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Cabarrus County Strategic Plan:

Opioid Settlement Funds

Prepared For
Cabarrus County

May 20, 2024

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INTRODUCTION

In 2021, nationwide settlements were reached to resolve all opioid litigation brought by states and local subdivisions against pharmaceutical distributors and manufacturers, with subsequent agreements in 2022 against pharmacy chains and additional manufacturers. These historic opioid settlement agreements, which total more than $56 billion, will provide funds to states and local governments to address the crisis in their communities. North Carolina was awarded $1.5 billion to address communities affected by the opioid epidemic, with 85 percent of these funds being distributed to North Carolina counties and municipalities, encouraging a locally tailored response. In partnership with municipalities, Cabarrus County stands to receive approximately $21,980,750 over 18 years (2022–2038) in settlement funds.

This funding has significant potential to address the immediate needs of people affected by opioids and overdose while responding to structural barriers to care. To inform the use of these funds, Cabarrus County elected to undertake a collaborative strategic planning process. This collaborative planning process provided opportunities to engage the community—both professionals working in and around this space as well as those with lived experience—to hear the needs of residents, understand current services offered and existing strengths, and explore barriers to accessing care, with a goal of using this information to make informed decisions.

The outcome of this process, which is detailed in the pages to come, is an identified set of strategies that the County can fund to address the crisis, while offering enough flexibility to make adjustments as the crisis continues to evolve. These settlement funds alone are insufficient to fully address the needs of the community and end this crisis overnight, but they offer important resources and opportunities for collective action that can help stem the tide and create the path toward a brighter future.

The Impact of the Opioid Crisis on North Carolinians & Strategies to Address the Problem

The opioid crisis is a health and human services crisis. According to the North Carolina Department of Health and Human Services (NCDHHS) Dashboard:

- From 2000 to 2022, more than 37,000 North Carolinians lost their lives to opioid overdose.[1] In 2022, 4,339 died from an overdose—the highest annual total over this timeframe.
- In 2022, more than 11 North Carolinians died each day from a drug overdose.[1] Most (78%) of these overdose deaths were attributed to manufactured fentanyl.
- From 2000 to 2022, Cabarrus County witnessed 770 opioid overdose deaths, with 74 in 2022, resulting in an annual rate of 34.2 per 100,000 residents.1

The opioid crisis has wreaked havoc on the lives of individuals and families. It also has challenged our communities and the key institutions that we all rely upon, impacting everything from government to healthcare to education. The problem is deep and complex and requires collective action to meaningfully address the issue.

Strategies to Address the Crisis

North Carolina Opioid and Substance Use Action Plan

In 2017, the NCDHHS launched **North Carolina's Opioid and Substance Use Action Plan** to address the opioid crisis. The action plan was updated in 2019 and 2021 to keep current with the opioid epidemic and the needs of individuals with lived experience. Collaboration between state and local governments and across different organizations has been a hallmark of the approach in North Carolina.

The NCDHHS has also developed a dashboard to provide integration and visualization of state, regional, and county-level metrics that measure progress toward reaching the goal of addressing the opioid epidemic through a lens of equity and lived experience. The table below tracks five of the action plan metrics in North Carolina and Cabarrus County since 2017, when the plan was launched.

[1] North Carolina Department of Health and Human Services. Opioid and Substance Use Action Plan Data Dashboard. Available at: https://www.ncdhhs.gov/opioid-and-substance-use-action-plan-data-dashboard. Accessed September 5, 2023.

Table A. NCDHHS Dashboard

Metric	Year
Action Plan Metric	North Carolina
	Cabarrus County

Metric	2018	2019	2020	2021	2022	2023
Overdose Deaths	2,301	2,352	3,304	4,041	4,439	*
	58	43	75	73	74	*
Emergency Department Visits	12,049	12,208	14,958	16,816	16,937	16,932
	243	214	319	300	300	336
Residents Receiving Dispensed Opioids	1,721,997	1,605,281	1,431,663	1,355,132	*	*
	37,681	35,421	30,684	28,994	*	*
Number of children in foster care due to parental substance use	6,761	6,724	6,746	6,700	*	*
	30	51	65	77	*	*
Number of uninsured individuals and Medicaid beneficiaries with an opioid use disorder that are served by treatment programs	39,658	43,611	46,689	48,637	*	*
	846	850	969	900	*	*

*Data not available

North Carolina Memorandum of Agreement

The NC **Memorandum of Agreement (MOA)** established between the state attorney general and local governments aims to increase transparency about and direction for how opioid settlement funds must be spent, after a funding plan is approved by the Board of County Commissioners. The MOA governs how North Carolina uses the proceeds of any settlements to address the opioid epidemic. The MOA ensures that:

1. All funds will directly address the opioid epidemic, with an emphasis on high-impact strategies.
2. North Carolina is able to maximize resources to abate the crisis. All 100 counties, plus the state itself, need to sign onto the MOA for our state to receive the maximum payout.
3. A high level of transparency and accountability is given.

Opioid settlement funds can only be used to address the opioid epidemic and should utilize high-impact strategies. The strategies fall into three broad categories: Prevention, Treatment, and Recovery (definitions below).

Table B. Category Definitions

Categories	Prevention	Treatment	Recovery
Definition	Prevent future addiction and address trauma by supporting children and families	Therapies and various evidence-based treatments to address substance use disorder	Services focused on harm reduction provided to help individuals maintain their recovery

The MOA offers local governments two options:

MOA A: Through Option A, a local government may fund one or more strategies from a shorter list of evidence-based, high-impact strategies to address the epidemic. Under Option A, counties have access to 12 strategies to support programs and services that serve persons with Opioid Use Disorder (OUD) or any co-occurring Substance Use Disorder (SUD) or mental health conditions.

MOA B: Through Option B, a local government may fund one or more strategies from a longer list of strategies after engaging in collaborative strategic planning. Under Option B, counties have access to a wider array of strategies.

Cabarrus County decided to undergo the Collaborative Strategic Planning Process to provide access to all potential strategies identified via MOA A as well as the broader list of strategies in MOA B. The strategies for MOA A and B are outlined below.

MOU A	MOU B
Collaborative Strategic Planning	Treat Opioid Use Disorder
Evidence-based Addiction treatment	Support People in Treatment and Recovery
Recovery Support Services	Connect People Who Need Help to The Help They Need
Recovery Housing Support	Address the Needs of Criminal Justice Involved Populations
Employment-related services	Address the Needs of Pregnant or Parenting Women and their Families, Including Babies with Neonatal Abstinence Syndrome
Early Intervention	Prevent Over-Prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids
Naloxone Distribution	Prevent Misuse of Opioids
Post-overdose Response Team	Prevent Overdose Deaths and Other Harms (Harm Reduction)
Syringe Services Program	First Responders
Criminal Justice Diversion Program	Leadership, Planning, and Coordination
Addiction Treatment for Incarcerated Persons	Training
Reentry Programs	Research

Requirements of the MOA include that local governments are expected to publicly report when they have adopted a resolution for funding expenditures. HMA recognizes the importance of assisting Cabarrus County with that commitment. Requirements of this public report are included in the Appendix.

With the almost $22 million allotted, the County will receive roughly $1.5 million per year (on average) to support programs. The County must be purposeful with its funding strategies to ensure that the funds are geared directly toward strategies that not only meet the identified needs of the community but will also have a high impact.

