NC Opioid Settlements Measures Models

North Carolina Association of County Commissioners

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August 2023

The NC Association of County Commissioners Opioid Settlements Technical Assistance Team (NCACC OSTAT) strives to improve the health of NC communities and supports counties in planning for and utilizing opioid settlement funds, and maximizing impact through technical assistance, outreach, education, and collaboration. As such, OSTAT helps local governments meet their reporting requirements outlined in the NC Memorandum of Agreement (NC MOA) including the Annual Impact Report.

These measures models were designed to help local governments report on process, quality, and outcome measures associated with the planning and implementation of opioid abatement strategies. They served as the foundation for developing the Impact Report Measures Workbook, which local governments use to capture strategy-specific data for Annual Impact Report. We expect these measures models, and mechanics associated with the Annual Impact Report, to become more standardized and refined as the evaluation of opioid abatement strategies evolves.

Results-Based Accountability™ and logic model design fostered the creation of these measures models. Each measures model reflects the underlying logic of one of the 12 high-impact opioid abatement strategies listed in Exhibit A of the NC MOA. Each model lists the strategy name and has columns for activities, process measures, quality measures, outcome measures, indicators, and a results statement. Each model also contains a list of assumptions related to the various components of the model.

NCACC OSTAT, Injury Prevention Research Center (IPRC) at UNC-Chapel Hill, NC Department of Health and Human Services, and NC Department of Justice partnered closely to create the NC Opioid Settlement Measures Models. The following organizations were also essential to the creation of this collection of measures models and NCACC OSTAT is tremendously grateful for their contributions to this effort: Duke University Department of Population Health Sciences, UNC Formerly Incarcerated Transitions Program, Technical Assistance Collaborative, and Vital Strategies.

If you have questions about the NC Opioid Settlement Measures Models, or wish to reproduce any of its contents, please contact opioidsettlement@ncacc.org.

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy: **#1, Collaborative Strategic Planning**[1]					
Activities	**Process Measures**[2, 5, 6, 7, 8] **How much did you do?**	**Quality Measures**[2, 5, 8] **How well did you do it?**	**Outcome Measures**[2, 5, 8] **Is anyone better off?**	**Indicators**[3]	**Results Statement**[3]
--- Program Level ---				**--- Population Level ---**	
Staff Support Facilitation Services Activities listed in Exhibit C of the NC MOA	# of staff hired to lead Collaborative Strategic Planning efforts related to the Opioid Settlements # of meetings facilitated to support Collaborative Strategic Planning efforts related to the Opioid Settlements # of collaborative strategic plans produced, in which all of the following activities were completed: Diverse stakeholders engaged (Y/N) Facilitator designated (Y/N) Related planning efforts built upon (Y/N) Shared vision agreed upon (Y/N) Key indicator(s) identified (Y/N) Root causes explored and identified (Y/N) Potential strategies identified and evaluated (Y/N) Gaps in existing efforts identified (Y/N) Strategies prioritized (Y/N) Goals, measures, and evaluation plan identified (Y/N) Alignment of strategies considered (Y/N) Organizations identified (Y/N) Budgets and timelines developed (Y/N) Recommendations offered[9] (Y/N)	% of recommendations[9] offered that are approved by local officials % of stakeholder categories (as outlined in Exhibit C Item A Detail) that were met during the collaborative strategic planning process % of stakeholders involved in collaborative strategic planning process who feel that they were heard in the process **People with lived experience, from a directly impacted community, and/or people who use drugs are involved in the planning and implementation of your local government's overdose prevention and harm reduction work.[4] (Y/N)** **As part of your overdose prevention and harm reduction efforts, your local government has concrete partnerships with community-based organizations that work with historically marginalized populations.[4] (Y/N)**	% of recommendations[9] implemented during the reporting period	**Reduce drug overdose deaths by 2038** **Reduce illicit drug overdose deaths by 2038 (subset measure of the above)** **Reduce drug overdose ED visits by 2038**	**All people in NC are healthy and have connections to supports and services within a culture of care.**

Assumptions:

1. Measures models help us understand the links between our activities and desired results. This series of models was developed to reflect the underlying logic of the 12 high impact, evidence-based opioid abatement strategies listed in NC MOA Exhibit A, which guides the work of local governments supported by funding from the National Opioid Settlements.
2. These models will be used to develop the Annual Impact Report Guide, which will list recommended measures for each Exhibit A strategy. For the 2023 FY, local governments can select the measures they choose to report on. Only one measure per measure type (i.e., process, quality, outcome) is required. The hope is that local governments will choose to report on more than minimum requirements.
3. The three indicators (i.e., long-term outcomes) and the results statement are the same for every Exhibit A strategy logic model. The 12 Exhibit A strategies create synergy that we hope will reduce the rates of drug overdose.
4. Measures that appear in multiple models are shown in bold. These include: "# of unique participants, who use opioids and/or have OUD, served" and "# of naloxone kits distributed" as process measures; "% of participants, who use opioids and/or have OUD, who are satisfied w/ services" as a quality measure; and, "# of community overdose reversals using naloxone" and "% of patients who report getting the social and emotional support they need" as program-level outcome measures. There are also four universal measures that ask: a) about involving people with lived/living experience, b) about partnerships with historically marginalized populations, c) # of naloxone kits distributed and d) # of community overdose reversals using naloxone.
5. Data for process measures, quality measures and program-level outcome measures will be available from the programs, projects, sites, etc. funded by opioid settlement funds. Data is also available for population-level outcomes from OSUAP Data Dashboard.
6. As the NC MOA states, local governments will report on "demographic information on the participation or performance of people of color and other historically marginalized groups"; local governments may use NCDHHS' definition for Historically Marginalized Populations, which states these populations "are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status." For the collection of program-level demographic data, local governments and their subrecipients can securely store demographic data and keep individuals' demographic data confidential.
7. Baseline for process measures is "0".
8. When opioid settlement funds are braided with other funding to support programs, the resulting outputs and outcomes are proportionate to the level of funding.
9. One strategic plan may result in multiple recommendations that are presented to a local governing body.

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy:
#2, Evidence-based Addiction Treatment - Medication-Assisted Treatment (MAT)[1]

