THE SOLVE APPROACH 2.0

A Renewed Strategic Plan for the Prevention of Harmful Substance Use and Overdose in Harnett County

2026 – 2029

Prepared by the Harnett County Opioid Task Force

For consideration and adoption by the Harnett County Board of Commissioners

Submitted in fulfillment of Exhibit C of the North Carolina Memorandum of Agreement Among the State of North Carolina and Local Governments on Proceeds Relating to the Settlement of Opioid Litigation

THE SOLVE APPROACH

Stigma reduced. We continue to confront the stigma that isolates people who use substances and those who love them. Stigma is the largest single barrier to help-seeking, and the work of dissolving it never ends.

Ownership shared. No agency, no profession, and no single body of knowledge owns this work. Lived experience, professional practice, moral conviction, and academic study each carry a piece of the truth, and the response belongs to all of us together.

Learning continuous. We treat our plan as a living document. We measure what we do, we listen to what the community tells us, and we adjust.

Values foundational. Our work rests on the dignity of every person, the priority of those facing the heaviest barriers, and the conviction that recovery and a stable life are possible. Values, not metrics alone, guide our choices.

Equity centered. We attend deliberately to rural geography, language, race and ethnicity, age, and economic status, including the Coharie Tribe and our Black, Hispanic, AI/AN, and lowest-income neighbors. Without intentional attention to who carries the heaviest burden, response always concentrates where access is already easiest.

We will SOLVE this together.

Introduction

In November 2023, the Harnett County Board of Commissioners adopted The SOLVE Approach as the county's first comprehensive strategic plan to prevent harmful substance use and overdose. That plan, revised in July 2024, organized our work around three coordinated arenas, Education and Prevention, Treatment and Recovery, and Harm Reduction, and committed the county to a tiered prevention logic that meets people where they are. Over the past two years, we have done much of what we said we would do, and we have learned a great deal we did not yet know.

Over the first two years of collective action, fentanyl-positive overdose deaths fell approximately 72%, nearly twice the statewide rate during that same period. The question before us is how to sustain and institutionalize those gains.

SOLVE 2.0 is not a replacement. It is a faithful continuation. It carries forward what worked, retires what no longer fits our context, and adds what the past two years of listening, data, and lived experience have asked of us. It re-frames our three arenas to better reflect how care actually moves through our community: Education, Prevention & Early Intervention; Treatment & Harm Reduction; and Recovery & Wellbeing. It formalizes our commitment to decision-making that draws from four sources of knowledge, lived, professional, moral, and academic, and it commits to honoring each.

The opioid settlement funds that support this plan are finite. Harnett County is projected to receive approximately $11 million across eighteen years, with the largest annual disbursements occurring early in the schedule and declining thereafter. That arithmetic should focus us. Every dollar we spend must build either lasting infrastructure or a measurable life saved. SOLVE 2.0 is written with that fiduciary discipline in mind.

Why a Renewed Plan

The North Carolina Memorandum of Agreement requires each local government receiving settlement funds under Option B to engage in a collaborative strategic planning process and to update that plan as conditions warrant. Three developments make this the right moment to renew:

- First, the landscape has changed. Fentanyl and stimulant co-use have re-shaped the risk profile of overdose. Our 2022 overdose death count of 61 has been followed by sustained, if uneven, declines, and our work must move from emergency response toward sustainable infrastructure.
- Second, our understanding has changed. Community listening sessions, a community health survey, key-informant interviews, and an updated secondary data analysis (CHA 2025) have surfaced new priorities and new clarity about what is actually working.
- Third, our task force has matured. We now have several years of execution behind us and a larger roster of partners (health, law enforcement, faith, education, recovery community, foster and family services, etc.) who have learned to plan together, fund together, and account together.

The Strategic Planning Process

SOLVE 2.0 was developed between October 2025 and July 2026 through a deliberative process modeled on the original SOLVE planning cycle and on the North Carolina Association of County Commissioners' strategic planning worksheets. The process satisfied Exhibit C of the Memorandum of Agreement and was designed to mirror the rigor and inclusion of the 2023 effort while being shorter, more focused, and informed by everything we have learned since.

1. CHA Stakeholder Roundtables and Planning Summit

Five community listening sessions were convened, hosted in Anderson Creek, Lilington, Erwin, Coats, and Benhaven. Each session was designed to surface lived experience, frontline professional observations, and community priorities. In April 2026, the task force hosted a strategic planning summit, including people in recovery and their families, first responders and law enforcement, treatment and behavioral health providers, faith and community leaders, to allow more candid discussion of barriers and gaps.

2. Key Informant Interviews and the Community Health Survey

Twenty-two semi-structured key informant interviews were conducted with leaders representing the ten stakeholder categories required by Exhibit C: local officials, healthcare providers, social service providers, education and employment representatives, payers and funders, law enforcement, employers, community groups, people with lived experience, and stakeholders attentive to community diversity. Interviews were transcribed and coded thematically. In parallel, a bilingual (English and Spanish) Community Health Survey was administered from August through November and received 407 responses, providing population-level signal on perceived barriers, awareness of resources, and support for specific strategies.

3. Secondary Data Analysis

The task force reviewed secondary indicators from the Harnett County Community Health Assessment (published March 2026) and from the State Center for Health Statistics. Indicators were selected by relevance to overdose prevention, treatment access, harm reduction, and recovery support, and a Community Capacity Inventory was developed to document existing programs, contracts, and partnerships that the plan would either braid into or coordinate with.

4. Task Force Priority-Setting

In May 2026, the task force completed a structured paired-comparison prioritization of twelve candidate key activities derived from the listening sessions, interviews, survey, and secondary data. Seventeen members participated. The results, together with the qualitative themes and the status review of SOLVE 1.0, formed the basis for the goals, strategies, and initiatives in the chapters that follow.

What We Learned from SOLVE 1.0

The Opioid Task Force conducted a full status review of the twenty-three initiatives committed to in SOLVE 1.0 and grouped them into four categories: accomplished, partially accomplished, reconsidered, and not yet accomplished. That review, summarized below, is the empirical floor on which SOLVE 2.0 stands.

Accomplished (13 initiatives, 57%)

The following SOLVE 1.0 initiatives reached implementation and will continue as standing operations of the task force or its partners:

- Naloxone in all Harnett County Schools
- Medication-Assisted Treatment / Medications for Opioid Use Disorder in the Harnett County Detention Center, Phases 1 and 2
- Annual Faith and Recovery Conference, hosted in partnership with local congregations
- Post-Overdose Response Team, coordinated with EMS and behavioral health partners
- Mental Health First Aid training, with more than 200 community members trained
- Low-barrier naloxone distribution at release from custody
- Primary care MOUD integration with two participating practices
- Sharps container placement at high-traffic public locations
- Child Exposure to Substances public awareness campaign
- Community naloxone distribution through libraries, faith partners, and community events
- Behavioral health and MAT expansion in partnership with regional providers
- Health and safety kit distribution
- Law Enforcement Assisted Diversion (LEAD) pre-charge framework, scoped and piloted

Partially Accomplished (3 initiatives, 13%)

- Recovery and transitional housing, partnerships scoped, no operational beds yet
- Faith / DSS / Health Department foster-grandparent collaboration, convened, not yet institutionalized
- Parent advocacy group, early formation, requires sustained convening support