STRATEGIC PLANNING PROCESS

A collaborative strategic planning process was created to follow all requirements noted in the Memorandum of Agreement (MOA). This strategic plan is the result of months of conversations and planning that **engaged key stakeholders in meaningful discussions to inform the strategies reflected in this document**. This process created the opportunity to hear from these stakeholders – described further below – and access the full scope of strategies made available under Option B of the MOA. The strategic planning process was led by the community response team (CRT), which included members of the County's Behavioral Health Department, County Manager's Office, Emergency Services Department, and Sheriff's Office, as well as one member from the Board of Commissioners. The CRT **met regularly to review data, discuss stakeholder feedback received, and identify what strategies the County should consider funding to address opioid misuse, overdose, and related issues**. The County contracted with Health Management Associates (HMA) as a **neutral facilitator for the collaborative strategic planning process.**

Data Collection and Related Planning Efforts

At the outset of the planning process, **HMA reviewed data and previous opioid-related efforts to ensure building upon former and/or current efforts.** Some examples include, but are not limited to, reports and assessments that address addiction, drug misuse, overdose, and related issues. Data reviewed included the North Carolina Opioid Action Plan dashboard, as well as county-developed reports, such as the 2023 State of the County Report. To understand historical needs identified by the community, we reviewed recent Community Needs Assessments – where mental and behavioral health and substance use have been identified as the top three priorities in recent years (2016 & 2020). HMA also reviewed the North Carolina Opioid and Substance Use Action Plan document and the North Carolina Institute of Medicine's May 2023 report titled, 'Practical Considerations for North Carolina's Community Leaders: The Challenges, Opportunities, and Transformative Potential of Opioid Settlement Funds'. These resources ensured our understanding of statewide strategies. Lastly, HMA and the CRT reviewed the Johns Hopkins Bloomberg School of Public Health report entitled "Principles for the Use of Funds from the Opioid Litigation". These principles were used in the design of the collaborative planning process and were ultimately adopted by the CRT to guide its work.

HMA also worked closely with the County to identify any previously committed opioid settlement funds, as well as existing/planned efforts that align with this work. Examples included discussions with the Medication Assisted Treatment (MAT) in Detention and MAT Community Paramedicine teams that were launching programs resourced by opioid settlement funds during our planning process, as well as the County's planned Behavioral Health Urgent Care (BHUC) and Facility Based Crisis Center that are currently in development. The development of the BHUC and the Facility Based Crisis Center is supported by $32.5 million from the State. Set to open in mid-2025, collectively, these facilities will address the complex navigation challenges by providing a "no wrong door" approach to receiving walk-in/drop-off patients in crises. Beds will serve FBC, substance use disorder and psychiatric residential treatment needs.

These existing/planned efforts were incorporated into our strategy identification process. To further ensure that the plan builds on previous efforts, we conducted focus groups with community coalitions that serve as hubs for collaborative planning. Focus groups with the Mental Health Advisory Board, Early Childhood Taskforce, and Juvenile Crime Prevention Council – described further below – ensured that our work built upon the best and most current thinking related to opioid prevention, treatment, and recovery.

Stakeholder Engagement

Central to the strategic planning process was engaging in authentic discussions with diverse members of the community, both residents, professionals, and those with lived experience. Hearing the needs of our residents, understanding the current services offered and their existing strengths, exploring barriers to accessing care, and considering root causes of addiction and overdose were vital in reaching our goal of utilizing information to make informed decisions.

Cabarrus County recognized the importance of having the right voices represented at the table throughout the process and worked to identify individuals and organizations that best represent the realities, needs, and values of those impacted by – or invested in – the opioid crisis.

The planning process included a multi-pronged approach to engagement that included a community survey and a series of focus groups.

Community Survey

HMA administered an anonymous community survey between January 17 and March 15 of 2024. The survey was available in both English and Spanish and asked for feedback on strengths, opportunities, unmet needs, and barriers to care, as well as a set of demographic questions to better understand the respondent pool. In total, 257 individuals completed the survey. Survey responses were coded and presented to the CRT for review.

Interviews and Focus Groups

HMA also conducted a series of interviews and focus groups to better understand the thoughts, experiences, and perspectives of a broad array of individuals impacted by the opioid crisis. This included several focus groups with individuals who are currently misusing or have previously misused opioids. Each group engaged was asked for feedback on strengths, opportunities, unmet needs, and barriers to care. While the focus groups were anonymous to support open and honest feedback, the engagements were transcribed, capturing key themes and takeaways. Below (Table C) is a summary of the focus groups and interviews conducted. This list was informed by the CRT and aligns with the requirements of the collaborative strategic planning process set forth by the state.

Table C. Stakeholder Engagement List

Stakeholder/Stakeholder Groups	Notes
Mental Health Advisory Board	The MHAB is a 26-member board that discusses cross-cutting health-related issues. Below is a brief summary of participating sectors: • Mayors, law enforcement, judges, and the District Attorney's office • Public health, mental health providers, and the hospital • EMS, human services, and schools
Early Childhood Taskforce	The ECT is a 15-member board that advises the Board of Commissioners on matters related to the development of children, from birth through five years of age
Juvenile Crime Prevention Council	• The JCPC is a 26-member board that: • Reviews the needs of at-risk youth • Evaluates juvenile services and programs • Promotes public awareness • Develops intervention strategies • Provides funding for services, treatment, and counseling
School Representatives	A focus group was convened that included staff from both Cabarrus County Schools and the Kannapolis School District
Healthcare Representatives	A focus group was convened that included several representatives from the following organizations: • Atrium Health • Cabarrus Health Alliance • Suda Institute
Faith-Based and Housing Representatives	A focus group was convened that included representatives from the following organizations: • Amazing Grace Advocacy • Bridges to Recovery • Cooperative Ministry • Safer Communities Ministry • We Build Concord
Monarch Behavioral Health	An interview was conducted with the leadership from Monarch
City of Concord	A focus group was conducted with representatives from the City of Concord administration. Concord assigned their settlement funds for Cabarrus County to manage and distribute.

Stakeholder/Stakeholder Groups	Notes
MAT in Detention Team	A focus group was convened with representatives of the recently launched MAT in Detention Program (which was funded using opioid settlement dollars), including representation from: • Cabarrus County Sheriff's Department • Cabarrus Health Alliance • Southern Health Partners
MAT Community Paramedicine	A focus group was convened with representatives of the recently launched MAT Community Paramedicine Program (which was funded using opioid settlement dollars), including representation from: • Atrium Health (including family and emergency medicine representatives) • Cabarrus County EMS Department
Latino Community Leaders	A focus group was convened with Latino community leaders that included representatives from the following organizations: • Atrium • Blue Cross Blue Shield of North Carolina Foundation • Cabarrus Health Alliance • City of Concord • El Puente • Habitat for Humanity
AYA House	An interview was conducted with the executive director of AYA House
Individuals with Lived Experience	Four separate focus groups were held with individuals with lived experience, recruited from the SUN and RISE Clinics and Daymark Recovery Services, as well as individuals currently detained in the jail for opioid-related offenses. • SUN Clinic Participants • RISE Clinic Participants • Daymark Recovery Services Participants • Jail Detainees

Themes from Stakeholder Engagement

Feedback from the community survey and focus groups was coded and analyzed to identify the top themes captured from the various groups. In addition to our data review and discussions with the CRT, these results **supported the identification of root causes of addiction, drug misuse, overdose, and related community issues, and lifted community voices.** The input also supported the **review of existing programs, services, and supports, as well as gaps in the local continuum of care.**

Table D below summarizes recurring themes from the focus groups. This table is not meant to capture all that was shared, but instead, the things that were shared consistently across the various groups. To better understand the feedback captured, the results are segmented by focus groups that included representatives from community-based organizations, professionals working in and around the opioid crisis, the taskforces listed above, and individuals with lived and living experience. This segmentation helps us to better understand where perspectives between professionals working in this space and those who are directly impacted by opioid use. The table breaks down the results by identified strengths and community needs, barriers, or opportunities for improvement. The themes that emerged in both groups are shown in a colored and bolded font. Overall, you can see the strong similarities in the feedback gathered between the two groups.

The figure below presents themes that emerged related to the root causes of addiction and drug misuse within the county.

