J Master Settlement Agreement found at <https://nationalopioidsettlement.com/> are Master Settlement Agreements under the meaning of this MOU.
9. “State” shall mean the State of New Mexico.

B. Allocation of the Opioid Settlement Proceeds

1. The Parties shall in good faith negotiate to identify an appropriate settlement administrator to receive and distribute Opioid Funds pursuant to this MOU (“Settlement Administrator”). The costs of the Settlement Administrator shall be paid jointly by the Parties prior to the distribution of Opioid Funds under this MOU with the State bearing 50% of those costs and the Local Governments bearing 50% of those costs.
2. Opioid Funds shall not be considered funds of the State or any Local Government unless and until such time as an allocation is made to the State or any Local Government pursuant to this Section.
3. If each and every Local Government as defined in Section A.1 joins both Master Settlements Agreements no later than March 7, 2022, after paying the costs of the Settlement Administrator, the Settlement Administrator shall allocate the remainder of the Opioid Funds as follows: (i) 45% to the State of New Mexico (“State Share”) and (ii) 55% to the Local Governments (the “LG Share”); provided, however, that the Settlement Administrator shall set aside the portion of the LG Share into the Attorney Fee Backstop Fund as provided in Section D below.
4. The LG Share will be divided into regions, each of which will be referred to as a “Region” and will consist of either: (1) a single Participating County that does not have any Participating Cities as listed on Exhibit C, (2) a single Participating County and all of its Participating Cities as listed on Exhibit C beneath the Participating County, or (3) a single Participating City. Two or more Regions may at their discretion form a group (“Multicounty Region”). Regions that do not choose to form a Multicounty Region will be their own Region.
5. The LG Share will be distributed to each Region as set forth in Exhibit C. In Regions with more than one member, members of the Region may agree to have the funds allocated to the Region suballocated amongst themselves in any manner they collectively choose or to have all funds allocated to the Region distributed to a single member of the Region. By July 1, 2022, each Region with more than one member shall communicate to the Settlement Administrator how the Region’s portion of the LG Share shall be distributed to the Region or that the members of the Region have agreed to extend the deadline to reach agreement. Absent a different agreement timely being reached among the members of the Region, the default allocation to members of a Region with more than one member is the formula from Exhibit G to the Distributor

Master Settlement Agreement and the J&J Master Settlement Agreement. The Settlement Administrator shall make all distributions to Regions with more than one member or their members in accordance with instructions received or the default allocation described in the previous sentence; provided, however, that the Settlement Administrator shall not make any distributions to a Region with more than one member prior to July 1, 2022, or such later deadline to reach an agreement agreed to by the members of a Region and timely communicated to the Settlement Administrator.

6. Except as provided herein or as provided by court order, 100% of the State Share and the LG Share, regardless of allocation, shall be utilized only for Opioid Related Expenditures.

C. Compliance Reporting and Accountability

1. Every Participating Local Government shall create a separate fund or project on its financial books and records that is designated for the receipt and expenditure of each entity's portion of the LG Share, called the "LG Abatement Fund." Funds in an LG Abatement Fund shall not be commingled with any other money or funds of the Local Government. A Local Government may invest LG Abatement Fund funds consistent with the investment of other funds of a Local Government.
2. Funds in a LG Abatement Fund may be expended by a Local Government only for Opioid Related Expenditures. For avoidance of doubt, funds in a LG Abatement Fund may not be expended for costs, disbursements, or payments made or incurred prior to the Settlement.
3. As part of the State or a Participating Local Government's annual audit pursuant to the State Audit Act, NMSA 1978, Chapter 12, Article 6, both the State fund and each LG Abatement Fund shall be audited to provide reasonable assurances that the LG Abatement Fund disbursements are consistent with the terms of this MOU. If any such audit reveals an expenditure inconsistent with the terms of this MOU, the State or the Local Government shall immediately redirect an amount equal to the funds associated with the inconsistent expenditure from another revenue source that may permissibly be expended for such purposes to an Opioid Related Expenditure. Either the State or the Participating Local Government who has been found to have expended funds inconsistently with this MOU will be ineligible to receive further distributions of the LG Share unless and until such a redirection is accomplished and confirmed by the State Auditor. The Settlement Administrator shall be instructed to hold either the State or that Local Government's future portion of the LG Share in escrow until instructed to release those funds by the State Auditor.
4. Local Governments may combine their respective portion of the LG Share with other Local Governments or the State.

