GATESPRING

Rutherford County Collaboration Strategic Planning Report & Recommendations

Prepared by:

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SECTION ONE

PRELIMINARY PLANNING

A. ENGAGE DIVERSE STAKEHOLDERS

Rutherford County undertook a collaborative, evidence-informed engagement process led by Gatespring in partnership with the Rutherford County Opioid Strategic Planning Committee and a broad cross-section of the community. Together, this coordinated effort brought in representatives from every stakeholder category identified in Exhibit C of the North Carolina Memorandum of Agreement (MOA) and the NCACC Collaborative Strategic Planning Toolkit (2024). The process was intentionally designed to be broad, balanced, and sustained, ensuring meaningful participation from institutional partners as well as community voices.

Engagement methods included structured committee meetings, targeted focus groups, and in-depth interviews. These activities captured perspectives from local government, healthcare, social services, education and workforce development, payers and funders, law enforcement, employers, community organizations, and individuals with lived experience. More than seventy-five stakeholders contributed through interviews and related activities, supplemented by eleven site visits that grounded findings and recommendations in the lived realities of Rutherford County communities (Gatespring, 2025).

Particular emphasis was placed on engaging people who use drugs to elevate the voices of individuals still facing challenges related to substance use and to better understand key barriers to care and recovery. In addition, the perspectives of peer support specialists, recovery coaches, and family members were intentionally sought to capture a wider range of lived and shared experiences. This approach reflects best practice guidance in the NCACC Toolkit, which underscores the importance of lived experience in shaping system-level strategies (NCACC, 2024).

Through this approach, Rutherford County established a representative and durable coalition whose active participation informed every stage of the analysis and recommendation development. The breadth and depth of engagement not only ensured compliance with MOA requirements but also produced a community-driven framework that strengthens accountability, supports equitable decision-making, and lays the foundation for sustained system improvements (Gatespring, 2025).

TABLE A.1. STAKEHOLDER ENGAGEMENT SUMMARY

Stakeholder Category	Representative Roles or Organizations	Engagement Frequency
Rutherford County Opioid Strategic Planning Committee	Convening body guiding the process and representing all categories listed below	Always
Local officials	Town Managers; County HR Director; County Manager	Always
Healthcare providers	EMS County Director; Blue Ridge FQHC; Preferred Choice Healthcare Clinical Director; Behavioral Health Management Regional Director; Rutherford Regional Hospital; Clarvida	Always
Social service providers	Rutherford County Department of Social Services; Peer Support Specialists	Always
Education and employment service providers	Superintendent of Rutherford County Schools; Chief Academic Officer; Dean of Students and Student Advocacy Coordinator at Isothermal Community College	Always
Payers and funders	Dogwood Health Trust; RHI Legacy Foundation; NCDHHS; Local Government	Always
Law enforcement	Rutherford County Sheriff; District 41 District Attorney	Always
Employers	Representatives from non-profits, local governments, healthcare providers, manufacturers, food and beverage, construction; Isothermal Community College workforce initiatives	Always
Community groups	ACRN; Out of the Ashes; NAMI South Mountains; United Way of Rutherford County; Foothills Regional; Rutherford Housing Partnership; Mutual aid groups	Always
Stakeholders with lived experience	Peer Support Specialists; Recovery Coaches; PWUD	Always
Stakeholders reflecting diversity of community	Grahamtown Team; Alianza Hispaña; Peer Support Specialist, PWUD, LGBTQIA+	Always

B. DESIGNATE FACILITATOR

Facilitator:

Scott Luetgenau, MSW, LCAS, CSI

Founder & Principal Consultant, Gatespring

Email: scott@gatespring.org

Scott Luetgenau is a nationally recognized addiction and public health consultant with more than a decade of experience enhancing systems of care for individuals affected by substance use disorders. As founder of Gatespring, he partners with government agencies, healthcare systems, and community organizations to develop and implement evidence-based, locally tailored solutions.

He offers specialized expertise in the areas of Medication for Opioid Use Disorder (MOUD), jail-based treatment integration, harm reduction, opioid settlement planning, and the design of recovery-oriented systems. Scott's leadership has guided major county, state, and regional projects, including learning collaboratives in New Mexico to implement MOUD in detention centers, and multi-county strategic planning processes across North Carolina and Texas. Previously, he served as director of North Carolina's largest opioid treatment program, where he expanded access to care from 275 to over 700 patients. He has also delivered technical assistance nationwide through the Opioid Response Network (Substance Abuse and Mental Health Services Administration), supporting coalitions, correctional facilities, FQHCs, and treatment programs in managing both clinical and operational challenges.

In addition to consulting, Scott has held prominent leadership roles within state and professional organizations, such as serving as Vice-Chair of the North Carolina Association for the Treatment of Opioid Dependence, Finance Chair for Addiction Professionals of North Carolina, and Vice-Chair of the North Carolina Substance Use Disorder Federation. He is also an experienced trainer, creating opioid treatment-related courses for the North Carolina State University School of Social Work to translate evidence-based best practices to frontline providers.

Scott currently leads Rutherford County's opioid settlement strategy as the designated facilitator, guiding collaborative planning, implementation of funded initiatives, and the design of evidence-based systems of care. A person in long-term recovery, he brings systems thinking, authenticity, and a pragmatic, data-driven approach rooted in lived experience. His facilitation prioritizes structural change, sustainable impact, and strategies proven to improve outcomes.

C. BUILD UPON RELATED PLANNING

The Rutherford County Collaborative Strategic Planning process was structured to intentionally build upon existing planning efforts at the local, regional, and state levels, in alignment with Exhibit C of the North Carolina MOA and the NCACC Toolkit guidance (NCACC, 2024). This framework ensured the integration of current community priorities with evidence from major existing analyses and initiatives.

The process drew on the **Housing Needs Assessment for Rutherfordton**, which provided a detailed evaluation of market conditions, demographic trends, and housing gaps, along with targeted recommendations (Bowen National Research, 2022). The **2025 Action Plan for the Town of Rutherfordton** offered a strategic framework for economic development, workforce expansion, and infrastructure, rooted in sustained community engagement (Town of Rutherfordton, 2025).

Public health and education planning efforts were also foundational. The **School Health Advisory Council (SHAC) Comprehensive Needs Triennial Assessment** identified district-wide strengths and opportunities in school health and wellness programming (Rutherford County Schools, 2025). The **Parks and Recreation Master Plan** guided strategies for enhancing recreational infrastructure and quality-of-life investments (Town of Rutherfordton, 2018).

Broader health system and community needs were addressed through the **Foothills Regional Commission Community Health Assessment** (Foothills Regional Commission, 2024) and the **Rutherford Regional Health System Community Health Needs Assessment** (Rutherford Regional Health System, 2021), both of which provide recent data on service gaps, health disparities, and priorities for countywide improvement.

Economic and school system development perspectives were integrated using the **CEDS Annual Report** (Foothills Regional Commission, 2024) and the **Rutherford County Schools Strategic Plan** (Rutherford County Schools, 2025), ensuring alignment across key policy areas.

To ground the planning in demographic and economic realities, the **Rutherford County Profile** produced by the UNC Carolina Population Center and myFutureNC (2025), provided current local data on educational attainment, labor force participation, income, and opportunity youth rates. This profile highlighted pressing challenges in workforce alignment and postsecondary achievement, further guiding strategic priorities.

Finally, state and regional metrics from the **North Carolina Community Health Needs Assessment Portal** (North Carolina Department of Health and Human Services, n.d.) contextualized local trends within broader patterns.

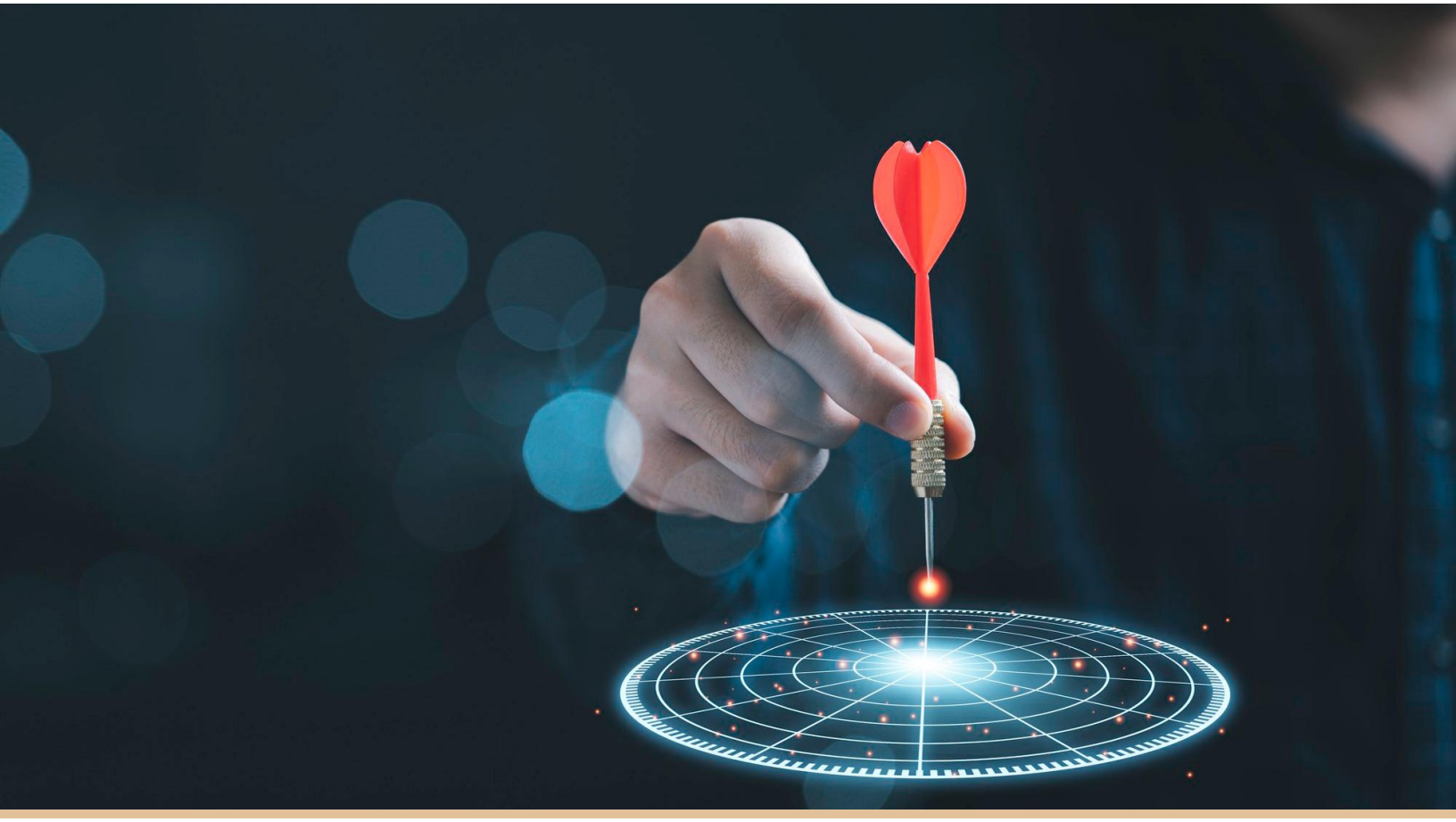
D. AGREE ON SHARED VISION

The Rutherford County Opioid Strategic Planning Committee affirmed a clear and actionable shared vision to guide both recommendations and future implementation efforts. This vision foregrounds the commitment to a comprehensive, equitable, and evidence-based response to opioid use disorder (OUD), one that integrates prevention, harm reduction, treatment, and recovery as essential, interconnected elements of a unified continuum of care (NCACC, 2024).