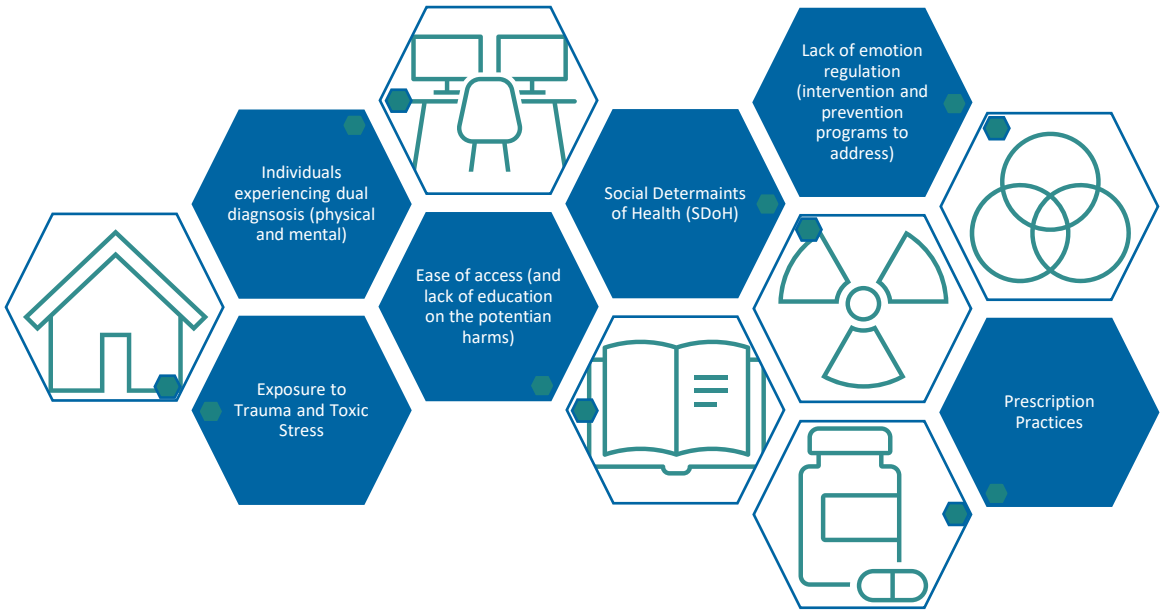

Table D. Summary of Focus Group Themes

Community-Based Organizations, Taskforces, and Other Professionals	Individuals with Lived Experience
Strengths	Strengths
• **Great treatment programs (e.g., SUN Clinic, RISE Clinic, and Daymark)** • **Expansion of harm reduction strategies and services (e.g., Naloxone distribution)** • Strong cross-sector collaboration • Committed community-based organizations • Growing access to medication assisted treatment (MAT)	• **Great treatment programs (e.g., SUN Clinic, RISE Clinic, and Daymark)** • **Expansion of harm reduction strategies and services* (e.g., Naloxone distribution)** **though more are needed* • Peer support and caring staff • Programs that do not kick you out for a relapse
Gaps/Community Needs/Barriers & Opportunities for Improvement	Gaps/Community Needs/Barriers & Opportunities for Improvement

- **Stigma**
- **Lack of knowledge of what is available and how to navigate between services/systems**
- **More peer support services**
- **Need for more community education/training about the crisis and resources available**
- **Limited housing options (transitional, supportive, affordable, etc.)**
- **Need better support for individuals existing incarceration**
- **Better access to detox facilities**
- **Challenges related to serving un/under-insured individuals and families**
- **Transportation can limit access**
- No longer-term treatment options
- More youth-focused prevention
- More support for parents and families (including pregnant persons)
- Need for more culturally-responsive services (including services offered in Spanish)
- More services to address the Social Determinants of Health (e.g., food, housing, employment, etc.)
- Staffing shortages in the behavioral health sector
- Long wait times for service (tied to staffing shortages)

- **Stigma**
- **Lack of knowledge of what is available and how to navigate between services/systems**
- **Employ persons with lived experience to support others (i.e., peer support)**
- **Need for more community outreach and education**
- **Limited housing options (transitional, supportive, affordable, etc.)**
- **Need better support for individuals existing incarceration**
- **Better access to detox facilities**
- **Access to and affordability of MAT**
- **Transportation can limit access**
- Improve access to shelters and safe places to go
- Need for more harm reduction services (Naloxone, syringe exchanges, etc.).
- Need for more on-demand/immediate services
- Mobile services to improve access to care
- More recovery support services (housing, employment, education, legal services, etc.)

Table E below includes themes that emerged from the community survey. They are broken down by strengths and community needs, barriers, and opportunities for improvement. Items shown in blue and bolded font indicate an alignment with the feedback received via the focus groups. Overall, we see strong similarities between the survey and focus group results.

Table E. Summary of Survey Themes

Results from Community Survey
Strengths
Great treatment programs (e.g., SUN Clinic, RISE Clinic, and Daymark) **Expansion of harm reduction strategies and services (e.g., Naloxone distribution)** Cabarrus Health Alliance Growing awareness of the opioid crisis, but needs to be expanded Some fast treatment options available Public health, EMS, and law enforcement have been important stakeholders

Gaps/Community Needs/Barriers & Opportunities for Improvement

- **Stigma**
- **Need for more community outreach and education**
- **Lack of knowledge of what is available and how to navigate between services/systems**
- **Limited housing options (transitional, supportive, affordable, etc.)**
- **No longer-term treatment options**
- **Access to and affordability of Medication Assisted Treatment**
- **Need for more harm reduction services (Naloxone, syringe exchanges, etc.).**
- **Need for more on-demand/immediate services**
- **Need for more culturally-responsive services (including services offered in Spanish)**
- **More youth-focused prevention**
- **More support for parents and families (including pregnant persons)**
- **More services to address the Social Determinants of Health (e.g., food, housing, employment)**
- **Services for un/underinsured individuals**
- Need a wide range of options – one size does not fit all
- Employment and vocational training
- Lack of wraparound services
- More focus on equity and equitable services
- Fear of arrest keeps people from accessing care
- More access to services in remote areas of the County

Strategy Identification & Prioritization

The themes outlined above were presented to the CRT for review. These emerging themes were then cross-walked to the NC Memorandum of Agreement to identify strategies the County would need to select in order to pursue the needs and opportunities identified. The CRT then **reviewed and prioritized the strategies based on needs identified, impact, and sustainability (cost)**. The prioritized strategies are reflected in the sections below. Overall, the CRT gleaned several key takeaways from the stakeholder input that drove the prioritization process:

1. The County already has several projects in development that address some of the needs identified (e.g., the MAT in Detention/MAT Community Paramedicine Programs and the Behavioral Health Urgent Care)
2. A strong network of local providers is working in this space.
3. There is a need to support better navigation to and from services and engage peers in the treatment and recovery process
4. There is a need to educate the community—youth in particular—about the dangers of opioid use and the supports that are available
5. MAT is crucial, especially for higher-risk populations (e.g., pregnant persons, jail detainees, low-income individuals)
6. While housing is a major need, the County is not well-positioned to expand availability with the limited opioid settlement funds available

THE STRATEGIC FRAMEWORK

Vision for Fund Use

Identifying a shared vision that can serve as a guide to achieving positive community change is critical in advancing this type of collective work.

This will help ensure that investments made from Opioid Settlement Funds have the potential to improve community health and well-being and address the root causes of addiction, drug misuse, overdose, and related issues. The CRT opted to **adopt an existing vision for fund use** that was developed by the Johns Hopkins Bloomberg School of Public Health called '**Principles for the Use of Funds From the Opioid Litigation**'. These principles were used when assessing the strategies selected and will continue to serve as guideposts when making funding and implementation decisions in the future. They are outlined below:

Table F. John Hopkins Bloomberg School of Public Health's Principles

PRINCIPLES	
Principle 1	Spend settlement money to save lives
Principle 2	Use evidence to guide spending
Principle 3	Invest in youth prevention
Principle 4	Focus on racial equity
Principle 5	Develop a fair and transparent process for deciding where to spend the funding

Prioritized Strategies and Population-Level Measures

Table G below captures the prioritized strategies from MOAs A and B, aligned with the broad categories of prevention, treatment, and recovery. The strategies are identified with a number and/or letter that corresponds with the MOA document, with additional detail about specific activities to be pursued captured in the following section. Note: Many of the treatment and recovery strategies overlap and thus are reflected in both columns. The table also captures initial population-level measures, which will be tracked during the implementation process to support assessing effectiveness. Program-level measures will also be established with contractors, and examples can be found in the Strategic Plan Detail section below. These population-level measures align with several identified in the North Carolina Opioid Action Plan.

