CASWELL COUNTY BOARD OF COMMISSIONERS **October 18, 2021**

MEMBERS PRESENT	**OTHERS PRESENT**
David J. Owen, Chairman	Bryan Miller, County Manager
Jeremiah Jefferies, Vice Chairman	Carla R. Smith, Clerk to the Board
William E. Carter	Debra Ferrell, The Caswell Messenger
John D. Dickerson	Brian Ferrell, County Attorney (Joined Remote)
Nathaniel Hall	
Rick McVey	
Steve Oestreicher	

The Board of Commissioners for the County of Caswell, North Carolina, met in regular session on Monday, October 18, 2021, at 6:30 pm in the Historic Courthouse.

WELCOME:

Chairman Owen called the meeting to order and paused for a moment of Silent Prayer. Then the Board of Commissioners and all the guest in attendance recited the Pledge of Allegiance.

PUBLIC COMMENTS:

The following individuals appeared before the Board to make public comments:

Earnestine Hamlett: I want to address the Board of Commissioners on a few things.

1. When will you put the Confederate Monument and the redesigning of the town square back on the agenda? You went out in July I believe with a closed session on the matter and now its October.
2. What goes through your mind when you say the Pledge of Allegiance, especially the part that say, "One nation under God with liberty and justice for all"? What goes through your mind and your heart when you say that? Or are you just repeating it verbatim?
3. This artwork of the Confederate monument does not represent the values of this county, nor does it represent the values of this Board, according to the sworn oath that you took when you were elected. So, I'm asking you tonight, let's live up to the county motto by "Preserving the past and embracing the future". Thank you.

Landon Woods: 4810 Highway 86 North in Yanceyville. I'm here to speak on the mandatory vaccines issue. I believe that it is against our Constitution to force a vaccine on to people. This is the progressives that mainly talk about the mandatory vaccines. The same progressives who say that they learn from the past and they talk bad about conservatives being too traditional and living in the past. The same progressives are the ones who think that we need to demand people get a vaccine, or they get fired from their jobs, they're not allowed to be in stores and restaurants. Don Lemon with CNN said that if people don't get the vaccine, they shouldn't be allowed in entertainment centers, sports arenas, and even grocery stores. So, now we are telling people either submit to our agenda or you are not even allowed to buy food for your family. I believe

that goes against everything that America stands for and it's eerily similar to 1938 in Nazi, Germany, when people were commanded to wear a star on their side to enter into stores to buy and sell. It goes against everything that we stand for. The same progressives will say it's her body, her choice, when she wants to kill her unborn child. But if the same woman doesn't want to take the mandatory vaccine, that seems to be a problem. And I think that goes against everything we stand for as a nation. Thank you.

The following public comments were emailed to the Board and were shared with the Commissioners via email.

From: Elin Armeau-Claggett elinarmeau@comcast.net

CASWELL Commissioners,

AGENDA ITEMS: Opioid MOA, Ethics Policy & Mandatory Vaccinations
These may be pertinent issues but there are wide ranged basic problems within the county that are not being discussed or solved month after month.

SOLID WASTE (pictures attached):
Remember 2021 when our tax bill increased $53 for Solid Waste Fees? Remember 2021 when the minimum cost to dump anything increased to $5? Remember 2021 when $650,000 spending was unaccounted for between Jan-April? Remember when COVID was blamed? Storm debris from Feb. is over 20 ft. high. Every direction you look at the landfill is trashed - literally. Bins are overflowing. Caswell Tax dollars at work and no one cares enough to change. Where is the fiscal and managerial accountability?


DETENTION CENTER:
The Sheriff projected total revenues for Detention Center at $708,600 and expenditures of approx. $1,750,000 + debt service to pay for the building. Over $1 million loss was approved by Commissioners without one question of expenditures. Any first quarter fiscal update or accountability?

HWY ACCIDENTS/DEATHS:
Any update on traffic light at the intersection of Park Springs Rd & Hwy 86 N? Accidents continue. Last DOT update to the BOCC was 12/2020 - no traffic pattern studies visible. Who is responsible to follow-through with this public safety concern?

BROADBAND
Any update on broadband after the last contract was cancelled? Still no service when driving 8 miles in any direction within Caswell from our house. Who is accountable to f/u with the state contracts and what is the update on cell towers?.

WEBSITE: No HR updates since May 2021 on job on the county gov't website - that's 6 months. Still listing Home Health Nurse even though Commissioners approved the sale of the Home Health Agency. Listings on Sheriff's or PHD websites don't match HR listings. No posting for Asst. County Manager. Just a few examples and again, who is accountable?

Thank you,

Elin Claggett

RECOGNITIONS:

Commissioner Carter wanted to recognize all the fire fighters and first responders for the job they have done. It's been several accidents lately. Had one case in the county in Providence and Ed Heinz was there broadcasting. It was at the 86 Convenience Mart where a man had passed. When the first responders and EMS got on the scene, they were able to bring him back. So, Mr.

Carter wanted to recognize the First Responders, EMS, and the Sheriff's Department for the job they are doing.

Chairman Owen said tonight he wears his pink shirt. This month is Cancer Awareness Month. I wear it in recognition of all those who are survivors. Mr. Owen's wife is a survivor of 30 years now, and for all the other residents of Caswell County who are survivors, and those who are now battling breast cancer. We have lost many because of that, but we do want to recognize those who are survivors.

AGENDA:

APPROVAL OF AGENDA:

Commissioner Hall said he requested three items be on the agenda for tonight, and two of them are on here. The third item was the redesign of the square. Commissioner Hall asked to add the redesign of the square and move them all under action items. Chairman Owen asked if there were any objections from the Board. Commissioner Dickerson said to move it to an action item with no prior advertising to the community, people that have a vested interest on the issue will not be here before our votes called. So, Commissioner Dickerson would say that the redesign of the square especially should be advertised before we put that on the agenda. Chairman Owen said he has spoken with Commissioner Hall about that. Commissioner Carter said he thought we had worked on mandatory vaccines about three meetings ago. We took action on it, and we decided we were not going to require County employees to take the vaccination. Chairman Owen said that meeting he was not present. County Manager Miller said, there was no action taken on it. It received a motion but died due to lack of a second. Chairman Owen agreed with Commissioner Dickerson that for the redesign of the square we need to give people time to know that we are going to take some kind of action. Then Chairman Owen asked if anybody else had any other objections to the changes requested. Commissioner McVey said he thinks we need to know the costs associated with the redesign and the people should be here. Commissioner Hall said he will go along with the consensus of the Board on this. Commissioner Oestreicher said all along we have been waiting on the costs before we understand what the action is. Mr. Oestreicher also said in regard to the mandatory vaccinations we are still waiting for the OSHA guidelines or regulations on that before we can take action on that. He was not sure of the proposal for the Ethics policy, so he has no opinion on that. Commissioner Carter said about the items on the square, the County Manager was supposed to bring a cost back before we can make a decision on that. As for the vaccines it was a consensus of the Board that night. Chairman Owen said in defense of the County Manager, I don't think the County Manager has received this Boards thoughts on whether he and staff should proceed. It should be an official action for him to proceed to get the actual costs estimates of not only relocating the monuments on the square but also the redesign cost for the square. He will have to have some guidelines on that as well. Commissioner Carter asked where we will get all the money to do this. Chairman Owen said the Board needs to direct the County Manager on whether we want him to proceed with

