

North Carolina Opioid Settlements

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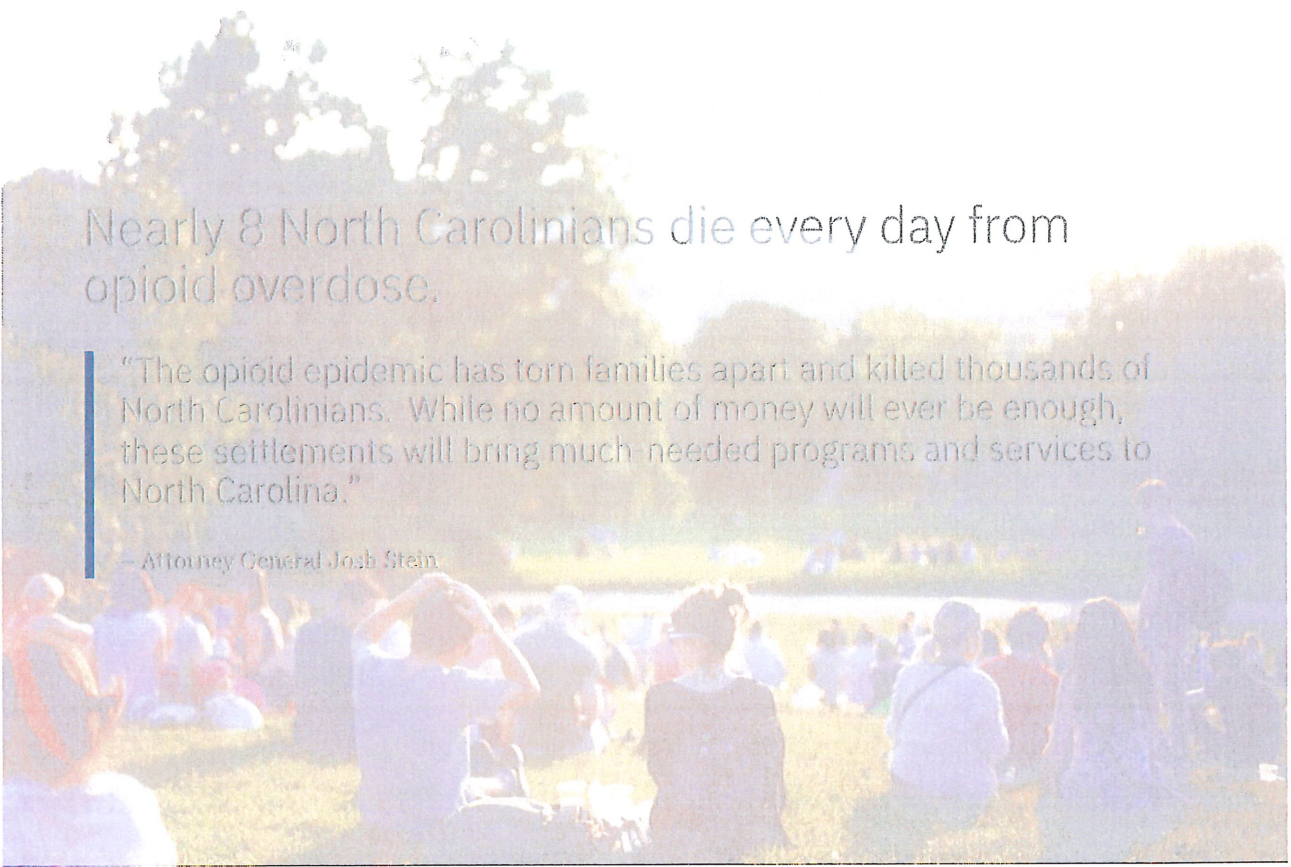
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All of the above information can be found at: <https://ncopioidsettlement.org/>

North Carolina Opioid Settlements

Welcome to CORE-NC: Community Opioid Resources Engine for North Carolina

Home



Nearly 8 North Carolinians die every day from opioid overdose.

"The opioid epidemic has torn families apart and killed thousands of North Carolinians. While no amount of money will ever be enough, these settlements will bring much needed programs and services to North Carolina."