D. Payment of Counsel and Opioid Litigation Expenses

1. Each of the Litigating Local Governments has contracted with outside counsel (“Counsel”) for representation in the Litigation. In consideration for Counsel’s representation, each of the Litigating Local Governments contracted with its Counsel for a contingency fee applied to each Litigating Local Government’s recovery.³
2. The Distributor Master Settlement Agreement and the J&J Master Settlement Agreement provide for the payment of attorney’s fees and legal expenses owed by States and Participating Local Governments to outside counsel retained for Opioid Litigation. To effectuate this, the Court in the MDL Litigation has established a fund to compensate attorneys for services rendered and expenses incurred that have benefitted plaintiffs generally in the litigation (the “National Attorney Fee Fund”). The National Attorney Fee Fund is subdivided into sub-funds, including the Contingency Fee Sub-fund.
3. Because there is uncertainty regarding what Counsel for Litigating Local Governments (“Counsel”) will recover as compensation from the National Attorney Fee Fund, the Parties agree that the Participating Local Governments will create a New Mexico attorney’s fees and costs fund (the “New Mexico Backstop Fund”) to compensate Counsel only in the event Counsel does not recover an amount equal to a 15% contingent fee from of the Contingency Fee Sub-fund of the National Attorney Fee Fund. For the avoidance of doubt, collectively, Counsel is limited to being paid, at most, and assuming adequate funds are available under the Contingency Fee Sub-fund of the National Attorneys Fee Fund and the New Mexico Backstop Fund, attorney’s fees totaling fifteen percent (15%) of the LG Share less the Local Government’s portion of the expenses of the Settlement Administrator.
4. Counsel for the Litigating Local Governments must first seek recovery from the Contingency Fee Sub-fund of the National Attorney Fee Fund before applying to the New Mexico Backstop Fund and may not recover from the New Mexico Backstop Fund any amounts recovered from the Contingency Fee Sub-fund of the National Attorney Fee Fund. For the avoidance of doubt, Counsel need only make a single application to the Contingency Fee Sub-fund of the National Attorney Fee Fund before applying to the New Mexico Backstop Fund.
5. After paying the Local Governments’ share of the costs of the Settlement Administrator, the Administrator shall deposit in the New Mexico Backstop Fund an amount equal to 15% of the LG Share and distribute the remainder of the funds allocated to Local Governments as set forth in Section B.5 above. No funds from the State Share shall be used to pay Local Governments’ attorneys’ fees and no funds from the State Share shall be paid to the New Mexico Backstop Fund.

³ For purposes of this MOU, the parties agree not to dispute that such contingency fee agreements are permissible under the State Procurement Code, NMSA 1978 Sections 13-1-28 to -199. However, nothing in this MOU should be construed to indicate that the State agrees that such contingency fee agreements are permissible under the State Procurement Code.

6. To ensure that all Counsel for Litigating Local Governments receive compensation, if there is only one Litigating Local Government in a Region, then that counsel will apply for its contingency fee based on the Region's recovery. If there is more than one Litigating Local Government in a Region, then the Counsel will apply for its contingency fee based on Exhibit G to the Master Settlement Agreement unless the Local Government receives an alternative, negotiated amount in which case the fifteen percent maximum recovery shall be based on that recovery amount.
7. Payments to counsel for Participating Subdivisions shall be made from the New Mexico Backstop Fund in the same percentages and over the same period as the Contingency Fee Fund for each National Settlement as set forth in Exhibit R §(II)(S)(1) of the Distributor Settlement Agreement and Exhibit R §(II)(A)(1) of the Janssen Settlement Agreement.
8. Any funds remaining in the New Mexico Backstop Fund in excess of the amounts needed to cover the deficiency in attorney's fees as provided in this Section shall be distributed as follows. A Litigating Local Government whose Counsel did not need to recover their entire fifteen percent contingent fee from the New Mexico Backstop Fund will receive a direct allocation from the New Mexico Backstop Fund calculated by subtracting from the amount calculated in accordance with Section D.6 the amount distributed to the Local Government's counsel from the New Mexico Backstop Fund.
9. If, after making the distributions provided for in Section D.8, there remains any funds in the New Mexico Backstop fund, those funds will be distributed to Regions in accordance with Exhibit C and Section B.5.