VISION STATEMENT

Rutherford County envisions a future where all individuals and families have meaningful access to quality, evidence-based treatment and services that address the wide-ranging effects of opioid use disorder. The county is committed to strengthening access at every point in the continuum of care—by investing in prevention, harm reduction, treatment, and recovery supports—ensuring that no resident is left behind. Priorities include promoting community education about OUD and effective treatment options, increasing access to lifesaving interventions such as naloxone and medications for opioid use disorder (MOUD), and supporting programs that meet the fundamental needs of individuals and families.

Rutherford County recognizes that people who use drugs often experience pervasive stigma and are disproportionately impacted by adverse social determinants of health. Driven by this understanding, the county commits to advancing strategies that improve the conditions in which residents are born, grow, live, work, and age so that all community members have opportunities to thrive (North Carolina Department of Health and Human Services, 2025; Town of Rutherfordton, 2025). This shared vision will be the foundation for collaborative, accountable, and sustainable action across agencies and the broader community.



E. IDENTIFY KEY INDICATOR(S)

Rutherford County will monitor a core set of population- and program-level indicators to evaluate progress toward the shared vision articulated by the Opioid Strategic Planning Committee. The selected indicators are aligned with the North Carolina Opioid Action Plan Data Dashboard, which brings together state and local metrics and is recommended for monitoring community impact and driving continuous quality improvement (NC Department of Health and Human Services, 2025; NCACC, 2024; Dolan Fliss et al., 2023). Locally relevant measures have also been integrated to reflect the county's strategies and implementation context.

Recommended key indicators include:

- Percent of the population receiving early intervention and overdose prevention education
- Number of naloxone kits distributed
- Number of patients served at office-based opioid treatment (OBOT) sites, including Blue Ridge FQHC and Rutherford Regional Health System
- Number of referrals to OBOT or opioid treatment programs (OTP)
- Number of adolescents and adults initiating substance use disorder treatment following an inpatient admission, outpatient visit, intensive outpatient program encounter, partial hospitalization, telehealth visit, or initiation of medication treatment within 14 days of diagnosis
- Number of unique individuals diagnosed with OUD who are prescribed MOUD
- Number of unique individuals with OUD or opioid use engaged in recovery support services
- Rates of overdose deaths and overdose emergency department visits

Together, these measures provide a comprehensive evaluation framework, capturing prevention, harm reduction, treatment, and recovery domains of the continuum of care. Tracking each indicator over time will enable the county to assess implementation fidelity, measure system-wide improvements, and inform data-driven course corrections in alignment with state and local opioid response priorities (NCACC, 2024; NC Department of Health and Human Services, 2025).

F. IDENTIFY AND EXPLORE ROOT CAUSES

Root causes of opioid use disorder (OUD) and related harms in Rutherford County were identified through a mixed-methods approach combining quantitative county-level data with qualitative insights from community engagement. Sources included the Western North Carolina (WNC) Healthy Impact Community Health Survey, the 2024 Community Health Assessment Executive Summary, and regional and national assessments, along with 51 semi-structured interviews with stakeholders, agency leaders, justice personnel, and individuals with lived experience and active substance use. This comprehensive process illuminated intersecting systemic drivers shaping the OUD crisis in the county (Foothills Regional Commission, 2024).

Economic hardship was found to be a central factor. Rutherford County's poverty and unemployment rates continue to surpass state averages, reflecting the decline of its historic manufacturing and textile base. While manufacturing remains significant, elevated workplace injury rates and transitions to lower-wage service work contribute to economic instability and increased risk of opioid misuse. Communities like Rutherford with high unemployment and underemployment often see limited access to healthy lifestyle choices and opportunity, compounding vulnerability (County Health Rankings, 2024; Appalachian Regional Commission, 2019).

Housing insecurity further amplifies risk. Data from the WNC Healthy Impact Report identified Rutherford County among the region's leaders in unhealthy or unsafe housing, with more than 20% of residents reporting poor housing and nearly 9% experiencing homelessness within three years (WNC Healthy Impact, 2021). Financial precarity is pervasive, with nearly half of residents unable to meet a $400 emergency expense—rates exceeding both regional and national averages.

Barriers to healthcare and treatment access are severe. The patient-to-provider ratio in Rutherford is much higher than average, and the county currently lacks an opioid treatment program (OTP). Access to methadone and MOUD requires travel outside the county, which delays care for many. This structural gap persists even as the county continues to rank among the top North Carolina counties for overdose deaths (North Carolina Department of Health and Human Services, 2025; Foothills Regional Commission, 2024). Interviews revealed that for some, incarceration is viewed as the only pathway to treatment—though criminal justice involvement further reduces future employment and recovery prospects.

Social and behavioral determinants are also foundational. Survey and interview data show high rates of loneliness, poor self-rated mental health, and persistent community pessimism regarding the opioid crisis's solvability. Over half of respondents reported loneliness, and over a fifth expressed dissatisfaction with life—themes that echo research on the "diseases of despair" driving opioid misuse in Appalachian and rural areas (Appalachian Regional Commission, 2019; WNC Healthy Impact, 2021).

Together, these findings identify three interconnected root causes driving OUD in Rutherford County:

- Economic hardship and limited employment opportunity
- Insufficient healthcare and addiction treatment capacity
- Social isolation, poor mental health, and community despair

These factors interact to sustain risk and challenge recovery, indicating that effective strategies must address not only clinical care and harm reduction, but also meaningful investment in economic stability, safe housing, and social support systems (NC Department of Health and Human Services, 2025; Appalachian Regional Commission, 2019).

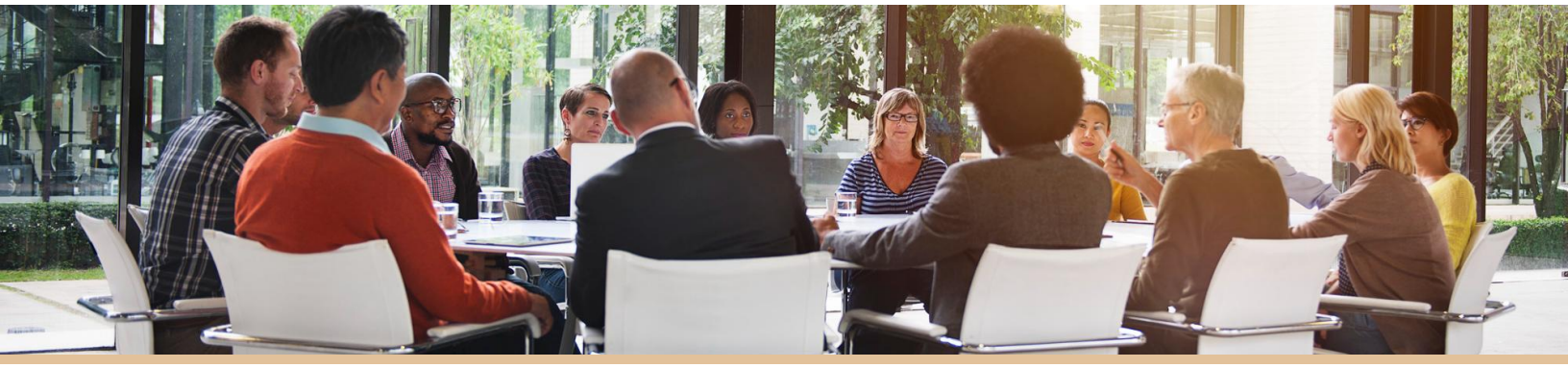


TABLE G.1

Root cause or aspect of the opioid epidemic to be addressed: Barriers to accessing SUD treatment and recovery services

Exhibit A or B	Number or Letter	Strategy Name	How do you know that this strategy will be effective at addressing the root cause/aspect mentioned above?
A	2	Expand Access to Evidence-Based Treatment (MOUD)	**Rationale:** Local barriers include long waits, few Medicaid-accepting prescribers, travel burden, cost, and stigma. Gaps are acute for justice-involved residents. **Evidence:** Buprenorphine, methadone, and XR-naltrexone reduce overdose mortality and improve retention and functioning; guidelines recommend full-formulary access and rural expansion (Volkow & Blanco, 2023; ASAM, 2020; Sordo et al., 2017). **Quotes:** "There's no one in this county prescribing Suboxone and taking Medicaid." "After jail, people end up right back where they started." (Rutherford County Collaborative Strategic Planning Interviews, 2025).
A	11	Addiction Treatment for Incarcerated Persons (Jail-Based MOUD)	**Rationale:** Highest risk period is post-release. Local capacity is limited. **Evidence:** Jail-based MOUD reduces post-release overdose mortality and increases linkage to community care (Brinkley-Rubinstein et al., 2018; National Academies of Sciences, Engineering, and Medicine, 2019). **Quotes:** "We lose too many people in the first weeks after release." "Treatment in jail changes the trajectory." (Rutherford County Collaborative Strategic Planning Interviews, 2025).
A	8	Post-Overdose Response Teams (PORT)	Rationale: Stakeholders stressed immediate outreach after nonfatal overdose. **Evidence:** PORT models increase treatment referrals and reduce repeat overdose when paired with peers and harm reduction (Bailey et al., 2023; Barocas et al., 2022). **Quotes:** "Reaching people quickly is key." "We're missing the window after an OD." (Rutherford County Collaborative Strategic Planning Interviews, 2025).
A	7	Naloxone Saturation	**Rationale:** Residents report limited access and lingering stigma. **Evidence:** Community distribution and OEND programs reduce overdose mortality and improve knowledge and attitudes (Razaghizad et al., 2021; Wheeler et al., 2015). **Quotes:** "I know people who died because nobody had Narcan." "People need to know where to get it and not be scared to ask." (Rutherford County Collaborative Strategic Planning Interviews, 2025).
A	9	Syringe Service and Harm Reduction Programs	**Rationale:** Need for sterile supplies, HIV/HCV testing, fentanyl test strips, and referrals. **Evidence:** SSPs reduce HIV/HCV transmission, increase treatment entry, and offer trusted access to health and social services (Des Jarlais & Carrieri, 2023; Centers for Disease Control and Prevention, 2021). **Quotes:** "Too many hepatitis C cases could have been prevented." "If folks are going to use, help them do it safely and find help." (Rutherford County Collaborative Strategic Planning Interviews, 2025).
A	3	Peer Recovery Support Services	**Rationale:** Peers build trust, navigate systems, and smooth transitions from EDs, jails, and hospitals. **Evidence:** Meta-analyses show improved engagement and retention and fewer acute episodes (Watson et al., 2023). **Quotes:** "Having a peer coach made all the difference." "People trust those who've been through it." (Rutherford County Collaborative Strategic Planning Interviews, 2025).
B	C6	Emergency Department and Hospital Training	**Rationale:** Missed opportunities in ED due to low comfort with OUD care. **Evidence:** ED-initiated buprenorphine and stigma-aware protocols improve treatment engagement and reduce unsafe return to use (D'Onofrio et al., 2023). **Quotes:** "The ER could do more than patch people up." "Staff need tools to start treatment and link people the same day." (Rutherford County Collaborative Strategic Planning Interviews, 2025).
A	10	Criminal Justice Diversion Programs (Recovery Court)	**Rationale:** "Revolving door" dynamics without treatment. **Evidence:** Diversion to care reduces recidivism and overdose and can yield net savings; recovery courts improve stability and engagement (Marr, 2022; Graves & Fendrich, 2024). **Quotes:** "Jail just makes things worse." "Every time someone cycles in and out, the problem grows." (Rutherford County Collaborative Strategic Planning Interviews, 2025).