— Attorney General Josh Stein

About the Opioid Settlements

North Carolina is part of a historic \$26 billion agreement that will help bring desperately needed relief to communities impacted by opioids. These funds will be used to support treatment, recovery, harm reduction, and other life-saving programs and services in communities throughout the state. North Carolina's Opioid and Substance Use Action Plan lays out concrete strategies to advance prevention, reduce harm, and connect people to the care that they need.

North Carolina Opioid Settlements

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About the Opioid Settlements

What are the Opioid Settlements?

In July 2021, Attorney General Josh Stein announced a historic \$26 billion agreement that will help bring desperately needed resources to communities harmed by the opioid epidemic. The agreement resolves litigation over the role of four companies in creating and fueling the opioid epidemic. The agreement also requires significant industry changes that will help prevent this type of crisis from ever happening again.

[Read More](#)

What is the North Carolina Memorandum of Agreement (MOA)?

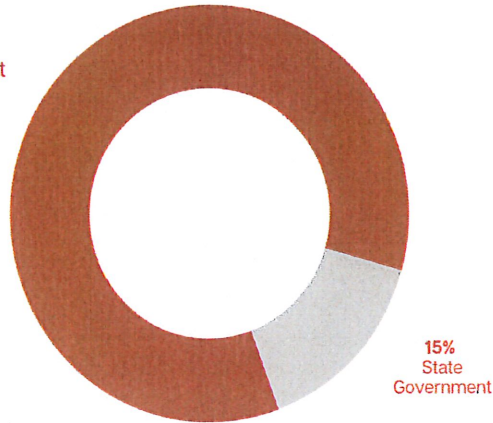
A Memorandum of Agreement (MOA) between the State and local government directs how opioid settlement funds are distributed and used in our state. To maximize funds flowing to North Carolina communities on the front lines of the opioid epidemic, the MOA allocates 15 percent of settlement funds to the State and sends the remaining 85 percent to NC's 100 counties and 17 municipalities.

[Visit the NC MOA Resource Center to read the FAQ on the MOA](#)

[Learn More from the NC Department of Justice](#)

[Learn More from the NC Association of County Commissioners](#)

85%
of NC settlement
funds will go to
counties and
municipalities



85% of NC settlement funds will go to counties and municipalities

The agreement also ensures transparency about how local governments will use the funds. Counties and municipalities that receive settlement funds will need to create a special revenue fund that will be subject to audit. They will also complete annual financial and impact reports that will be available to the public on this website.

How much total funding will my county or city be receiving?

Settlement funds are being allocated to 100 counties and 17 municipalities based on a formula the national counsel representing local governments developed. Funds will begin to be distributed to counties and municipalities in 2022 and continue over a period of 18 years.

[See how much total funding each county and municipality could get from these settlements](#)

How do local agencies spend the money once it arrives?

Before spending settlement funds, every local county or municipality must first select which opioid mitigation strategies they would like to fund.



See our Resources for Strategy Selection

How will local agencies report on what they spend?

Any local government that spends opioid settlement funds will be required to file financial reports and impact information on an annual basis.

[Read More](#)

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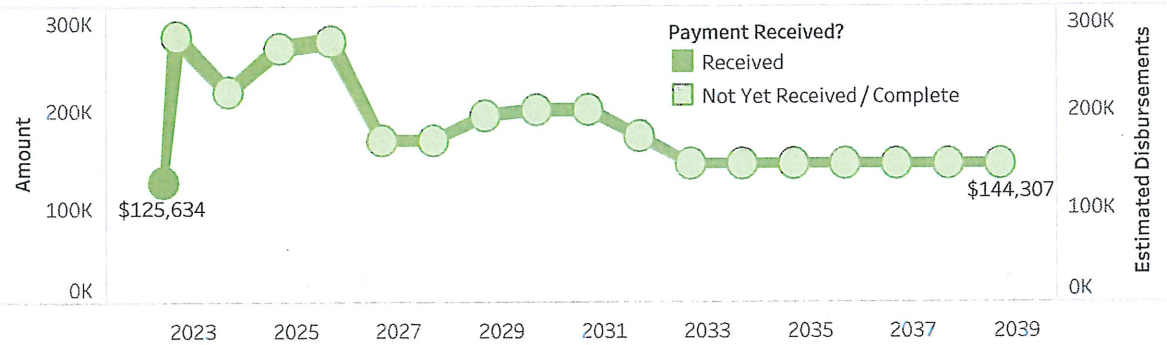
Choose a Place:

Jackson

18 Year Payment to Jackson during 2022-2038:

\$3,270,043

Payments Over Time - Jackson



Payment Table - Jackson

Year	Season	Amount
2022	Spring	\$125,634
	Summer	\$276,293
2023	Summer	\$218,670
2024	Summer	\$263,739
2025	Summer	\$271,506
2026	Summer	\$168,370
2027	Summer	\$168,370
2028	Summer	\$194,078
2029	Summer	\$200,199
2030	Summer	\$200,199
2031	Summer	\$172,834
2032	Summer	\$144,307
2033	Summer	\$144,307
2034	Summer	\$144,307
2035	Summer	\$144,307
2036	Summer	\$144,307
2037	Summer	\$144,307
2038	Summer	\$144,307

Download Local
Payout Schedule:



Download Payouts
for All Locations:



North Carolina Opioid Settlements

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Resources

How Should Counties and Cities Spend their Settlement Funds?

The Memorandum of Agreement (MOA) offers local governments two options:

- Under **Option A**, a local government may fund one or more strategies from a **shorter list** (Exhibit A) of evidence-based, high-impact strategies to address the epidemic.
- Under **Option B**, a local government engages in a **collaborative strategic planning process** (Exhibit C) involving a diverse array of stakeholders and may then fund a strategy from the Exhibit A list or a **longer list of strategies** (Exhibit B) included in the national settlements.

**EXHIBIT A TO NC MOA:
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.

EXHIBIT B TO NC MOA:

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 telementoring to assist community-based providers in rural or underserved areas.
9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.
10. 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.

PART TWO: PREVENTION

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

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

1. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).
2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.
3. Continuing Medical Education (CME) on appropriate prescribing of opioids.
4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.
5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:
 - a. Increase the number of prescribers using PDMPs;
 - b. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or
 - c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.
6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.
7. Increase electronic prescribing to prevent diversion or forgery.
8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Fund media campaigns to prevent opioid misuse.
2. Corrective advertising or affirmative public education campaigns based on evidence.
3. Public education relating to drug disposal.
4. Drug take-back disposal or destruction programs.
5. Fund community anti-drug coalitions that engage in drug prevention efforts.
6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).
7. Engage non-profits and faith-based communities as systems to support prevention.
8. 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.
9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.
10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.
11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.
12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or other drug misuse.

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

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

1. 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 and outreach workers, persons being released from jail or prison, or other members of the general public.
2. Public health entities that provide free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.
4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.
5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.
6. Public education relating to emergency responses to overdoses.
7. Public education relating to immunity and Good Samaritan laws.
8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.
9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.
10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.
11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.
12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.
13. Support screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in sections C, D, and H of this Exhibit relating to first responders, support the following:

1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.
2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

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

1. Statewide, regional, local, or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services; to support training and technical assistance; or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
2. A dashboard to share reports, recommendations, or plans to spend Opioid Settlement Funds; to show how Opioid Settlement Funds have been spent; to report program or strategy outcomes; or to track, share, or visualize key opioid-related or health-related indicators and supports as identified through collaborative statewide, regional, local, or community processes.
3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.
4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

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

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.
2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

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

1. Monitoring, surveillance, data collection, and evaluation of programs and strategies described in this opioid abatement strategy list.
2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.
4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.
5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.
6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).
7. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.
8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.
9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

**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
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

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 recommendations	Offer recommendations to local governing body (e.g., the county board, city council, or other local governing body)	Report recommendations to governing body

ITEM A DETAIL: STAKEHOLDER INVOLVEMENT

	STAKE-HOLDERS	DESCRIPTION	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 health plans, LME-MCOs, private insurers, and foundations	same
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