Reconsidered (2 initiatives, 9%)

Two SOLVE 1.0 initiatives have been reconsidered in light of changed conditions and will not be carried forward as originally framed:

- Establishment of a standalone Recovery Community Organization, task force has determined that recovery community functions are better supported through partnerships with existing regional RCOs and the faith and recovery network than through a new free-standing entity

- SERVE and S.O.L.V.E. Communication Network, superseded by the maturing task force communication structure and the SolveHarnett.org platform

Not Yet Accomplished (5 initiatives, 21%)

Five SOLVE 1.0 initiatives have not yet reached implementation. Each was reviewed for continued relevance. Four are carried forward into SOLVE 2.0 as priorities, and one is folded into a broader strategy:

- HARTS transportation pilot, carried forward as the top-ranked priority of SOLVE 2.0
- Syringe Service Program, carried forward, with revised scoping that emphasizes mobile and faith-partnered access
- School-based targeted support, carried forward, folded into the early-intervention strategy for at-risk youth
- Recovery-friendly workplaces, folded into the employer engagement component of Goal 3
- Recovery Court, carried forward as a Goal 3 priority in partnership with the District Court

The LAMP Lens: Four Sources of Knowledge

SOLVE 2.0 organizes its work around key insights from four sources of knowledge: lived, academic, moral, and professional (L.A.M.P.). None of the four is sufficient on its own, and none stands above the rest.

Lived Wisdom

The insight that comes from personal experience, memory, and place. It includes the wisdom of people who have used substances, people in recovery, family members, and people who have lost loved ones. It also includes the everyday knowledge of those who know this county intimately: its patterns, and what the people closest to the work understand that outside expertise tends to miss. Lived wisdom keeps strategy honest, telling us what actually helps rather than what only sounds helpful. SOLVE 2.0 commits to lived-experience representation on the task force, on each subcommittee, and in every phase of evaluation.

Academic Expertise

The knowledge built through research, learning, and critical inquiry. Its role is not only to test whether a strategy works and to separate correlation from coincidence, but to make knowledge more shareable across the table: helping partners interpret data, frame sharper questions, and put their own wisdom to work. Used well, academic expertise strengthens the other three forms of wisdom rather than speaking over them. Through our partnership with Campbell University's Department of Public Health, SOLVE 2.0 has an embedded evaluation function for each subcommittee and a commitment to building the analytic capacity of partners across the coalition.

Moral Wisdom

The values-based understanding shaped by faith, ethics, and meaning-making. It is carried in faith communities and also in civic and cultural traditions, in secular commitments to justice and healing, and in the moral convictions of families and neighbors. Moral wisdom answers what data cannot: why this work matters, and to whom we are accountable. In a county where churches are often the densest community infrastructure outside the schools, faith leadership is operationally indispensable, but moral wisdom is broader than any one tradition. SOLVE 2.0 keeps seats of leadership on the task force for faith leaders and makes room for the wider range of moral and cultural voices that carry meaning in this community.

Professional Expertise

The applied skill developed through training, service, and practice. It is held by clinicians, first responders, social workers, peer specialists, teachers, pharmacists, and law enforcement officers, the people who carry the work day to day. Professional expertise tells us whether a strategy can actually be operated in our county, with our

staff, on our budget, and it turns shared intention into workable procedure. SOLVE 2.0 keeps the task force's professional leadership intact across subcommittees.

Tiered Prevention Logic

SOLVE 2.0 retains the tiered prevention logic that anchored SOLVE 1.0 and extends it to harm reduction and recovery. Every strategy and initiative in this plan can be located in one of three tiers, and the plan deliberately invests across all three.

Primary Prevention

Universal strategies that reduce the conditions giving rise to harmful substance use in the first place, community resilience, school-based prevention, family strengthening, and broad public education. Primary prevention is the widest tier and the slowest to show effects in mortality data. It is also the tier without which the other two never become sustainable.

Secondary Prevention

Targeted strategies for populations at elevated risk, at-risk youth, families involved with DSS, justice-involved individuals, survivors of domestic violence, and people with chronic pain. Secondary prevention is where the highest-leverage opportunities to interrupt the trajectory toward substance use disorder live.

Tertiary Prevention

Strategies for people already experiencing substance use disorder, treatment access, MOUD, harm reduction, overdose response, re-entry, and recovery support. Tertiary prevention is where mortality is reduced most directly and most quickly. It is also where SOLVE 1.0 made the largest measurable gains, and where SOLVE 2.0 invests in durable infrastructure rather than emergency response.

The three tiers correspond to, but do not map perfectly onto, the three strategic Goals that follow. Each Goal contains work in multiple tiers, by design.

Our Strategies

Goal 1 Education, Prevention & Early Intervention

Opioid harm in Harnett County begins upstream of use. Adverse childhood experiences, parental substance use, and exposure to violence are documented predictors of later substance use disorder. Families involved with DSS and survivors of domestic violence are populations the SOLVE 1.0 review and the listening sessions repeatedly identified as carrying elevated pediatric risk. Prevention reach across the four high schools is not yet standardized. The Community Schools framework is still emerging. Naloxone is present in schools but the surrounding education, referral pathways, and recovery-supportive student supports are uneven.

Stigma is the second condition. Across the listening sessions and key informant interviews, families described shame and fear of community judgment as reasons they delayed asking for help. The Task Force's own enumeration of root causes names hopelessness, untreated mental illness, and stigma-adjacent conditions as drivers of opioid-related harm in the county. The strategies in Goal 1 are designed against these conditions together. Universal education and stigma reduction lower the social cost of help-seeking. School-based and Community Schools work creates a reliable point of universal contact with adolescents. Family-centered early intervention coordinates the DSS, Health Department, recovery community, and faith network around families already at elevated risk, rather than relying on each system to reach those families on its own.

Goal 2 Treatment & Harm Reduction

Mortality from opioid use disorder in Harnett County is driven by friction between readiness to engage and reaching care, not by an absence of treatment infrastructure. MOUD is available in the Detention Center. Naloxone has been distributed in volume since SOLVE 1.0. Buprenorphine prescribers operate in the county. The primary care MOUD network is small, the plan commits to expanding it from two to five practices over three years. A majority of Harnett residents obtain primary care outside the county. Transportation was the most consistently named barrier across listening sessions, key informant interviews, and the community health survey.

The transition windows are where most of the mortality risk concentrates. The period immediately after release from custody, the hours after a non-fatal overdose, and discharge from emergency or inpatient care are documented high-mortality windows in the opioid-use-disorder trajectory. The residents at highest risk, people who use alone, people in unstable housing, people newly released from custody, agricultural workers in the eastern townships, monolingual Spanish-speaking households, are reached through harm-reduction channels before they are reached through appointment-based care. The strategies in Goal 2 follow this fact. Treatment Access and Continuity invests in the points of contact people actually use: primary care, pharmacy, the jail, and the post-overdose visit. Transportation to Care treats the most named barrier as a public-health intervention.

Harm Reduction and Overdose Response sustains the community-embedded contact that reaches the residents farthest from clinic-based care, with a seventy-two-hour Post-Overdose Response Team engagement target.