TABLE G.2

Root cause or aspect of the opioid epidemic to be addressed: Environmental drivers that impede access and retention, including housing, employment, transportation, prevention for youth, family trauma, stigma, and legal concerns

Exhibit A or B	Number or Letter	Strategy Name	How do you know that this strategy will be effective at addressing the root cause/aspect mentioned above?
A	4	Recovery Housing Support	**Rationale:** Unstable or unsafe housing drives relapse, especially after treatment or jail. Many homes exclude MOUD. **Evidence:** Recovery housing improves abstinence and functioning, reduces recidivism, and supports MOUD adherence; reentry linkage strengthens outcomes (Jason & Ferrari, 2010; Polcin et al., 2010; Dewey et al., 2024; Mericle et al., 2025). **Quotes:** "People relapse going straight from jail to the street." "Safe, medication-friendly housing is scarce." (Rutherford County Collaborative Strategic Planning Interviews, 2025).
A	5	Employment-Related Services	**Rationale:** Unemployment and records block stability; services are scarce. **Evidence:** Employment interventions improve recovery rates, quality of life, and reentry outcomes (Tzablah et al., 2023). **Quotes:** "Trying to get a job with a record is almost impossible." "Work was what finally kept me focused on recovery." (Rutherford County Collaborative Strategic Planning Interviews, 2025).
A and B	5; B7	Transportation Supports	**Rationale:** Distance and cost prevent access to clinics, court, jobs, and recovery supports. **Evidence:** Vouchers, shuttles, ride-share, and rural transit partnerships increase appointment adherence and service access (Syed et al., 2013; Ngo & Anand, 2024). **Quotes:** "No bus. No car. No care." "Transportation is the first barrier people name." (Rutherford County Collaborative Strategic Planning Interviews, 2025).
A	6	Early Intervention for Youth	**Rationale:** Schools asked for structured, evidence-based programs with parent components to break generational cycles. **Evidence:** Universal school-family prevention reduces later SUD risk and yields strong return on investment (Spoth et al., 2009; Jones et al., 2020). **Quotes:** "The only way to break cycles is to start early." "Parents want tools that actually work." (Rutherford County Collaborative Strategic Planning Interviews, 2025).
B	E8	Enhanced Support for Children and Families Experiencing Trauma	**Rationale:** Children and caregivers affected by substance use lack trauma-informed supports. **Evidence:** Family-centered, trauma-informed care reduces adverse childhood experiences, improves stability, and lowers intergenerational risk (Lang et al., 2015; Patrick et al., 2023). **Quotes:** "Kids are carrying the weight of addiction at home." "Caregivers need practical, trauma-informed help." (Rutherford County Collaborative Strategic Planning Interviews, 2025).
B	12	Stigma Reduction Initiatives	**Rationale:** Stigma blocks care at every step and undermines workforce and family engagement. **Evidence:** Contact-based and message-tested campaigns improve attitudes and treatment uptake; provider training improves practice behavior (McGinty & Barry, 2020). **Quotes:** "We will not fix outcomes if people feel judged at the door." "Language and tone matter." (Rutherford County Collaborative Strategic Planning Interviews, 2025).
B	H7	Good Samaritan Law Education	**Rationale:** Fear and low awareness suppress 911 calls during overdoses. **Evidence:** Education about protections increases call rates and reduces fatalities (Rees et al., 2017). **Quotes:** "People are afraid to call for help." "I tell folks it's safe to call, but they don't believe it." (Rutherford County Collaborative Strategic Planning Interviews, 2025).

H. IDENTIFY GAPS IN EXISTING EFFORTS — SUMMARY

Despite notable progress and a committed network of partners, persistent service gaps continue to limit reach and impact in Rutherford County's opioid response (NCACC, 2024; Gatespring, 2025; Rutherford County Collaborative Strategic Planning Interviews, 2025). Key areas where unmet needs remain are outlined below:

- **Capacity:** The scale of critical services remains insufficient. No in-county opioid treatment program (OTP) exists; Medicaid-accepting MOUD prescribers are limited; rapid access and same-day starts are rare. Recovery housing rarely accepts MOUD, especially for women and families. Behavioral health for children and caregivers has long waitlists. Peer support is expanding but thinly staffed, and harm reduction teams lack stable funding, knowledge, and coverage across systems.
- **Coverage:** Gaps persist geographically and temporally. Rural and high-risk populations experience uneven access to naloxone, syringes, and harm reduction education. Transportation and prevention programs are inconsistently available after hours or countywide, and reentry supports vary by time and location.
- **Coordination:** Transitions in care are fragile. Hospitals, jail, and community services lack standardized handoff practices and shared protocols. Data-sharing is minimal; stigma-reduction practices and public education are inconsistent; and there is no unified Good Samaritan law messaging strategy.
- **Continuity:** Services often fail to bridge critical periods. Processes like Medicaid reactivation, prescription fills, rapid follow-up, and transportation are inconsistently available in the days following overdose or release. Program data systems lack outcome tracking, hindering ongoing quality improvement.

These themes have directly informed the design and prioritization of the county's selected strategies—with an emphasis on practical capacity-building, expanded coverage, robust care coordination, and continuous support throughout the care continuum (NCACC, 2024; Gatespring, 2025).

TABLE H.1

Prompt: For each favored strategy, identify what programs, services, or supports are already working on it in Rutherford County, then note remaining gaps.

Exhibit A or B	Number or Letter	Strategy Name	What other programs, services or supports are working on this strategy? What gaps exist?
A	2	Expand access to evidence-based treatment (MOUD)	**Current efforts:** Blue Ridge Health provides OBOT and behavioral health. United Way supports access to medications for uninsured and underinsured residents. Some primary care and ED prescribers initiate MOUD in limited cases. **Gaps:** No in-county OTP for methadone. Few Medicaid-accepting prescribers and limited same-day starts. Transportation, cost, and stigma impede access. Limited warm handoffs from ED and jail to community MOUD. Waitlists persist.
A	3	Peer recovery support services	**Current efforts:** Peers active through United Way and community organizations; emerging peer presence in hospital settings. **Gaps:** Insufficient coverage across settings and hours; limited peer roles in ED and jail; inconsistent supervision and career ladders; funding instability; few formal pathways that pair peers with clinicians and probation.
A	4	Recovery housing support	**Current efforts:** Limited recovery housing options; short-term stabilization and informal sober homes; United Way provides short-term assistance for transitional housing. **Gaps:** Very few MOUD-accepting beds in-county; scarcity of women's and family units; weak linkage to reentry and employment; inconsistent quality standards and outcome data.
A	5	Employment-related services	**Current efforts:** NCWorks and Isothermal Community College offer training and placement; United Way provides work gear and limited reentry supports. **Gaps:** Few second-chance employers; limited job developers familiar with recovery needs; irregular record-relief services; minimal coordination between treatment providers and workforce agencies.
A and B	5; B7	Transportation supports	**Current efforts:** Limited medical and social-service transportation; ad hoc gas cards and ride supports. **Gaps:** Inadequate evening and weekend hours; long rural distances; few on-demand options for ED discharge or jail release; limited funding for recurring rides to treatment, court, and work.
A	6	Early intervention for youth	**Current efforts:** School counselors, nurses, and SHAC activities provide prevention and screening supports; some classroom education occurs. **Gaps:** No countywide, evidence-based universal curriculum with a parent component; limited training and referral pathways for staff; few school-linked behavioral health providers; limited data sharing and evaluation.
A	7	Naloxone saturation	**Current efforts:** First responders carry naloxone; United Way's mobile efforts distribute naloxone with education; partners provide trainings on request. **Gaps:** Coverage uneven in rural areas and among high-risk groups; limited leave-behind programs; inconsistent restocking and tracking; stigma and low public awareness persist.