E. Other Terms

1. The Parties agree to make such amendments as necessary to implement the intent of this Agreement. After this Agreement becomes effective, amendments may only be made to this Agreement if approved in writing by the Office of the Attorney General and at least two-thirds of the Participating Local Governments. Amendments to the amount or timing of the distribution of funds to the Participating Local Governments require participation of one hundred percent (100%) of the Participating Local Governments that would be impacted by the amendment.
2. This Agreement shall be governed by and construed under the laws of the State of New Mexico using New Mexico law. Any action related to the provisions of this Agreement, except as otherwise provided in the National Settlement Agreements, must be adjudicated by the New Mexico state courts of Santa Fe County in the State of New Mexico.
3. This Agreement does not supersede or alter the terms of the Master Settlement Agreement except to the extent those terms allow for a State-Subdivision Agreement to do so.

4. If any part of this Agreement is declared invalid or becomes inoperative for any reason, such invalidity or failure shall not affect the validity and enforceability of any other provision.
5. This Agreement may be executed in counterparts, each of which shall be deemed an original and all of which together shall be considered one and the same agreement. A signature transmitted by facsimile or electronic image shall be deemed an original signature for purposes of executing this Agreement.
6. Each person signing this Agreement represents that he or she is fully authorized to enter into the terms and conditions of, and to execute, this Agreement on behalf of the named governmental entity.

SIGNATURE BLOCKS TO BE INSERTED

Exhibit A
NM Subdivisions Required to Participate in Both Opioid Deals
To Assure 100% Payment

Bernalillo County	City of Albuquerque
Catron County	City of Alamogordo
Chaves County	City of Artesia
Cibola County	City of Carlsbad
Colfax County	City of Clovis
Curry County	City of Deming
De Baca County	City of Española
Doña Ana County	City of Farmington
Eddy County	City of Gallup
Grant County	City of Hobbs
Guadalupe County	City of Las Cruces
Harding County	City of Las Vegas
Hidalgo County	City of Lovington
Lea County	City of Portales
Lincoln County	City of Rio Rancho
Los Alamos County	City of Roswell
Luna County	City of Santa Fe
McKinley County	City of Sunland Park
Mora County	Town of Bernalillo
Otero County	Village of Los Lunas
Quay County	
Rio Arriba County	
Roosevelt County	Albuquerque Public School District
San Juan County	
San Miguel County	
Sandoval County	
Santa Fe County	
Sierra County	
Socorro County	
Taos County	
Torrance County	
Union County	
Valencia County	

EXHIBIT E

List of Opioid Remediation Uses

**Schedule A
Core Strategies**

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

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

1. Expand training for first responders, schools, community support groups and families; and
2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

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

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;
2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;
3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and
4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

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

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment (“*SBIRT*”) services to non-Medicaid eligible or uninsured pregnant women;
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder (“*OUD*”) and other Substance Use Disorder (“*SUD*”)/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and
3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

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

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

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

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;
2. Expand warm hand-off services to transition to recovery services;
3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;
4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and
5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **TREATMENT FOR INCARCERATED POPULATION**

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

G. **PREVENTION PROGRAMS**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);
2. Funding for evidence-based prevention programs in schools;
3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);
4. Funding for community drug disposal programs; and
5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

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

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

Schedule B
Approved Uses

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

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

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

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (“*MAT*”) approved by the U.S. Food and Drug Administration.
2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (“*ASAM*”) continuum of care for OUD and any co-occurring SUD/MH conditions.
3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.
4. Improve oversight of Opioid Treatment Programs (“*OTPs*”) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.
5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.
6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.
7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

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

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.
9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.
10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.
12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (“*DATA 2000*”) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a *DATA 2000* waiver.
13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry’s Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.
14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry’s Provider Clinical Support Service for Medication–Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.
2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.
3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved 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 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 (“*PAARF*”);
 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 (“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 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.