getting cost estimates or not. Chairman Owen said from what he is hearing the consensus of the Board is to get the County Manager to proceed to get costs estimates of relocating the monuments and redesigning the square. Commissioner Jefferies said we have talked about this for a year or more, we can't keep on talking about it. We need to do something. Chairman Owen said the consensus is to have the County Manager get cost estimates and as quickly as possible. The County Manager asked if the second meeting in November was too late. Chairman Owen said that is fine because it will probably take awhile to get those estimates in. Commissioner Oestreicher said part of the issue on this was the new location for the various monuments. Mr. Oestreicher said he was not sure if that had been defined, and that will figure into costs. Chairman Owen said his understanding was that the Board had given consensus that they would be moved to the left side of the Courthouse. That would be the cheapest place and give us a base unless there are some objections to the monuments being moved there. So, we will not include that on the agenda. Commissioner Dickerson said the other factor is that there are a pending State law barring localities from requiring mandatory vaccinations and that was the other bit of information we were waiting on before we made a decision. We come down this road and the State decides to bar it, then where will we go. Chairman Owen asked if the mandatory vaccinations could remain a discussion item. Commissioner Hall said he brought it up because the Board tends to drag these things on. Every opportunity we get, we are finding an excuse for not acting. We need to act and let people know where we stand. Mr. Hall said he is not concerned with what OSHA says, because there are businesses in this country that are already doing mandatory vaccinations. It makes good public health sense. That is what we need to be concerned with.

Chairman Owen then had to pause to have a citizen leave the meeting who was speaking after public comments had ended.

Commissioner Hall asked if the Ethics Policy could be an action item also. We already have an Ethics Policy, but Mr. Hall has some suggestions.

So Mandatory vaccines and Ethics Policy will move to action items with some discussion.

A **motion** was made by Commissioner Hall and seconded by Commissioner McVey and **carried unanimously** to approve the agenda as revised. (Commissioner Carter, Dickerson, Hall, Jefferies, McVey, Oestreicher, and Owen voted in favor)

Attorney Brian Ferrell asked Chairman Owen just because we are on a remote meeting notice, if you will do roll call voting this evening. That will keep us in line with the statutory requirements for remote meetings.

APPROVAL OF CONSENT AGENDA:

a. September 20, 2021Regular Meeting Minutes
b. September 27, 2021 Public Hearing Minutes
c. October 4, 2021 Regular Meeting Minutes
d. October 5, 2021 Redistricting Meeting Minutes

A **motion** was made by Commissioner Jefferies and seconded by Commissioner Owen and **carried unanimously** to approve the Consent Agenda with no corrections or amendments. (Commissioner Carter, Dickerson, Hall, Jefferies, McVey, Oestreicher, and Owen voted in favor)

DISCUSSION ITEMS:

There were no discussion items.

ACTION ITEMS:

OPIOID MOA:

The County Manager said Commissioners, the next step in this process is for Caswell County local government to sign on to the settlements (one State and One Federal) by January 2, 2022. North Carolina stands to receive approximately $750 million through opioid litigation settlements if all 100 counties and all municipalities with a population over 10,000 participate. These funds will be available starting in 2022 to support treatment, recovery, harm reduction, and other life-saving programs and services.

North Carolina's share of settlement funds will be distributed among state and local governments as outlined in a Memorandum of Agreement (MOA) which is in your agenda packet. More than 80 local governments have already joined and signed the memorandum of agreement in North Carolina. It is important to note signing onto the settlements is separate from signing onto the NC MOA.

I am recommending that the Board authorize Caswell County to sign on to the NC MOA at this time. The National Settlement Agreement will be on an upcoming agenda well before January 2, 2022 deadline.

Chairman Owen said he wanted to make note for the Commissioner. The reason we were asked to hold off on these is because there was some discussion about local litigations being paid more money. That's not the case because we signed the agreement with the national firm. All the national litigation teams have signed off on a waiver that if they are receiving funds from the national litigation funds, there will be no local funds. They signed off on that. We signed with the national firm and not a local firm. We were afraid we would have to pay money for that, but that will not be the case. Commissioner Hall asked how this will impact the suit that we signed off on with the national firm in terms of dollars. Chairman Owen said this gives the State more

leverage and they will receive that money. County Manager Miller said part of the settlement agreements that are made with the distributors allocating money to the national funds to be paid. So that's where the money will come from for the national funds. Chairman Owen said that money is already accounted for. Commissioner Hall said his question is what we get out of this for signing on with this national firm. It does not impact in any way the money we will receive. That's already determined in this package. To be quite honest from what Chairman Owen understands, whether we sign or not every county still gets money out of this. What this does by each county signing it is it gives better leverage for the State. The County Manager said that is correct. It gives North Carolina a better chance of recovering more of the opioid settlement. This type of settlement is not similar to that of the tobacco lawsuits that you had many, many years ago. The County Manager said he knows that the counties at that time fell under served by the settlement from the tobacco litigation. The NCACC stepped in and was a major player in the opioid litigation to make sure individual counties got the majority of the money, instead of the State taking the majority. Commissioner Hall said that's right, and we had that discussion when we were deciding to sign on with a separate law firm. What assurance are we getting that we will be treated any different this time. The County Manager said that is in the memorandum of agreement that we are asking for permission to sign off on tonight. The funding mechanisms for those is laid out in the MOA. Chairman Owen said it's already laid out and we know how much we will be getting. That will not change. The State has already gotten their cut. The rest of that money, 85%, is what is going to the counties in North Carolina. The formula they have in the MOA, we can figure out roughly what we are going to get. It will be over 18 years. Commissioner Hall said we talked about the tobacco settlement, and we decided to go out and hire an attorney. Now the deal has been made and the money will be sent to the State to divvy it up. Mr. Hall understands they may have a formula in there, but that formula may not be in our best interest. The County Manager said if we could ask our County Attorney to talk a little bit about multi-district litigation and how that plays into what we're talking about now.