Exhibit A or B	Number or Letter	Strategy Name	What other programs, services or supports are working on this strategy? What gaps exist?
A	8	Post-Overdose Response Teams (PORT)	**Current efforts:** EMS, ED, and law enforcement conduct immediate response and occasional follow-up calls; some informal peer outreach. **Gaps:** No formalized PORT with 24–72 hour outreach, data-driven referrals, and joint response protocols; limited data-sharing agreements; few rapid MOUD starts tied to PORT.
A	9	Syringe service and harm reduction programs	**Current efforts:** Mobile harm reduction provides sterile supplies, naloxone, wound care, and HIV/HCV testing with linkages to care. **Gaps:** Insufficient hours, geography, and staffing to meet demand; limited fixed-site access; need for broader fentanyl test strip distribution, safe disposal options, and faster pathways to MOUD and HCV treatment.
A	10	Criminal justice diversion programs (recovery court, pre-arrest, pre-trial)	**Current efforts:** Stakeholders exploring recovery court and diversion options; case-by-case deflection occurs. **Gaps:** No fully implemented recovery court; limited capacity for pre-arrest and pre-trial diversion; few standardized clinical pathways to treatment and peers; data systems and outcomes tracking not in place.
A	11	Jail-based treatment expansion (MOUD in jail)	**Current efforts:** Rutherford County Jail is taking steps to improve SUD care and coordination; some screening and referral happens. **Gaps:** Partial MOUD formulary; limited induction and maintenance while incarcerated; weak continuity on release; Medicaid reactivation and pharmacy processes inconsistent; few peers or navigators embedded in reentry.
B	C6	Emergency department and hospital training in SUD	**Current efforts:** Hospital partners exploring ED-initiated buprenorphine; some peer presence and stigma-reduction training. **Gaps:** No standardized order sets and standing protocols for screening, initiation, and warm handoff; variable staff confidence; limited same-day linkage to OBOT; need consistent training and metrics.
B	E8	Enhanced supports for children and families experiencing trauma	**Current efforts:** DSS, schools, and community agencies provide counseling, case management, and limited family supports. **Gaps:** Insufficient trauma-informed, family-centered behavioral health capacity; long waitlists; few integrated services that coordinate schools, pediatric care, and community providers; scarce respite and caregiver supports.
B	12	Stigma reduction initiatives	**Current efforts:** Ad hoc education by partners and peers; some staff trainings. **Gaps:** No coordinated countywide campaign with message testing, trusted messengers, and evaluation; limited provider-facing stigma training tied to practice change; no shared language policy across agencies.
B	H7	Good Samaritan Law education	**Current efforts:** Peers and harm reduction partners share information during outreach and trainings. **Gaps:** No unified, sustained public campaign; inconsistent messaging across first responders, schools, and community groups; many residents remain unsure of protections when calling 911.

SECTION TWO

PRIORITY PLANNING

I. PRIORITIZE STRATEGIES

Rutherford County prioritized strategies through a criteria-based process that balanced urgency, feasibility, equity, and long-term impact. Using the NCACC Collaborative Strategic Planning Toolkit as the framework, each option was weighed for alignment with Exhibit A and Exhibit B compliance, readiness of the local system, ability to braid funds, and contribution to a coherent continuum from prevention through recovery. Life-saving and access-enabling investments were placed first, with foundational supports and system-building initiatives sequenced to follow. The resulting prioritization elevates immediate mortality reduction and treatment access (MOUD expansion, jail-based care, naloxone saturation, PORT, syringe services, peer recovery) while advancing structural enablers that stakeholders identified as essential to sustained progress, including recovery housing, transportation, employment supports, family and youth services, culturally responsive care, and workforce development (Gatespring Planning Interviews, 2025; NCACC, 2024).

Community voice drove the ordering. Residents and front-line providers consistently described long waits for MOUD, the absence of an in-county OTP, and the burden of traveling out of county to start or maintain treatment. One interviewee summarized the stakes plainly: "There's not enough people in this county prescribing Suboxone and taking Medicaid. People who want help get tired of waiting," while another noted, "Like, the closest thing to rehab in this county is the jail." These accounts reinforced local data showing a lack of in-county methadone access and higher-than-average overdose mortality, underscoring the need to move MOUD and justice-linked treatment to the top of the list (Gatespring Planning Interviews, 2025; NCACC, 2024).

Stakeholders also emphasized the structural barriers that make-or-break outcomes. "If there's no ride, there's no treatment. It's that simple," and the absence of low-barrier shelter means "we don't have a homeless shelter… That of course just compounds… we're not going to be successful in treatment because there's not a way to get involved in it." These realities justified placing transportation, recovery housing, and employment supports high in the queue, with youth prevention and family-centered services integrated to break intergenerational risk. The prioritization therefore pairs near-term overdose prevention with medium-term capacity building and long-term prevention, consistent with the expectation that counties stage investments across a continuum and plan for sustainability (Gatespring Planning Interviews, 2025; NCACC, 2024).

J. IDENTIFY GOALS, MEASURES, AND EVALUATION PLAN

Evaluation will answer three plain questions for each strategy: How much did we do, how well did we do it, and is anyone better off. Rutherford will use a mix of process, quality, and outcome indicators that match Exhibit A and Exhibit B intents, with data pulled from clinical partners, EMS and ED systems, jail and courts, FQHCs, community programs, and county data systems. This structure follows the NCACC guidance to articulate measures up front, pair them with data sources, and document collection frequency and responsibility (NCACC, 2024).

Process measures will capture reach and timeliness, such as naloxone kits distributed, PORT contacts within 72 hours, same-day MOUD starts from ED or jail, peer encounters, recovery housing placements, rides provided, and participation in prevention groups. Quality measures will track fidelity and equity, including wait times to MOUD, continuity at transitions of care, culturally responsive service uptake, and percent of recovery residences that accept residents on MOUD. Outcome measures will track what matters most: nonfatal and fatal overdoses, treatment initiation within 14 days of diagnosis, 90-day retention on MOUD, ED utilization, recidivism following diversion or jail release, viral hepatitis testing and linkage, school attendance for youth programs, and family stability metrics. To reduce burden and increase credibility, Rutherford will leverage existing reporting where possible and establish MOUs for data-sharing and a shared analytics plan with an academic partner. The county will also explore partnering with the NC Collaboratory to evaluate settlement impact and with state agencies to standardize indicators across counties (NCACC, 2024).

Continuous improvement will be built into implementation. Quarterly reviews will surface what is working, where equity gaps persist, and which braiding opportunities can accelerate progress. Interview insights will be used as a standing sense-check to ensure the numbers reflect lived experience. As one participant put it, "You get tired of asking for help when no one can help you." The evaluation plan keeps that challenge front and center by tying access, timeliness, and outcomes to decisions about scaling or redesigning programs (Gatespring Planning Interviews, 2025).

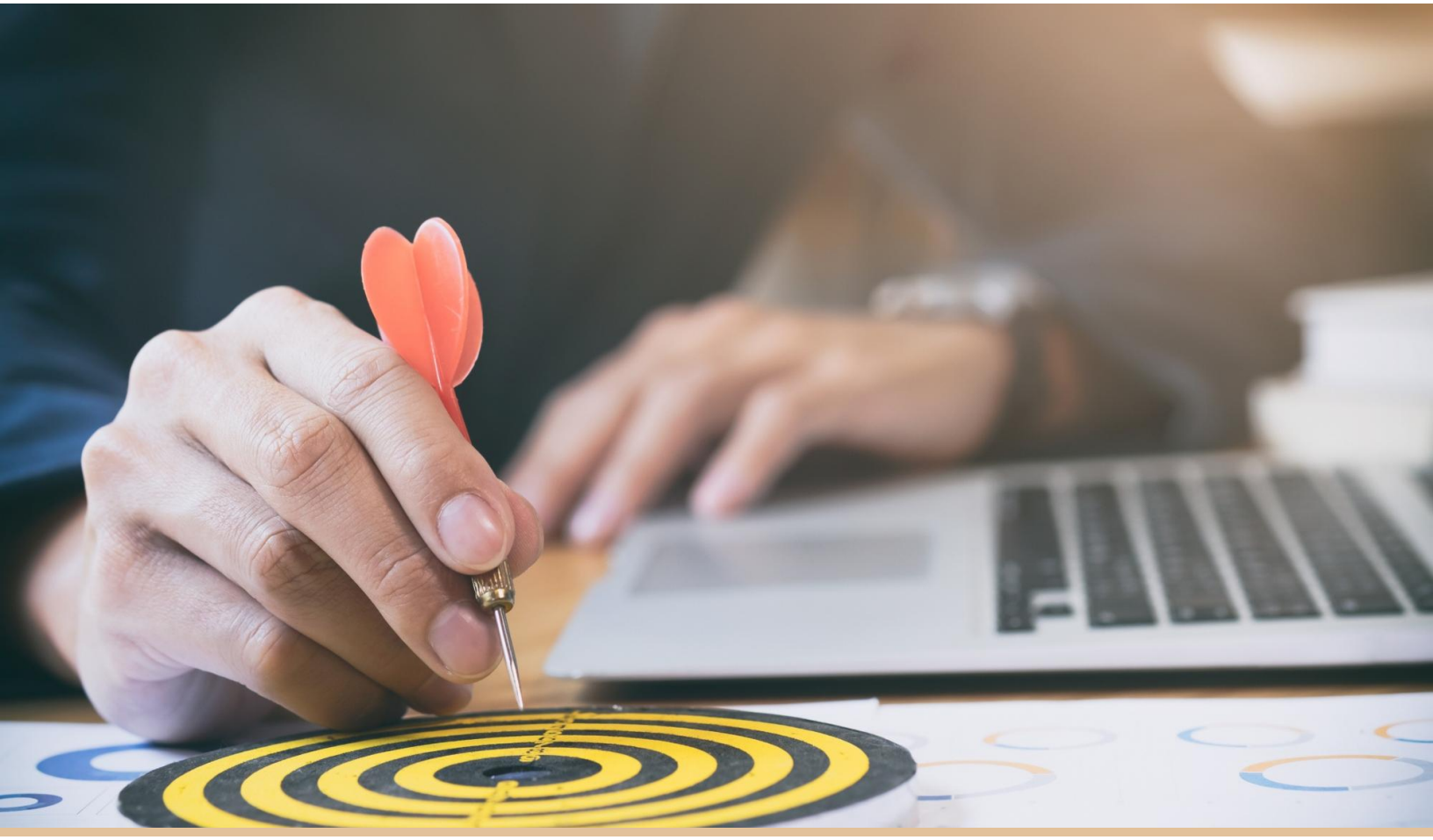


TABLE J.1 — JAIL-BASED TREATMENT EXPANSION (MOUD IN JAIL)

Evaluation Question	Measures	Data Sources
How much did you do?	Number screened; number started/continued on MOUD; bridge scripts issued	Jail medical records; pharmacy logs
How well did you do it?	Percent eligible on MOUD; percent with 7-day appointment; Medicaid reactivation at release	Jail care management; DSS eligibility data
Is anyone better off?	30-day MOUD continuity; 30- and 90-day overdose and recidivism rates	Community EHR; EMS; courts data

WHY PRIORITIZED?

Post-release overdose risk is highest. Jail MOUD lowers mortality and improves linkage (Brinkley-Rubinstein et al., 2018; NASEM, 2019; NCACC, 2024).

GOAL

Offer screening, induction, and maintenance for all eligible inmates, with bridge meds and 7-day follow-up.

TABLE J.2 — EVIDENCE-BASED ADDICTION TREATMENT IN COMMUNITY (MOUD)

Evaluation Question	Measures	Data Sources
How much did you do?	MOUD initiations; active MOUD patients; referrals to OBOT or OTP	Clinic EHR; referral logs; payer claims
How well did you do it?	Percent same-day starts; 7-day follow-up kept; median wait time	Scheduling data; EHR
Is anyone better off?	30- and 90-day retention; ED visits and overdoses per patient; self-reported functioning	EHR; EMS and ED data; client surveys

WHY PRIORITIZED?