Goal 3 Recovery & Wellbeing

Sustained recovery in Harnett County is constrained by the conditions a person returns to. The listening sessions and the Task Force prioritization process named housing, employment, transportation, and community belonging as conditions that shape whether early recovery is sustained. The period immediately following release from the Detention Center is a documented high-mortality window in opioid use disorder. MOUD continuity at release, peer navigation, and warm handoffs to housing and employment are partial rather than systematic, this is what the plan's Re-Entry Services Expansion is designed to close.

Recovery capital is unevenly distributed across the county. Recovery-friendly employer relationships have been built through Faith and Recovery Network outreach but are not yet at the scale of a county-wide program. Recovery, transitional, and supportive housing capacity has not been systematically catalogued, the Housing Summit and three-year action plan committed under Strategy 3.2 are the first step toward that catalogue. Certified peer specialist capacity is not yet sufficient to staff PORT, re-entry, and family navigation simultaneously. The Task Force's enumeration of root causes (economic stress, unemployment, unstable housing, etc.) names the same conditions the recovery community surfaces from lived experience. Goal 3 addresses those conditions directly. Re-Entry and Justice-Involved Populations invests in the post-release window. Housing, Employment, and Recovery Capital builds the material conditions of sustained recovery. Family Reconnection and Community Belonging rebuilds the relational and civic supports that the other conditions have thinned.

Goal 1: Education, Prevention & Early Intervention

Goal 1 carries the work of universal and targeted prevention. It reaches the broad community through education and resilience-building, and it reaches identified at-risk populations, youth, families involved with DSS, survivors of domestic violence, through early intervention. It is the tier of the plan where the strongest long-term return on settlement investment lives.

Strategy 1.1 Universal Education and Stigma Reduction

We will sustain and expand community-wide education that builds accurate understanding of substance use disorder, reduces stigma, and equips ordinary residents to act.

Key Initiatives

- **Community Mental Health First Aid.** Continue MHFA training with the goal of training an additional 300 residents over three years, with targeted modules for faith leaders, employers, and educators.
- **Quarterly Faith Leader Trainings.** Support a quarterly meeting of faith leaders (rotating to host churches throughout the county) to provide trainings such as Community Resilience Model Training, suicide prevention, and MHFA for congregations.
- **SolveHarnett.org as a public-facing hub.** Maintain and expand the website as the single public-facing source for resources, training, naloxone access, and recovery support information.
- **Education Through Public Libraries.** Expand educational initiatives related to the prevention of harmful substance use and behavioral health that are located in libraries and co-designed by library staff.

Strategy 1.2 School-Based and Community-Schools Prevention

Schools are the most reliable point of universal contact with young people in Harnett County, and they carry the heaviest weight in primary prevention. We will deepen the partnership between the Opioid Task Force, Harnett County Schools, and the Health Department to embed substance use prevention, behavioral health navigation, and family supports in identified high-need school sites, and to keep naloxone, awareness, and referral pathways available across every school.

Key Initiatives

- **Community Schools framework in identified sites.** Implement a community-schools framework in two identified high-need schools, with embedded behavioral health navigation and family supports.
- **Naloxone in all schools.** Sustain naloxone availability and training across all Harnett County Schools, including supplementary trainings for new staff each year.
- **Recovery supports for students.** Develop a framework, in partnership with the school district, for supporting students in recovery and students whose family members are in recovery.

Strategy 1.3 Family-Centered Early Intervention

Some of the highest-risk trajectories toward substance use disorder begin in childhood adversity, foster involvement, parental substance use, exposure to domestic violence. SOLVE 2.0 will close the gap between DSS,

the Health Department, the recovery community, and the faith network so that families at elevated risk encounter a coordinated set of supports rather than a series of separate programs.

Key Initiatives

- **Foster youth and DV early intervention.** Implement a coordinated early-intervention package for families involved with DSS and survivors of domestic violence, including family-based intervention and connection to behavioral health.
- **Faith / DSS / Health Department collaboration.** Institutionalize the faith-DSS-Health Department collaboration around foster and grandparent caregivers, with a recurring quarterly convening.

Goal 2: Treatment & Harm Reduction

SOLVE 2.0 brings Treatment and Harm Reduction into a single Goal. SOLVE 1.0 separated them; two years of execution have convinced us they are one continuous body of work. The same people, the same partners, and the same settings, the jail, the emergency department, primary care, the pharmacy, the post-overdose visit, are where both belong. Goal 2 is where mortality is reduced most directly. It is also where we will invest most in durable infrastructure during the high-funding years of the settlement.

Strategy 2.1 Treatment Access and Continuity

The barriers most often cited by residents are not the existence of treatment but access to transportation, workable hours, insurance coverage, language congruence, and continuity across transitions. We will expand treatment access by investing in the points of contact people use--primary care, pharmacy, the jail, and the post-overdose visit--and by removing the friction that turns interest in care into a missed appointment.

Key Initiatives

- **MOUD in the Detention Center.** Sustain the MOUD program in the Harnett County Detention Center, with continued naloxone-at-release and a 30-day continuity protocol. In addition, explore opportunities to expand capacity to provide evidence-based medications for OUD and AUD, including for individuals with polysubstance use (such as methadone, buprenorphine, and naltrexone), with both induction and therapeutic maintenance.
- **Primary care MOUD expansion.** Expand primary care OBOT partnerships from two to five practices over three years, with technical assistance and peer support. Work should include increasing awareness of the SOLVE strategies for clinicians and patients.
- **Pharmacy-based MOUD and naloxone.** Develop a Harnett County Pharmacy Partnership for standing-order naloxone, fentanyl test strip distribution, and, where state regulation permits, buprenorphine dispensing partnerships.
- **Resource Navigation.** Develop capacity within the Harnett County Health Department to assist individuals who are seeking treatment for substance use to connect with supportive services.

Strategy 2.2 Transportation to Care

Transportation was the most consistently named barrier across listening sessions, interviews, and the community health survey. Fifty-nine percent of Harnett County residents already obtain primary care outside the county, and for many of our residents in recovery the practical question is not whether help exists but whether they can get to it. We will treat transportation as a public health intervention.

Key Initiatives

- **HARTS transportation pilot.** Investigate a treatment- and recovery-supportive transportation pilot through Harnett Area Rural Transit System (HARTS), with dedicated scheduling and a sliding-scale fare structure.

- **Provider-side transportation contracts.** Negotiate transportation contracts with the highest-volume MOUD and behavioral health providers receiving Harnett County referrals.
- **Transportation navigator function.** Add transportation navigation to the family navigator role described in Goal 1, so that no individual referral closes due to a transportation barrier alone.

Strategy 2.3 Harm Reduction and Overdose Response

Harm reduction saves lives in the time it takes treatment access to expand. We will sustain and extend the harm-reduction work that has reduced overdose mortality over the past two years, with a particular focus on the places and moments in which overdose risk is highest: post-release, post-overdose, post-discharge from emergency or inpatient care, and in the homes of people who use alone.

Key Initiatives

- **Post-Overdose Response Team.** Continue and strengthen the Post-Overdose Response Team, with peer specialist staffing and a 72-hour engagement target.
- **Community naloxone distribution.** Sustain low-barrier naloxone distribution through libraries, faith partners, community events, sharps containers, and SolveHarnett.org, with an annual distribution target of 2,500 doses.
- **Syringe Service Program.** Stand up a faith-partnered, mobile-first Syringe Service Program offering wound care, naloxone, fentanyl test strips, and warm referral, scoped to operate within North Carolina law.