Attorney Ferrell said first of all, I'd like to say Commissioner Hall is recollecting correctly some of the preliminary discussions we had at the outset of this process. Mr. Hall is also probably recalling the difficulty counties had in receiving any real, tangible, substantial benefit from the tobacco litigation. Where the State essentially maintains this trust fund and the purse strings, and the trickle down did not come as some would have thought it should to the local level. This MOU is a little different, and it's different because Commissioner Hall is not the only person in County Government who remembers how challenging to the local governments that tobacco settlement was. So, this MOU is the product of what they call a 555 committee, which essentially involves county attorney's across the state, county managers across the state, and other local government officials getting in a room over many months, going on a year now, and hammering out this MOU that involves not only the division of funds, but it really puts parameters on how the funds can be used, when they're drawn down, and what the money is going to go to. Because the counties were sensitive to the fact that they would possibly, if the

State controlled all of that, not receive the ultimate benefit of the bargain. So, that's sort of a little bit of the background of how we got to the MOU stage and county governments were at the table during that negotiation. The reason why it's important I believe that the NCACC would say it's important to move forward with the MOU and also some of the lawyers involved is because the defendants are sensitive to the fact that there are these individual lawsuits, like Caswell filed. Caswell filed its own lawsuit as a plaintiff against all of these named defendants. So, we have an individual lawsuit, just like thousands of other local governments across the country. So, the defendants are saying well unless we have some certainty that there's a collective buy in about how the settlement will work, we're reluctant to settle with any one entity. So, we want to make sure that the State Attorney General is satisfied and that all these counties and cities are more or less satisfied. The idea is that this state of North Carolina, the local governments, cities, towns, and counties there in show their solidarity in the negotiations in this settlement by signing on to the MOU and thus hopefully, generating a more favorable settlement overall to North Carolina because the defendants have some assurance that at least to this state most of the multi-district litigation, that the county manager was talking about, will end with the resolution. So those are some of the differences to the tobacco settlement. A little bit of the background on how heavily this agreement has been negotiated with other Commissioners. Attorney Ferrell said I'm sorry when I mentioned the 555, I didn't mention that County Commissioners were at the table in that group as well. Of course, that's vital to the team. I understand Commissioner Hall's concerns. Our lawsuit is certainly yours to control, but that's a little bit about how we've arrived at the MOU and why it's important in the overall process to the defendants and, quite frankly, to the counties to have some certainty over what they'll receive and what they can spend it on. And I talked a little bit there, but I'm not sure I answered the question. I'm happy to answer any direct questions.

Commissioner Oestreicher asked does signing this MOA or MOU back us out of the other litigation that we have already undertaken. Attorney Ferrell said no. If you'll remember that litigation involved a laundry list of defendants. The current settlement that we're talking about is really just a subset of the defendants who have essentially reached some agreement in principle, with many of the plaintiffs. So, the litigation as to other defendants will continue. So that lawsuit, if you will, until it's finally resolved at the end will continue, but the settlement we're talking about is just to a subset of the defendants. So, the MOU is sort of the internal document, if you will, among the similarly situated plaintiffs in North Carolina saying okay, if we settle this to these defendants, this is how we agree that the flow of funds will come down and how we'll distribute it so that those settling defendants will have some certainty around that process. So, it won't resolve the case for all time, but it'll resolve it to a subset of the defendants.

Commissioner Oestreicher said he did a little bit of the math, and he thinks he did it right. If you look at the numbers in here, what this works out to be for Caswell County is $7,200 a year for 18 years. Do we think that's fair? The County Manager said no, the last time he did the math it

was over $1 million total settlement. Mr. Miller couldn't remember the exact number, but he was thinking it was 1.2 million or 1.4 million. Commissioner Oestreicher went over how he calculated the settlement payment. Attorney Brian Ferrell said I have not crunched the actual totals but, of course, what you're looking at there on the MOU is sort of a percentage. That was derived by a number of factors. Population being one and perhaps some documented negative outcomes, too. What I would suggest is perhaps your litigation counsel and County Manager when the actual settlement is proposed will certainly have more definite numbers to share with the Board before it ultimately signs off on any settlement or dismissal of claims.

Chairman Owen said we have until January 2, 2022 to decide so we can hold off on this to get further questions answered. Commissioner Dickerson asked what the final total on legal fees was. At one point they were talking about more compensation than what was coming down the line. How did that work out? Is it a standard sum? Chairman Owen said it was his understanding that when the National suit was settled with these companies, they signed an agreement that we would not have to pay any local attorneys. We signed with the National company, who is responsible for paying the local attorneys. Commissioner Hall said he had one final question. You made the comment that the State has got their money. Chairman Owen said in the settlement the State will get 15% of the settlement, he thinks. So, Commissioner Hall asked will the State get their money over 18 years also or did they negotiate something different. Chairman Owen said as far as he knows the State will get the same payment schedule that we are. Attorney Ferrell said he is not 100% sure about that detail. Chairman Owen said he has not seen anything that he has read on this where the State will get their money different from the counties, but we can research that. Commissioner Hall said he just don't want them sitting on our money.

Chairman Owen asked what the pleasure of the Board was. Commissioner Oestreicher said we have two suits here basically. We have our own where we signed up with the smaller group. Chairman Owen said no we signed with the National Firm, and they hired the local attorneys. Commissioner Oestreicher said we still have a pending suit in addition to this suit. Chairman Owen said yes, but it could be more than that. Commissioner Oestreicher said he hopes his math is wrong, but if you take $750 million divided by 18, divide it by the number of counties, and then divide it by population, we are not getting much. If whatever we get from this is in addition to whatever is in the other lawsuits, that's okay. But it sounds to Mr. Oestreicher that what's in this is a subset of the national suit. We need a lot more analysis and understanding to make an intelligent decision with what's at stake. Chairman Owen said just so the Board knows. This suit will settle with these companies. There are four of them that they have settled with. That's where this money we are getting from this suit is coming from. Any other litigation that occurs or any money that comes from any other company we will get our share of that too, but this is just for those four companies. Commissioner Oestreicher asked if those four companies are not included in the suit we already have. Chairman Owen said yes, but there is a laundry list of defendants in that, but these have chosen to settle. Commissioner Oestreicher asked if we sign

this will we walk away from any settlements from the other companies. Chairman Owen said no, not from any other companies. Commissioner Oestreicher said the State can't sign away our rights. Chairman Owen said the only thing is you won't get the money. Chairman Owen said let's look at this and review the memorandum and put it on the next agenda.

Then Commissioner Dickerson said if we were to pull out of this agreement and not be bound by it, again we would be on the hook to fight as a small county. As it is now, we have $1.2 million for 18 years as a sure thing. Mr. Dickerson said he would much rather deal with that than to have to look at the monstrously legal bills to go up against those companies on our own.

Again, Chairman Owen asked for the pleasure of the Board. Do you want to make a motion or put it on the next agenda? County Manager Miller said he went through the math, and it is $1,037,521.43 that Caswell County will receive over 18 years. That would be $57,640 a year.

A **motion** was made by Commissioner Dickerson and seconded by Commissioner Hall and **carried 6-1** to accept the terms of the settlement with these four companies. (Commissioners Carter, Dickerson, Hall, Jefferies, McVey, and Owen voted for the motion. Commissioner Oestreicher voted against the motion.)