Table G. Prioritized Strategies

Categories	Prevention	Treatment	Recovery
Definition	Prevent future addiction and address trauma by supporting children and families	Therapies and various treatments (evidence-based) to address substance use disorder	Services (focused on harm reduction) provided to help individuals maintain their recovery
Prioritized Strategies	MOA A.6. Early Intervention MOA A.7. Naloxone distribution	MOA A.2. Evidence-based Addiction Treatment	
		MOA A.3. Recovery Support Services	
		MOA B.C. Connect People Who Need Help to the Help They Need	
		MOA A.11. & A.12. Addiction Treatment for Incarcerated Persons & Reentry Programs	
		MOA B.E. Address the Needs of Pregnant or Parenting Women and their Families, Including Babies with Neonatal Abstinence Syndrome	
		MOA A.1.Collaborative Strategic Planning	
Population-Level Measures	• Overdose Deaths • Overdose Death Rates, by Race/Ethnicity • Illicit Opioid Overdose Deaths • Emergency Department Visits • Number of children in foster care due to parental substance use • Number of uninsured individuals and Medicaid beneficiaries with an opioid use disorder that are served by treatment programs • Patients receiving buprenorphine		

IDENTIFIED STRATEGIES AND EXAMPLE ACTIVITIES & INDICATORS

The tables below provide additional details on the strategies, example activities, and key indicators that were prioritized by the CRT. The activity-level language comes directly from the MOA document. To better convey the priorities of the CRT, activity and indicator examples have also been included. While implementation will be managed through a Request for Proposal (RFP) process or expansion of existing programs within the County (and thus specific activities funded and indicators may shift somewhat), the table provides direction and alignment for the opioid settlement funds.

MOA A, Strategy 1: Collaborative Strategic Planning

An important component of ensuring the effective implementation of the strategies identified above is building Cabarrus County's capacity for oversight and monitoring. This strategy will allow the County to hire and/or re-assign staff to support this important work. Responsibilities of new/reassigned staff may include RFP development, contract monitoring, data collection and reporting, and ongoing communication and coordination with contracted partners, relevant county departments, and state oversight bodies.

MOA A, Strategy 1: Collaborative Strategic Planning		
Allowable Activities Prioritized by the CRT	Activity Examples	Indicator Examples
Provide resources to staff government oversight and management of opioid abatement programs.	• Hire/re-assign County staff to oversee, manage, and support opioid abatement programs	• # of engagements with contracted partners • % of contracted partners adhering to reporting requirements • % of contracts operating in compliance

MOA A, Strategy 2: Evidence-based Addiction Treatment

Treating OUD via medication assisted treatment (MAT)[2] is central to addressing the impacts of the opioid crisis. The CRT has prioritized expanding MAT programs, as well as supporting the newly launched MAT Community Paramedicine program. Alongside evidence-based behavioral therapies, MAT is seen by many as the gold standard for treatment. Despite several providers in the community offering these services, data and stakeholder feedback reflects that it is insufficient to meet the level of need experienced in the community.

MOA A, Strategy 2: Evidence-based Addiction Treatment		
Allowable Activities Prioritized by the CRT	Activity Examples	Indicator Examples
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.	• MAT • MAT + Evidence-based behavioral health • Low Barrier Buprenorphine	• # of providers who dispense methadone, buprenorphine, and naltrexone • # of unique patients with OUD served (breakdown by demographics) • # of patients who were connected to treatment • # of patients who adhere to treatment
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.	• MAT Community Paramedicine (already funded through FY 27 at 930K) • MAT Technical Assistance • Other Mobile Treatment Teams	• # of EMS programs offering MAT in the County • # of patients served through EMS-based MAT programs • # of patients who declined EMS-based MAT services • # of patients who declined linkage to treatment

MEDICATION ASSISTED TREATMENT (MAT)

MAT is the use of medications in combination with evidence-based behavioral therapy to address substance use disorder and help individuals maintain recovery. There are three drugs approved by the Federal Drug Administration to treat opioid dependence: buprenorphine (suboxone), methadone, and naltrexone (vivitrol). Treatment via MAT is not time limited. Benefits of MAT include decreases in overdose deaths, decreases in illicit opioid use, increases in social functioning and retention in treatment, decreases in engagement in criminal activity, and improvements in outcomes for pregnant and breastfeeding women and their children. MAT also reduces risk of infection and transmission of infectious diseases. The County currently partners with two providers, Daymark and Cabarrus Health Alliance to provide MAT to individuals experiencing OUD in the community.

[2] Substance Abuse and Mental Health Services Administration. Medications for Substance Use Disorders. April 11, 2024. Available at: https://www.samhsa.gov/medications-substance-use-disorders.

MOA A, Strategy 3: Recovery Support Services

Supporting people in treatment for and recovering from OUD includes the use of evidence-based or evidence-informed programs or strategies. The Substance Abuse and Mental Health Services Administration (SAMHSA) has defined recovery as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential." Recovery should be developed based on an individual's strengths, talents, coping abilities, resources, and personal values. In the recovery process, individuals should be supported by their community, peers, friends, and family members. Importantly, recovery will be a unique journey for all individuals. Some individuals may benefit from medication in combination with peer support and behavioral health, while others may be drawn to faith-based organizations, self-care, or other approaches. Peer support specialists, a strategy already being funded through a resolution developed by the County in December of 2023, are people living in recovery from SUD who have the capacity to provide support to others via their personal lived experience. Peer support specialists[3] have found success in navigating their own recovery process and providing supports to individuals in recovery within the communities where they reside. In addition to peer support, care navigators support linkages to care and harm reduction services.

The Role of Peer Support Specialists[3]	
A peer support specialist does / is …	**A peer support specialist does not / is not …**
Share their experience in meaningful / strategic ways	Serve as the sole support
Relatable	Serve in the role of therapist / behavioral health specialist
Provide affirmation and normalization	Make decisions for others
Destigmatize	Speak for others (unless asked)
Build relationships	Function as the navigator or resources
Provide individualized support	An Uber or babysitter
	A policing system

[3] Welch M B, Baird C, & Seibel C L. Portland State University, with sponsorship from the Department of Health and Human Services. What Is Peer Support and What Is NOT Peer Support? Available at: https://pdxscholar.library.pdx.edu/socwork_fac/447/.

MOA A, Strategy 3: Recovery Support Specialists		
Allowable Activities Prioritized by the CRT	Activity Examples	Indicator Examples
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.	• Certified peer support specialists (already funded through FY 25 at 210K to Cabarrus Health Alliance)	• # of peer support specialists • #/% of participants connected with peer support specialists • Satisfaction with services
	• Navigation to community-based services	• # of care navigators • #/% of participants connected with care navigators • Satisfaction with services • # of referrals to recovery supports, harm reduction services, primary healthcare

MOA A, Strategy 6: Early Intervention

The strategy of Early Intervention allows the County to support programs that discourage and prevent misuse of opioids. Stakeholder engagement identified two specific activities that are most needed within the County. Stakeholders first identified a need for evidence-based curriculums that de-stigmatize mental health and educate the community on signs of mental health and SUD. Stakeholders also highlighted the need for prevention programs in school settings that engage youth and families. The infographic below provides examples of the role that schools can play in prevention efforts.