Goal 3: Recovery & Wellbeing

Goal 3 widens our attention beyond services for people in recovery to the conditions that make life workable in our county. People who use drugs, and people in early recovery, deserve a community that is safe for them today and gives attention to a better tomorrow by strengthening health-supporting dimensions such as housing, employment, peer support, transportation, and community integration.

Strategy 3.1 Re-Entry and Justice-Involved Populations

The two weeks following release from custody are among the highest-mortality windows in the trajectory of opioid use disorder. SOLVE 2.0 invests deliberately in the re-entry window and in the broader infrastructure of justice-involved recovery, diversion before charge, treatment in custody, and recovery court for those who can be served better outside the standard prosecution pathway.

Key Initiatives

- **Re-Entry Services Expansion.** Implement a coordinated re-entry package: MOUD continuity at release, naloxone and overdose education at release, peer navigation in the first 72 hours and 30 days, and warm handoffs to housing and employment.
- **Law Enforcement Assisted Diversion (LEAD).** Operationalize the LEAD pre-charge framework piloted under SOLVE 1.0, with funded case management and a formal multi-agency MOU.
- **Recovery Court.** Establish a Recovery Court in partnership with the District Court, building on lessons from comparable North Carolina counties.

Strategy 3.2 Housing, Employment, and Recovery Capital

Recovery capital is the sum of the resources, housing, employment, supportive relationships, civic participation, that make recovery sustainable. We will use the high-funding years of the settlement to build the housing and employment partnerships that have transformative potential for our communities.

Key Initiatives

- **Housing summit and action plan.** Convene a housing summit in 2027 and produce a three-year action plan to expand recovery, transitional, and permanent supportive housing capacity in Harnett County.
- **Recovery-friendly workplaces.** Launch a SOLVE Business Partners program for recovery-friendly workplaces, with employer training, hiring guidance, and an annual recognition.
- **Faith and Business SOLVE Partners.** Continue cultivating the Faith and Recovery Network as the operational backbone of community-level recovery support.

Strategy 3.3 Family Reconnection and Community Belonging

Substance use disorder is, in its deepest reach, a family and community phenomenon. The work of rebuilding belonging runs through the same channels that prevention runs through, schools, faith communities, civic groups, neighborhoods, but it carries the additional weight of grief, reconciliation, and slow rebuilding.

Key Initiatives

- **Parent advocacy and family support.** Sustain the parent advocacy group and expand it into a network of family support groups across the five municipalities.
- **Recovery-supportive student supports.** Implement the recovery-supportive student supports framework developed under Goal 1.
- **Grief, loss, and reconciliation.** Develop, in partnership with faith communities and the recovery community, a Harnett County framework for honoring those lost to overdose and supporting bereaved families.

Priority Populations and Disaggregated Reporting

SOLVE 2.0 names the following priority populations. The list is operational, not symbolic, each population is associated with at least one named strategy, indicator, and access-barrier reduction commitment. Race and ethnicity reporting is disaggregated wherever the data are statistically defensible at the county level; where small-cell suppression is required by the NC State Center for Health Statistics, three-year rolling rates are reported instead of single-year rates.

Named Priority Populations

- **The Coharie Tribe.** A state-recognized American Indian tribe with members residing in Harnett County and the surrounding region. SOLVE 2.0 commits to consultation with the Coharie Tribal Administration on substance-use programming, to disaggregated American Indian / Alaska Native reporting in every indicator where statistical disclosure rules permit, and to inclusion of tribal cultural and language considerations in the design of recovery support services. The Tribe is invited to a standing seat on the Task Force.
- American Indian / Alaska Native residents broadly, including but not limited to Coharie Tribal members.
- Black residents of Harnett County, with attention to the historically Black communities of Dunn, Erwin, and the eastern townships.
- Hispanic and Latino/a residents, including monolingual Spanish-speaking households, with attention to migrant agricultural workers in the eastern portion of the county.
- Pregnant women and parents with substance use disorder, including the families of infants born with neonatal opioid withdrawal syndrome (NOWS).
- Justice-involved adults, including the detention-center population, individuals on probation or parole, and individuals exiting the detention center in the prior 90 days.
- Adolescents and emerging adults (ages 13–24), including students in the four high schools and Campbell University students.
- Veterans, particularly those with co-occurring chronic pain conditions and mental health diagnoses.
- Residents experiencing homelessness or housing instability.
- Residents living in the four high-poverty census tracts of the county.
- Faith-community congregants in the small and historically Black congregations of the western and northern townships.

Disaggregated Indicator Set

The following indicators are reported by race and ethnicity in every Annual Impact Report. The reporting follows NC State Center for Health Statistics small-cell suppression standards and uses three-year rolling rates where annual cell sizes are below ten. American Indian / Alaska Native reporting will include a footnote identifying Coharie Tribal members where the Tribe consents and where state data sources allow.

- Opioid-involved overdose deaths per 100,000 residents.
- Emergency department visits for opioid overdose per 100,000 residents.
- EMS naloxone administrations per 100,000 residents.
- Treatment admissions for opioid use disorder per 1,000 residents.
- Post-overdose follow-up engagement rate (proportion of non-fatal overdoses contacted by the post-overdose response team within 72 hours).
- Buprenorphine prescribing rate per 1,000 residents.
- Detention-center MOUD enrollment rate (proportion of bookings with substance use diagnosis starting or continuing treatment).
- Neonatal Opioid Withdrawal Syndrome (NOWS) incidence per 1,000 live births.
- Plan of Safe Care completion rate for opioid-exposed infants.
- Recovery Capital Scale change scores at 90 days, 6 months, and 12 months for funded recovery-services participants.

A note on framing. *SOLVE 2.0 uses the operational language of priority populations and access barriers throughout the strategy chapters and the rubric in Appendix F. Naming who carries the disproportionate burden, measuring outcomes for those populations, and removing the barriers that prevent care from reaching them is the unifying work this plan asks of every partner.*

Subcommittee Structure

SOLVE 2.0 is implemented through three standing subcommittees that report to the Opioid Task Force. The structure mirrors Chatham County's Sheriff's Prevention Partnership on Controlled Substances (SPPCS) model and aligns with the Exhibit A categories the state uses for tracking. Each subcommittee carries one or more strategies from Goals 1, 2, and 3 of SOLVE 2.0 and is accountable for two Impact indicators reported annually. A dedicated Opioid Settlement Coordinator, located in the County Manager's office or Health Department, supports all three subcommittees.

Goals, Measures, and Evaluation Plan

Exhibit C requires goals, measures, and an evaluation plan that addresses process, quality, and outcome. The following table provides the core measure set for SOLVE 2.0. Each strategy team will operate against the relevant rows of this table; the embedded evaluation function at Campbell University's Department of Public Health will produce an annual report to the Opioid Task Force and the Board of Commissioners.