Activities	Process Measures[2, 5, 6, 7, 9] How much did you do?	Quality Measures[2, 5, 9] How well did you do it?	Outcome Measures[2, 5, 9] Is anyone better off?	Indicators[3]	Results Statement[3]
	--- Program Level ---		Program Level & Population Level	--- Population Level ---	
Opioid Treatment Programs (OTPs) Qualified Providers of Office-Based Opioid Treatment (OBOT)[12] Federally Qualified Health Centers (FQHCs)[12] Other community-based programs[12] Treatment offered in conjunction with justice system programs	**# of naloxone kits distributed**[4, 10] # of OTPs that dispense methadone, buprenorphine, and naltrexone # of OTPs that dispense only methadone # of OTP-based medical providers who prescribe methadone for OUD patients[11] # of referrals to opioid treatment programs **# of unique patients** with OUD served at OTP[4, 8] # of office-based clinics offering MOUD within county # of individual OBOT providers who prescribe buprenorphine for patients[11] # of buprenorphine prescriptions provided at OBOT # of naltrexone doses provided at OBOT # of referrals to OBOT **# of unique patients** with OUD served at OBOT[4, 8] # of FQHCs offering MOUD within county # of individual FQHC providers who prescribe buprenorphine for patients[11] # of buprenorphine prescriptions provided at FQHC # of naltrexone doses provided at FQHC # of referrals to FQHC MAT services **# of unique patients** with OUD served at FQHC[4, 8] # of hospitals offering in-patient MOUD within county # of hospitalists who prescribe buprenorphine for patients[11] # of buprenorphine prescriptions provided through in-patient services in hospitals # of naltrexone doses provided through in-patient services in hospitals # of referrals to in-patient MAT services **# of unique hospital in-patients** with OUD served with MAT[4, 8] # of emergency departments offering MOUD within county # of emergency department providers who prescribe buprenorphine for patients[11] # of short-term buprenorphine prescriptions (14 days or less) provided in the ED # of longer-term buprenorphine prescriptions (15 days or more) provided in the ED # of naltrexone doses provided in the emergency department # of referrals from emergency department to community providers **# of unique emergency department patients** with OUD served with MAT[4, 8] # of Local Health Departments (LHD) offering MOUD within county # of individual LHD-based providers who prescribe buprenorphine for patients[11] # of buprenorphine prescriptions provided at LHD # of naltrexone doses provided at LHD # of referrals to LHD MAT services **# of unique patients** with OUD served at LHD with MAT[4, 8] # of EMS programs offering MOUD within county # of individual EMS providers who prescribe buprenorphine for patients [11] # of buprenorphine prescriptions provided through EMS-based MAT programs # of naltrexone doses through EMS-based MAT programs # of referrals to EMS-based MAT programs # of unique patients who received pre-hospital buprenorphine treatment from EMS during a non-fatal overdose encounter # of unique patients with OUD served through EMS-based MAT programs **# of unique patients** with OUD who declined services through EMS-based MAT programs[4, 8] # of Syringe Service Programs (SSPs) offering MOUD within county [11] # of providers who prescribe buprenorphine for patients at/through an SSP # of buprenorphine prescriptions provided through SSPs # of naltrexone doses provided through SSPs # of referrals to SSP-based MAT services **# of unique patients** with OUD served through SSPs with MAT[4, 8] # of patients who are justice-involved that are referred to any MAT program[8]	% of referrals to OTP services that resulted in 1st appointment attended % of referrals to OBOT services that resulted in 1st appointment attended at office-based clinic % of referrals to OBOT services that resulted in 1st appointment attended at FQHC **% of patients, who have OUD, who are satisfied w/ services[4]** **People with lived experience, from a directly impacted community, and/or people who use drugs are involved in the planning and implementation of your local government's overdose prevention and harm reduction work.[4]** **As part of your overdose prevention and harm reduction efforts, your local government has concrete partnerships with community-based organizations that work with historically marginalized populations.[4]** % of referrals to OBOT services that resulted in 1st appointment for treatment attended at LHD % of referrals to EMS-based MAT services that resulted in 1st appointment for treatment attended % of referrals to SSP-based MAT services that resulted in 1st appointment for treatment attended % of referrals from justice system programs that resulted in 1st appointment for treatment attended	# of community overdose reversals using naloxone (program level) % of patients with OUD who adhere to treatment __ months after first appointment (program level, recommended measure at six months) **% of patients who report getting the social and emotional support they need (program level)[4]** # of patients with OUD who received evidence-based addiction treatment services across programs and settings (population level) % of residents receiving dispensed buprenorphine prescriptions (population level) % of individuals with OUD served by treatment programs who are uninsured or Medicaid beneficiaries (population level)	**Reduce drug overdose deaths by 2038** **Reduce illicit drug overdose deaths by 2038 (subset measure of the above)** **Reduce drug overdose ED visits by 2038**	**All people in NC are healthy and have connections to supports and services within a culture of care.**

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy:
#2, Evidence-based Addiction Treatment - Medication-Assisted Treatment (MAT)[1]

Assumptions and Definitions

1. Measures models help us understand the links between our activities and desired results. This series of models was developed to reflect the underlying logic of the 12 high impact, evidence-based opioid abatement strategies listed in NC MOA Exhibit A, which guides the work of local governments supported by funding from the National Opioid Settlements.
2. These models will be used to develop the Annual Impact Report Guide, which will list recommended measures for each Exhibit A strategy. For the 2023 FY, local governments can select the measures they choose to report on. Only one measure per measure type (i.e., process, quality, outcome) is required. The hope is that local governments will choose to report on more than minimum requirements.
3. The three indicators (i.e., long-term outcomes) and the results statement are the same for every Exhibit A strategy logic model. The 12 Exhibit A strategies create synergy that we hope will reduce the rates of drug overdose.
4. Measures that appear in multiple models are shown in bold. These include: "# of unique participants, who use opioids and/or have OUD, served" and "# of naloxone kits distributed" as process measures; "% of participants, who use opioids and/or have OUD, who are satisfied w/ services" as a quality measure; and, "# of community overdose reversals using naloxone" and "% of patients who report getting the social and emotional support they need" as program-level outcome measures. There are also four universal measures that ask: a) about involving people with lived/living experience, b) about partnerships with historically marginalized populations, c) # of naloxone kits distributed and d) # of community overdose reversals using naloxone.
5. Data for process measures, quality measures and program-level outcome measures will be available from the programs, projects, sites, etc. funded by opioid settlement funds. Data for population-level outcomes will be available, at the county- and state-level, from OSUAP Data Dashboard.
6. As the NC MOA states, local governments will report on "demographic information on the participation or performance of people of color and other historically marginalized groups"; local governments may use NCDHHS' definition for Historically Marginalized Populations, which states these populations "are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status." For the collection of program-level demographic data, local governments and their subrecipients can securely store demographic data and keep individuals' demographic data confidential.
7. Baseline for process measures is "0".
8. A unique patient may participate in multiple treatment programs so there may be some duplication of unique patients when numbers across programs, project, sites, etc., are aggregated for the strategy-specific impact report. A patient may receive services across local government boundaries (e.g., a person with OUD may reside in one county and receive services in another county). Number of referrals do not equate to number of unique patients because one individual may receive multiple referrals.
9. When opioid settlement funds are braided with other funding to support programs, the resulting outputs and outcomes are proportionate to the level of funding.
10. A naloxone kit contains two doses.
11. A provider may participate in multiple support programs so there may be some duplication of # of providers.
12. Office-Based Opioid Treatment (OBOT) providers may operate in a variety of settings. The model distinguishes between OBOT providers in office-based clinics, FQHCs, and other community-based programs (i.e., hospitals, emergency departments, local health departments, EMS programs and syringe services programs.)

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy: **#3. Recovery Support Services**[1]

Activities	Process Measures[2, 5, 7, 9] How much did you do?	Quality Measures[2, 5, 9] How well did you do it?	Outcome Measures[2, 5, 9] Is anyone better off?	Indicators[3]	Results Statement[3]
	--- Program Level ---		--- Program Level & Population Level ---	--- Population Level ---	
Peer support specialists or care navigators Access to services (including addiction treatment, recovery support, harm reduction services, and primary healthcare) Other services or supports needed to improve health or well-being	**# of unique participants, who use opioids and/or have OUD, served**[4, 6, 8] # of total contacts with all participants of the program # of participants who use opioids and/or have OUD, referred to addiction treatment # of participants who use opioids and/or have OUD, referred to recovery supports (e.g., employment services, housing services, etc.) # of participants who use opioids and/or have OUD, referred to harm reduction services (e.g., syringe and supply access, overdose prevention education, disease prevention, etc.) # of participants who use opioids and/or have OUD, referred to primary healthcare # of participants who use opioids and/or have OUD, referred to other services # of peer support specialists/care navigators **# of naloxone kits distributed**[4, 10]	**% of participants, who use opioids and/or have OUD, who are satisfied w/ services**[4] % of referrals that results in linkage (e.g., first appointment) % of staff with lived experience with OUD % of participants who received naloxone kit **People with lived experience, from a directly impacted community, and/or people who use drugs are involved in the planning and implementation of your local government's overdose prevention and harm reduction work.** [4] **As part of your overdose prevention and harm reduction efforts, your local government has concrete partnerships with community-based organizations that work with historically marginalized populations.** [4]	% of participants with OUD who adhere to addiction treatment at __ months (program level, recommended measure at six months) % of participants with OUD who have obtained employment at __ months, through engagement with recovery support services at __ months (program level, recommended measure at six months) % of participants with OUD who retain housing at __ months through engagement with recovery support services at __ months (program level, recommended measure at six months) % of participants with OUD engaged with harm reduction services at __ months (program level, recommended measure at six months) % of participants with OUD using primary healthcare services at __ months (program level, recommended measure at six months) % of participants with OUD using other services at __ months (program level, recommended measure at six months) **% of patients who report getting the social and emotional support they need (program level)** [4] % of residents receiving dispensed buprenorphine prescriptions (population level) % of individuals with OUD served treatment programs by who are uninsured or Medicaid beneficiaries (population level) Unemployment rate (population level) % of housing & homelessness 211 calls (population level)	**Reduce drug overdose deaths by 2038** **Reduce illicit drug overdose deaths by 2038 (subset measure of the above)** **Reduce drug overdose ED visits by 2038**	**All people in NC are healthy and have connections to supports and services within a culture of care.**

Assumptions:

1. Measures models help us understand the links between our activities and desired results. This series of models was developed to reflect the underlying logic of the 12 high impact, evidence-based opioid abatement strategies listed in NC MOA Exhibit A, which guides the work of local governments supported by funding from the National Opioid Settlements.
2. These models will be used to develop the Annual Impact Report Guide, which will list recommended measures for each Exhibit A strategy. For the 2023 FY, local governments can select the measures they choose to report on. Only one measure per measure type (i.e., process, quality, outcome) is required. The hope is that local governments will choose to report on more than minimum requirements.
3. The three indicators (i.e., long-term outcomes) and the results statement are the same for every Exhibit A strategy logic model. The 12 Exhibit A strategies create synergy that we hope will reduce the rates of drug overdose.
4. Measures that appear in multiple models are shown in bold. These include: "# of unique participants, who use opioids and/or have OUD, served" and "# of naloxone kits distributed" as process measures; "% of participants, who use opioids and/or have OUD, who are satisfied w/ services" as a quality measure; and, "# of community overdose reversals using naloxone" and "% of participants who report getting the social and emotional support they need" as program-level outcome measures. There are also four universal measures that ask: a) about involving people with lived/living experience, b) about partnerships with historically marginalized populations, c) # of naloxone kits distributed and d) # of community overdose reversals using naloxone.
5. Data for process measures, quality measures and program-level outcome measures will be available from the programs, projects, sites, etc. funded by opioid settlement funds. Data for population-level outcomes will be available, at the county- and state-level, from OSUAP Data Dashboard.

6. As the NC MOA states, local governments will report on “demographic information on the participation or performance of people of color and other historically marginalized groups”; local governments may use NCDHHS’ definition for Historically Marginalized Populations, which states these populations “are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status.” For the collection of program-level demographic data, local governments and their subrecipients can securely store demographic data and keep individuals’ demographic data confidential.
7. Baseline for process measures is “0”.
8. A unique participant may participate in multiple support programs so there may be some duplication of unique participants when numbers across programs, project, sites, etc., are aggregated for the strategy-specific impact report. A participant may receive services across local government boundaries (e.g., a person with OUD may reside in one county and receive services in another county). Number of referrals do not equate to number of unique participants because one individual may receive multiple referrals.
9. When opioid settlement funds are braided with other funding to support programs, the resulting outputs and outcomes are proportionate to the level of funding.
10. A naloxone kit contains two doses.

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy: **#4. Recovery Housing Supports**[1]

Activities	Process Measures[2, 5, 7, 9] How much did you do?	Quality Measures[2, 5, 9] How well did you do it?	Outcome Measures[2, 5, 9] Is anyone better off?	Indicators[3]	Results Statement[3]
	--- Program Level ---		--- Program Level & Population Level ---	--- Population Level ---	
Assist people in treatment or recovery, or people who use drugs, with: -Rent -Application fees -Move-in deposits -Utilities help Recovery housing to individuals receiving MAT Landlord incentive program Eviction prevention program Rapid rehousing Permanent supportive housing	**# of unique participants, who have OUD, served[4, 6, 8]** # of people with OUD who received assistance with rent # of people with OUD who received assistance with application fees # of people with OUD who received assistance with deposits # of people with OUD who received assistance with utilities # of programs where access is not contingent on sobriety, min. income requirements, lack of a criminal record, completion of treatment, participation in services, or other unnecessary conditions # of programs with services which are informed by a harm-reduction philosophy that recognizes that drug and alcohol use and addiction are a part of some tenants' lives # of programs where substance use in and of itself, without other lease violations, is not considered a reason for eviction # of programs in contact with the HUD-funded Continuum of Care (CoC) or Balance of State Continuum of Care (BoS CoC) for your area **# of naloxone kits distributed[4, 10]**	% of participants with OUD who have been assisted with rent % of participants with OUD who have been assisted with application fees % of participants with OUD who have been assisted with deposits % of participants with OUD who have been assisted with utilities % of participants with OUD who have achieved individual plans/treatment goals % of participants with OUD needing crisis services/hospitalization Average # of days from initial referral to primary engagement **% of participants, who have OUD, who are satisfied w/ services[4]** **People with lived experience, from a directly impacted community, and/or people who use drugs are involved in the planning and implementation of your local government's overdose prevention and harm reduction work.[4] (Y/N)** **As part of your overdose prevention and harm reduction efforts, your local government has concrete partnerships with community-based organizations that work with historically marginalized populations.[4] (Y/N)**	# of Housing First or related programs available to connect people who use drugs to housing services (program level) % of participants with OUD who retain permanent housing at __ months (program level, recommended measure at six months) % of participants with OUD who retain permanent housing at one year (program level) **% of participants who report getting the social and emotional support they need (program level)[4]** **# of community overdose reversals using naloxone (program level)[4]** % of housing & homelessness 211 calls (population level)	**Reduce drug overdose deaths by 2038** **Reduce illicit drug overdose deaths by 2038 (subset measure of the above)** **Reduce drug overdose ED visits by 2038**	**All people in NC are healthy and have connections to supports and services within a culture of care.**

Assumptions:

1. Measures models help us understand the links between our activities and desired results. This series of models was developed to reflect the underlying logic of the 12 high impact, evidence-based opioid abatement strategies listed in NC MOA Exhibit A, which guides the work of local governments supported by funding from the National Opioid Settlements.
2. These models will be used to develop the Annual Impact Report Guide, which will list recommended measures for each Exhibit A strategy. For the 2023 FY, local governments can select the measures they choose to report on. Only one measure per measure type (i.e., process, quality, outcome) is required. The hope is that local governments will choose to report on more than minimum requirements.
3. The three indicators (i.e., long-term outcomes) and the results statement are the same for every Exhibit A strategy logic model. The 12 Exhibit A strategies create synergy that we hope will reduce the rates of drug overdose.
4. Measures that appear in multiple models are shown in bold. These include: "# of unique participants, who use opioids and/or have OUD, served" and "# of naloxone kits distributed" as process measures; "% of participants, who use opioids and/or have OUD, who are satisfied w/ services" as a quality measure; and, "# of community overdose reversals using naloxone" and "% of participants who report getting the social and emotional support they need" as program-level outcome measures. There are also four universal measures that ask: a) about involving people with lived/living experience, b) about partnerships with historically marginalized populations, c) # of naloxone kits distributed and d) # of community overdose reversals using naloxone.
5. Data for process measures, quality measures and program-level outcome measures will be available from the programs, projects, sites, etc. funded by opioid settlement funds. Data for population-level outcomes will be available, at the county- and state-level, from OSUAP Data Dashboard.
6. As the NC MOA states, local governments will report on "demographic information on the participation or performance of people of color and other historically marginalized groups"; local governments may use NCDHHS' definition for Historically Marginalized Populations, which states these populations "are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status." For the collection of program-level demographic data, local governments and their subrecipients can securely store demographic data and keep individuals' demographic data confidential.
7. Baseline for process measures is "0".
8. A unique participant may participate in multiple support programs so there may be some duplication of unique participants when numbers across programs, project, sites, etc., are aggregated for the strategy-specific impact report. A participant may receive services across local government boundaries (e.g., a person with OUD may reside in one county and receive services in another county). Number of referrals do not equate to number of unique participants because one individual may receive multiple referrals.
9. When opioid settlement funds are braided with other funding to support programs, the resulting outputs and outcomes are proportionate to the level of funding.
10. A naloxone kit contains two doses.

Note: This model contains activities not listed in the Exhibit A description. Activities reflect best practices shared during the NCACC + NCDHHS Recovery Housing webinar.