Region	Percentage
Albuquerque City	22.75405%
Bernalillo County	18.61695%
Catron County	0.11300%
Chaves County	2.53589%
Roswell City	
Cibola County	0.77232%
Colfax County	0.74486%
Curry County	1.40564%
Clovis City	
De Baca County	0.06507%
Dona Ana County	7.08120%
Las Cruces City	
Sunland Park City	
Eddy County	2.59800%
Carlsbad City	
Artesia City	
Grant County	1.80574%
Guadalupe County	0.18692%
Harding County	0.01026%
Hidalgo County	0.19656%
Lea County	2.04006%
Lovington City	
Hobbs City	
Lincoln County	1.22087%
Los Alamos County	0.59155%
Luna County	0.83744%
Deming City	
McKinley County	1.79376%
Gallup City	
Mora County	0.19040%
Otero County	2.57461%
Alamogordo City	
Quay County	0.47335%
Rio Arriba County	4.59829%
Espanola City	
Roosevelt County	0.53969%
Portales City	
Sandoval County	4.55731%
Bernalillo Town	
Rio Rancho City	
San Juan County	3.81849%
Farmington City	
San Miguel County	1.66611%

Las Vegas City	
Santa Fe City	4.54090%
Santa Fe County	3.51432%
Sierra County	1.03085%
Socorro County	0.73630%
Taos County	1.74291%
Torrance County	0.70715%
Union County	0.11089%
Valencia County	3.82830%
Los Lunas Village	

EXHIBIT G

Subdivisions Eligible to Receive Direct Allocations from the Subdivision Fund and Default Subdivision Fund Allocation Percentages

The Subdivisions set forth on this Exhibit G are eligible to receive direct allocations from the Subdivision Fund, if such Subdivisions are otherwise eligible to receive such funds under this Agreement. By default, the Subdivisions set forth on this Exhibit G shall include: (1) all Litigating Subdivisions that are General Purpose Governments; (2) all counties and parishes in States with functional counties or parishes; (3) all Subdivisions that are the highest level of General Purpose Government in States without functional counties or parishes; and (4) all other Subdivisions that are General Purpose Governments with a population of 10,000 or greater. A State may elect to add any additional Subdivisions to this Exhibit G at any time prior to the Initial Participation Date.

Immediately upon the effectiveness of any State-Subdivision Agreement, Allocation Statute, Statutory Trust, or voluntary redistribution allowed by Section V.D.3 (or upon the effectiveness of an amendment to any State-Subdivision Agreement, Allocation Statute, Statutory Trust, or voluntary redistribution allowed by Section V.D.3) that addresses allocation from the Subdivision Fund, whether before or after the Initial Participation Date, this Exhibit G will automatically be amended to reflect the allocation from the Subdivision Fund pursuant to the State-Subdivision Agreement, Allocation Statute, Statutory Trust, or voluntary redistribution allowed by Section V.D.3.

For the avoidance of doubt, inclusion on this Exhibit G shall not create any claim for any amount of the Settlement Fund, and no such amounts shall be allocated or distributed to any Subdivision included herein if such Subdivision does not otherwise meet all requirements to receive any such funds pursuant to this Agreement.

The Parties recognize the benefits of remediation funds reaching all communities, including through direct payments from the Subdivision Fund. However, to promote efficiency in the use of such funds and avoid administratively-burdensome disbursements that would be too small to add a meaningful abatement response, certain Subdivisions do not receive a direct allocation from the Subdivision Fund. However, such Subdivisions will benefit from Opioid Remediation in their community, and are eligible to receive direct benefits from the Abatement Accounts Fund in their State. All settlement funds, whether allocated to a Settling State, an Abatement Accounts Fund or a Subdivision listed on this Exhibit G can be used for Opioid Remediation in communities not listed herein.