Goal	Process measures	Quality measures	Outcome measures
Goal 1: Education, Prevention & Early Intervention	Number of residents trained (MHFA, resiliency); number of school sites served; number of at-risk youth referred	Trainee satisfaction and self-efficacy scores; fidelity to evidence-based curriculum; referral-to-engagement rates	Youth past-30-day use; ED visits for adolescent overdose; DSS substance-related case re-openings
Goal 2: Treatment & Harm Reduction	MOUD enrollments; naloxone units distributed; transportation rides delivered; SSP encounters	72-hour engagement after overdose; 30-day MOUD continuation; client-rated quality of care	Overdose death count; overdose ED visits; non-fatal overdose 911 calls; MOUD prevalence per 1,000 adults
Goal 3: Recovery & Wellbeing	Re-entry cases served; LEAD referrals; Recovery Court enrollments; housing units identified	Re-entry retention at 30/90/180 days; LEAD case closure outcomes; employer training completion	Recidivism among participating populations; housing stability at 12 months; employment among program participants

Annual Reporting Cycle

The Opioid Task Force will produce an annual SOLVE Report each December (starting Dec 2027), summarizing process, quality, and outcome measures for each strategy and identifying mid-course corrections. The annual report will be presented to the Harnett County Board of Commissioners and posted publicly at SolveHarnett.org.

Budgets and Timelines

SOLVE 2.0 covers the three-year planning horizon of 2026 through 2029 and is calibrated to the high-funding window of the opioid settlement. The following table provides indicative budget bands for each strategy. Final annual budgets will be presented to the Board of Commissioners in the standard county budget cycle and braided, where possible, with non-settlement funding to extend reach and sustainability.

Strategy	2026-2027	2027-2028	2028-2029
1.1 Universal Education and Stigma Reduction	$60,000	$60,000	$50,000
1.2 School-Based and Community-Schools Prevention	$120,000	$140,000	$140,000
1.3 Family-Centered Early Intervention	$90,000	$110,000	$110,000
2.1 Treatment Access and Continuity	$180,000	$180,000	$160,000
2.2 Transportation to Care	$100,000	$100,000	$100,000
2.3 Harm Reduction and Overdose Response	$110,000	$110,000	$110,000
3.1 Re-Entry and Justice-Involved Populations	$650,000	$650,000	$800,000
3.2 Housing, Employment, and Recovery Capital	$50,000	$80,000	$100,000
3.3 Family Reconnection and Community Belonging	$60,000	$70,000	$70,000
Task Force Coordination	$80,000	$80,000	$80,000

The estimates above are planning figures, not appropriations. They are sized to not exceed the total three-year settlement envelope consistent with Harnett County's projected disbursement schedule, with reserve held for opportunity, partnership, and emergent need.

Appendix A: Exhibit C Compliance Crosswalk

The North Carolina Memorandum of Agreement, Exhibit C, requires that each Option B local government engage in a collaborative strategic planning process that includes fourteen specific activities. The following crosswalk maps each activity to the section of SOLVE 2.0 that satisfies it.

#	Exhibit C Activity	Where addressed in SOLVE 2.0
A	Engage diverse stakeholders representing the ten Exhibit C stakeholder categories	Strategic Planning Process; Appendix B (Stakeholder Engagement Inventory)
B	Designate a facilitator for the strategic planning process	Strategic Planning Process, Dr. David Tillman, Campbell University, designated facilitator
C	Build upon related planning efforts and community assessments	Introduction; Strategic Planning Process Step 3 (Secondary Data Analysis, CHA 2025, Community Capacity Inventory)
D	Agree on a shared vision for the use of opioid settlement funds	The SOLVE Approach; Tiered Prevention Logic; Our Strategies
E	Identify key indicators of opioid-related harm and assets	Goals, Measures, and Evaluation Plan; Introduction
F	Identify root causes of opioid-related harm in the community	What We Learned from SOLVE 1.0; Four Sources of Knowledge; Strategy intros throughout
G	Identify and evaluate potential strategies	Opioid Task Force Initiative Priorities; Appendix E (Prioritization Results)
H	Identify gaps in current programs and services	What We Learned from SOLVE 1.0, Not Yet Accomplished and Partially Accomplished sections
I	Prioritize strategies for funding	Appendix E (Prioritization Results); Opioid Task Force Initiative Priorities (ranked)
J	Establish goals, measures, and an evaluation plan including process, quality, and outcome measures	Goals, Measures, and Evaluation Plan
K	Align strategies through braiding of funds, regional coordination, and partnerships	Budgets and Timelines; partnerships named throughout Goal 1, 2, and 3
L	Identify organizations responsible for implementing each strategy	Each strategy will belong to a subcommittee
M	Establish budgets and timelines for implementation	Budgets and Timelines
N	Provide recommendations to the local governing body	This plan in its entirety, submitted for adoption by the Harnett County Board of Commissioners

Appendix B: Stakeholder Engagement Inventory

Exhibit C requires engagement of ten stakeholder categories. The following inventory documents the categories, the Harnett County stakeholders engaged in the SOLVE 2.0 process, and the mechanisms of engagement.

Category	Representative Stakeholders Engaged	Engagement Mechanism
A-1. Local officials	Harnett County Board of Commissioners; municipal leadership (Dunn, Angier, Erwin, Lillington, Coats); county manager; Harnett County Health Department	Task force membership; briefings; adoption process
A-2. Healthcare providers	Harnett Health; primary care practices; behavioral health providers; pharmacies; community paramedicine & PORT Team	Task force seats; key informant interviews; provider roundtable
A-3. Social service providers	Harnett County DSS; family resource organizations; food and housing partners	Task force seats; key informant interviews
A-4. Education and employment representatives	Harnett County Schools; Campbell University; workforce development partners	Task force seats; key informant interviews
A-5. Payers and funders	Medicaid LME/MCO partner; private payers; foundation partners	Task force seats; key informant interviews
A-6. Law enforcement	Harnett County Sheriff's Office; municipal police; District Attorney's Office; Detention Center	Task force seats; first-responder roundtable
A-7. Employers	Local employers; chamber of commerce	Task force seats; key informant interviews
A-8. Community groups	Recovering Hope Network of faith leaders; civic clubs; cooperative extension	Task force seats; faith roundtable; listening sessions
A-9. People with lived experience and families	People in recovery; family members; parent advocacy group	Task force seats; key informant interviews
A-10. Stakeholders attentive to community diversity	Spanish-language community partners; rural-geography stakeholders; faith leaders representing diverse traditions	Bilingual survey; listening sessions in five municipalities; key informant interviews

Appendix C: Prioritization Results

In May 2026, seventeen members of the Opioid Task Force completed a paired-comparison prioritization of twelve candidate key activities. The following table summarizes the totals and the resulting rank order, which directly informed the prominence given to each strategy and initiative in SOLVE 2.0.

Rank	Candidate Key Activity	Total Score
1	D. Transportation pilot (HARTS, faith volunteer network, provider contracts)	142
2	C. Prevention and early intervention for at-risk youth	118
3	L. Expanding re-entry services	114
4	J. Pharmacy-based MOUD	106
5	A. Developing Law Enforcement Assisted Diversion (LEAD)	104
6	B. Recovery Court	100
7	K. Foster youth and domestic violence early intervention	98
8	E. Community Schools prevention framework	94
9	I. MHFA and community resiliency trainings	92
10	F. Syringe Service Program	76
11	G. Faith and business SOLVE Partners	52
12	H. Housing summit	24

Note on interpretation: rank order informed prominence but did not by itself determine inclusion or exclusion. The housing summit, ranked twelfth, is nevertheless retained as a Goal 3 initiative because housing was named in every listening session and in the majority of key informant interviews, and because the summit is the necessary first step toward a multi-year housing strategy. Conversely, several highly-ranked items are scoped modestly in early years to allow infrastructure to be built before scale.