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy: **#5. Employment-related Services**[1]

Activities	Process Measures[2, 5, 7, 9] How much did you do?	Quality Measures[2, 5, 9] How well did you do it?	Outcome Measures[2, 5, 9] Is anyone better off?	Indicators[3]	Results Statement[3]
	--- Program Level ---		--- Program Level & Population Level ---	--- Population Level ---	
Job training	**# of unique participants, who have OUD, served**[4, 6, 8] # of job training sessions offered	**% of participants, who have OUD, who are satisfied w/ services**[4] % of participants who showed improvement from pre-test to post-test in trainings	% of participants who received job-placement services that are employed ___ months after placement (program level, recommended measure at six months)	**Reduce drug overdose deaths by 2038** **Reduce illicit drug overdose deaths by 2038 (subset measure of the above)**	**All people in NC are healthy and have connections to supports and services within a culture of care.**
Job skills	# of job skill building trainings offered				
Job placement	# of people assisted with job placement	% of training participants who sought job placement services	**% of participants who report getting the social and emotional support they need (program level)** [4]		
Interview coaching	# of interview coaching session offered	% of interview coaching participants who improved interviewing skills		**Reduce drug overdose ED visits by 2038**	
Resume review	# of resume review sessions offered	% of resume review participants who improved resumes	Unemployment rate (population level)		
Professional attire	# of participants who received professional attire	% of participants who say they have the professional attire needed			
Relevant course at community colleges or vocational schools	# of participants in community college courses	% of participants in community college courses, who completed their course(s)			
Transportation services	# of requests for transportation assistance fulfilled	% of requests for transportation assistance fulfilled			
Transportation vouchers	# of transportation vouchers distributed	% of transportation vouchers used			
Other supports	**# of naloxone kits distributed**[4, 10]	**People with lived experience, from a directly impacted community, and/or people who use drugs are involved in the planning and implementation of your local government's overdose prevention and harm reduction work.** [4] **(Y/N)** **As part of your overdose prevention and harm reduction efforts, your local government has concrete partnerships with community-based organizations that work with historically marginalized populations.** [4] **(Y/N)**	**# of community overdose reversals using naloxone (program level)** [4]		

Assumptions:

1. Measures models help us understand the links between our activities and desired results. This series of models was developed to reflect the underlying logic of the 12 high impact, evidence-based opioid abatement strategies listed in NC MOA Exhibit A, which guides the work of local governments supported by funding from the National Opioid Settlements.
2. These models will be used to develop the Annual Impact Report Guide, which will list recommended measures for each Exhibit A strategy. For the 2023 FY, local governments can select the measures they choose to report on. Only one measure per measure type (i.e., process, quality, outcome) is required. The hope is that local governments will choose to report on more than minimum requirements.
3. The three indicators (i.e., long-term outcomes) and the results statement are the same for every Exhibit A strategy logic model. The 12 Exhibit A strategies create synergy that we hope will reduce the rates of drug overdose.

4. Measures that appear in multiple models are shown in bold. These include: "# of unique participants, who use opioids and/or have OUD, served" and "# of naloxone kits distributed" as process measures; "% of participants, who use opioids and/or have OUD, who are satisfied w/ services" as a quality measure; and, "# of community overdose reversals using naloxone" and "% of participants who report getting the social and emotional support they need" as program-level outcome measures. There are also four universal measures that ask: a) about involving people with lived/living experience, b) about partnerships with historically marginalized populations, c) # of naloxone kits distributed and d) # of community overdose reversals using naloxone.
5. Data for process measures, quality measures and program-level outcome measures will be available from the programs, projects, sites, etc. funded by opioid settlement funds. Data for population-level outcomes will be available, at the county- and state-level, from OSUAP Data Dashboard.
6. As the NC MOA states, local governments will report on "demographic information on the participation or performance of people of color and other historically marginalized groups"; local governments may use NCDHHS' definition for Historically Marginalized Populations, which states these populations "are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status." For the collection of program-level demographic data, local governments and their subrecipients can securely store demographic data and keep individuals' demographic data confidential.
7. Baseline for process measures is "0".
8. A unique participant may participate in multiple support programs so there may be some duplication of unique participants when numbers across programs, project, sites, etc., are aggregated for the strategy-specific impact report. A participant may receive services across local government boundaries (e.g., a person with OUD may reside in one county and receive services in another county). Number of referrals do not equate to number of unique participants because one individual may receive multiple referrals.
9. When opioid settlement funds are braided with other funding to support programs, the resulting outputs and outcomes are proportionate to the level of funding.
10. A naloxone kit contains two doses.

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy: **#6. Early Intervention**[1]

Activities[11]	**Process Measures**[2, 5, 7, 9] **How much did you do?**	**Quality Measures**[2, 5, 9] **How well did you do it?**	**Outcome Measures**[2, 5, 9] **Is anyone better off?**	**Indicator**[3]	**Results Statement**[3]
	--- Program Level ---		**--- Program Level & Population Level ---**	**--- Population Level ---**	
Youth Mental Health First-Aid Peer-based programs Training programs (including programs targeting parents, family members, caregivers, teachers, school staff, peers, neighbors, health or human services professionals, and others in contact with children/adolescents)	# of Youth Mental Health First-Aid training programs held # of unique participants trained in Mental Health First-Aid # of trainers who provide Youth Mental Health First-aid programs # of peer-based training programs held # of unique participants trained in peer-based program # of trainers who provide peer-based programs # of other early intervention training programs held # of unique participants trained in other early intervention programs # of trainers who provide other early intervention programs **# of naloxone kits distributed**[4, 10]	% of participants who are satisfied w/ training % of participants who feel more confident in supporting children and adolescents who may be struggling % of participants who improved skills in supporting children and adolescents who may be struggling % of participants who improved knowledge in supporting children and adolescents who may be struggling **People with lived experience, from a directly impacted community, and/or people who use drugs are involved in the planning and implementation of your local government's overdose prevention and harm reduction work.**[4] **(Y/N)** **As part of your overdose prevention and harm reduction efforts, your local government has concrete partnerships with community-based organizations that work with historically marginalized populations.**[4] **(Y/N)**	% of participants who report using skills/knowledge gained in training (program level) **% of participants who report getting the social and emotional support they need (program level)**[4] % of short-term suspensions[12] (program level) **# of community overdose reversals using naloxone (program level)**[4]	**Reduce drug overdose deaths by 2038** **Reduce illicit drug overdose deaths by 2038 (subset measure of the above)** **Reduce drug overdose ED visits by 2038**	**All people in NC are healthy and have connections to supports and services within a culture of care.**

Assumptions and Definitions

1. Measures models help us understand the links between our activities and desired results. This series of models was developed to reflect the underlying logic of the 12 high impact, evidence-based opioid abatement strategies listed in NC MOA Exhibit A, which guides the work of local governments supported by funding from the National Opioid Settlements.
2. These models will be used to develop the Annual Impact Report Guide, which will list recommended measures for each Exhibit A strategy. For the 2023 FY, local governments can select the measures they choose to report on. Only one measure per measure type (i.e., process, quality, outcome) is required. The hope is that local governments will choose to report on more than minimum requirements.
3. The three indicators (i.e., long-term outcomes) and the results statement are the same for every Exhibit A strategy logic model. The 12 Exhibit A strategies create synergy that we hope will reduce the rates of drug overdose.
4. Measures that appear in multiple models are shown in bold. These include: "# of unique participants, who use opioids and/or have OUD, served" and "# of naloxone kits distributed" as process measures; "% of participants, who use opioids and/or have OUD, who are satisfied w/ services" as a quality measure; and, "# of community overdose reversals using naloxone" and "% of participants who report getting the social and emotional support they need" as program-level outcome measures. There are also four universal measures that ask: a) about involving people with lived/living experience, b) about partnerships with historically marginalized populations, c) # of naloxone kits distributed and d) # of community overdose reversals using naloxone.
5. Data for process measures, quality measures and program-level outcome measures will be available from the programs, projects, sites, etc. funded by opioid settlement funds. Data for population-level outcomes will be available, at the county- and state-level, from OSUAP Data Dashboard.
6. As the NC MOA states, local governments will report on "demographic information on the participation or performance of people of color and other historically marginalized groups"; local governments may use NCDHHS' definition for Historically Marginalized Populations, which states these populations "are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status." For the collection of program-level demographic data, local governments and their subrecipients can securely store demographic data and keep individuals' demographic data confidential.
7. Baseline for process measures is "0".
8. A unique participant may participate in multiple support programs so there may be some duplication of unique participants when numbers across programs, project, sites, etc., are aggregated for the strategy-specific impact report. A participant may receive services across local government boundaries (e.g., a person with OUD may reside in one county and receive services in another county). Number of referrals do not equate to number of unique participants because one individual may receive multiple referrals.
9. When opioid settlement funds are braided with other funding to support programs, the resulting outputs and outcomes are proportionate to the level of funding.
10. A naloxone kit contains two doses.
11. Funded activities related to Early Intervention strategy may include programs, services, or trainings to encourage early identification and intervention for children or adolescents who may be struggling with problematic use of drugs or mental health conditions. Broad primary prevention activities (e.g., anti-drug campaigns) are not included in the Option A, Early Intervention strategy and are instead more appropriate for Option B under the NC MOA.
12. % of short-term suspensions (Number of out-of-school short-term suspensions in educational facilities for all grades per 100 students) is collected by NC Department of Public Instruction and an indicator for HNC 2030.