MANDATORY VACCINATIONS:

Commissioner Hall said we had a lot of discussion probably about a month ago. At a meeting about 3 weeks ago, Commissioner Hall was on Zoom. He could see and hear everything that was said, but nobody could hear him. He tried to second the motion when it came up. Commissioner Hall could not be heard because of technical difficulties. Mr. Hall wanted to bring this matter back before the Board to take action on it and move on. Chairman Owen asked for the pleasure of the Board.

A **motion** was made by Commissioner Hall and seconded by Commissioner Jefferies and **failed 2 -5** to require mandatory vaccinations for all employees that work for Caswell County. (Commissioners Hall and Jefferies voted for the motion. Commissioner Carter, Dickerson, McVey, Oestreicher, and Owen voted against the motion.)

ETHICS POLICY:

Commissioner Hall said at the last meeting the Chairman made a comment about some things that bothered him as it related to the actions of the Planning Board. Commissioner Hall had the same feelings, but once the Chairman made the comment there was no need to echo that. Commissioner Hall said he went home and looked at our Ethics Policy. We have two. We have the Ethics Policy for Commissioners and the Ethics Policy for employees. Neither of these policies applied to Boards and Committee members that we appoint. So, Commissioner Hall suggested that the County Manager and staff combine those two policies into one and include in

the policy that the policy is applicable to Commissioners, employees, and any appointees to Boards and Commissions. Commissioner Dickerson said that's a lot of information condensed and without seeing it he doesn't know what his feelings would be on it until he sees the revised policy. Chairman Owen said he assumes that is what Mr. Hall wanted. The County Manager and staff would work on the policy and bring it back to the Board for approval. Commissioner Hall said yes, but he would assume all the Commissioners have seen the Ethics Policy for the Commissioners. The employee policy is only 8-10 lines. Then Commissioner Oestreicher said in the agenda packet there were 3 pages, but they appear to be out of order. The Clerk confirmed that the pages were out of order. The Commissioners' ethics policy should be 2 pages and the employee ethics policy have one page. Commissioner Oestreicher asked if Commissioner Hall wanted both policies combined. Commissioner Hall said yes, have the County Manager and staff revise the policy to omit any redundancy.

Commissioner Hall said we want to make this policy applicable to people appointed to the Boards and Commissions by the Board of Commissioners. Mr. Hall's final thing he wants done is to indicate how people will be held accountable if they are accused of violating the Ethics Policy. Commissioner Hall said he would assume for employees and boards and commissions that it could come to the Board of Commissioners, but for the Commissioners, it might not be appropriate for this Board to adjudicate issues for other Board members. So, when we ask staff to do this, we need to ask them to come up with some recommendations for how accusations of ethics violations for the Board members to be adjudicated. Commissioner Jefferies asked that the policy be read before voting on it.

Commissioner Dickerson said if we are going to look at ethics for boards and passing rules for everyone to follow, he thinks the Board needs to have a frank discussion about some kind of policy being put into place that commissioners can not come before this Board requesting money for grants any more because it makes us all look bad. When we sit here and dole out grant money to a sitting commissioner, and Mr. Dickerson doesn't think that should be taking place. Mr. Dickerson thinks the money doled out to Commissioners and whatever we have left in that grant should be divided up amongst the fire departments in this county. That way all the citizens in the county would benefit greatly from it. So, if you want to talk about doing the right thing let's talk about doing that. Chairman Owen said that money did not go to a commissioner. Commissioner Dickerson said it went to groups that they were members of. Commissioner Carter agreed with Mr. Dickerson. Chairman Owen said we need to look a little deeper because a sitting commissioner is paid by the County to do water inspections. Commissioner Dickerson thinks getting paid for a service is different from getting grants from a fund that set up to benefit the whole county. There was $100,000 designated to cover the needs of all people in this county and $32,000 of that money was allocated in the form of grants to entities that Commissioners on this Board are tied to. So, 1/3 of the money was taken out the pot. The least we can do if they don't want to give that back is to take what we have left and divide it up amongst the fire departments.

That way you are actually distributing that money out and everyone in this county will be beneficiaries of it. That's the fair way to do it.

Commissioner Hall said that is not an ethic issue. These were federal dollars allocated to mitigate from the COVID pandemic. Everybody had the opportunity and still has the opportunity to apply. To give it to somebody based on their personal preface is an ethics problem.

Commissioner Dickerson said everyone in this county is not a commissioner, and for this Board to decide to give money to fellow Commissioner's charities, that is an ethics breach in his opinion. Commissioner Dickerson said it may be legal, but it certainly seems unethical to a lot of people in this county. Commissioner Hall said that is why he brought this up about this policy. Once we get this handled and we find a way to adjudicate it, anyone that wants to bring up an ethics issue against any Commissioner will be able to do so.

Chairman Owen said let's deal with the policy first and then we can address Commissioner Dickerson's issue.

Commissioner Dickerson said but we are talking about ethics. We are talking about rules and upgrading procedures. The frank discussion about how we handle giving out money to anyone commissioner that has a link to a charity, we need to be talking about that. We need to be setting some type of rules not just saying majority rules. It is legal but is it ethical. Do we want to go down this road again and stir up a hornet's nest when we can take the opportunity while we are talking about ethics and put safeguards in place where we keep that from happening again?

Commissioner Oestreicher said most of the members of this Board are here out of a sense of social duty to the county. Many of the members of this Board sit on other boards out of a sense of duty to the county and to the activities that organization performs for the county. Commissioner Oestreicher said he is not aware of any Commissioner that is on any of those boards that would receive financial compensation from those other boards, as a result of receiving money from the COVID funds from the Federal Government. That is a key component of conflict of interest and ethics. That means receiving direct compensation. Commissioner Oestreicher said charging people with that is an egregious statement.

Commissioner Dickerson said we will know more about this in the future because he has contacted the State and is waiting on a return call from another attorney.

Chairman Owen said so we will proceed with the recommendation of Commissioner Hall on the Ethics Policy and combine them and include Boards and Commissions.

A **motion** was made by Commissioner Hall and seconded by Commissioner Oestreicher and **carried unanimously** to have the Commissioners Ethics Policy and the Employee Ethics Policy be combined and include that all Boards and Commissions that the Board of Commissioners appoint members to will be subject to the Ethics Policy. (Commissioner Carter, Dickerson, Hall, Jefferies, McVey, Oestreicher, and Owen voted in favor)

COUNTY MANAGER'S UPDATES:

County Manager Miller said he wanted to give the Board a quick update on redistricting.

CASWELL COUNTY REDISTRICTING:

After our last special meeting relating to redrawing of Caswell's electoral districts, a lot of time was spent trying to form the districts in a manner that met all the criteria set forth by the board. Unfortunately, at this time we haven't achieved anything that works.

After seeing the struggle to redraw the districts, I went back to the data to see why this was so difficult. The data from the decennial census showed several reasons why we are experiencing problems with keeping the districts compact, having a commissioner in each district, and maintaining two minority majority districts.