Appendix D: Progress, Outcome, and Impact Metrics Framework

SOLVE 2.0 distinguishes three levels of measurement. The distinction follows the standard public-health evaluation hierarchy and aligns with the categories that CORE-NC and the NC Opioid Action Plan Dashboard use in scoring Annual Impact Reports. Every funded strategy must specify at least one Progress metric, one Outcome metric, and one Impact metric. Impact metrics may be shared across strategies at the subcommittee level (see Subcommittee Structure and Impact Indicators).

Level	Definition	Examples
PROGRESS (activity / output)	What was done. Counts of activities, services delivered, people reached. Reported quarterly. Indispensable for accountability and operational management but does not, by itself, demonstrate change.	Number of naloxone kits distributed. Number of MHFA trainings delivered. Number of school staff trained in YMHFA. Number of post-overdose visits completed within 72 hours. Number of detention-center bookings screened for OUD. Number of Plan of Safe Care referrals initiated.
OUTCOME (short- to medium-term change in the people reached)	What changed in the people or systems that received the activity. Knowledge, attitude, behavior, skill, or short-term clinical status change. Reported quarterly or biannually. Measured with pre/post instruments, self-report surveys, or near-term clinical indicators.	Pre/post knowledge gain in school-based opioid awareness sessions. Pre/post stigma-attitude change among trained faith leaders. Self-efficacy to administer naloxone (pre/post). Recovery Capital Scale at 90 days (relative to intake). MOUD retention at 90 days. Linkage-to-care rate for PORT-engaged individuals. Reduction in self-reported risky use behaviors among SSP participants.
IMPACT (long-term population change)	What changed in the county-level population over multiple years. Reported annually. Often requires multi-year rolling averages because of small county-level cell sizes. Disaggregated by race and ethnicity wherever cells permit.	Opioid-involved overdose mortality rate per 100,000. ED visits for opioid overdose per 100,000. MOUD initiation rate per 1,000 OUD cases. Past-30-day opioid misuse prevalence among high-school students. NOWS incidence per 1,000 live births. Buprenorphine prescribing capacity per 1,000 residents. Plan of Safe Care completion rate.

How metrics flow into reporting

Each subcommittee submits a one-page metrics report to the Task Force each quarter, structured in three blocks: Progress (the activities completed this quarter), Outcome (the measured change in participants reached this quarter, where measurement was scheduled), and Impact (the current standing of the subcommittee's two Impact indicators relative to baseline and target). The Settlement Coordinator compiles the three reports into a single quarterly Task Force dashboard. The Annual Impact Report is built from the four most recent quarterly dashboards plus the annual update of Impact indicators from state data systems.

Appendix E. Measurement Matrix by Goal and Key Activity

The matrix below applies the Progress – Outcome – Impact framework to every key activity in SOLVE 2.0. Each row names one strategy or key activity from the body of the plan and specifies the indicators that will be tracked at each level. Progress and Outcome indicators are activity-specific. Impact indicators are shared at the subcommittee level (per Subcommittee Structure and Impact Indicators) so that no single strategy is held accountable, in isolation, for county-level population change.

Goal 1: Education, Prevention & Early Intervention

Strategy / Key Activity	Progress (activity / output)	Outcome (short- to medium-term change)	Impact (long-term population change)
1.1 Universal Education and Stigma Reduction (MHFA, Faith and Recovery Conference, Child Exposure to Substances campaign, Community Resiliency curriculum, SolveHarnett.org)	Residents trained in MHFA per year; trainings delivered to faith leaders, employers, and educators; conference attendance; campaign reach (impressions, materials distributed, bilingual share); unique visitors to SolveHarnett.org.	Pre/post knowledge gain among MHFA trainees; pre/post stigma-attitude change (5-item short-form scale) among trained faith leaders and employers; self-reported intent to refer or intervene at 3 months; awareness of local resources in community survey.	County-level adult past-year stigma score in biennial community survey; help-seeking rate (% of survey respondents who report it is acceptable to seek treatment in our community), disaggregated by race and ethnicity.
1.2 School-Based and Community-Schools Prevention (Community Schools framework, naloxone in all schools, early intervention for at-risk youth, evidence-based curriculum review, recovery-supportive student supports), Activity E	Number of school sites implementing the community-schools framework; YMHFA-trained school staff per site; naloxone units placed and refreshed per school; at-risk youth referred through the coordinated pathway; curriculum review milestones completed.	Pre/post knowledge and self-efficacy among students in school-based opioid awareness sessions; pre/post YMHFA self-efficacy among trained staff; referral-to-engagement rate for at-risk youth (% reaching first appointment within 30 days); school-reported behavioral incidents related to substances.	NC YRBS past-30-day opioid misuse prevalence among Harnett high-school students, three-year rolling, disaggregated by race and ethnicity; first-time opioid prescriptions to county residents aged 12–24 per 1,000 (NC CSRS), three-year rolling.
1.3 Family-Centered Early Intervention (foster youth and DV early intervention, faith/DSS/Health Department collaboration, parent advocacy and peer support, behavioral health navigation for families), Activity K	Families served by the coordinated early-intervention package; quarterly faith/DSS/Health Department convenings held; parent advocacy group meetings convened and attendance; family-navigator caseload; referrals closed within 30 days.	Pre/post family-functioning self-report among participating families; caregiver reported sense of support and resource awareness; reduction in repeat DSS substance-related case openings within 12 months; behavioral health appointment kept-rate for referred families.	DSS substance-related case re-openings within 12 months, county-level; NOWS-affected infants with documented Plan of Safe Care follow-through at 12 months, disaggregated by race and ethnicity.

Goal 2: Treatment & Harm Reduction

Strategy / Key Activity	Progress (activity / output)	Outcome (short- to medium-term change)	Impact (long-term population change)
2.1 Treatment Access and Continuity (Detention Center MOUD Phases 1 and 2, primary care MOUD expansion, pharmacy-based MOUD and naloxone, Activity J, regional behavioral health expansion, telehealth-supported MOUD)	Detention bookings screened for OUD; MOUD inductions and continuations in custody; primary care practices offering MOUD (target: five); pharmacy partners distributing naloxone and fentanyl test strips; telehealth MOUD inductions completed.	MOUD retention at 30, 90, and 180 days (Brief Addiction Monitor); 30-day MOUD continuation rate at release from custody; client-rated quality of care (provider survey); proportion of induction referrals reaching first appointment within 14 days.	MOUD initiation rate per 1,000 county residents with diagnosed OUD, disaggregated by race and ethnicity; buprenorphine prescribing rate per 1,000 residents, disaggregated by race and ethnicity and by municipality (capacity proxy).
2.2 Transportation to Care (HARTS pilot, faith-partner volunteer driver network, provider-side transportation contracts, transportation navigator function), Activity D (rank 1)	HARTS rides delivered for treatment and recovery purposes; trained and insured volunteer drivers; provider transportation contracts executed and rides reimbursed; navigator transportation cases opened and closed.	Appointment kept-rate for clients using each transportation channel; client-reported reduction in transportation as a barrier (pre/post navigator engagement); time from referral to first appointment for transportation-supported clients.	Treatment admissions for opioid use disorder per 1,000 residents, disaggregated by race and ethnicity and geography; proportion of OUD residents reporting transportation as a barrier in biennial community survey.
2.3 Harm Reduction and Overdose Response (Post-Overdose Response Team, community naloxone distribution, Syringe Service Program, Activity F, sharps container placement, health and safety kits)	Naloxone kits distributed (target: 2,500 doses per year); PORT contacts attempted and completed within 72 hours; SSP encounters; sharps containers placed and serviced; health and safety kits distributed.	Self-efficacy to recognize and respond to overdose (pre/post) among trained recipients; documented overdose reversals attributed to distributed kits (EMS and voluntary participant report); PORT linkage-to-care rate at 30 days; reduction in self-reported risky use behaviors among SSP participants.	Opioid-involved overdose mortality rate per 100,000 residents, three-year rolling, disaggregated by race and ethnicity; proportion of non-fatal overdoses followed by PORT contact within 72 hours, disaggregated by race and ethnicity (target: ≥ 60 percent by FY2028).