Educate students and families about the dangers of opioid use and how to prevent misuse	Deliver evidence-based programs within the school curriculum	Provide a strengths-based perspective that provide youth and families with protective factors	Provide harm reduction tools on school campus to mitigate overdoses (e.g. naloxone)	Support youth and families in active recovery

MOA A, Strategy 6: Early Intervention		
Allowable Activities Prioritized by the CRT	Activity Examples	Indicator Examples
Fund 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.	• Teen Mental Health First Aid and/or other evidence-based curricula	• # of Teen Mental Health First Aid sessions held • # of individuals trained
	• Community education on opioids, the local impact, root causes, and prevention, including culturally-specific events • Parent/family-oriented education events	• # of community education sessions held • # of participants, by geography and target population

Create and/or support recovery high schools	• Recovery High School support/ expansion	• # of students served • #/% of students meeting recovery goals • #/% of students meeting academic goals

MOA A, Strategy 7: Prevent Overdose Deaths and Other Harms (Harm Reduction) through Naloxone Distribution

At the heart of preventing overdose deaths and other risks associated with OUD (e.g., infectious disease transmission) is utilizing methods that encourage harm reduction. Harm reduction is an evidence-based approach that is driven by public health strategies. Through harm reduction models, individuals who are experiencing an OUD crisis are first and foremost kept alive and safe. Harm reduction models also allow for meaningful connections with individuals who can support connections to services and resources that will improve physical and mental health, as well as social well-being, all the while eliminating barriers to access. A key component of harm reduction models is ensuring that individuals experiencing OUD have access to naloxone to prevent overdose. This strategy can help to ensure that naloxone is accessible, particularly for at-risk individuals, and that there is education provided related to harm reduction models to increase awareness across the community.

MOA A, Strategy 7: Prevent Overdose Deaths and Other Harms (Harm Reduction) through Naloxone Distribution		
Allowable Activities Prioritized by the CRT	Activity Examples	Indicator Examples
Increase 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, individuals at high risk of overdose, schools, community navigators, outreach workers, persons being released from jail or prison, or other members of the general public.	• Purchase and distribute naloxone • Target distribution to people at-risk of overdoes and their social network	• # of intranasal/ intramuscular naloxone kits purchased • # of intranasal/ intramuscular naloxone kits distributed • # of agencies offering naloxone to people at high-risk of overdose • Zip codes for those receiving naloxone (to determine saturation rates)
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.	• Naloxone training/ education • Increase education/ awareness of good Samaritan laws • Increase EMS and law enforcement awareness of best practices at an overdose scene	• # of intranasal/ intramuscular naloxone kits distributed • # of trainings on harm reduction (e.g., overdose prevention, safer use practice, disease prevention) provided • # of training participants, by geography and target populations

MOA A, Strategies 11 & 12: Address the Needs of Criminal-Justice Involved Persons through Addiction Treatment for Incarcerated Persons and Reentry Programs

This strategy addresses the needs of individuals with OUD who are engaged with (or at risk of becoming engaged with) the justice system or transitioning out of incarceration through evidence-based interventions. The County has already begun to meet the needs of this population through the dedicated funding that will increase the detention center's capacity to provide MAT to individuals in incarceration. Research has demonstrated that initiating and/or continuing MAT to inmates reduces drug use, overdose events, and recidivism, while simultaneously promoting recovery.[4] [5] In addition, for individuals transitioning out of detention centers, overdose is a leading cause of death, with the first two weeks being the period with the highest risk. In addition to MAT in Detention, there are opportunities to provide community supports through re-entry programs that develop person-centered transition plans. SAMHSA has provided best practices for re-entry programs and noted several important characteristics for successful re-entry, especially for individuals who experience behavioral health disorders or SUD. For re-entry to be successful, planning should be an iterative and dynamic process that occurs at several time points, including pre-release, at-release, and post-release. In addition, it is essential that individuals are connected to community-based services that mirror the treatment they received during their incarceration, thus ensuring continuity of care. For individuals who have not been linked to services during incarceration or may require additional services, navigators should help them connect to evidence-based services that are readily accessible upon release. Re-entry from incarceration can lead to several barriers in accessing care including lack of continuity of treatment, access to housing (due to being ineligible for resources), and ability to obtain meaningful employment.[6] This strategy provides an opportunity to not only support justice-involved individuals during detention, but also to support them as they transition back to the community, with the ultimate goal of decreasing recidivism.

"There is evidence that people who are released from prison or jail and are employed are less likely to recidivate.
Yet, unemployment rates are almost five times higher for formerly incarcerated individuals than for the general population."

– SAMHSA

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[4] Lee JD, McDonald R, Grossman E, McNeely J, Laska E, Rotrosen J, Gourevitch M N. National Library of Medicine. Opioid treatment at release from jail using extended- release naltrexone: a pilot proof-of-concept randomized effectiveness trial. Available at: **https://pubmed.ncbi.nlm.nih.gov/25703440/#:~:text=Conclusion%3A%20Extended%2Drelease%20naltrexone%20is,treatment%2Das%2Dusual%20condition**.

[5] Lee J D, Friedmann P D, Kinlock TW et. al. National Library of Medicine. Extended-Release Naltrexone to Prevent Opioid Relapse in Criminal Justice Offenders. Available at: **https://pubmed.ncbi.nlm.nih.gov/27028913/**.

[6] Substance Abuse and Mental Health Services Administration (SAMHSA). Best Practices for Successful Reentry From Criminal Justice Settings for People Living With Mental Health Conditions and/or Substance Use Disorders. Available at: **https://store.samhsa.gov/sites/default/files/pep23-06-06-001.pdf**.

MOA A, Strategies 11 & 12: Address the Needs of Criminal-Justice Involved Persons through Addiction Treatment for Incarcerated Persons and Reentry Programs		
Allowable Activities Prioritized by the CRT	Activity Examples	Indicator Examples
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.	• MAT in Detention (already funded through FY 27, at $1,447,702 to Cabarrus Health Alliance ($702,702) + Cabarrus County Sheriff Department ($745,000) • MAT Technical Assistance	• # of people who are incarcerated screened as having OUD • # of people who receive MAT for OUD • # of referrals made for continued MAT support that result in first appointment
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, have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.	• Re-entry programs • Evidence-based interventions (e.g., MAT)	• # of written transition plans developed prior to release • # of re-entry navigators/peer support on staff • # of participants with OUD who are referred to addiction treatment

MOA B, Strategy C: Connect People Who Need Help to the Help They Need

Connect People Who Need Help to the Help They Need is a strategy focused on providing connections to care for people who have – or are at risk of developing – OUD through evidence-based strategies. One need highlighted throughout the strategic planning process was the need for additional services that provide individuals with OUD the opportunity to stabilize in a safe and monitored setting. In the County, there are currently two initiatives that would increase the number of beds available for stabilization. In addition, some of these beds will be specifically dedicated to adolescents, which was another key need highlighted during the research process.

Behavioral Health Urgent Care

North Carolina has experienced a rise in the number of behavioral health urgent care (BHUC) and facility-based crisis (FBC) centers opening across the state. In April of 2024, NCDHHS announced that it will dedicate nearly $15 million to nine BHUC centers across the state, increasing the state's capacity by 50 percent.[7] The County is developing its own BHUC center, which is set to open in 2026. BHUC centers are intended to provide services to individuals aged four and older who are experiencing a behavioral health crisis related to an SUD, mental health disorder, and/or intellectual/developmental disability (I/DD) diagnosis, or any combination of the above. Services within BHUC include triage, assessment (crisis/risk), evaluation, intervention, and discharge planning. Services provided via a BHUC are meant to serve as a safe alternative to, and diversion from, emergency departments or incarceration. BHUC clients should be evaluated, stabilized, and referred to an appropriate level of care, ideally within their own community.[8]

Facility-Based Crisis Center

In addition to the BHUC development, the County is also in the process of developing an FBC center, which will also open in 2026. This crisis center will have at least six beds dedicated to adolescents. Like BHUCs, FBCs provide an alternative to hospitalization for individuals who are experiencing a crisis related to mental health, SUD, or I/DD. These short-term services are provided in a full-time residential facility. FBC centers serve as an alternative to hospitalization and incarceration, offering similar services including assessment/evaluation, detox, psychiatric evaluation, peer support groups, long-term outpatient treatment plans, medication management, and referrals to hospitalization as needed.

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[7] North Carolina Department of Health and Human Services. Investment in Strengthening North Carolina's Behavioral Health Crisis Response System. April 8, 2024. Available at: **https://www.ncdhhs.gov/news/press-releases/2024/04/08/investment-strengthening-north-carolinas-behavioral-health-crisis-response-system**.