The data shows that of the 961 people lost over the past ten years, 523 of those people were minorities. That means 54% of those that left Caswell were minorities and our population only consists of 38.3% minorities. In the existing minority districts, District 3 lost a total of 115 people overall but lost 273 people with minority status. This means that 273 minorities left and 158 people in the majority moved into that district. In District 4, the district lost a total of 381 people. 360 of those that were lost were minorities. Districts 1 and two both lost population, 370 and 140 people respectively, but gained in minority population by 39 and 45 respectively. District 5 gained 5 people in population and gained 26 people with minority status. This means that the minority population is lower that it was 10 years ago definitely, but it also means that minorities are more evenly dispersed throughout all communities. There are still communities that have very heavily weighed census tracts for both minorities and non-minorities. This makes it somewhat easier when trying to form minority district, but those districts are not nearly as compact as in years past.

So, the point I'm trying to make is this:

1. We are still working on the districts.
2. We hope to have something by this Friday.
3. I would recommend the board hold a special meeting this Friday to review what we have or possibly Thursday.
4. Do so with tempered expectations and know that all the priorities you had may not be possible.

Chairman Owen talked with the Board to see what time worked for the Board. Thursday evening was the consensus. Chairman Owen said 5:00 pm so it gives everyone time to get here.

The County Manager said we hope to have the maps ready by Friday and hold a Public Hearing at the November 1st meeting.

Chairman Owen asked if we could have the meeting at the library. The County Manager said he would call the Library Director.

Chairman Owen said the meeting will be Thursday at 5:00 pm at the library. We will notify the Commissioners if this changes.

COMMISSIONER COMMENTS:

There were no comments from any of the commissioners.

ANNOUNCEMENTS AND UPCOMING EVENTS:

No announcements.

ADJOURNMENT:

A **motion** was made at 7:40 pm by Commissioner McVey and seconded by Commissioner Dickerson and **carried unanimously** to adjourn the meeting. (Commissioners Carter, Dickerson, Hall, Jefferies, McVey, Oestreicher and Owen voted for the motion)

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Carla R. Smith
Clerk to the Board

David J. Owen
Chairman

Attachments:

Code of Ethics for the
Board of Commissioners of
Caswell County, North Carolina

WHEREAS, public officials are charged with upholding the public trust, and;

WHEREAS, public trust in its elected officials is essential to the orderly and successful conduct of the public's business and government, and;

WHEREAS, the proper operation of democratic representative government depends upon public confidence in the integrity of the government and the responsible exercise of the public trust conferred upon public officials, and;

WHEREAS, it is incumbent upon public officials to be conform the exercise of their public duties in an ethical manner which warrants the trust of the public, and;

WHEREAS, Section 160A-86 of the North Carolina General Statutes requires local governing boards to adopt a code of ethics.

NOW THEREFORE, the Caswell County Board of Commissioners adopts the following Code of Ethics as a guide for members of this Board to follow in the course of conducting the business of the public.

CODE OF ETHICS

The purpose of this Code of Ethics is to establish guidelines for ethical standards of conduct for the Board of Commissioners and to assist in the determination of what conduct is appropriate in particular cases. It is not a substitute for the law or the best judgment of a board member.

SECTION 1.

Board members should obey all laws applicable to their official actions and should be guided by the spirit as well as the letter of the law. Mere disagreement with the policy position of another Board member does not warrant a charge of unethical behavior and the making of such a charge is itself unethical.

Board members should endeavor to keep current, using all resources available to them, about new or ongoing legal or ethical issues which they might face in their official duties.

SECTION 2.

Board members should act with integrity and independence from improper influence as they exercise their official duties. For example they should:

- Be unaffected by improper influence while at the same time be open to consideration of the opinions and ideas of others.
- Disclose contacts and information about issues that they receive outside of public meetings and refrain from seeking or receiving information about quasi-judicial matters outside of the quasi-judicial proceeding itself.
- Treat other board members and the public with respect.
- Not reach conclusions on issues until all sides have been heard
- Avoid conflicts of interest
- Board members should make decisions based on the public good and not on their desires or considerations of special interests.

SECTION 3.

a. Board members should avoid impropriety in the exercise of their official duties. Although opinions may vary about what behavior is appropriate in any given situation, this Board will consider impropriety in terms of whether a reasonable person who is aware of all the relevant facts and circumstances surrounding the member's action would conclude that the action was inappropriate.

b. If a board member believes that his or her action, while legal and ethical, may give the appearance of not being so, he or she should seek the advice of the board's attorney and should consider publicly disclosing the facts of the situation and the steps taken, if any, to resolve it.

SECTION 4.

Board members should faithfully perform the duties of their office, and should always keep in mind the trust placed in them by the public. Members should faithfully attend and prepare for meetings, should be willing to bear their fair share of the Board's workload and should be willing to put the Board's interests above their own in the conduct of the public's business.

SECTION 5.

Board members should conduct the affairs of the Board in an open and public manner, comply with all applicable laws governing open meetings and public records and should respect the sanctity of closed sessions.

Adopted this 17th day of April, 2017.

_____ _____

Bryan S. Miller - County Manager Kenneth D. Travis - Board Chairman

Code of Ethics for the
Employees of
Caswell County, North Carolina

CODE OF ETHICS

County employees are expected to discharge their duties conscientiously and to conduct themselves in a manner, on and off the job, which will reflect favorably upon the county. Specifically:

a) Employees shall refrain from any use of their position, which is motivated by the desire for private gain for themselves or other persons. They must conduct themselves in such a manner that there is no suggestion of the extracting of private advantage from their employment with the county.
b) Employees shall exercise discretion in their care of personal financial activities to avoid any legal liabilities, which would reflect unfavorably upon the county. Questionable cases should be discussed with the supervisor and if necessary, the supervisor and employee should consult the County Attorney.
c) Employees shall not use their positions, in any way, to coerce, or give the appearance of coercing, another person to provide any financial benefit to the employee or to other persons.
d) Employees shall avoid any action, which might result in giving preferential treatment to any organization or person; losing his independence or impartiality of action; or affecting adversely the confidence of the public in the integrity of the county.
e) An employee who witnesses another employee engaging in an unlawful act on the job shall report that employee to that employee's supervisor, who is to notify the department head, who in turn will notify the County Manager.

The purpose of this Code of Ethics is to establish guidelines for ethical standards of conduct for the Employees of Caswell County and to assist in the determination of what conduct is appropriate in particular cases. It is not a substitute for the law or the best judgment of an employee.

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_____
Bryan S. Miller, County Manager

_____
Employee

_____
Date

Adopted November 21, 2011

MEMORANDUM OF AGREEMENT
BETWEEN THE STATE OF NORTH CAROLINA AND LOCAL GOVERNMENTS
ON PROCEEDS RELATING TO THE SETTLEMENT OF OPIOID LITIGATION

Contents

Background Statement

Capitalized terms not defined below have the meanings set forth in the Definitions section of the Statement of Agreement.