Goal 3: Recovery & Wellbeing

Strategy / Key Activity	Progress (activity / output)	Outcome (short- to medium-term change)	Impact (long-term population change)
3.1 Re-Entry and Justice-Involved Populations (Re-Entry Services Expansion, Activity L, Law Enforcement Assisted Diversion, Activity A, Recovery Court, Activity B, MOUD continuity at release)	Re-entry cases served with the coordinated package; LEAD pre-charge referrals accepted and active; Recovery Court enrollments; naloxone-at-release units distributed; warm handoffs to housing and employment completed.	Re-entry retention in services at 30, 90, and 180 days; LEAD case closure outcomes (employment, housing, treatment engagement); Recovery Court graduation rate; 30-day post-release MOUD continuation rate; self-reported quality of life at 6 months.	Proportion of justice-involved OUD residents linked to community-based treatment within 30 days of release, disaggregated by race and ethnicity; one-year recidivism rate among participating populations; opioid-involved overdose deaths within 14 days of release.

Strategy / Key Activity	Progress (activity / output)	Outcome (short- to medium-term change)	Impact (long-term population change)
3.2 Housing, Employment, and Recovery Capital (Housing summit and action plan, Activity H, recovery-friendly workplaces, Faith and Business SOLVE Partners, Activity G, peer support workforce)	Housing summit convened and three-year action plan published; recovery, transitional, and supportive housing units identified or developed; employer partners enrolled in SOLVE Business Partners; certified peer specialist FTEs funded across PORT, re-entry, and family navigation.	Employer training completion and pre/post stigma-attitude change; clients placed in recovery-friendly employment retained at 90 and 180 days; Recovery Capital Scale change from intake to 12 months for funded recovery-services participants; peer-supported clients reporting strengthened social support.	Housing stability at 12 months among participating populations (proportion in stable housing); employment among program participants at 12 months; Recovery Capital Scale change score at 12 months, disaggregated by race and ethnicity.
3.3 Family Reconnection and Community Belonging (parent advocacy and family support, Faith and Recovery Network, civic and neighborhood belonging initiatives, community-grief and reconciliation programming)	Parent advocacy and family support groups operating across the five municipalities; Faith and Recovery Network quarterly convenings; participating congregations and civic partners; community grief and reconciliation events delivered.	Participant-reported sense of belonging and social support (validated short-form scale, pre/post); family-functioning self-report; volunteer and peer engagement hours sustained at 6 and 12 months; faith leader self-efficacy to accompany recovery (pre/post).	Community survey index of belonging and trust (biennial), disaggregated by race and ethnicity; proportion of residents in recovery reporting durable supportive relationships at 12 months in funded contracts.

Note on matrix use. *Funded applicants under the RFA process in Appendix must select at least one Progress, one Outcome, and one Impact indicator from the matrix row that corresponds to their proposed strategy, or propose a defensible substitute. Where the same key activity appears under more than one strategy (for example, peer specialists serving both PORT and re-entry), applicants choose the row whose Impact indicator best matches the population they will reach.*

Appendix F: Proposal Review Process and Scoring Rubric

SOLVE 2.0 will operate a competitive Request-for-Applications (RFA) process beginning in FY2027 to award sub-grants to community-based organizations. The process below is adapted from the rubric used by peer counties and from the funding-process design notes the Task Force has reviewed. The rubric is organized around the operational language of priority populations and access barriers, in keeping with the Task Force's commitment that SOLVE 2.0 remain unifying across political dispositions. The substantive commitment to serving the populations carrying disproportionate opioid-related harm and to removing access barriers is built into the rubric under Category 5.

F.1 Recommended RFA Cadence

Two release windows per year are recommended:

- Spring window: release in April; applications due in late May; awards announced in June.
- Fall window: release in October; applications due in November; awards announced in December.

Multi-year awards (up to three years) are permitted with continuation applications and updated budgets at each annual checkpoint. Funds are disbursed as reimbursements for documented services.

F.2 Minimum Eligibility Requirements

Before scoring, proposals must meet all of the requirements below. Proposals failing any requirement are returned to the applicant with feedback and do not advance to scoring.

- Clearly relates to opioid prevention, treatment, recovery support, harm reduction, crisis response, education, or system improvement.
- Serves Harnett County residents or directly benefits Harnett County systems or community partners.
- Identifies a defined population, setting, or community focus.
- Includes a proposed budget and basic implementation plan.
- Does not duplicate an existing service without explaining the added value.
- Identifies a healthcare or clinical partner (required for treatment and recovery proposals; encouraged for all others).

F.3 Scoring Rubric, 100 Points

Category	Max	What Reviewers Look For
1. Alignment with SOLVE 2.0 and Settlement Priorities	**15**	Proposal connects clearly to one or more Goals of SOLVE 2.0 and to one or more Exhibit A or Exhibit B strategies. Strong proposals explain why the project is an appropriate use of opioid settlement funds and which subcommittee will steward the work.
2. Severity of Community Need and Local Relevance	**15**	Proposal identifies a specific Harnett County need, gap, or priority population. Strong proposals use local data, community input, service utilization trends, overdose data, school or community needs, or partner feedback to show that the problem is real, urgent, and not already fully addressed.
3. Expected Impact on Opioid-Related Harm	**20**	Proposal has strong potential to reduce opioid-related harm, improve access to care, prevent substance use, increase overdose-prevention capacity, strengthen recovery supports, or improve crisis response. Strong proposals clearly explain who will benefit, how many people may be reached, and what meaningful change is expected.
4. Evaluation Plan and Measurable Outcomes	**15**	Proposal includes clear, realistic, measurable outcomes using the Progress / Outcome / Impact framework in Appendix E. Strong proposals identify at least one indicator at each level, the data source, the timeline for measurement, and how findings will be used. Measures go beyond counting activities.
5. Reach into Priority Populations and Reduction of Access Barriers	**15**	Proposal prioritizes populations carrying disproportionate opioid-related harm or facing the heaviest barriers to care. SOLVE 2.0 priority populations include the Coharie Tribe and broader American Indian / Alaska Native residents; Black residents; Hispanic and Latino/a residents; pregnant women and parents; justice-involved adults; adolescents and emerging adults; veterans; residents experiencing homelessness; residents in high-poverty census tracts; and faith-community congregants in small and historically Black congregations. Strong proposals identify the specific population they will reach, the access barriers that have prevented care from reaching that population, and the concrete steps the project will take to remove those barriers.
6. Feasibility and Implementation Readiness	**10**	Proposal includes a realistic work plan, staffing plan, timeline, partnerships, and

Category	Max	What Reviewers Look For
		implementation strategy. Strong proposals show that the applicant has the capacity, experience, relationships, and infrastructure to complete the project within the funding period.
7. Community Partnership and Lived Experience	**5**	Proposal demonstrates meaningful involvement of community partners and of people with lived or living experience of substance use or recovery. Strong proposals show community members in planning, implementation, outreach, interpretation of findings, or decision-making roles.
8. Budget Strength and Cost-Effectiveness	**5**	Budget is clear, reasonable, justified, and tied directly to proposed activities. Strong proposals demonstrate responsible use of limited funds and show that the expected benefit is proportional to the amount requested.