[8] North Carolina Department of Health and Human Services. Division of Mental Health, Developmental Disabilities, & Substance Abuse Services. State-Funded Behavioral Health Urgent Care. Available at: **https://files.nc.gov/ncdhhs/documents/files/State-Funded-Behavioral-Health-Urgent-Care--BHUC---effective-2-1-2020.pdf**.

MOA B, Strategy C: Connect People Who Need Help to the Help They Need (Connections to Care)		
Allowable Activities Prioritized by the CRT	Activity Examples	Indicator Examples
8. 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.	• Behavioral Health Urgent Care (in development)	• # of referrals to MAT that resulted in first appointment attended • # of patients served with OUD (breakdown by demographics)
	• Facility-based crisis for children/young adults (e.g., Cabarrus Regional Behavioral Health Center)	• # of referrals to MAT that resulted in first appointment attended • # of patients served with OUD (breakdown by demographics)

MOA B, Strategy E: Address the Needs of Pregnant or Parenting Women and Their Families

This strategy addresses the needs of pregnant and parenting persons who are experiencing SUD through evidence-based and informed interventions. The use of opioids during pregnancy can have a vast range of detrimental effects on the pregnant person and the fetus, including a variety of birth defects, miscarriage, Neonatal Abstinence Syndrome, preterm birth, and maternal mortality.[9] One allowable activity to address the needs of pregnant and parenting persons is to ensure that they have access to MAT in low-barrier settings, rather than allowing them to withdraw, as withdrawal during pregnancy is linked to negative outcomes and higher rates of relapse. [10] As with the utilization of MAT across other populations, pairing MAT with behavioral therapy such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) or Eye Movement Desensitization and Reprocessing (EMDR) is highly encouraged. In addition to supports for pregnant persons, this strategy also provides supports to parents managing OUD. Parental substance use is a known adverse childhood experience (ACE) that increases exposure to toxic environments, dysregulated attachment patterns, behavioral issues, and involvement with the child welfare system.[11] Programs should include evidence-based practices that specifically address these ACEs as well as evidence-based parenting programs. Parent and Child Interaction Therapy (PCIT), an evidence-based model, enhances the parent-child relationship while providing parents with effective strategies to manage their children's behaviors. Research has demonstrated that PCIT is an effective modality to address the needs of families with SUD.[12]

MOA B, Strategy E: Address the Needs of Pregnant or Parenting Women and their Families, Including Babies with Neonatal Abstinence Syndrome		
Allowable Activities Prioritized by the CRT	**Activity Examples**	**Indicator Examples**
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.	• MAT for pregnant persons	• # of pregnant persons who are screened as having OUD • # of pregnant persons who receive MAT for OUD • # of referrals made for continued MAT support that result in first appointment

[9] Gangi E. Treatment for Pregnant Women with Opioid Use Disorder—Cabarrus County. Available at: https://ncimpact.sog.unc.edu/2020/04/treatment-for-pregnant-women-with-opioid-use-disorder-cabarrus-county/.

[10] Centers for Disease Control and Prevention. Treatment for Opioid Use Disorder Before, During, and After Pregnancy. Available at: https://www.cdc.gov/pregnancy/opioids/treatment.html.

[11] Waite D, Greiner MV, Laris Z. Putting Families First: How the Opioid Epidemic Is Affecting Children And Families, and the Welfare Policy Options to Address It. *Journal of Applied Research on Children.* 2018;9(1).

[12] Victory E, Han R, Druskin L, Phillips S, McNeil, C. Parent-Child Interaction Therapy (PCIT) as a Treatment for Families Impacted by the Opioid Crisis.

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.	• Evidence-based, trauma-focused practices and parenting programs	• # of children/family members who are referred to trauma-focused services • Satisfaction with services

IMPLEMENTING THE PLAN

Cabarrus County has elected to implement the strategies and activities outlined above through the direct funding of county-operated programs, as well as through the allocation of funds to non-county organizations serving Cabarrus County (e.g., community-based organizations, hospitals, Federally Qualified Health Centers, medical groups, and others). The sections below outline the planned process to support the successful implementation and evaluation of opioid settlement funded efforts.

Fund Allocation and Budgeting

Once the strategies and corresponding budget allocations are approved, the County will finalize the plan and process for selecting fund recipients. **The County anticipates funding both county-operated programs, as well as programs/activities operated by non-county organizations**. Funding for county-operated programs can be transferred directly, while Requests for Proposals (RFPs) will be released for programs operated by non-county organizations. The intent is to use settlement funding to expand services and programs, develop new and innovative programs based on gaps and community needs, and help with capital expansion of facilities to help serve persons experiencing OUD.

RFPs will align with the funded strategies and include the prioritized activities and indicator examples identified by the CRT to guide applicants. This will allow applicants to offer creative and innovative approaches, and tailor proposed services to the communities they serve.

To date, the County has allocated approximately $2.8 million in opioid settlement funds to support programs such as MAT in Detention and MAT Community Paramedicine. The table below captures proposed budget allocations, by strategy, covering Fiscal Years 2024 – 25 through 2028 – 29. This new funding allocation totals approximately $6.66 million.

THE PROCESS

Cabarrus County elected to undertake a collaborative strategic planning process. This collaborative planning process provided opportunities to engage the community—both professionals working in and around this space as well as those with lived experience—to hear the needs of residents, understand current services offered and existing strengths, and explore barriers to accessing care, with a goal of using this information to make informed decisions.

Proposed Budget Allocation						
Strategy	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
MOU A.1. Collaborative Strategic Planning	$96,174	$96,174	$96,174	-	-	$288,522
MOU A.2. Evidence-based Addiction Treatment	-	-	-	$465,000	$465,000	$930,000
MOU A.3. Recovery Support Services	-	-	$90,000	$100,000	$106,000	$296,000
MOU A.6. Early Intervention	$371,472	$251,472	$251,472	$0	$0	$874,416
MOA A.7. Prevent Overdose Deaths and Other Harms	$50,000	$110,000	$113,000	$116,500	$120,000	$509,500
MOA A.11 Addiction Treatment for Incarcerated Persons	-	-	-	$323,500	$342,425	$665,925
MOA A.12 Reentry Programs	-	-	-	$271,439	$287,726	$559,165
MOA B, Strategy C: Connect People Who Need Help to the Help They Need	-	$351,374	$351,374	-	-	$702,748
MOA B, Strategy E: Address Needs of Pregnant Women and their Families	$361,563	$378,756	$396,981	$341,299	$361,776	$1,840,375
Total	**$879,209**	**$1,187,776**	**$1,299,001**	**$1,617,738**	**$1,682,927**	**$6,666,651**

In an RFP response, organizations will be asked to provide a detailed implementation plan, in which they will discuss how the program/services will be brought to fruition, as well as a requested budget amount and proposed metrics for evaluation. Responses to the RFP should also honor the spirit of the MOA, which highlights the importance of using programs and interventions that are evidence-based/informed, trauma-competent, and embrace the harm reduction approach. The County will provide general guidance regarding award amounts to inform proposal development. We also anticipate that the contract duration will be no more than two to three years, with opportunities to renew.

The County will review and evaluate all applicants, assessing the alignment with the prioritized strategies, feasibility (informed by the implementation plan), sustainability, and anticipated impact. The County will then select organizations and agencies with responsibility to implement each strategy and identify the human, material, and capital resources to implement each strategy. The County will announce anticipated awardees and award amounts. These organizations will then enter final contract negotiations, outlined further below. The total dollars awarded will align with the approved budget, as approved by the Board of County Commissioners for each strategy.

For directly funded programs, the County will request the development of detailed implementation plans, budgets, and metrics for evaluation. The County will review and evaluate these internal applicants, in a similar process to that of the external RFP respondents.

For each potential strategy identified, the County will consider opportunities to braid Opioid Settlement Funds with other funding streams to pursue creative solutions. The County will develop a detailed global budget for each strategy with anticipated expenditures, along with timelines for completing components of each strategy. The County will appropriate the opioid settlement funds in the annual budget ordinance or an amendment to the annual budget ordinance.