WHEREAS, the State of North Carolina (the "State"), North Carolina counties and municipalities, and their people have been harmed by misconduct committed by certain entities that engage in or have engaged in the manufacture, marketing, promotion, distribution, or dispensing of an opioid analgesic ("Pharmaceutical Supply Chain Participants"); and

WHEREAS, certain North Carolina counties and municipalities, through their counsel, and the State, through its Attorney General, are separately engaged in ongoing investigations, litigation and settlement discussions seeking to hold Pharmaceutical Supply Chain Participants accountable for the damage caused by their misconduct; and

WHEREAS, the State and the Local Governments share a common desire to abate and alleviate the impacts of the misconduct described above throughout North Carolina and in its local communities; and

WHEREAS, while the Local Governments and the State recognize the sums which may be available from the aforementioned litigation will likely be insufficient to fully abate the public health crisis caused by the opioid epidemic, they share a common interest in dedicating the most resources possible to the abatement effort; and

WHEREAS, settlements resulting from the investigations and litigation with Johnson & Johnson, AmerisourceBergen, Cardinal Health, and McKesson are anticipated to take the form of a National Settlement Agreement; and

WHEREAS, this Memorandum of Agreement ("MOA") is intended to facilitate compliance by the State and by the Local Governments with the terms of the National Settlement Agreement and, to the extent appropriate, in other settlements related to the opioid epidemic reached by the state of North Carolina; and

WHEREAS, North Carolina's share of settlement funds from the National Settlement Agreement will be maximized only if all North Carolina counties, and municipalities of a certain size, participate in the settlement; and

WHEREAS, the National Settlement Agreement will set a default allocation between each state and its political subdivisions unless they enter into a state-specific agreement regarding the distribution and use of settlement amounts (a "State-Subdivision Agreement"); and

WHEREAS, this MOA is intended to serve as such a State-Subdivision Agreement under the National Settlement Agreement; and

WHEREAS, the aforementioned investigations and litigation have caused some Pharmaceutical Supply Chain Participants to declare bankruptcy, and it may cause additional entities to declare bankruptcy in the future; and

WHEREAS, this MOA is also intended to serve as a State-Subdivision Agreement under resolutions of claims concerning alleged misconduct in manufacture, marketing, promotion, distribution, or dispensing of an opioid analgesic entered in bankruptcy court that provide for payments (including payments through a trust) to both the State and North Carolina counties and municipalities and allow for the allocation between a state and its political subdivisions to be set through a state-specific agreement ("Bankruptcy Resolutions"); and

WHEREAS, specifically, this MOA is intended to serve under the Bankruptcy Resolution concerning Purdue Pharma L.P. as a statewide abatement agreement, and under this MOA, a statewide abatement agreement is a type of State-Subdivision Agreement.

Statement of Agreement

The parties hereto agree as follows:

A. Definitions

As used in this MOA:

The terms "Bankruptcy Resolution," "MOA," "Pharmaceutical Supply Chain Participant," "State," and "State-Subdivision Agreement" are defined in the recitals to this MOA.

"Coordination group" refers to the group described in **Section E.7** below.

"County Incentive Fund" is defined in **Section G** below.

"Governing Body" means (1) for a county, the county commissioners of the county, and (2) for a municipality, the elected city council, town council, board of commissioners, or board of aldermen for the municipality.

"Incentive Eligible Local Government" is defined in **Section G** below.

"Local Abatement Funds" are defined in **Section B.2** below.

"Local Government" means all counties and municipalities located within the geographic boundaries of the State of North Carolina that have chosen to sign on to this MOA.

"MDL Matter" means the matter captioned *In re: National Prescription Opiate Litigation,* MDL 2804 pending in the United States District Court for the Northern District of Ohio.

"MDL Parties" means all parties who participated in the matter captioned *In re: National Prescription Opiate Litigation,* MDL 2804 pending in the United States District Court for the Northern District of Ohio as Plaintiffs.

"National Settlement Agreement" means a national opioid settlement agreement with the Parties and one or all of the Settling Defendants concerning alleged misconduct in manufacture, marketing, promotion, distribution, or dispensing of an opioid analgesic.

"Opioid Settlement Funds" shall mean all funds allocated by the National Settlement Agreement and any Bankruptcy Resolutions to the State or Local Governments for purposes of opioid remediation activities or restitution, as well as any repayment of those funds and any interest or investment earnings that may accrue as those funds are temporarily held before being expended on opioid remediation strategies. Not included are funds made available in the National Settlement Agreement or any Bankruptcy Resolutions for the payment of the Parties' litigation expenses or the reimbursement of the United States Government.

"Parties" means the State of North Carolina and the Local Governments.

"Settling Defendants" means Johnson & Johnson, AmerisourceBergen, Cardinal Health, and McKesson, as well as their subsidiaries, affiliates, officers, and directors named in a National Settlement Agreement.

"State Abatement Fund" is defined in **Section B.2** below.

B. Allocation of Settlement Proceeds

1. Method of distribution. Pursuant to the National Settlement Agreement and any Bankruptcy Resolutions, Opioid Settlement Funds shall be distributed directly to the State and to Local Governments in such proportions and for such uses as set forth in this MOA, provided Opioid Settlement Funds shall not be considered funds of the State or any Local Government unless and until such time as each annual distribution is made.

2. Overall allocation of funds. Opioid Settlement Funds shall be allocated as follows: (i) 15% directly to the State ("State Abatement Fund"), (ii) 80% to abatement funds established by Local Governments ("Local Abatement Funds"), and (iii) 5% to a County Incentive Fund described in **Section G** below.

3. Allocation of funds between Local Governments. The Local Abatement Funds shall be allocated to counties and municipalities in such proportions as set forth in **Exhibit G**, attached hereto and incorporated herein by reference, which is based upon the MDL Matter's Opioid Negotiation Class Model. The proportions shall not change based on population changes during the term of the MOA. However, to the extent required by the terms of the National Settlement Agreement, the proportions set forth in **Exhibit G** shall be adjusted: (i) to provide no payment from the National Settlement Agreement to any listed county or municipality that does not participate in the National Settlement Agreement; and (ii) to provide a reduced payment from the National Settlement Agreement to any listed county or municipality that signs onto the National Settlement Agreement after the initial participation deadline.

4. Municipal allocations. Within counties and municipalities:

a. Local Governments receiving payments. The proportions set forth in **Exhibit G** provide for payments directly to (i) all North Carolina counties, (ii) North Carolina municipalities with populations over 75,000 based on the United States Census Bureau's Vintage 2019 population totals, and (iii) North Carolina municipalities who are also MDL Parties as of January 1, 2021.

b. Municipality may direct payments to county. Any municipality allocated a share in **Exhibit G** may elect to have its share of current or future annual distributions of Local Abatement Funds instead directed to the county or counties in which it is located. Such an election may be made by January 1 each year to apply to the following fiscal year. If a municipality is located in more than one county, the municipality's funds will be directed based on the MDL Matter's Opioid Negotiation Class Model.