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy: **#7. Naloxone**[1]

Activities	Process Measures[2, 5, 7, 9] How much did you do?	Quality Measures[2, 5, 9] How well did you do it?	Outcome Measures[2, 5, 9] Is anyone better off?	Indicators[3]	Results Statement[3]
---	Program Level ---		--- Program Level & Population Level ---	--- Population Level ---	
Syringe Service Programs Post-overdose response teams Naloxone upon release from jail/prison EMS or hospital ED supplying naloxone to people at risk (or their social networks) Community-based orgs that provide services to people who use drugs Providing naloxone to first responders (firefighters/police)	**# of unique participants, who use opioids and/or have OUD, served**[4, 6, 8] **# of intramuscular naloxone kits distributed**[4, 10] **# of intranasal naloxone kits distributed**[4, 10] # of trainings on harm reduction (e.g., overdose prevention, safer use practice, disease prevention) provided # of people trained in harm reduction # of naloxone trainings # of people trained on naloxone	**% of participants, who have OUD, who are satisfied w/ services**[4] % of naloxone distributed to EMS % of naloxone distributed to hospital ED % of naloxone distributed to community-based organizations % of naloxone distributed to firefighters % of naloxone distributed to police % of those trained who report they know how to respond to an opioid overdose and administer naloxone # of months in past year that program had to ration naloxone The program has sufficient naloxone to respond to overdose situations. (Y/N) **People with lived experience, from a directly impacted community, and/or people who use drugs are involved in the planning and implementation of your local government's overdose prevention and harm reduction work.**[4] **(Y/N)** **As part of your overdose prevention and harm reduction efforts, your local government has concrete partnerships with community-based organizations that work with historically marginalized populations.**[4] **(Y/N)**	**# of community overdose reversals using naloxone (program level)**[4] # of patients who were visited by EMS more than once because of overdose (program level) # of patients who were admitted to the ED more than once because of overdose (program level) **% of patients who report getting the social and emotional support they need (program level)**[4]	**Reduce drug overdose deaths by 2038** **Reduce illicit drug overdose deaths by 2038 (subset measure of the above)** **Reduce drug overdose ED visits by 2038**	**All people in NC are healthy and have connections to supports and services within a culture of care.**

Assumptions:

1. Measures models help us understand the links between our activities and desired results. This series of models was developed to reflect the underlying logic of the 12 high impact, evidence-based opioid abatement strategies listed in NC MOA Exhibit A, which guides the work of local governments supported by funding from the National Opioid Settlements.
2. These models will be used to develop the Annual Impact Report Guide, which will list recommended measures for each Exhibit A strategy. For the 2023 FY, local governments can select the measures they choose to report on. Only one measure per measure type (i.e., process, quality, outcome) is required. The hope is that local governments will choose to report on more than minimum requirements.
3. The three indicators (i.e., long-term outcomes) and the results statement are the same for every Exhibit A strategy logic model. The 12 Exhibit A strategies create synergy that we hope will reduce the rates of drug overdose.
4. Measures that appear in multiple models are shown in bold. These include: "# of unique participants, who use opioids and/or have OUD, served" and "# of naloxone kits distributed" as process measures; "% of participants, who use opioids and/or have OUD, who are satisfied w/ services" as a quality measure; and, "# of community overdose reversals using naloxone" and "% of participants who report getting the social and emotional support they need" as program-level outcome measures. There are also four universal measures that ask: a) about involving people with lived/living experience, b) about partnerships with historically marginalized populations, c) # of naloxone kits distributed and d) # of community overdose reversals using naloxone.
5. Data for process measures, quality measures and program-level outcome measures will be available from the programs, projects, sites, etc. funded by opioid settlement funds. Data for population-level outcomes will be available, at the county- and state-level, from OSUAP Data Dashboard.
6. As the NC MOA states, local governments will report on "demographic information on the participation or performance of people of color and other historically marginalized groups"; local governments may use NCDHHS' definition for Historically Marginalized Populations, which states these populations "are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status." For the collection of program-level demographic data, local governments and their subrecipients can securely store demographic data and keep individuals' demographic data confidential.
7. Baseline for process measures is "0".
8. A unique participant may participate in multiple support programs so there may be some duplication of unique participants when numbers across programs, project, sites, etc., are aggregated for the strategy-specific impact report. A participant may receive services across local government boundaries (e.g., a person with OUD may reside in one county and receive services in another county). Number of referrals do not equate to number of unique participants because one individual may receive multiple referrals.
9. When opioid settlement funds are braided with other funding to support programs, the resulting outputs and outcomes are proportionate to the level of funding.
10. A naloxone kit contains two doses.

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy: **#8, Post-Overdose Response Team**[1]					
Activities	**Process Measures**[2, 5, 7, 9] **How much did you do?**	**Quality Measures**[2, 5, 9] **How well did you do it?**	**Outcome Measures**[2, 5, 9] **Is anyone better off?**	**Indicators**[3]	**Results Statement**[3]
--- Program Level ---			**--- Program Level & Population Level ---**	**--- Population Level ---**	
Connect people who have experienced non-fatal drug overdoses to: addiction treatment, recovery support, harm reduction services, primary healthcare, and other services	**# of unique participants, who use opioids and/or have OUD, served**[4, 6, 8] # of established agency-level network partners # of referrals to PORT following an overdose reversal # of people who experience an overdose who agree to talk with a PORT member # of total contacts with all participants who use opioids and/or have OUD # of participants who use opioids and/or have OUD, referred to addiction treatment # of participants who use opioids and/or have OUD, referred to recovery supports (e.g., employment services, housing services, etc.) # of participants who use opioids and/or have OUD, referred to harm reduction services (e.g., syringe and supply access, overdose prevention education, disease prevention, etc.) # of participants who use opioids and/or have OUD, referred to primary healthcare # of participants who use opioids and/or have OUD, referred to other services **# of naloxone kits distributed**[4, 10]	**% of participants, who use opioids and/or have OUD, who are satisfied w/ services**[4] % of EMS calls for opioid overdose **People with lived experience, from a directly impacted community, and/or people who use drugs are involved in the planning and implementation of your local government's overdose prevention and harm reduction work.**[4] **(Y/N)** **As part of your overdose prevention and harm reduction efforts, your local government has concrete partnerships with community-based organizations that work with historically marginalized populations.**[4] **(Y/N)**	% of participants with OUD who adhere to addiction treatment at __ months (program level, recommended measure at six months) % of participants with OUD who have obtained employment at __ months, through engagement with recovery support services at __ months (program level, recommended measure at six months) % of participants with OUD who retain housing at __ months through engagement with recovery support services at __ months (program level, recommended measure at six months) % of participants with OUD engaged with harm reduction services at __ months (program level, recommended measure at six months) % of participants with OUD using primary healthcare services at __ months (program level, recommended measure at six months) **# of community overdose reversals using naloxone (program level)**[4] **% of participants who report getting the social and emotional support they need (program level)**[4] % of residents receiving dispensed buprenorphine prescriptions (population level) % of individuals with OUD served by treatment programs who are uninsured or Medicaid beneficiaries (population level) % housing & homelessness 211 calls (population level) Unemployment rate (population level)	**Reduce drug overdose deaths by 2038** **Reduce illicit drug overdose deaths by 2038 (subset measure of the above)** **Reduce drug overdose ED visits by 2038**	**All people in NC are healthy and have connections to supports and services within a culture of care.**

Assumptions:

1. Measures models help us understand the links between our activities and desired results. This series of models was developed to reflect the underlying logic of the 12 high impact, evidence-based opioid abatement strategies listed in NC MOA Exhibit A, which guides the work of local governments supported by funding from the National Opioid Settlements.
2. These models will be used to develop the Annual Impact Report Guide, which will list recommended measures for each Exhibit A strategy. For the 2023 FY, local governments can select the measures they choose to report on. Only one measure per measure type (i.e., process, quality, outcome) is required. The hope is that local governments will choose to report on more than minimum requirements.
3. The three indicators (i.e., long-term outcomes) and the results statement are the same for every Exhibit A strategy logic model. The 12 Exhibit A strategies create synergy that we hope will reduce the rates of drug overdose.
4. Measures that appear in multiple models are shown in bold. These include: "# of unique participants, who use opioids and/or have OUD, served" and "# of naloxone kits distributed" as process measures; "% of participants, who use opioids and/or have OUD, who are satisfied w/ services" as a quality measure; and, "# of community overdose reversals using naloxone" and "% of participants who report getting the social and emotional support they need" as program-level outcome measures. There are also four universal measures that ask: a) about involving people with lived/living experience, b) about partnerships with historically marginalized populations, c) # of naloxone kits distributed and d) # of community overdose reversals using naloxone.