Implementation and Evaluation Planning

For all awarded programs – both county-operated and those selected via the RFP process – the County will engage in final contract negotiations, during which the implementation plan, budget, and evaluation plan will be finalized. **The evaluation plan will include project goals and at least one process measure (how much did you do?), one quality measure (how well did you do it?), and one outcome measure (is anyone better off?) for each awardee**. These measures, in addition to the implementation plan, are what the County will utilize to evaluate the impact and effectiveness of the contractor. The County will establish the process whereby awardees will submit data and progress updates over the contract period. These data – as well as the population-level measures identified previously – will serve as the basis for the overall evaluation of the impact of opioid settlement fund utilization. Importantly, all counties are required to submit annual financial and impact reports, further promoting transparency and accountability.

Monitoring, Evaluation, and Compliance

We anticipate quarterly reports on implementation plan progress, budget spend, and metric results. Therefore, HMA will help the county develop a framework for evaluation on an ongoing basis. A regular reporting frequency will allow the County to ensure the proper and effective use of funding and provide additional support and technical assistance as needed. The County will ensure alignment with all state reporting requirements, such as requirements about producing spending authorization reports within 90 days of authorization. The County will also produce an annual financial report and annual impact report within 90 days of the fiscal year-end, as required. These annual reports will capture the aggregate financial and impact data, and report on implementation progress to date. This annual report will allow the County to evaluate the global and strategy-specific impacts of the opioid settlement fund utilization and adjust its approach accordingly. The opioid crisis continues to evolve, and this approach will allow the County to evolve with it.

FINAL APPROVAL OF RECOMMENDATIONS BY GOVERNING BODY

HMA will present the final Three Year Collaborative Strategic Planning Process recommendations of the Cabarrus County Board of Commissioners for approval, which will include the identified MOA Option B strategies and budget, as required to initiate the implementation steps outlined above. Once approved, the County will develop and release RFP(s), make funding determinations, finalize contracts and implementation/evaluation plans, and release opioid settlement funds.

APPENDIX

Compliance with Collaborative Strategic Planning Process and Use of Settlement Funds Requirements

Requirements of MOA B include that local governments are expected to report publicly once they have adopted a resolution for funding expenditures, and HMA recognizes the importance of assisting Cabarrus County with that commitment. Below is a summary of some of the key requirements in the MOA.

EXHIBIT A KEY REQUIREMENTS IN THE MOA

KEY REQUIREMENTS	
Establish a fund	A local government receiving opioid settlement funds must secure and account for these funds in a special revenue fund.
Authorize spending	Before spending opioid settlement funds, a local government must authorize the expenditure of these funds in a manner that satisfies MOA requirements as well as state law. The MOA does not require that a local government spend all the funds it receives in a particular fiscal year by the end of that fiscal year. It allows a local government to roll funds over from year to year as long as it reports the amount of opioid settlement funds in the special revenue fund at the end of one fiscal year and the beginning of the following fiscal year. In addition to adopting the authorizing resolution that the MOA requires, a local government's governing board must appropriate the opioid settlement funds through a legal budget ordinance before funds can be obligated and expended. Under current law, there are two budgeting options available to local governments: • The annual budget ordinance, or an amendment to the annual budget ordinance; or • A capital project ordinance for capital projects that are consistent with the MOA. While some local governments have considered a grant project ordinance for opioid settlement funds, the NC DOJ does not believe this is a viable option at present (August 2023) unless legislation is passed to clarify the availability of this option for opioid settlement funds. The local government's governing board may appropriate the opioid settlement funds in the annual budget ordinance or an amendment to the annual budget ordinance. The amount of opioid settlement funds estimated to be expended during the fiscal year is included as revenue, and corresponding appropriations are made by department, function, or project in accordance with NCGS § 159-13. The appropriations must be consistent with the authorizing resolution required by the MOA.

KEY REQUIREMENTS	
Understand and follow the options	A local government must spend opioid settlement funds on opioid remediation activities authorized under Option A or Option B as detailed in the MOA, requiring strict compliance. The local government must adopt a resolution that states each specific strategy it intends to fund, along with the amount dedicated to that specific strategy for a specified period of time. For this reason, the MOA does not allow a local government to authorize the expenditure of a single amount of funds on multiple strategies. The MOA provides that a local government may contract with a nonprofit, charity, or other entity to use opioid settlement funds to implement opioid remediation strategies in a manner consistent with all of the substantive and procedural requirements of the MOA and all other applicable laws and rules. The MOA permits a local government to spend opioid settlement funds on the salary and fringe benefits of an employee if certain reporting conditions are satisfied. The MOA permits a local government to spend opioid settlement funds on a building, vehicle, or other capital asset if certain conditions are satisfied.
Understand and follow all reporting requirements	A local government must comply with all reporting requirements in the MOA, including the following: • The local spending authorization report due within 90 days of the authorization of the expenditure of opioid settlement funds. • The Option B report and recommendations due within 90 days of presentation to the governing body. • The annual financial report (Exhibit E) due within 90 days of any fiscal year in which opioid settlement funds are received, held, or expended. • The annual impact report (Exhibit F) due within 90 days of any fiscal year in which opioid settlement funds are received, held, or expended. • A local government that contracts with a third party to implement opioid remediation strategies under the MOA must ensure that the third party complies with the MOA. To ensure that this happens, the local government should include relevant MOA requirements in its contract with the third party.
Hold annual meeting	The MOA requires that each county receiving opioid settlement funds hold at least one annual meeting open to the public, with all municipalities in the county invited to the meeting to receive input on proposed uses of the opioid settlement funds and to encourage collaboration among local governments. The MOA does not specify when the annual meeting should take place and does not clarify whether the term “annual” refers to the fiscal year or the calendar year (however, the fiscal year is being assumed by most).

HIGH-IMPACT OPIOID ABATEMENT STRATEGIES (“OPTION A” List)

In keeping with the National Settlement Agreement, opioid settlement funds may support programs or services listed below that serve persons with Opioid Use Disorder (OUD) or any co-occurring Substance Use Disorder (SUD) or mental health condition.

As used in this list, the words “fund” and “support” are used interchangeably and mean to create, expand, or sustain a program, service, or activity.

1. Collaborative strategic planning. Support collaborative strategic planning to address opioid misuse, addiction, overdose, or related issues, including staff support, facilitation services, or any activity or combination of activities listed in Exhibit C to the MOA (collaborative strategic planning).

2. Evidence-based addiction treatment. Support evidence-based addiction treatment consistent with the American Society of Addiction Medicine’s national practice guidelines for the treatment of opioid use disorder – including Medication-Assisted Treatment (MAT) with any medication approved for this purpose by the U.S. Food and Drug Administration – through Opioid Treatment Programs, qualified providers of Office-Based Opioid Treatment, Federally Qualified Health Centers, treatment offered in conjunction with justice system programs, or other community-based programs offering evidence-based addiction treatment. This may include capital expenditures for facilities that offer evidence-based treatment for OUD. (If only a portion of a facility offers such treatment, then only that portion qualifies for funding, on a pro rata basis.)

3. Recovery support services. Fund evidence-based recovery support services, including peer support specialists or care navigators based in local health departments, social service offices, detention facilities, community-based organizations, or other settings that support people in treatment or recovery, or people who use drugs, in accessing addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need to improve their health or well-being.

4. Recovery housing support. Fund programs offering recovery housing support to people in treatment or recovery, or people who use drugs, such as assistance with rent, move-in deposits, or utilities; or fund recovery housing programs that provide housing to individuals receiving Medication-Assisted Treatment for opioid use disorder.

5. Employment-related services. Fund programs offering employment support services to people in treatment or recovery, or people who use drugs, such as job training, job skills, job placement, interview coaching, resume review, professional attire, relevant courses at community colleges or vocational schools, transportation services or transportation vouchers to facilitate any of these activities, or similar services or supports.

