NEW MEXICO OPIOID ALLOCATION AGREEMENT

A. Definitions

As used in this New Mexico Opioid Allocation Agreement ("NMOAA"):

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 NMOAA.

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 NMOAA 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 Master Settlement Agreements.
[2] "Janssen" means Johnson & Johnson, Janssen Pharmaceuticals, Inc., OrthoMcNeil-Janssen Pharmaceuticals, Inc., and Janssen Pharmaceuticals, Inc.

8. "Master Settlement Agreements" shall mean the agreements documenting a Settlement. For the purposes of this NMOAA 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 NMOAA.

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 NMOAA ("Settlement Administrator"). The costs of the Settlement Administrator shall be paid jointly by the Parties prior to the distribution of Opioid Funds under this NMOAA 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 the 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 Master

Settlement Agreements. 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 NMOAA. If any such audit reveals an expenditure inconsistent with the terms of this NMOAA, 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 NMOAA 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 Master Settlement Agreements 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 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.

4. Counsel 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. 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 LG 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.

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

[3] For purposes of this NMOAA, 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 NMOAA should be construed to indicate that the State agrees that such contingency fee agreements are permissible under the State Procurement Code.

Litigating Local Government in a Region, then the Counsel will apply for its contingency fee based on Exhibit G to the Master Settlement Agreements 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 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 NMOAA. After this NMOAA becomes effective, amendments may only be made to this NMOAA 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 NMOAA 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 NMOAA, except as otherwise provided in the Master Settlement Agreements, must be adjudicated by the New Mexico state courts of Santa Fe County in the State of New Mexico.

3. This NMOAA does not supersede or alter the terms of the Master Settlement Agreements except to the extent those terms allow for a State-Subdivision Agreement to do so.

4. If any part of this NMOAA 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 NMOAA 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 NMOAA.

6. Each person signing this NMOAA represents that he or she is fully authorized to enter into the terms and conditions of, and to execute, this NMOAA on behalf of the named governmental entity.

SIGNATURE BLOCKS TO BE INSERTED

IN WITNESS WHEREOF, the parties hereby execute the NMOAA as of the date set forth below.

ON BEHALF OF THE LOCAL GOVERNMENTS:

_____ Date: _____
Albuquerque Public School District
Printed: _____

_____ Date: _____
Bernalillo County
Printed: _____

_____ Date: _____
Catron County
Printed: _____

_____ Date: _____
Chaves County
Printed: _____

_____ Date: _____
Cibola County
Printed: _____

_____ Date: _____
City of Alamogordo
Printed: _____

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City of Albuquerque
Printed: _____

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City of Artesia

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City of Carlsbad
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City of Clovis
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City of Deming
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City of Española
Printed: _____

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City of Farmington
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City of Gallup
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City of Hobbs
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City of Las Cruces
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City of Las Vegas
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City of Lovington
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City of Portales
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City of Rio Rancho
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City of Roswell
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City of Santa Fe
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City of Sunland Park
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Colfax County
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Curry County
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De Baca County
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Doña Ana County
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Eddy County
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Grant County
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Harding County
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Lea County
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Lincoln County
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Los Alamos County
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Luna County
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McKinley County
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Mora County
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Otero County
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Quay County
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Rio Arriba County
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Roosevelt County
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San Juan County
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San Miguel County
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Santa Fe County
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Sierra County
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Socorro County
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Taos County
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Torrance County

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_____ Date: _____
Town of Bernalillo
Printed: _____

_____ Date: _____
Union County
Printed: _____

_____ Date: _____
Valencia County
Printed: _____

_____ Date: _____
Village of Los Lunas
Printed: _____

ON BEHALF OF THE STATE OF NEW MEXICO:

Brian McMath Digitally signed by Brian McMath Date: 2022.03.08 17:04:09 -07'00'
_____ Date: March 7, 2022
Office of the Attorney General
State of New Mexico
Printed: Brian E. McMath