5. Use of funds for opioid remediation activities. This MOA requires that except as related to the payment of the Parties' litigation expenses and the reimbursement of the United States Government, all Opioid Settlement Funds, regardless of allocation, shall be utilized only for opioid remediation activities.

6. Relationship of this MOA to other agreements and resolutions. All Parties acknowledge and agree the National Settlement Agreement will require a Local Government to release all its claims against the Settling Defendants to receive Opioid Settlement Funds. All Parties further acknowledge and agree based on the terms of the National Settlement Agreement, a Local Government may receive funds through this MOA only after complying with all requirements set forth in the National Settlement Agreement to release its claims. This MOA is not a promise from any Party that any National Settlement Agreement or Bankruptcy Resolution will be finalized or executed.

C. Payment of Litigating and Non-Litigating Parties

No Party engaged in litigating the MDL Matter shall receive a smaller payment than a similarly situated non-litigating Party, other than as based on the Allocation Proportions in **Exhibit G** or based on the eligibility criteria for payments from the County Incentive Fund as provided by **Section G** below.

D. Special Revenue Fund

1. Creation of special revenue fund. Every Local Government receiving Opioid Settlement Funds shall create a separate special revenue fund, as described below, that is designated for the receipt and expenditure of the Opioid Settlement Funds.

2. Procedures for special revenue fund. Funds in this special revenue fund shall not be commingled with any other money or funds of the Local Government. The funds in the

special revenue fund shall not be used for any loans or pledge of assets, unless the loan or pledge is for an opioid remediation purpose consistent with the terms of this MOA and adopted under the process described in **Section E.6** below. Although counties or municipalities may make contracts with or grants to a nonprofit, charity, or other entity, counties or municipalities may not assign to another entity their rights to receive payments from the national settlement or their responsibilities for funding decisions.

3. Interest earned on special revenue fund. The funds in the special revenue fund may be invested, consistent with the investment limitations for local governments, and may be placed in an interest-bearing bank account. Any interest earned on the special revenue fund must be used in a way that is consistent with this MOA.

E. Opioid Remediation Activities.

1. Limitation on use of funds. Local Governments shall expend Opioid Settlement Funds only for opioid-related expenditures consistent with the terms of this MOA and incurred after the date of the Local Government's execution of this MOA, unless execution of the National Settlement Agreement requires a later date.

2. Opportunity to cure inconsistent expenditures. If a Local Government spends any Opioid Settlement Funds on an expenditure inconsistent with the terms of this MOA, the Local Government shall have 60 days after discovery of the expenditure to cure the inconsistent expenditure through payment of such amount for opioid remediation activities through budget amendment or repayment.

3. Consequences of failure to cure inconsistent expenditures. If a Local Government does not make the cure required by **Section E.2** above within 60 days, (i) future Opioid Fund payments to that Local Government shall be reduced by an amount equal to the inconsistent expenditure, and (ii) to the extent the inconsistent expenditure is greater than the expected future stream of payments to the Local Government, the Attorney General may initiate a process up to and including litigation to recover and redistribute the overage among all eligible Local Governments. The Attorney General may recover any litigation expenses incurred to recover the funds. Any recovery or redistribution shall be distributed consistent with **Sections B.3 and B.4** above.

4. Annual meeting of counties and municipalities within each county. Each county receiving Opioid Settlement Funds shall hold at least one annual meeting with all municipalities in the Local Government's county invited in order to receive input as to proposed uses of the Opioid Settlement Funds and to encourage collaboration between local governments both within and beyond the county. These meetings shall be open to the public.

5. Use of settlement funds under Option A and Option B. Local Governments shall spend Opioid Settlement Funds from the Local Abatement Funds on opioid remediation activities using either or both of the processes described as Option A and Option B below, unless the relevant National Settlement Agreement or Bankruptcy Resolution further limit the spending.

a. Option A.

i. Without any additional strategic planning beyond the meeting described in **Section E.4** above, Local Governments may spend Opioid Settlement Funds from the list of High-Impact Opioid Abatement Strategies attached as **Exhibit A**. This list is a subset of the initial opioid remediation strategies listed in the National Settlement Agreement.

ii. **Exhibit A** may be modified as set forth in Exhibit D below; provided, however, that any strategy listed on **Exhibit A** must be within the list of opioid remediation activities for the then-current National Settlement Agreement. Opioid remediation activities undertaken under a previously authorized strategy list may continue if they were authorized at the time of the Local Government's commitment to spend funds on that activity.

b. Option B.

i. A Local Government that chooses to participate in additional voluntary, collaborative, strategic planning may spend Opioid Settlement Funds from the broader list of categories found in **Exhibit B**. This list contains all the initial opioid remediation strategies listed in the National Settlement Agreement.

ii. Before spending any funds on any activity listed in **Exhibit B**, but not listed on **Exhibit A**, a Local Government must first engage in the collaborative strategic planning process described in **Exhibit C**. This process shall result in a report and non-binding recommendations to the Local Government's Governing Body described in **Exhibit C** (right-hand column).

iii. A Local Government that has previously undertaken the collaborative strategic planning process described in **Exhibit C** and wishes to continue implementing a strategy listed in **Exhibit B**, but not listed in **Exhibit A**, shall undertake a new collaborative strategic planning process every four years (or more often if desired).

iv. A Local Government that has previously undertaken the collaborative strategic planning process described in **Exhibit C** that wishes to implement a new strategy listed in **Exhibit B** but not listed in **Exhibit A**, shall undertake a new collaborative strategic planning process.

v. Two or more Local Governments may undertake a single collaborative strategic planning process resulting in a report and recommendations to all of the Local Governments involved.

6. Process for drawing from special revenue funds.

    a. Budget item or resolution required. Opioid Settlement Funds can be used for a purpose when the Governing Body includes in its budget or passes a separate resolution authorizing the expenditure of a stated amount of Opioid Settlement Funds for that purpose or those purposes during a specified period of time.

    b. Budget item or resolution details. The budget or resolution should (i) indicate that it is an authorization for expenditure of opioid settlement funds; (ii) state the specific strategy or strategies the county or municipality intends to fund pursuant to Option A or Option B, using the item letter and/or number in **Exhibit A** or **Exhibit B** to identify each funded strategy, and (iii) state the amount dedicated to each strategy for a stated period of time.

7. Coordination group. A coordination group with the composition and responsibilities described in **Exhibit D** shall meet at least once a year during the first three years that this MOA is in effect. Thereafter, the coordination group shall meet at least once every three years until such time as Opioid Settlement Funds are no longer being spent by Local Governments.