Long waits, few Medicaid prescribers, no local OTP. Expanding MOUD reduces deaths/retention (Volkow & Blanco, 2023; Sordo et al., 2017; NCACC, 2024).

GOAL

Enable same-day starts when appropriate and sustain 30 to 90 days of treatment continuity.

TABLE J.3 — POST-OVERDOSE RESPONSE TEAM

Evaluation Question	Measures	Data Sources
How much did you do?	PORT outreaches; people contacted; kits and referrals provided	PORT logs; EMS and ED notifications
How well did you do it?	Percent outreach within 72 hours; warm handoffs completed; contact rate	PORT QA logs; partner referral data
Is anyone better off?	7- and 30-day engagement; repeat overdose trend	EHR; EMS; ED data

WHY PRIORITIZED?

Outreach within 24 to 72 hours improves linkage and reduces repeat overdose (Bailey et al., 2023; Barocas et al., 2022).

GOAL

Provide rapid outreach to survivors and families with direct linkage to MOUD, peers, and harm reduction.

TABLE J.4 — NALOXONE SATURATION

Evaluation Question	Measures	Data Sources
How much did you do?	Kits distributed; trainings delivered; leave-behind activations	Distribution logs; training rosters; EMS records
How well did you do it?	Percent priority sites stocked; time to restock; knowledge gain	Stock audits; pre-post quizzes
Is anyone better off?	Bystander administrations; fatal and nonfatal overdose trend	EMS; ED; medical examiner data

WHY PRIORITIZED?

Overdose deaths are preventable. Access and knowledge are uneven (Razaghizad et al., 2021; Wheeler et al., 2015).

GOAL

Saturate high-risk settings and neighborhoods with naloxone and education.

TABLE J.5 — SYRINGE SERVICE AND HARM REDUCTION PROGRAMS

Evaluation Question	Measures	Data Sources
How much did you do?	Encounters; sterile supplies; HIV/HCV tests; FTS distribution	SSP logs; testing records
How well did you do it?	Geographic coverage; evening and weekend hours; percent positives linked	Program calendars; linkage tracking
Is anyone better off?	Confirmed linkage to MOUD and HCV treatment; new HIV/HCV case trend	EHR; public health surveillance

WHY PRIORITIZED?

Prevents infections and builds a bridge to care (CDC, 2021; Des Jarlais & Carrieri, 2023).

GOAL

Expand mobile and fixed-site access to sterile supplies, testing, wound care, fentanyl test strips, and linkage to MOUD and HCV treatment.

TABLE J.6 — PEER RECOVERY SUPPORT SERVICES

Evaluation Question	Measures	Data Sources
How much did you do?	Peer encounters; warm handoffs; sites and hours covered	Peer logs; partner MOUs
How well did you do it?	Contact-to-engagement conversion; supervision and fidelity checks	QA reviews; supervision records
Is anyone better off?	30-day engagement after handoff; client-reported recovery capital	EHR; client surveys

WHY PRIORITIZED?

Peers improve engagement and retention, especially at transitions (Watson et al., 2023).

GOAL

Embed certified peers in ED, jail, PORT, clinics, and courts with supervision and clear pathways.

TABLE J.7 — ED AND HOSPITAL SUD TRAINING

Evaluation Question	Measures	Data Sources
How much did you do?	Staff trained; order sets approved; MOUD starts in ED	Training rosters; EHR
How well did you do it?	Percent eligible started; percent discharged with appointment and bridge meds	EHR; discharge planning logs
Is anyone better off?	72-hour and 30-day show rates; repeat ED visit or overdose trend	EHR; EMS; ED data

WHY PRIORITIZED?

Missed opportunities after overdose. ED-initiated buprenorphine improves outcomes (D'Onofrio et al., 2023).

GOAL

Adopt order sets, standing protocols, and warm handoffs for same-day MOUD starts.

TABLE J.8 — CRIMINAL JUSTICE DIVERSION PROGRAMS

Evaluation Question	Measures	Data Sources
How much did you do?	Diversion enrollments; hearings; clinical assessments	Court dockets; program registry
How well did you do it?	Time referral to assessment; percent with care plan; peer assignment rate	Program logs
Is anyone better off?	Treatment engagement at 30 and 90 days; new charges during program; graduation rate	Court MIS; EHR

WHY PRIORITIZED?

Without diversion, people cycle between jail and crisis. Diversion improves engagement and public safety (Marr, 2022; NCACC, 2024).

GOAL

Stand up recovery court and pre-arrest or pre-trial deflection with clinical pathways and peers.

TABLE J.9 — RECOVERY HOUSING SUPPORT

Evaluation Question	Measures	Data Sources
How much did you do?	Beds funded; beds MOUD-accepting; placements from jail or treatment	Contracts; provider reports
How well did you do it?	Time to placement; occupancy rate; percent meeting standards	Program QA; audits
Is anyone better off?	90-day housing retention; treatment retention; employment or education status	HMIS; EHR; workforce records

WHY PRIORITIZED?

Stable housing supports treatment and reduces recidivism. MOUD-accepting beds are scarce (Jason & Ferrari, 2010; Polcin et al., 2010; Mericle et al., 2025).

GOAL

Increase MOUD-accepting beds that meet quality standards, with dedicated reentry slots.

TABLE J.10 — EMPLOYMENT-RELATED SERVICES

Evaluation Question	Measures	Data Sources
How much did you do?	Participants served; placements; employers engaged	Program MIS; employer MOUs
How well did you do it?	Time to placement; percent living-wage placements; retention services delivered	Program logs; wage records
Is anyone better off?	90-day job retention; income change; reduced justice involvement	Wage records; court data

WHY PRIORITIZED?

Work supports recovery and stability (Tzablah et al., 2023).

GOAL

Provide job development, placements, and record-related supports for people in recovery and reentry.

TABLE J.11 — TRANSPORTATION SUPPORTS

Evaluation Question	Measures	Data Sources
How much did you do?	Rides by purpose; vouchers issued and redeemed	Transit logs; voucher system
How well did you do it?	On-time pickup rate; time from request to ride; no-show reduction	Dispatch data; appointment data
Is anyone better off?	First-appointment show rate; 30-day treatment retention; employment retention	EHR; program and employer data

WHY PRIORITIZED?

Distance and cost block access to clinics, court, work, and supports (Syed et al., 2013; Ngo & Anand, 2024).

GOAL

Provide reliable rides and vouchers, including on-demand trips for ED discharge and jail release.

TABLE J.12 — EARLY INTERVENTION FOR YOUTH

Evaluation Question	Measures	Data Sources
How much did you do?	Students and parents reached; schools participating	School rosters; program reports
How well did you do it?	Curriculum fidelity checks; staff training completion	Fidelity tools; training records
Is anyone better off?	Pre-post knowledge and attitude change; discipline and absentee trends	Student surveys; school MIS

WHY PRIORITIZED?

Upstream prevention reduces later substance use and improves lifetime outcomes (Spoth et al., 2009; Jones et al., 2020).

GOAL

Implement an evidence-based school program with a parent component countywide.

TABLE J.13 — ENHANCED SUPPORTS FOR CHILDREN AND FAMILIES EXPERIENCING TRAUMA

Evaluation Question	Measures	Data Sources
How much did you do?	Families served; visits delivered; respite hours provided	Provider MIS
How well did you do it?	Wait time to first visit; care plan completion; caregiver participation rate	Scheduling data; charts
Is anyone better off?	Caregiver stress and functioning scales; child symptom reduction; school stability	Standardized scales; school data

WHY PRIORITIZED?

Family trauma is both a consequence and driver of addiction (Lang et al., 2015; Patrick et al., 2023).

GOAL

Expand trauma-informed, family-centered services and respite supports.

TABLE J.14 — STIGMA REDUCTION INITIATIVES

Evaluation Question	Measures	Data Sources
How much did you do?	Campaign impressions; provider trainings delivered	Media buys; training rosters
How well did you do it?	Provider policy adoption; message recall and sentiment	Policy audits; community surveys
Is anyone better off?	Treatment inquiries and referrals; provider stigma scale change	Hotline logs; referrals; provider surveys

WHY PRIORITIZED?

Stigma blocks care and undermines workforce engagement. Contact-based campaigns and language policies can shift behavior (McGinty & Barry, 2020; NCACC, 2024).

GOAL

Deploy a message-tested public campaign and a provider language policy with training.

TABLE J.15 — GOOD SAMARITAN LAW EDUCATION

Evaluation Question	Measures	Data Sources
How much did you do?	Outreach events and materials distributed; audiences reached	Outreach logs
How well did you do it?	Public knowledge of protections; partner adoption of unified messaging	Community surveys; partner checklists
Is anyone better off?	911 calls during overdose events; fatality rate trend	911 dispatch data; EMS; medical examiner data

WHY PRIORITIZED?

Confusion about protections suppresses 911 calls during overdoses. Education increases calls and saves lives (Rees et al., 2017).

GOAL

Raise awareness of protections to increase emergency calls and reduce deaths.

K. CONSIDER KEY WAYS TO ALIGN STRATEGIES & L. IDENTIFY ORGANIZATIONS

Rutherford will actively braid opioid settlement funds with other sources to stretch impact and avoid duplication. Opportunities include the potential to leverage Dogwood Health Trust for capital and bridge funding of criminal justice diversion efforts and regional care solutions, coordinating with HRSA-funded FQHC initiatives to expand same-day MOUD and behavioral health integration, pursuing SAMHSA grants for PORT, peer workforce, and family-focused trauma services, and using state partnerships to pilot rural OTP access, ED-initiated buprenorphine, and Good Samaritan outreach. The county will also tap free technical assistance from the SAMHSA-supported Opioid Response Network, the Addiction Technology Transfer Center Network, and the Prevention Technology Transfer Center Network to accelerate implementation design and workforce training. These alignment actions follow the NC DOJ's direction to braid funds, form strategic partnerships, and develop regional solutions that strengthen the continuum rather than fund stand-alone projects (NCACC, 2024).

Regional collaboration is a practical necessity. Stakeholders described burnout among providers and fragmentation across programs: "There are so many people trying to do good here, but they're burning out," and "Whoever is providing services needs… a healthy referral network… collaborative care… we got to figure out a way to pull it off." Rutherford will invite Polk, McDowell, and neighboring counties into shared initiatives where scale matters most, such as mobile MOUD, syringe services, and specialty reentry supports. The county will also explore a shared analytics partnership with a North Carolina university to evaluate settlement impact across counties and report actionable insights for course correction (Gatespring Planning Interviews, 2025; NCACC, 2024).