Total: 100 points. Scoring guidance: Full points for exceptional response (clear, specific, well-supported, highly competitive). 75% for strong response with minor gaps. 50% for adequate response lacking detail or evidence. 25% for weak response with major gaps. 0 for not addressed or not relevant.

F.4 Score Interpretation

- 90–100: Highest priority for funding.
- 80–89: Strong proposal; fund if resources allow.
- 70–79: Moderate proposal; consider only if priority gaps remain.
- Below 70: Not recommended for funding without significant revision.

F.5 Automatic Red Flags (additional review required regardless of score)

- Vague connection to opioid-related outcomes.
- No clear target population.
- No measurable outcomes.
- Budget appears inflated or poorly justified.
- Duplicates an existing program without clear added value.
- Minimal community connection or no evidence of trust with the population served.
- Relies heavily on one-time activities with unclear lasting impact.
- Proposes research or data collection without a clear benefit to the community.

F.6 Tie-Breaker Criteria for Close Scores

- Which proposal addresses the most urgent opioid-related need in Harnett County?
- Which proposal is most likely to produce measurable improvement, not just increased activity?
- Which proposal reaches people at highest risk of overdose, untreated opioid use disorder, stigma, or lack of access to services?
- Which proposal fills a gap rather than duplicating services already available?
- Which proposal has the strongest partnerships and community trust?
- Which proposal offers the greatest expected impact for the amount of funding requested?
- Which proposal has the greatest chance of continuing, informing future work, or creating system-level change after the funding period ends?

F.7 Review Panel Composition

Each RFA cycle is scored by members of the relevant subcommittee and should include at least one member from each area of the LAMP Lens (a person with lived experience, a person with academic expertise, a faith leader or person representing the moral wisdom of the community, and a person with relevant professional expertise). Reviewers declare conflicts of interest in writing prior to scoring and recuse from any proposal involving a current employer, family member, or organization in which the panelist has a financial interest.

F.8 Reviewer Final Judgment

Each scoring sheet concludes with a single reviewer-judgment question: "If only one proposal could be funded, would this proposal represent one of the strongest uses of limited opioid settlement dollars?" Reviewers select one of four answers (strongly recommend fund; fund if resources allow; needs revision; do not recommend) and provide a brief written explanation. This question functions as a calibration check on the numeric scoring.

Appendix G: NC MOA Exhibit A / Exhibit B Strategy Crosswalk

Each Key Initiative is mapped to the single NC MOA identifier that most specifically references the activity. Where a specific Exhibit B sub-item (e.g., B-D-1-d for LEAD) names the activity, that sub-item is used. Where no B sub-item is more specific, the Exhibit A high-impact strategy is used.

Goal 1 — Education, Prevention & Early Intervention

Strategy 1.1 — Universal Education and Stigma Reduction

Key Initiative	Exhibit A/B identifier
Community Mental Health First Aid (300 additional residents; faith leader, employer, educator modules)	A6
Quarterly Faith Leader Trainings (Community Resilience Model, suicide prevention, stigma reduction)	B-G-7
SolveHarnett.org as a public-facing hub	B-G-2
Education Through Public Libraries	B-G-6

Strategy 1.2 — School-Based and Community-Schools Prevention

Key Initiative	Exhibit A/B identifier
Community Schools framework in identified sites (embedded behavioral health navigation, family supports)	B-G-12
Naloxone in all schools (sustained availability, annual staff training)	B-H-4
Recovery supports for students and students with family members in recovery	B-B-14

Strategy 1.3 — Family-Centered Early Intervention

Key Initiative	Exhibit A/B identifier
Foster youth and DV early intervention (family-based intervention; coordinated supports for DSS-involved and DV-exposed families)	B-E-8
Faith / DSS / Health Department collaboration (foster and grandparent caregiver convening)	B-E-6

Goal 2 — Treatment & Harm Reduction

Strategy 2.1 — Treatment Access and Continuity

Key Initiative	Exhibit A/B identifier
MOUD in the Detention Center, Phase 2 (30-day continuity protocol; naloxone-at-release)	A11
Primary care MOUD expansion (2 → 5 practices; TA and peer support)	B-A-1
Pharmacy-based MOUD and naloxone (Harnett County Pharmacy Partnership; standing-order naloxone; fentanyl test strips; buprenorphine where permitted)	B-A-1
Resource Navigation within the Harnett County Health Department	B-C-16

Strategy 2.2 — Transportation to Care

Key Initiative	Exhibit A/B identifier
HARTS transportation pilot (dedicated scheduling; sliding-scale fare; recovery-supportive routing)	B-B-7
Provider-side transportation contracts (highest-volume MOUD and behavioral health providers)	B-B-7

Transportation navigator function (extends the family navigator role from Goal 1)	B-B-7

Strategy 2.3 — Harm Reduction and Overdose Response

Key Initiative	Exhibit A/B identifier
Post-Overdose Response Team (peer specialist staffing; 72-hour engagement target)	A8
Community naloxone distribution (libraries, faith partners, community events, sharps containers, SolveHarnett.org; annual target)	A7
Syringe Service Program (faith-partnered, mobile-first; wound care, naloxone, fentanyl test strips, warm referral; NC GS 90-113.27)	A9

Goal 3 — Recovery & Wellbeing

Strategy 3.1 — Re-Entry and Justice-Involved Populations

Key Initiative	Exhibit A/B identifier
Re-Entry Services Expansion (MOUD continuity at release; naloxone and overdose education; peer navigation at 72 hours and 30 days; warm hand-offs)	A12
Law Enforcement Assisted Diversion (LEAD), operationalized with funded case management and multi-agency MOU	B-D-1-d
Recovery Court, in partnership with District Court	B-D-3

Strategy 3.2 — Housing, Employment, and Recovery Capital

Key Initiative	Exhibit A/B identifier
Housing summit and three-year action plan (recovery, transitional, permanent supportive housing capacity)	A4
Recovery-friendly workplaces (SOLVE Business Partners: employer training, hiring guidance, annual recognition)	A5
Faith and Business SOLVE Partners (Faith and Recovery Network as operational backbone)	B-B-10

Strategy 3.3 — Family Reconnection and Community Belonging

Key Initiative	Exhibit A/B identifier
Parent advocacy and family support (network of family support groups across the five municipalities)	B-B-6
Recovery-supportive student supports (framework developed under Goal 1)	B-B-14
Grief, loss, and reconciliation (framework for honoring those lost to overdose; supporting bereaved families)	B-E-8