5. Data for process measures, quality measures and program-level outcome measures will be available from the programs, projects, sites, etc. funded by opioid settlement funds. Data for population-level outcomes will be available, at the county- and state-level, from OSUAP Data Dashboard.
6. As the NC MOA states, local governments will report on "demographic information on the participation or performance of people of color and other historically marginalized groups"; local governments may use NCDHHS' definition for Historically Marginalized Populations, which states these populations "are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status." For the collection of program-level demographic data, local governments and their subrecipients can securely store demographic data and keep individuals' demographic data confidential.
7. Baseline for process measures is "0".
8. A unique participant may participate in multiple support programs so there may be some duplication of unique participants when numbers across programs, project, sites, etc., are aggregated for the strategy-specific impact report. A participant may receive services across local government boundaries (e.g., a person with OUD may reside in one county and receive services in another county). Number of referrals do not equate to number of unique participants because one individual may receive multiple referrals.
9. When opioid settlement funds are braided with other funding to support programs, the resulting outputs and outcomes are proportionate to the level of funding.
10. A naloxone kit contains two doses.

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy: **#9, Syringe Services Program**[1]

Activities	Process Measures[2, 5, 7, 9] How much did you do?	Quality Measures[2, 5, 9] How well did you do it?	Outcome Measures[2, 5, 9] Is anyone better off?	Indicators[3]	Results Statement[3]
	--- Program Level ---		--- Program Level & Population Level ---	--- Population Level ---	
Provide syringes Dispose of used syringes Provide Naloxone Provide other harm reduction supplies Connections to care (includes connection to prevention, treatment, recovery support, behavioral healthcare, primary healthcare, and other services)	**# of unique participants, who use opioids and/or have OUD, served**[4, 6, 8] # of total contacts the program had with all participants # of syringes distributed # of types of supplies distributed (not count of individual items) # of trainings on harm reduction (e.g., overdose prevention, safer use practice, disease prevention) provided to participants # of participants trained on harm reduction (e.g., overdose prevention, safer use practice, disease prevention) # of participants the program referred to treatment for OUD # of participants the program referred to treatment for mental health services # of participants the program referred to primary care services # of participants the program referred to employment resources # of participants the program referred to housing resources **# of naloxone kits distributed**[4, 10]	% of participants who report they have enough sterile syringes to cover every injection between SSP visits % of participants who increase their knowledge of harm reduction practices Program has adequate supplies to meet the needs of your participants (Y/N) People with OUD are integral to the leadership and decision making of the organization providing the SSP (Y/N) Program demonstrates embodiment of the Principles of Harm Reduction (Y/N) **People with lived experience, from a directly impacted community, and/or people who use drugs are involved in the planning and implementation of your local government's overdose prevention and harm reduction work.**[4] **(Y/N)** **As part of your overdose prevention and harm reduction efforts, your local government has concrete partnerships with community-based organizations that work with historically marginalized populations.** [4] **(Y/N)**	% of participants with OUD engaged with SSP services at __ months (program level, recommended measure at six months) % of participants with OUD who adhere to addiction treatment at __ months (program level, recommended measure at six months) % of participants with OUD using mental health services at __ months (program level, recommended measure at six months) % of participants with OUD using primary healthcare services at __ months (program level, recommended measure at six months) % of participants with OUD who have obtained employment at __ months, through engagement with recovery support services at __ months (program level, recommended measure at six months) % of participants with OUD who retain housing at __ months through engagement with recovery support services at __ months (program level, recommended measure at six months) **% of participants who report getting the social and emotional support they need (program level)**[4] **# of community overdose reversals using naloxone (program level)** [4] % of residents receiving dispensed buprenorphine prescriptions (population level) % of individuals with OUD served by treatment programs who are uninsured or Medicaid beneficiaries (population level) % of housing & homelessness 211 calls (population level) Unemployment rate (population level)	**Reduce drug overdose deaths by 2038** **Reduce illicit drug overdose deaths by 2038 (subset measure of the above)** **Reduce drug overdose ED visits by 2038**	**All people in NC are healthy and have connections to supports and services within a culture of care.**

Assumptions:

1. Measures models help us understand the links between our activities and desired results. This series of models was developed to reflect the underlying logic of the 12 high impact, evidence-based opioid abatement strategies listed in NC MOA Exhibit A, which guides the work of local governments supported by funding from the National Opioid Settlements.
2. These models will be used to develop the Annual Impact Report Guide, which will list recommended measures for each Exhibit A strategy. For the 2023 FY, local governments can select the measures they choose to report on. Only one measure per measure type (i.e., process, quality, outcome) is required. The hope is that local governments will choose to report on more than minimum requirements.
3. The three indicators (i.e., long-term outcomes) and the results statement are the same for every Exhibit A strategy logic model. The 12 Exhibit A strategies create synergy that we hope will reduce the rates of drug overdose.

4. Measures that appear in multiple models are shown in bold. These include: "# of unique participants, who use opioids and/or have OUD, served" and "# of naloxone kits distributed" as process measures; "% of participants, who use opioids and/or have OUD, who are satisfied w/ services" as a quality measure; and, "# of community overdose reversals using naloxone" and "% of participants who report getting the social and emotional support they need" as program-level outcome measures. There are also four universal measures that ask: a) about involving people with lived/living experience, b) about partnerships with historically marginalized populations, c) # of naloxone kits distributed and d) # of community overdose reversals using naloxone.
5. Data for process measures, quality measures and program-level outcome measures will be available from the programs, projects, sites, etc. funded by opioid settlement funds. Data for population-level outcomes will be available, at the county- and state-level, from OSUAP Data Dashboard.
6. As the NC MOA states, local governments will report on "demographic information on the participation or performance of people of color and other historically marginalized groups"; local governments may use NCDHHS' definition for Historically Marginalized Populations, which states these populations "are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status." For the collection of program-level demographic data, local governments and their subrecipients can securely store demographic data and keep individuals' demographic data confidential.
7. Baseline for process measures is "0".
8. A unique participant may participate in multiple support programs so there may be some duplication of unique participants when numbers across programs, project, sites, etc., are aggregated for the strategy-specific impact report. A participant may receive services across local government boundaries (e.g., a person with OUD may reside in one county and receive services in another county). Number of referrals do not equate to number of unique participants because one individual may receive multiple referrals.
9. When opioid settlement funds are braided with other funding to support programs, the resulting outputs and outcomes are proportionate to the level of funding.
10. A naloxone kit contains two doses.