Lead implementers will be identified through competitive RFAs beginning in 2026, consistent with the county's approved path to move strategies from planning to procurement. The solicitation will specify the goals, measures, equity commitments, and coordination expectations described above, and it will favor applicants that can demonstrate data capacity, braid multiple funding streams, accept residents on MOUD where applicable, and formalize handoffs across the continuum. This approach keeps the county neutral, promotes accountability, and aligns funding to the strategies that the community elevated through the planning process (NCACC, 2024; Gatespring Planning Interviews, 2025).

Finally, these narratives slot directly into the report's Section Two templates and mirror the conventions already used for J-tables and K/L cross-walks. The same indicators, root-cause framing, and community quotes threaded through the earlier sections carry forward here to ensure coherence from problem statement to prioritized action and evaluation (NCACC, 2024; Rutherford Report and Recommendations draft).

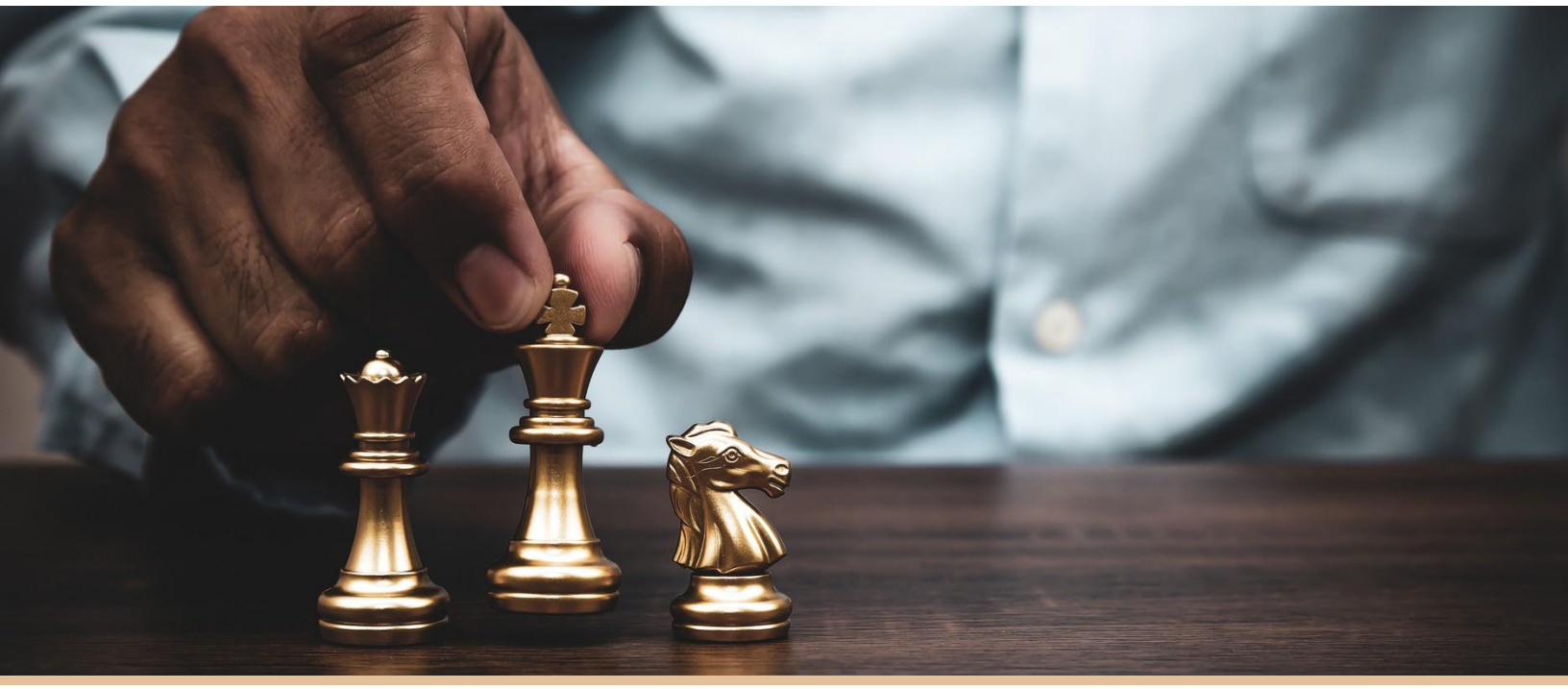


TABLE K.1 — JAIL-BASED TREATMENT EXPANSION (MOUD IN JAIL)

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
A	11	Jail-based treatment expansion (MOUD in jail)	Settlement for start-up/staff, jail medical budget, Medicaid, SAMHSA/HRSA, philanthropy	Tele-MOUD, regional OTP partnership, reentry slots	Sheriff, medical vendor, courts, DSS, SAMHSA/ATTC TA	Bridge scripts & ride, peer navigation, academic eval partner

TABLE L.1 — JAIL-BASED TREATMENT EXPANSION (MOUD IN JAIL)

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
A	11	Jail-based treatment expansion (MOUD in jail)	Provider via RFA: jail medical, SUD provider, OTP partner	Addiction-trained MD/NP, RN/LPN, pharmacist, care coordinator, navigator, peer, Medicaid, data, legal counsel	Secure med storage, EHR templates, telehealth cart, MOUD, discharge, vouchers, data agreements

TABLE K.2 — EVIDENCE-BASED ADDICTION TREATMENT IN COMMUNITY (MOUD)

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
A	2	Evidence-based addiction treatment in community (MOUD)	Settlement, Medicaid billing, HRSA FQHC, philanthropy, state pilot	Hub-spoke prescribers, after-hours teleMOUD, OTP linkage	Hospitals, pharmacies, ORN/ATTC	One-number access, rapid start clinics, data partnership

TABLE L.2 — EVIDENCE-BASED ADDICTION TREATMENT IN COMMUNITY (MOUD)

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
A	2	Evidence-based addiction treatment in community (MOUD)	Provider via RFA: FQHC, clinic, SUD provider, OTP	Addiction prescriber, pharmacist, nurse, clinician, care manager, peer, scheduler, benefits, data, quality	EHR templates, PDMP, bupe/XR, testing, telehealth, referral agreements, transport, materials

TABLE K.3 — POST-OVERDOSE RESPONSE TEAM (PORT)

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
A	8	Post-Overdose Response Team (PORT)	Settlement, hospital benefit, SAMHSA funds	Tri-county on-call/data sharing	EMS, ED, peers, harm reduction, law, ORN/PTTC	Home bupe starts, text follow-ups, next-day booking, FTS, leave-behind naloxone

TABLE L.3 — POST-OVERDOSE RESPONSE TEAM (PORT)

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
A	8	Post-Overdose Response Team (PORT)	EMS/hospital/community provider via RFA	PORT coordinator, EMT/paramedic, peer, clinician, data coord, legal/compliance, scheduler, driver	Alerts system, devices, kits, FTS, supplies, vouchers, secure database, referral forms

TABLE K.4 — NALOXONE SATURATION

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
A	7	Naloxone saturation	Settlement, state naloxone, philanthropy, hospital benefit	Bulk buy, mutual aid, shared vending/refill	Schools, libraries, faith, employers, PTTC/ATTC	24-hour kiosks, bar ambassadors, QR codes, seasonal blitzes

TABLE L.4 — NALOXONE SATURATION

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
A	7	Naloxone saturation	Public health or logistics CBO via RFA	Manager, trainers, logistics, data, outreach, peers	Kits, curriculum, kiosks, vehicle, inventory, comms, surveys

TABLE K.5 — SYRINGE SERVICE AND HARM REDUCTION

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
A	9	Syringe service & harm reduction	Settlement ops, public health, philanthropy, SAMHSA	Mobile/fixed-site regional routes, lab linkage	Health system for HCV, ORN for TA, academic partner	HCV clinics, disposal kiosks, pop-ups

TABLE L.5 — SYRINGE SERVICE AND HARM REDUCTION

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
A	9	Syringe service & harm reduction	CBO/health department via RFA	Lead, outreach, peer, nurse/NP, data, driver	Sterile supplies, FTS, wound kits, HIV/HCV tests, containers, van, PPE, referral MOUs

TABLE K.6 — PEER RECOVERY SUPPORT SERVICES

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
A	3	Peer recovery support services	Settlement, Medicaid billing, workforce grants, philanthropy	Regional peer supervisor pool/warmline	Hospitals, clinics, courts, jails, ATTC	Text check-ins, embedded peers on probation/court/clinic

TABLE L.6 — PEER RECOVERY SUPPORT SERVICES

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
A	3	Peer recovery support services	Peer services provider via RFA: CBO/clinic	Certified peer, supervisor, scheduler, manager, CQI, data	Laptops, phones, doc platform, stipend, office, curricula

TABLE K.7 — ED AND HOSPITAL SUD TRAINING WITH ED-INITIATED BUPRENORPHINE

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
B	C6	ED/hospital SUD training	Settlement, hospital quality, ATTC	Regional CME/series, order sets, shared discharge	ED, pharmacy, IT, peers, ORN/ATTC	"Start kit" for ED (order sets, meds, transport)

TABLE L.7 — ED AND HOSPITAL SUD TRAINING

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
B	C6	ED/hospital SUD training	Hospital/training vendor via RFA	Physician champion, pharmacy, nurse educators, social worker, IT, peer, project manager	Order sets, discharge protocol, reference cards, modules, XR inventory, EHR

TABLE K.8 — CRIMINAL JUSTICE DIVERSION PROGRAMS

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
A	10	Criminal justice diversion programs	Settlement, court pilot, federal justice, philanthropy	Regional benchbook/data system/treatment slots	Courts, DA, probation, treatment, ORN TA	Text reminders, cite-referrals, peer at first appearance

TABLE L.8 — CRIMINAL JUSTICE DIVERSION PROGRAMS

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
A	10	Criminal justice diversion programs	Coordinating entity via RFA w/ agreements	Coordinator, clinician, peers, manager, court liaison, data	Case platform, benchbook, forms, transport, incentives, eval plan

TABLE K.9 — RECOVERY HOUSING SUPPORT

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
A	4	Recovery housing support	Settlement ops, housing/rental, philanthropy, SAMHSA	Regional MOUD network, referral portal, shared standards	Housing authorities, courts, workforce, academic TA	Master-leasing, landlord incentive, social enterprise jobs/housing

TABLE L.9 — RECOVERY HOUSING SUPPORT

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
A	4	Recovery housing support	Housing operator/nonprofit via RFA	Director, manager, peer, clinician, employment, QA/compliance	Housing units, MOUD storage, transport, HMIS, supplies, maintenance

TABLE K.10 — EMPLOYMENT-RELATED SERVICES

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
A	5	Employment-related services	Settlement, WIOA, VR, philanthropy	Regional cohort/apprenticeship, job labs	Workforce, college, chambers, employers, ATTC	Record-relief clinics, wage subsidy, on-site fairs