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

Bernalillo County
Catron County
Chaves County
Cibola County
Colfax County
Curry County
De Baca County
Doña Ana County
Eddy County
Grant County
Guadalupe County
Harding County
Hidalgo County
Lea County
Lincoln County
Los Alamos County
Luna County
McKinley County
Mora County
Otero County
Quay County
Rio Arriba County
Roosevelt County
San Juan County
San Miguel County
Sandoval County
Santa Fe County
Sierra County
Socorro County
Taos County
Torrance County
Union County
Valencia County

City of Albuquerque
City of Alamogordo
City of Artesia
City of Carlsbad
City of Clovis
City of Deming
City of Española
City of Farmington
City of Gallup
City of Hobbs
City of Las Cruces
City of Las Vegas
City of Lovington
City of Portales
City of Rio Rancho
City of Roswell
City of Santa Fe
City of Sunland Park
Town of Bernalillo
Village of Los Lunas

Albuquerque Public School District

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

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

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

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

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

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

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

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment ("*SBIRT*") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("*OUD*") and other Substance Use Disorder ("*SUD*")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

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

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

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

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;

4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **TREATMENT FOR INCARCERATED POPULATION**

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

2. Increase funding for jails to provide treatment to inmates with OUD.

G. **PREVENTION PROGRAMS**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

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

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

Schedule B
Approved Uses

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

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

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

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment ("*MAT*") approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine ("*ASAM*") continuum of care for OUD and any co-occurring SUD/MH conditions.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs ("*OTPs*") to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

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

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 ("*DATA 2000*") to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.

14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication–Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

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

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

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

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

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

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

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative ("*PAARI*");

    2. Active outreach strategies such as the Drug Abuse Response Team ("*DART*") model;

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion ("*LEAD*") model;

    5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions ("*CTI*"), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

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

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

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

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

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.

6. Provide child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.

10. Provide support for Children's Services—Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

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

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

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Supporting enhancements or improvements to Prescription Drug Monitoring Programs ("*PDMPs*"), including, but not limited to, improvements that:

1. Increase the number of prescribers using PDMPs;

2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Funding media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Funding community anti-drug coalitions that engage in drug prevention efforts.

6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration ("*SAMHSA*").

7. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

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

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Providing training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

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

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, those that:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

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

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (*e.g.*, Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations, including individuals entering the criminal justice system, including, but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring ("*ADAM*") system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

Region	Percentage
Albuquerque City	22.7540246633%
Bernalillo County	18.6169292699%
Catron County	0.1129940051%
Chaves County	2.5358877708%
Roswell City	
Cibola County	0.7723148257%
Colfax County	0.7448541610%
Curry County	1.4056466248%
Clovis City	
De Baca County	0.0650725663%
Dona Ana County	7.0811945176%
Las Cruces City	
Sunland Park City	
Eddy County	2.5979985848%
Artesia City	
Carlsbad City	
Grant County	1.8057321396%
Guadalupe County	0.1869187026%
Harding County	0.0102668257%
Hidalgo County	0.1965507765%
Lea County	2.0400522723%
Hobbs City	
Lovington City	
Lincoln County	1.2208675842%
Los Alamos County	0.5915454490%
Luna County	0.8374453274%
Deming City	
McKinley County	1.7937565726%
Gallup City	
Mora County	0.1903934157%
Otero County	2.5746166552%
Alamogordo City	
Quay County	0.4733520608%
Rio Arriba County	4.5982959101%
Española City	
Roosevelt County	0.5396810214%
Portales City	
San Juan County	3.8184895185%
Farmington City	
San Miguel County	1.6661207044%
Las Vegas City	
Sandoval County	4.5573671729%

Bernalillo Town	
Rio Rancho City	
Santa Fe City	4.5408953413%
Santa Fe County	3.5143193357%
Sierra County	1.0308488455%
Socorro County	0.7363065077%
Taos County	1.7429125688%
Torrance County	0.7071523256%
Union County	0.1108929666%
Valencia County	3.8283030105%
Los Lunas Village	