As provided by Section V.D.4.c, the Allocation Percentages shown below apply to distribution of each Settling State's Subdivision Fund in the absence of a State-Subdivision Agreement, Allocation Statute, or Statutory Trust. The allocation that would have otherwise gone to General Purpose Government Subdivisions not listed below as receiving a direct allocation shall be (1) directed to the county or parish in which such Subdivision is located in Settling States with functional counties or parishes if the relevant county or parish is a Participating Subdivision or (2) to the highest-level General Purpose Government in which such Subdivision is located in Settling States without functional counties or parishes if the relevant highest-level General

Purpose Government is a Participating Subdivision. Where the relevant county, parish or highest-level General Purpose Government is not a Participating Subdivision, allocations of General Purpose Subdivisions not listed below as eligible to become Participating Subdivisions shall be allocated pursuant to Section VII.I. The redirecting of funds described in this paragraph is intended to promote the efficient use of Opioid Remediation funds while keeping, where possible, local control of the distribution of those funds.

Subdivisions with Consolidated Allocations - Qualified Subdivisions Only

State ID	Qualifying Subdivision	Consolidated State Allocation
NM1	Alamogordo City, New Mexico	0.9683526415%
NM2	Albuquerque City, New Mexico	26.1703568498%
NM3	Artesia City, New Mexico	0.5562791550%
NM4	Bernalillo County, New Mexico	15.2005970834%
NM5	Bernalillo Town, New Mexico	0.2863480762%
NM6	Carlsbad City, New Mexico	0.8261484924%
NM7	Catron County, New Mexico	0.1129940051%
NM8	Chaves County, New Mexico	1.0935494443%
NM9	Cibola County, New Mexico	0.7723148257%
NM10	Clovis City, New Mexico	0.9103511516%
NM11	Colfax County, New Mexico	0.7448541610%
NM12	Curry County, New Mexico	0.4952954732%
NM13	De Baca County, New Mexico	0.0650725663%
NM14	Deming City, New Mexico	0.2484870948%
NM15	Dona Ana County, New Mexico	4.1009817203%
NM16	Eddy County, New Mexico	1.2155709374%
NM17	Española City, New Mexico	1.0869232440%
NM18	Farmington City, New Mexico	1.4120396740%
NM19	Gallup City, New Mexico	0.7722895935%
NM20	Grant County, New Mexico	1.8057321396%
NM21	Guadalupe County, New Mexico	0.1869187026%
NM22	Harding County, New Mexico	0.0102668257%
NM23	Hidalgo County, New Mexico	0.1965507765%
NM24	Hobbs City, New Mexico	0.5477699843%
NM25	Las Cruces City, New Mexico	2.7789710876%
NM26	Las Vegas City, New Mexico	0.9509305850%
NM27	Lea County, New Mexico	1.3193643533%
NM28	Lincoln County, New Mexico	1.2208675842%
NM29	Los Alamos County, New Mexico	0.5915454490%
NM30	Los Lunas Village, New Mexico	1.0566950725%
NM31	Lovington City, New Mexico	0.1729179347%
NM32	Luna County, New Mexico	0.5889582326%
NM33	McKinley County, New Mexico	1.0214669791%
NM34	Mora County, New Mexico	0.1903934157%
NM35	Otero County, New Mexico	1.6062640137%
NM36	Portales City, New Mexico	0.2248670805%
NM37	Quay County, New Mexico	0.4733520608%
NM38	Rio Arriba County, New Mexico	3.5113726662%
NM39	Rio Rancho City, New Mexico	2.3456255907%
NM40	Roosevelt County, New Mexico	0.3148139409%
NM41	Roswell City, New Mexico	1.4423383265%
NM42	San Juan County, New Mexico	2.4064498445%
NM43	San Miguel County, New Mexico	0.7151901194%
NM44	Sandoval County, New Mexico	1.9253935060%
NM45	Santa Fe City, New Mexico	4.5408953413%

Subdivisions with Consolidated Allocations - Qualified Subdivisions Only

State ID	Qualifying Subdivision	Consolidated State Allocation
NM46	Santa Fe County, New Mexico	3.5143193357%
NM47	Sierra County, New Mexico	1.0308488455%
NM48	Socorro County, New Mexico	0.7363065077%
NM49	Sunland Park City, New Mexico	0.2012417097%
NM50	Taos County, New Mexico	1.7429125688%
NM51	Torrance County, New Mexico	0.7071523256%
NM52	Union County, New Mexico	0.1108929666%
NM53	Valencia County, New Mexico	2.7716079380%