TABLE L.10 — EMPLOYMENT-RELATED SERVICES

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
A	5	Employment-related services	Workforce provider via RFA	Developer, employer, manager, legal, data/eval	CRM, vouchers, tools, fees, IDs, transportation, job lab

TABLE K.11 — TRANSPORTATION SUPPORTS

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
A, B	5, B7	Transportation supports	Settlement, Medicaid non-emergency transport, philanthropy	Shared court/OTP shuttle, microtransit	Transit, ride-share, courts, clinics, ORN TA	Triggered ride scheduling, gas card, volunteer driver network

TABLE L.11 — TRANSPORTATION SUPPORTS

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
A, B	5, B7	Transportation supports	Vendor via RFA or interlocal	Dispatchers, drivers, scheduler, data/billing, manager	Vans, scheduling software, voucher platform, phones, safety

TABLE K.12 — EARLY INTERVENTION FOR YOUTH

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
A	6	Early intervention for youth	Settlement, block grant, school, philanthropy	Multi-district trainers/purchase, fidelity shared	Schools, SHAC, parents, PTTC	Youth leaders, fentanyl module, parent academy, naloxone kits

TABLE L.12 — EARLY INTERVENTION FOR YOUTH

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
A	6	Early intervention for youth	Education partner via RFA/school	Coordinator, school champion, teacher, parent facilitator, eval	Curriculum license, teacher guides, parent materials, surveys, translation

TABLE K.13 — ENHANCED SUPPORTS FOR CHILDREN AND FAMILIES EXPERIENCING TRAUMA

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
B	E8	Enhanced family/child trauma supports	Settlement, family funds, SAMHSA, HRSA, philanthropy	Provider network, collaborative, shared referral	Pediatrics, schools, DSS, family court, ATTC	Tele-parent coaching, mobile therapy, flexible respite vouchers

TABLE L.13 — ENHANCED SUPPORTS FOR CHILDREN AND FAMILIES EXPERIENCING TRAUMA

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
B	E8	Enhanced family/child trauma supports	Family provider via RFA: behavioral health, nonprofit	Licensed clinician, navigator, peer, respite coord, evaluator	Therapy space, telehealth, curriculum, childcare/respite, transport, data

TABLE K.14 — STIGMA REDUCTION INITIATIVES

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
B	12	Stigma reduction initiatives	Settlement, comms, hospitals/employers, philanthropy	Regional campaign/metrics, shared with Good Samaritan	Media, employers, schools, PTTC/ATTC, lived exp. messengers	Language policy, workplace certification, storytelling series

TABLE L.14 — STIGMA REDUCTION INITIATIVES

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
B	12	Stigma reduction initiatives	Comms vendor/nonprofit via RFA	Manager, creatives, media buyer, research/eval, liaison, lived exp. advisor	Creative assets, toolkit, media, social tools, survey, provider training

TABLE K.15 — GOOD SAMARITAN LAW EDUCATION

Exhibit	No. / Letter	Strategy Name	Braid Funds?	Regional Solutions?	Partnerships?	Creative Solutions?
B	H7	Good Samaritan Law education	Settlement, philanthropy, public safety training	Multi-county message kit, joint calendar, tied to OD spikes	EMS, law, schools, groups, PTTC, state legal	Driver ed/sports physicals/orientations, county text tip line

TABLE L.15 — GOOD SAMARITAN LAW EDUCATION

Exhibit	No. / Letter	Strategy Name	Responsible Organization	Human Resources	Material Resources
B	H7	Good Samaritan Law education	Outreach/comms lead via RFA w/ public safety	Campaign coord, trainer, legal, ambassador, evaluation	Message kits, posters, PSA, web/SMS, surveys, logistics

NOTE

For all strategies, Rutherford can request **free technical assistance** from the **Opioid Response Network**, the **Addiction Technology Transfer Center Network**, and the **Prevention Technology Transfer Center Network**. Consider **Dogwood Health Trust** and other local philanthropy for match or start-up costs, targeted **SAMHSA** and **HRSA** opportunities for expansion, and an **NC Collaboratory** partnership with an academic evaluator for county-level analytics and annual public impact briefs.

SECTION THREE

OPERATIONAL PLANNING

M. DEVELOP BUDGETS AND TIMELINES

STRATEGY 1:
JAIL-BASED TREATMENT EXPANSION (MOUD IN JAIL)

- **Exhibit A or B:** A
- **Number or Letter:** 11
- **First Strategy Name:** Jail-based treatment expansion (MOUD in jail)

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Hire / addiction team	X	X						
Protocol & contracting	X	X						
Service launch / deliver care		X	X	X	X	X	X	X
Peer / reentry program		X	X	X	X	X	X	X
Data / evaluation launch		X	X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$160,000	Clinical team, peer/reentry, benefits
Operating Costs	$35,000	Secure med storage, testing, EMR build, supplies
Contracted Services	$45,000	Pharmacy, evaluation, legal, TA
Administrative/Indirect	$17,000	Fiscal/HR/admin
Other	$35,000	Peer/transport, discharge meds, reentry tools
TOTAL	**$292,000**	

STRATEGY 2:
EVIDENCE-BASED ADDICTION TREATMENT IN COMMUNITY (MOUD)

- **Exhibit A or B:** A
- **Number or Letter:** 2
- **First Strategy Name:** Evidence-based addiction treatment in community (MOUD)

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Recruit / prescriber expansion	X	X						
Same-day / rapid start launch		X	X					
Community / after-hours teleMOUD		X	X	X	X	X	X	X
Peer / care management		X	X	X	X	X	X	X
Data & reporting buildout		X	X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$85,000	Prescriber, peer navigator, support team
Operating Costs	$20,000	Clinic tools, EHR, supplies
Contracted Services	$35,000	Training, TA, telehealth, pharmacy
Administrative/Indirect	$10,000	Fiscal/HR
Other	$15,000	Transportation, outreach, client incentives
TOTAL	**$165,000**	

STRATEGY 3:
POST-OVERDOSE RESPONSE TEAM (PORT)

- **Exhibit A or B:** A
- **Number or Letter:** 8
- **First Strategy Name:** Post-Overdose Response Team (PORT)

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Hire / train team	X	X						
Launch protocol, data sharing		X	X					
Service delivery		X	X	X	X	X	X	X
Peer / clinician rapid response		X	X	X	X	X	X	X
Data / quality improvement		X	X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$73,000	Coordinator, EMT/peer, scheduling, benefits
Operating Costs	$10,000	Response supplies, tech, call/alert system
Contracted Services	$20,000	Peer support, data analytics, evaluation
Administrative/Indirect	$7,000	Admin oversight, logistics
Other	$10,000	Naloxone, FTS, vouchers
TOTAL	**$120,000**	

STRATEGY 4:
NALOXONE SATURATION

- **Exhibit A or B:** A
- **Number or Letter:** 7
- **First Strategy Name:** Naloxone saturation

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Bulk purchasing	X	X	X	X	X	X	X	X
Public training / messaging		X	X	X	X	X	X	X
Distribution / partner rollout		X	X	X	X	X	X	X
Monitoring / restock / QA		X	X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$20,000	Coordinator, trainers
Operating Costs	$18,000	Materials, supply chain, packaging
Contracted Services	$8,000	Mobile distribution partner, pharmacy
Administrative/Indirect	$6,000	Fiscal/logistics
Other	$8,000	Refills, travel, evaluation
TOTAL	**$60,000**	

STRATEGY 5:
SYRINGE SERVICE AND HARM REDUCTION PROGRAMS

- **Exhibit A or B:** A
- **Number or Letter:** 9
- **First Strategy Name:** Syringe service and harm reduction programs

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Mobile / fixed-site expansion	X	X	X		X			
FTS / testing addition		X	X	X	X	X	X	X
Case management / peer linkage		X	X	X	X	X	X	X
Data / analytics, best practices		X	X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$48,000	Outreach, nurse, peer, management
Operating Costs	$15,000	Supplies, FTS, testing kits
Contracted Services	$8,000	Mobile van, evaluator
Administrative/Indirect	$4,000	Fiscal, legal
Other	$5,000	Data, housing linkage, reentry
TOTAL	**$80,000**	

STRATEGY 6:
PEER RECOVERY SUPPORT SERVICES

- **Exhibit A or B:** A
- **Number or Letter:** 3
- **First Strategy Name:** Peer recovery support services

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Hire / train peer workforce	X	X						
Establish site protocols / supervision		X	X					
Launch / cross-sector deployment		X	X	X	X	X	X	X
Monitor fidelity, evaluate impact		X	X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$65,000	2 FTE peers, supervisor, benefits
Operating Costs	$10,000	Laptops, phones, travel, supplies
Contracted Services	$10,000	Training, TA, supervision support
Administrative/Indirect	$6,000	Fiscal, HR
Other	$4,000	Stipend, client engagement funds
TOTAL	**$95,000**	

STRATEGY 7:
ED AND HOSPITAL SUD TRAINING WITH ED-INITIATED BUPRENORPHINE

- **Exhibit A or B:** B
- **Number or Letter:** C6
- **First Strategy Name:** ED/hospital SUD training with ED-initiated buprenorphine

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
CME protocol build	X	X						
Staff training, modules		X	X					
Launch protocol / order set			X	X	X	X	X	X
Evaluation and refreshers			X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$20,000	Physician champion, trainers
Operating Costs	$7,000	Training materials, CME
Contracted Services	$25,000	Workflow, EHR, protocol, external training
Administrative/Indirect	$6,000	Admin, scheduling
Other	$2,000	Evaluation, incentives
TOTAL	**$60,000**	

STRATEGY 8:
CRIMINAL JUSTICE DIVERSION PROGRAMS

- **Exhibit A or B:** A
- **Number or Letter:** 10
- **First Strategy Name:** Criminal justice diversion programs

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Contract with lead agency	X							
Court diversion design / protocol		X						
Staff hire, launch, benchbook		X		X	X	X	X	X
Supervision / PEER coordination			X	X	X	X	X	X
Ongoing case management / evaluation		X	X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$40,000	Coordinator, peer, court liaison
Operating Costs	$10,000	Supplies, forms
Contracted Services	$10,000	Evaluation, policy TA
Administrative/Indirect	$3,000	Admin, fiscal oversight
Other	$2,000	Participant incentives
TOTAL	**$65,000**	

STRATEGY 9:
RECOVERY HOUSING SUPPORT

- **Exhibit A or B:** A
- **Number or Letter:** 4
- **First Strategy Name:** Recovery housing support

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Housing provider contract / QA	X	X						
Launch / expand MOUD-accepting beds		X	X	X	X	X	X	X
Job / employment linkage set-up		X	X	X	X	X	X	X
Monitoring, data, compliance			X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$55,000	Director, house manager, peer lead
Operating Costs	$20,000	Furnishings, transport, food/household
Contracted Services	$15,000	Outcome evaluator, IT support
Administrative/Indirect	$10,000	QA, admin, reporting
Other	$5,000	Employment readiness supports
TOTAL	**$105,000**	