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy: **#10, Criminal Justice Diversion Programs**[1]

Activities	Process Measures [2, 5, 7, 9] How much did you do?	Quality Measures[2, 5, 9] How well did you do it?	Outcome Measures[2, 5, 9] Is anyone better off?	Indicators[3]	Results Statement[3]
	--- Program Level ---		--- Program Level & Population Level ---	--- Population Level ---	
Pre-arrest diversion programs	# of 911 calls with primary concern related to substance use # of dispositions where person was transported to services by law enforcement # of dispositions where person was stabilized in community # of arrest diversion referrals to pre-arrest diversion programs by law enforcement # of social referrals to pre-arrest diversion programs by law enforcement # of intakes for pre-arrest diversion programs completed # of unique participants enrolled in pre-arrest diversion programs[4, 6, 8] # of full-time pre-arrest diversion program staff # of participants on staff caseload (average) # of contacts with pre-arrest diversion program participants per month	**% of unique participants, who use opioids and/or have OUD, who are satisfied w/ services[4]** % of 911 calls related to substance use concerns % of people arrested who screen positive for OUD % of law enforcement officers who have referred to diversion program	% of referrals that resulted in enrollment in diversion program (program level) % of participants with OUD who adhere to treatment __ months after first appointment (program level) % of participants who have obtained/retained employment at __ months (program level) % of participants who obtained/retained housing at __ months (program level) % of participants engaged with harm reduction services at __ months (program level) % of participants using primary healthcare services at __ months (program level) % of participants using other services at __ months (program level) % of residents receiving dispensed buprenorphine prescriptions (population level) % of individuals with OUD served by treatment programs who are uninsured or Medicaid beneficiaries (population level) % of housing & homelessness 211 calls (population level) Unemployment rate (population level)	**Reduce drug overdose deaths by 2038** **Reduce illicit drug overdose deaths by 2038 (subset measure of the above)** **Reduce drug overdose ED visits by 2038**	**All people in NC are healthy and have connections to supports and services within a culture of care.**
Post-arrest diversion programs	# of people arrested who are screened for OUD # of referrals to post-arrest diversion programs by jail/correctional staff # of intakes for post-arrest diversion programs completed # of unique participants enrolled in post-arrest diversion programs[4, 6, 8] # of dedicated post-arrest diversion program staff # of contacts with post-arrest diversion program participants per month # of people at intake with no fixed address or address is shelter	**People with lived experience, from a directly impacted community, and/or people who use drugs are involved in the planning and implementation of your local government's overdose prevention and harm reduction work.[4] (Y/N)**			
Pre-trial service programs	# of referrals to pre-trial service programs by court staff # of intakes for pre-trial service programs completed # of unique participants enrolled in pre-trial service programs[4, 6, 8] # of contacts with pre-trial service program participants per month # of initial hearings annually for people identified as having opioid use disorder	**As part of your overdose prevention and harm reduction efforts, your local government has concrete partnerships with community-based organizations that work with historically marginalized populations.[4] (Y/N)**			
Connections to care (includes linkage to addiction treatment, recovery support, harm reduction services, primary healthcare, prevention, and other services)	# of participants who use opioids and/or have OUD, referred to addiction treatment[4, 8] # of participants who use opioids and/or have OUD, referred to recovery supports (e.g., employment services, housing services, etc.)[4, 8] # of participants who use opioids and/or have OUD, referred to harm reduction services (e.g., syringe and supply access, overdose prevention education, disease prevention, etc.)[4, 8] # of participants who use opioids and/or have OUD, referred to primary healthcare[4, 8] # of participants who use opioids and/or have OUD, referred to other services[4, 8]	% of participants connected to services			
Provide any of these services or support (listed in the parenthetical above)	# of participants who use opioids and/or have OUD, provided addiction treatment[4, 8] # of participants who use opioids and/or have OUD, provided with recovery support services (e.g., employment services, housing services, etc.)[4, 8] # of participants who use opioids and/or have OUD, provided with harm reduction services[4, 8] # of participants who use opioids and/or have OUD, provided with primary healthcare services[4, 8] # of participants who use opioids and/or have OUD, provided with other services[4, 8] **# of naloxone kits provided[4, 10]**	% of participants provided with services	**# of community overdose reversals using naloxone (program level)[4]** **% of participants who report getting the social and emotional support they need[4] (program level)**		

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy: **#10, Criminal Justice Diversion Programs**[1]

Assumptions:

1. Measures models help us understand the links between our activities and desired results. This series of models was developed to reflect the underlying logic of the 12 high impact, evidence-based opioid abatement strategies listed in NC MOA Exhibit A, which guides the work of local governments supported by funding from the National Opioid Settlements.
2. These models will be used to develop the Annual Impact Report Guide, which will list recommended measures for each Exhibit A strategy. For the 2023 FY, local governments can select the measures they choose to report on. Only one measure per measure type (i.e., process, quality, outcome) is required. The hope is that local governments will choose to report on more than minimum requirements.
3. The three indicators (i.e., long-term outcomes) and the results statement are the same for every Exhibit A strategy logic model. The 12 Exhibit A strategies create synergy that we hope will reduce the rates of drug overdose.
4. Measures that appear in multiple models are shown in bold. These include: "# of unique participants, who use opioids and/or have OUD, served" and "# of naloxone kits distributed" as process measures; "% of participants, who use opioids and/or have OUD, who are satisfied w/ services" as a quality measure; and, "# of community overdose reversals using naloxone" and "% of participants who report getting the social and emotional support they need" as program-level outcome measures. There are also four universal measures that ask: a) about involving people with lived/living experience, b) about partnerships with historically marginalized populations, c) # of naloxone kits distributed and d) # of community overdose reversals using naloxone.
5. Data for process measures, quality measures and program-level outcome measures will be available from the programs, projects, sites, etc. funded by opioid settlement funds. Data for population-level outcomes will be available, at the county- and state-level, from OSUAP Data Dashboard.
6. As the NC MOA states, local governments will report on "demographic information on the participation or performance of people of color and other historically marginalized groups"; local governments may use NCDHHS' definition for Historically Marginalized Populations, which states these populations "are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status." For the collection of program-level demographic data, local governments and their subrecipients can securely store demographic data and keep individuals' demographic data confidential.
7. Baseline for process measures is "0".
8. A unique participant may participate in multiple support programs so there may be some duplication of unique participants when numbers across programs, project, sites, etc., are aggregated for the strategy-specific impact report. A participant may receive services across local government boundaries (e.g., a person with OUD may reside in one county and receive services in another county). Number of referrals do not equate to number of unique participants because one individual may receive multiple referrals.
9. When opioid settlement funds are braided with other funding to support programs, the resulting outputs and outcomes are proportionate to the level of funding.
10. A naloxone kit contains two doses.

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy: **#11, Treatment for Incarcerated People**[1]

Activities	Process Measures[2, 5, 7, 9] How much did you do?	Quality Measures[2, 5, 9] How well did you do it?	Outcome Measures[2, 5, 9] Is anyone better off?	Indicators[3]	Results Statement[3]
	--- Program Level ---		--- Program Level & Population Level ---	--- Population Level ---	
MAT to persons incarcerated in jail or prison	# of people who are incarcerated screened as having OUD # of people who are incarcerated who receive methadone for OUD # of people who are incarcerated who receive buprenorphine for OUD # of people who are incarcerated who receive naltrexone for OUD # of group classes, for people who are incarcerated, held on overdose prevention # of people who are incarcerated that attended group classes on overdose prevention # of group classes, for staff, held on overdose prevention # of staff that attended group classes on overdose prevention **# of naloxone kits distributed to people who were incarcerated upon release[4, 10]** # of opioid overdose reversals using naloxone within the jail or prison # of deaths due to overdose within the jail or prison # of referrals made for continued MAT support upon release	**% of participants, who have OUD, who are satisfied w/ services[4]** % of people who are incarcerated that are screened for OUD % of people who increase knowledge about overdose prevention after attending group classes **% of people who were incarcerated that upon release received naloxone kits[4]** **People with lived experience, from a directly impacted community, and/or people who use drugs are involved in the planning and implementation of your local government's overdose prevention and harm reduction work. [4] (Y/N)** **As part of your overdose prevention and harm reduction efforts, your local government has concrete partnerships with community-based organizations that work with historically marginalized populations. [4] (Y/N)**	% of participants who are incarcerated that screen positive for OUD and then receive methadone in jail (program level) % of participants who are incarcerated that screen positive for OUD and then receive buprenorphine in jail (program level) % of participants who are incarcerated and screen positive for OUD and then receive naltrexone in jail (program level) % of participants who are incarcerated who started MAT in jail (program level) % of participants who are incarcerated who were on MAT before entering jail and continued MAT in jail (program level) % of total deaths within jail that are due to overdose (program level) **% of participants who report getting the social and emotional support they need[4] (program level)** % of residents receiving dispensed buprenorphine prescriptions (population level) % of individuals with OUD served by treatment programs who are uninsured or Medicaid beneficiaries (population level) **# of community overdose reversals using naloxone (program level) [4]**	**Reduce drug overdose deaths by xx% by 2038** **Reduce illicit drug overdose deaths by xx% by 2038 (subset measure of the above)** **Reduce drug overdose ED visits by xx% by 2038**	**All people in NC are healthy and have connections to supports and services within a culture of care.**

Assumptions:

1. Measures models help us understand the links between our activities and desired results. This series of models was developed to reflect the underlying logic of the 12 high impact, evidence-based opioid abatement strategies listed in NC MOA Exhibit A, which guides the work of local governments supported by funding from the National Opioid Settlements.
2. These models will be used to develop the Annual Impact Report Guide, which will list recommended measures for each Exhibit A strategy. For the 2023 FY, local governments can select the measures they choose to report on. Only one measure per measure type (i.e., process, quality, outcome) is required. The hope is that local governments will choose to report on more than minimum requirements.
3. The three indicators (i.e., long-term outcomes) and the results statement are the same for every Exhibit A strategy logic model. The 12 Exhibit A strategies create synergy that we hope will reduce the rates of drug overdose.
4. Measures that appear in multiple models are shown in bold. These include: "# of unique participants, who use opioids and/or have OUD, served" and "# of naloxone kits distributed" as process measures; "% of participants, who use opioids and/or have OUD, who are satisfied w/ services" as a quality measure; and, "# of community overdose reversals using naloxone" and "% of participants who report getting the social and emotional support they need" as program-level outcome measures. There are also four universal measures that ask: a) about involving people with lived/living experience, b) about partnerships with historically marginalized populations, c) # of naloxone kits distributed and d) # of community overdose reversals using naloxone.
5. Data for process measures, quality measures and program-level outcome measures will be available from the programs, projects, sites, etc. funded by opioid settlement funds. Data for population-level outcomes will be available, at the county- and state-level, from OSUAP Data Dashboard.
6. As the NC MOA states, local governments will report on "demographic information on the participation or performance of people of color and other historically marginalized groups"; local governments may use NCDHHS' definition for Historically Marginalized Populations, which states these populations "are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status." For the collection of program-level demographic data, local governments and their subrecipients can securely store demographic data and keep individuals' demographic data confidential.
7. Baseline for process measures is "0".
8. A unique participant may participate in multiple support programs so there may be some duplication of unique participants when numbers across programs, project, sites, etc., are aggregated for the strategy-specific impact report. A participant may receive services across local government boundaries (e.g., a person with OUD may reside in one county and receive services in another county). Number of referrals do not equate to number of unique participants because one individual may receive multiple referrals.
9. When opioid settlement funds are braided with other funding to support programs, the resulting outputs and outcomes are proportionate to the level of funding.
10. A naloxone kit contains two doses.

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy: **#12, Reentry**[1]					
Activities	**Process Measures**[2, 5, 7, 9] **How much did you do?**	**Quality Measures**[2, 5, 9] **How well did you do it?**	**Outcome Measures**[2, 5, 9] **Is anyone better off?**	**Indicators**[3]	**RBA: Results Statement**[3]
	--- Program Level ---		**--- Program Level & Population Level ---**	**--- Population Level ---**	
Connections to care (includes connection to addiction treatment, recovery support, harm reduction services, primary healthcare, and other services) Provide any of these services or support (listed in the parenthetical above)	**# of unique participants who use opioids and/or have OUD, enrolled**[4, 6, 8] # of written transition case plans developed prior to release # of written transition case plans updated during participation # of case management meetings attended by participants # of OUD treatment sessions attended by participants # of reentry navigators/peer support specialists on staff # of unique participants who use opioids and/or have OUD, provided with harm reduction education # of participants who use opioids and/or have OUD, referred to addiction treatment # of participants who use opioids and/or have OUD, referred to recovery supports (e.g., employment services, housing services, etc.) # of participants who use opioids and/or have OUD, referred to harm reduction services (e.g., syringe and supply access, overdose prevention education, disease prevention, etc.) # of participants who use opioids and/or have OUD, referred to primary healthcare # of participants who use opioids and/or have OUD, referred to other services # of participants who use opioids and/or have OUD, provided addiction treatment # of participants who use opioids and/or have OUD, provided with recovery support services (e.g., employment services, housing services, etc.) # of participants who use opioids and/or have OUD, provided with harm reduction services # of participants who use opioids and/or have OUD, provided with primary healthcare services # of participants who use opioids and/or have OUD, provided with other services **# of naloxone kits distributed**[4, 10]	**% of participants, who use opioids and/or have OUD, who are satisfied w/ services**[4] % of participants with updated transition case plan % of case management meetings attended by participants % of OUD treatment sessions attended by participants **People with lived experience, from a directly impacted community, and/or people who use drugs are involved in the planning and implementation of your local government's overdose prevention and harm reduction work.** [4] **As part of your overdose prevention and harm reduction efforts, your local government has concrete partnerships with community-based organizations that work with historically marginalized populations.** [4] % of participants who received naloxone kit	% of participants who experience an arrest (i.e., arrest for misdemeanor and/or low-level felony) within ___ months of completing program (program level, recommended measure at six months) % of participants with OUD who adhere to treatment at __ months (program level, recommended measure at six months) % of participants with OUD who have obtained employment at __ months, through engagement with recovery support services at __ months (program level, recommended measure at six months) % of participants with OUD who retain housing at __ months through engagement with recovery support services at __ months (program level, recommended measure at six months) % of participants with OUD engaged with harm reduction services at __ months (program level, recommended measure at six months) % of participants with OUD using primary healthcare services at __ months (program level, recommended measure at six months) **# of community overdose reversals using naloxone (program level)**[4] **% of participants who report getting the social and emotional support they need**[4] % of residents receiving dispensed buprenorphine prescriptions (population level) % of individuals with OUD served by treatment programs who are uninsured or Medicaid beneficiaries (population level) % of housing & homelessness 211 calls (population level) Unemployment rate (population level)	**Reduce drug overdose deaths by 2038** **Reduce illicit drug overdose deaths by 2038 (subset measure of the above)** **Reduce drug overdose ED visits by 2038**	**All people in NC are healthy and have connections to supports and services within a culture of care.**

North Carolina Opioid Settlements – North Carolina Memorandum of Agreement Exhibit A Strategy: **#12, Reentry**[1]

Assumptions:

1. Measures models help us understand the links between our activities and desired results. This series of models was developed to reflect the underlying logic of the 12 high impact, evidence-based opioid abatement strategies listed in NC MOA Exhibit A, which guides the work of local governments supported by funding from the National Opioid Settlements.
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3. The three indicators (i.e., long-term outcomes) and the results statement are the same for every Exhibit A strategy logic model. The 12 Exhibit A strategies create synergy that we hope will reduce the rates of drug overdose.
4. Measures that appear in multiple models are shown in bold. These include: "# of unique participants, who use opioids and/or have OUD, served" and "# of naloxone kits distributed" as process measures; "% of participants, who use opioids and/or have OUD, who are satisfied w/ services" as a quality measure; and, "# of community overdose reversals using naloxone" and "% of participants who report getting the social and emotional support they need" as program-level outcome measures. There are also four universal measures that ask: a) about involving people with lived/living experience, b) about partnerships with historically marginalized populations, c) # of naloxone kits distributed and d) # of community overdose reversals using naloxone.
5. Data for process measures, quality measures and program-level outcome measures will be available from the programs, projects, sites, etc. funded by opioid settlement funds. Data for population-level outcomes will be available, at the county- and state-level, from OSUAP Data Dashboard.
6. As the NC MOA states, local governments will report on "demographic information on the participation or performance of people of color and other historically marginalized groups"; local governments may use NCDHHS' definition for Historically Marginalized Populations, which states these populations "are often identified based on their race, ethnicity, social-economic status, geography, religion, language, sexual identity and disability status." For the collection of program-level demographic data, local governments and their subrecipients can securely store demographic data and keep individuals' demographic data confidential.
7. Baseline for process measures is "0".
8. A unique participant may participate in multiple support programs so there may be some duplication of unique participants when numbers across programs, project, sites, etc., are aggregated for the strategy-specific impact report. A participant may receive services across local government boundaries (e.g., a person with OUD may reside in one county and receive services in another county). Number of referrals do not equate to number of unique participants because one individual may receive multiple referrals.
9. When opioid settlement funds are braided with other funding to support programs, the resulting outputs and outcomes are proportionate to the level of funding.
10. A naloxone kit contains two doses.
11. County-level data on the rate of people with OUD in the criminal legal system is difficult to collect. SUD/OUD can occur after someone has been incarcerated. A person may screen negative for OUD upon entering jail/prison and OUD may not be identified until release planning.

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