6. Early intervention. Fund programs, services, or training to encourage early identification and intervention for children or adolescents who may be struggling with problematic use of drugs or mental health conditions, including Youth Mental Health First Aid, peer-based programs, or similar approaches. Training programs may

target parents, family members, caregivers, teachers, school staff, peers, neighbors, health or human services professionals, or others in contact with children or adolescents.

7. Naloxone distribution. Support programs or organizations that distribute naloxone to persons at risk of overdose or their social networks, such as Syringe Service Programs, post-overdose response teams, programs that provide naloxone to persons upon release from jail or prison, emergency medical service providers or hospital emergency departments that provide naloxone to persons at risk of overdose, or community-based organizations that provide services to people who use drugs. Programs or organizations involved in community distribution of naloxone may, in addition, provide naloxone to first responders.
8. Post-overdose response team. Support post-overdose response teams that connect persons who have experienced non-fatal drug overdoses to addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need to improve their health or well-being.

9. Syringe Service Program. Support Syringe Service Programs operated by any governmental or nongovernmental organization authorized by section 90-113.27 of the North Carolina General Statutes that provide syringes, naloxone, or other harm reduction supplies; that dispose of used syringes; that connect clients to prevention, treatment, recovery support, behavioral healthcare, primary healthcare, or other services or supports they need; or that provide any of these services or supports.

10. Criminal justice diversion programs. Support pre-arrest or post-arrest diversion programs, or pre-trial service programs, that connect individuals involved or at risk of becoming involved in the criminal justice system to addiction treatment, recovery support, harm reduction services, primary healthcare, prevention, or other services or supports they need, or that provide any of these services or supports.

11. Addiction treatment for incarcerated persons. Support evidence-based addiction treatment, including Medication-Assisted Treatment with at least one FDA-approved opioid agonist, to persons who are incarcerated in jail or prison.

12. Reentry Programs. Support programs that connect incarcerated persons to addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need upon release from jail or prison, or that provide any of these services or supports.

Additional Opioid Remediation Activities ("OPTION B" List)

This list shall be automatically updated to match the list of approved strategies in the most recent National Settlement Agreement.

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, the following:[1]

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. 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.

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

8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including tele mentoring to assist community-based providers in rural or underserved areas.
9. Support workforce development for addiction professionals who collaborate with persons with OUD and any co-occurring SUD/MH conditions.

10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.
11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD 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. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.
14. Development and dissemination of 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 treatment for or 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 following:

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. 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 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, the following:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.
2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.
3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.
4. Purchase automated versions of SBIRT and support ongoing costs of the technology.
5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.
6. 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, the following:

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:
    a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);
    b. Active outreach strategies such as the Drug Abuse Response Team (DART) model;
    c. "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;
    d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;
    e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or
    f. 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, 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, the following:

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. Training for obstetricians or other healthcare personnel that 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; 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 Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.
6. Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.
7. Enhanced family supports 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. 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.

EXHIBIT C to NC MOA

COLLABORATIVE STRATEGIC PLANNING PROCESS UNDER OPTION B

	ACTIVITY NAME	ACTIVITY DETAIL	CONTENT OF REPORT & RECOMMENDATIONS
A	Engage diverse stakeholders	Engage diverse stakeholders, per "ITEM A DETAIL" below, throughout the collaborative strategic planning process	Report on stakeholder engagement per "ITEM A DETAIL" below
B	Designate facilitator	Designate a person or entity to facilitate the strategic collaborative planning process. Consider a trained, neutral facilitator.	Identify the facilitator
C	Build upon any related planning	Build upon or coordinate with prior or concurrent planning efforts that address addiction, drug misuse, overdose, or related issues, including but not limited to community health assessments.	Report any related planning efforts you will build upon or coordinate with
D	Agree on shared vision	Agree on a shared vision for positive community change, considering how strategic investments of Opioid Settlement Funds have the potential to improve community health and well-being and address root causes of addiction, drug misuse, overdose, and related issues	Report on shared vision for positive community change
E	Identify key indicator(s)	Identify one or more population-level measures to monitor in order to gauge progress towards the shared vision. (The NC Opioid Action Plan Data Dashboard contains several such measures.)	Report on the key indicators selected
F	Identify and explore root causes	Explore root causes of addiction, drug misuse, overdose, and related issues in the community, using quantitative data as well as stakeholder narratives, community voices, the stories of those with lived experience, or similar qualitative information	Report on root causes as described

	ACTIVITY NAME	ACTIVITY DETAIL	CONTENT OF REPORT & RECOMMENDATIONS
G	Identify and evaluate potential strategies	Identify potential strategies to address root causes or other aspects of the opioid epidemic; identify these strategies (by letter or number) on EXHIBIT A or EXHIBIT B, and consider the effectiveness of each strategy based on available evidence	Identify and evaluate potential strategies
H	Identify gaps in existing efforts	For each potential strategy identified (or for favored strategies), survey existing programs, services, or supports that address the same or similar issues; and identify gaps or shortcomings	Report on survey of and gaps in existing efforts
I	Prioritize strategies	Prioritize strategies, taking into account your shared vision, analysis of root causes, evaluation of each strategy, and analysis of gaps in existing efforts	Report on prioritization of strategies
J	Identify goals, measures, and evaluation plan	For each strategy (or favored strategy), develop goals and an evaluation plan that includes at least one process measure (How much did you do?), at least one quality measure (How well did you do it?), and at least one outcome measure (Is anyone better off?)	Report on goals, measures, and evaluation plan for each chosen strategy
K	Consider ways to align strategies	For each potential strategy identified (or for favored strategies), consider opportunities to braid Opioid Settlement Funds with other funding streams; develop regional solutions; form strategic partnerships; or to pursue other creative solutions	Report on opportunities to align strategies as described
L	Identify organizations	Identify organizations and agencies with responsibility to implement each strategy; and identify the human, material, and capital resources to implement each strategy	Identify organizations and needs to implement each strategy

ACTIVITY NAME		ACTIVITY DETAIL	CONTENT OF REPORT & RECOMMENDATIONS
M	Develop budgets and timelines	Develop a detailed global budget for each strategy with anticipated expenditures, along with timelines for completing components of each strategy	Report budgets and timelines for each strategy
N	Offer recommen-dations	Offer recommendations to local governing body (e.g., the county board, city council, or other local governing body)	Report recommendations

ITEM A DETAIL: STAKEHOLDER INVOLVEMENT

ACTIVITY NAME		ACTIVITY DETAIL	CONTENT OF REPORT & RECOMMENDATIONS
A-1	Local officials	County and municipal officials, such as those with responsibility over public health, social services, and emergency services	Report stakeholder involvement (who and how involved in process)
A-2	Healthcare providers	Hospitals and health systems, addiction professionals and other providers of behavioral health services, medical professionals, pharmacists, community health centers, medical safety net providers, and other healthcare providers	same as above
A-3	Social service providers	Providers of human services, social services, housing services, and community health services such as harm reduction, peer support, and recovery support services	same
A-4	Education and employment service providers	Educators, such as representatives of K-12 schools, community colleges, and universities; and those providing vocational education, job skills training, or related employment services	same
A-5	Payers and funders	Health care payers and funders, such as managed care organizations, prepaid	same

ACTIVITY NAME		ACTIVITY DETAIL	CONTENT OF REPORT & RECOMMENDATIONS
		health plans, LME-MCOs, private insurers, and foundations	
A-6	Law enforcement	Law enforcement and corrections officials	same
A-7	Employers	Employers and business leaders	same
A-8	Community groups	Community groups, such as faith communities, community coalitions that address drug misuse, groups supporting people in recovery, youth leadership organizations, and grassroots community organizations	same
A-9	Stakeholders with "lived experience"	Stakeholders with "lived experience," such as people with addiction, people who use drugs, people in medication-assisted or other treatment, people in recovery, people with criminal justice involvement, and family members or loved ones of the individuals just listed	same
A-10	Stakeholders reflecting diversity of community	Stakeholders who represent the racial, ethnic, economic, and cultural diversity of the community, such as people of color, Native Americans, members of the LGBTQ community, and members of traditionally unrepresented or underrepresented groups	same