STRATEGY 10:
EMPLOYMENT-RELATED SERVICES

- **Exhibit A or B:** A
- **Number or Letter:** 5
- **First Strategy Name:** Employment-related services

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Hire / developers, job placement	X	X						
Launch career services / record clinics		X	X	X	X	X	X	X
Employer engagement cohorts			X	X	X	X	X	X
Training / evaluation wraparound		X	X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$32,000	Job developer, employer liaison
Operating Costs	$11,000	Supplies, print, outreach
Contracted Services	$9,000	Legal/record relief, evaluation
Administrative/Indirect	$5,000	Fiscal, reporting
Other	$3,000	Training materials, employer incentives
TOTAL	**$60,000**	

STRATEGY 11:
TRANSPORTATION SUPPORTS

- **Exhibit A or B:** A & B
- **Number or Letter:** 5; B7
- **First Strategy Name:** Transportation supports

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Contract vendor, set up dispatch	X							
Launch rides / voucher / coordination		X	X	X	X	X	X	X
Expand on-demand, integrate with clinics		X	X	X	X	X	X	X
Data tracking, coordination w/ partners			X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$44,000	Dispatchers, program manager
Operating Costs	$15,000	Vouchers, fuel, maintenance
Contracted Services	$9,000	Partner ride-share, evaluation
Administrative/Indirect	$7,000	Billing, reporting
Other	$10,000	On-demand tech, client outreach
TOTAL	**$85,000**	

STRATEGY 12:
EARLY INTERVENTION FOR YOUTH

- **Exhibit A or B:** A
- **Number or Letter:** 6
- **First Strategy Name:** Early intervention for youth

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Select curriculum, staff training	X	X						
Launch in all schools, parent ed		X	X	X	X	X	X	X
Fidelity checks, survey / evaluation		X	X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$22,000	Program coordinator, facilitators
Operating Costs	$8,000	Curriculum licenses, materials, printing
Contracted Services	$8,000	Training, evaluation, translation/access
Administrative/Indirect	$5,000	Oversight, data, scheduling
Other	$2,000	Incentives, internet/equipment
TOTAL	**$45,000**	

STRATEGY 13:
ENHANCED SUPPORTS FOR CHILDREN AND FAMILIES EXPERIENCING TRAUMA

- **Exhibit A or B:** B
- **Number or Letter:** E8
- **First Strategy Name:** Enhanced supports for children & families experiencing trauma

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Hire / contract clinical team	X	X						
Launch services, coordinate with DSS		X	X	X	X	X	X	X
Provide respite, family therapies		X	X	X	X	X	X	X
Data / impact, adjustment		X	X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$65,000	Clinician, navigator, respite coordinator
Operating Costs	$15,000	Play/therapy materials, client supports
Contracted Services	$15,000	Training, TA, evaluation
Administrative/Indirect	$7,000	Scheduling, outcome monitoring
Other	$3,000	Travel, translation, outreach
TOTAL	**$105,000**	

STRATEGY 14:
STIGMA REDUCTION INITIATIVES

- **Exhibit A or B:** B
- **Number or Letter:** 12
- **First Strategy Name:** Stigma reduction initiatives

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Vendor selection, design	X							
Message testing, campaign		X	X	X	X	X	X	X
Training for agencies			X	X	X	X	X	X
Survey, feedback, adjust		X	X	X	X	X	X	X

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$23,000	Manager, advisors, lived-experience stipends
Operating Costs	$7,000	Creative/production, surveys, venue fees
Contracted Services	$14,000	Design/placement, TA, research
Administrative/Indirect	$4,000	Comms, media analytics
Other	$2,000	Training, workplace resources
TOTAL	**$50,000**	

STRATEGY 14:
GOOD SAMARITAN LAW EDUCATION

- **Exhibit A or B:** B
- **Number or Letter:** H7
- **First Strategy Name:** Good Samaritan Law education

STRATEGY TIMELINE

Implementation Activity	July–Sept 2026	Oct–Dec 2026	Jan–Mar 2027	Apr–Jun 2027	July–Sept 2027	Oct–Dec 2027	Jan–Mar 2028	Apr–Jun 2028
Outreach toolkit / contractor	X							
Launch campaign, events		X	X	X	X	X	X	X
Surveys, message adjust			X	X	X	X	X	X
Evaluation report				X				

STRATEGY BUDGET

Line Item	Amount (Yr 1)	Description
Personnel/Fringe	$8,000	Campaign, trainers, ambassadors
Operating Costs	$6,000	Materials, event venues, travel
Contracted Services	$8,000	Campaign design, TA, evaluation
Administrative/Indirect	$2,000	Analytics, reporting
Other	$1,000	Partner incentives, minor supplies
TOTAL	**$25,000**	

OVERALL BUDGET SUMMARY TABLE (YEARS 1–3 IMPLEMENTATION PHASE)

Strategy Number & Name	Yr 1 (2026-27)	Yr 2 (2027-28)	Yr 3 (2028-29)	3-Yr Total
1. Jail-based treatment expansion (MOUD in jail)	$292,000	$298,000	$299,000	$889,000
2. Community MOUD	$165,000	$180,000	$175,000	$520,000
3. Post-Overdose Response Team (PORT)	$120,000	$120,000	$120,000	$360,000
4. Naloxone saturation	$60,000	$60,000	$60,000	$180,000
5. Syringe service & harm reduction	$80,000	$85,000	$90,000	$255,000
6. Peer recovery support	$95,000	$98,000	$100,000	$293,000
7. ED/hospital SUD training	$60,000	$35,000	$20,000	$115,000
8. Criminal justice diversion	$65,000	$75,000	$75,000	$215,000
9. Recovery housing support	$105,000	$115,000	$120,000	$340,000
10. Employment-related services	$60,000	$70,000	$70,000	$200,000
11. Transportation supports	$85,000	$90,000	$90,000	$265,000
12. Early intervention for youth	$45,000	$55,000	$55,000	$155,000
13. Enhanced family/child trauma supports	$105,000	$115,000	$120,000	$340,000
14. Stigma reduction initiatives	$50,000	$60,000	$40,000	$150,000
15. Good Samaritan Law education	$25,000	$25,000	$20,000	$70,000
TOTAL (3-Yr Implementation Phase)	**$1,412,000**	**$1,481,000**	**$1,444,000**	**$4,337,000**

BUDGET SUMMARY NARRATIVE

This budget was designed using national and North Carolina best practices for opioid settlement stewardship, emphasizing sustainability, braided funding, and staged investment to build capacity and avoid waste (NCACC, 2024; SAMHSA, 2022). The first three years focus on strategic infrastructure ("build, launch, and stabilize") while leaving sufficient reserve among the county's $9 million allocation for later-period innovation, course correction, and ongoing operations as external grant/insurance resources are brought into play throughout the entire funding window (Johns Hopkins, 2024; JAMA Network, 2023).

High-priority interventions—such as jail-based MOUD, comprehensive MOUD access, PORT, and harm reduction—receive the largest early investments because these address the most urgent gaps and are projected to yield the fastest impact on overdose, mortality, and criminal justice cycling (NASEM, 2019; CDC, 2023). For these categories, budgets reflect true personnel costs, startup infrastructure (e.g., protocols, IT, supplies), and outcome monitoring/quality improvement, in alignment with federal guidance (SAMHSA, 2022; NC DHHS, 2025).

Proposals for peer services, employment, housing, and stigma reduction are sized for breadth and phased scalability, with cost assumptions benchmarked against national and regional demonstration projects (SAMHSA, 2022; Vital Strategies, 2024). Each table's "contracted services" line assumes widespread use of technical assistance and specialized community expertise, a best practice for avoiding redundant hiring costs and fostering rapid cycle learning (Johns Hopkins, 2024).

To further ensure sustainability and equity, each strategy's budget is structured to maximize opportunities for Medicaid reimbursement, philanthropic co-investment, Workforce Innovation and Opportunity Act, HRSA, and SAMHSA grants, and local/shared infrastructure investments (NCACC, 2024, Section V; Vital Strategies, 2024). Each proposal includes capped indirect/administrative costs (typically 7–11%) to meet common standards for public funding accountability.

In summary, Rutherford County's opioid settlement budget plan is deliberate, accountable, and designed for maximum public impact across the continuum of care—empowering the county to build lasting capacity, target core gaps, and adapt as needs and evidence evolve (NCACC, 2024; CDC, 2023).

N. OFFER RECOMMENDATIONS

Date that recommendations will be provided to your local governing body:

Monday, September 8, 2025

RECOMMENDATIONS

After a collaborative, evidence-driven strategic planning process—grounded in community data, needs assessments, regional and national best practices, and sustained input from those most affected—the following actions are recommended for adoption by the Rutherford County Board of Commissioners:

- **Adopt the 15-strategy implementation portfolio** detailed in this report, with each initiative designed to address one or more core root causes of opioid harms and carefully prioritized for feasibility, impact, and sustainability.
- **Authorize phased funding** beginning with the FY 2026 cycle (July 1, 2026), consistent with the three-year operational budgets and timelines developed in Section M, and structured to conserve the long-term value of settlement resources.
- **Empower implementation partners**—through a transparent RFA and contracting process—to operationalize these strategies, working in close coordination with county agencies, health partners, justice stakeholders, and community members.
- **Convene a stakeholder oversight body** to provide transparent monitoring, accountability, and opportunities for ongoing community input, ensuring this plan remains responsive and effective in the years ahead.
- **Pursue blended and braided funding** by leveraging Medicaid, philanthropy, state and federal grants, and cross-sector partnerships to maximize the reach and sustainability of settlement-funded work.
- **Invest in robust data collection, reporting, and evaluation infrastructure** to support continuous quality improvement and learning, and to demonstrate the impact of these efforts for the community and governing bodies.
- **Commit to annual review and adjustment** of strategic and budgetary priorities, ensuring adaptability as needs, opportunities, and best practices evolve.

SIGNIFICANCE AND STRATEGIC RATIONALE

Adoption of these recommendations will enable Rutherford County to implement a nationally recognized, systems-based model for opioid epidemic response—one that closes critical treatment, prevention, and recovery gaps while maintaining flexible, judicious stewardship of settlement funds (NCACC, 2024; SAMHSA, 2022; NASEM, 2019). This planning process, characterized by cross-sector collaboration and lived experience engagement, has created an actionable roadmap to save lives, strengthen families, support economic and social stability, and build a healthier future for all county residents.

The recommendations are scheduled for formal presentation and public discussion at the commissioner's meeting on **Monday, September 8, 2025.**

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