F. Auditing, Compliance, Reporting, and Accountability

1. Audits under Local Government Budget and Fiscal Control Act. Local Governments' Opioid Settlement Funds are subject to financial audit by an independent certified public accountant in a manner no less than what is required under G.S. 159-34. Each Local Government must file an annual financial audit of the Opioid Settlement Funds with the Local Government Commission. If any such audit reveals an expenditure inconsistent with the terms of this MOA, the Local Government shall immediately report the finding to the Attorney General.

2. Audits under other acts and requirements. The expenditure of Opioid Settlement Funds is subject to the requirements of the Local Government Budget and Fiscal Control Act, Chapter 159 of the North Carolina General Statutes; Local Government Commission rules; the Federal Single Audit Act of 1984 (as if the Opioid Settlement Funds were federal funds); the State Single Audit Implementation Act; Generally Accepted Government Auditing Standards; and all other applicable laws, rules, and accounting standards. For expenditures for which no compliance audit is required under the Federal Single Audit Act of 1984, a compliance audit shall be required under a compliance supplement approved by the coordination group.

3. Audit costs. Reasonable audit costs that would not be required except for this Section F may be paid by the Local Government from Opioid Settlement Funds..

4. Access to persons and records. During and after the term of this MOA, the State Auditor and Department of Justice shall have access to persons and records related to this MOA and expenditures of Opioid Settlement Funds to verify accounts and data affecting fees or

performance. The Local Government manager/administrator is the point of contact for questions that arise under this MOA.

5. Preservation of records. The Local Government must maintain, for a period of at least five years, records of Opioid Settlement Fund expenditures and documents underlying those expenditures, so that it can be verified that funds are being or have been utilized in a manner consistent with the National Settlement Agreement, any Bankruptcy Resolutions, and this MOA.

6. Reporting.

   a. Annual financial report required. In order to ensure compliance with the opioid remediation provisions of the National Settlement Agreement, any Bankruptcy Resolutions, and this MOA, for every fiscal year in which a Local Government receives, holds, or spends Opioid Settlement Funds, the county or municipality must submit an annual financial report specifying the activities and amounts it has funded.

   b. Annual financial report timing and contents. The annual financial report shall be provided to the North Carolina Attorney General by emailing the report to opioiddocs@ncdoj.gov, within 90 days of the last day of the state fiscal year covered by the report. Each annual financial report must include the information described on **Exhibit E**.

   c. Reporting to statewide opioid settlement dashboard. Each Local Government must provide the following information to the statewide opioid settlement dashboard within the stated timeframes:

      i. The budget or resolution authorizing the expenditure of a stated amount of Opioid Settlement Funds for a specific purpose or purposes during a specified period of time as described in **Section E.6.b** above (within 90 days of the passage of any such budget or resolution);
      ii. If the Local Government is using Option B, the report(s) and non-binding recommendations from collaborative strategic planning described in **Section E.5.b.ii** above and **Exhibit C** (right hand column) (within 90 days of the date the report and recommendations are submitted to the local governing body for consideration);
      iii. The annual financial reports described in Section F.6.a and **Exhibit E** (within 90 days of the end of the fiscal year covered by the report); and
      iv. The impact information described in **Exhibit F** (within 90 days of the end of the fiscal year covered by the report).

      The State will create an online portal with instructions for Local Governments to report or upload each of these four items by electronic means.

d. Copy to NCDOJ of any additional reporting. If the National Settlement Agreement or any Bankruptcy Resolutions require that a Local Government file, post, or provide a report or other document beyond those described in this MOA, or if any Local Government communicates in writing with any national administrator or other entity created or authorized by the National Settlement Agreement or any Bankruptcy Resolutions regarding the Local Government's compliance with the National Settlement Agreement or Bankruptcy Resolutions, the Local Government shall email a copy of any such report, document, or communication to the North Carolina Department of Justice at opioiddocs@ncdoj.gov.

e. Compliance and non-compliance.

i. Every Local Government shall make a good faith effort to comply with all of its reporting obligations under this MOA, including the obligations described in **Section F.6.c** above.

ii. A Local Government that engages in a good faith effort to comply with its reporting obligations under **Section F.6.c** but fails in some way to report information in an accurate, timely, or complete manner shall be given an opportunity to remedy this failure within a reasonable time.

iii. A Local Government that does not engage in a good faith effort to comply with its reporting obligations under this MOA, or that fails to remedy reporting issues within a reasonable time, may be subject to action for breach of contract.

iv. Notwithstanding anything to the contrary herein, a Local Government that is in substantial compliance with the reporting obligations in this MOA shall not be considered in breach of this MOA or in breach of contract.

7. Collaboration. The State and Local Governments must collaborate to promote effective use of Opioid Settlement Funds, including through the sharing of expertise, training, technical assistance. They will also coordinate with trusted partners to collect and share information about successful regional and other high-impact strategies and opioid treatment programs.

G. County Incentive Fund

A Local Government receiving Settlement Proceeds pursuant to **Section B.4.a** shall be an Incentive Eligible Local Government if every municipality in the Local Government's county with population of at least 30,000 has executed this MOA by October 1, 2021, but no later than any such deadline set in the National Settlement Agreement for the highest possible participation in incentive structures for North Carolina. Each Incentive Eligible Local Government shall receive a share of the 5% County Incentive Fund set forth in **Section B.2.iii**, distributed pro rata among only Incentive Eligible Local Governments as set forth in **Exhibit G**. For purposes of the calculations required by this Section, populations will be based on United States Census Bureau's Vintage 2019 population totals, and a municipality with populations in multiple counties will be counted only toward the county which has the largest share of that municipality's population.

H. Effectiveness

1. When MOA takes effect. This MOA shall become effective at the time a sufficient number of Local Governments have joined the MOA to qualify this MOA as a State-Subdivision Agreement under the National Settlement Agreement or any Bankruptcy Resolution. If this MOA does not thereby qualify as a State-Subdivision Agreement, this MOA will have no effect.

2. Amendments to MOA.

    a. Amendments to conform to final national documents. The Attorney General, with the consent of a majority vote from a group of Local Government attorneys appointed by the Association of County Commissioners, may initiate a process to amend this MOA to make any changes required by the final provisions of the National Settlement Agreement or any Bankruptcy Resolution. The Attorney General's Office will provide written notice of the necessary amendments to all the previously joining parties. Any previously joining party will have a two-week opportunity to withdraw from the MOA. The amendments will be effective to any party that does not withdraw.

    b. Coordination group. The coordination group may make the changes authorized in **Exhibit D**.

    c. No amendments to allocation between Local Governments. Notwithstanding any other provision of this MOA, the allocation proportions set forth in **Exhibit G** may not be amended.

    d. General amendment power. After execution, the coordination group may propose other amendments to the MOA, subject to the limitation in **Section H.2.c** above. Such amendments will take effect only if approved in writing by the Attorney General and at least two-thirds of the Local Governments who are Parties to this MOA. In the vote, each Local Government Party will have a number of votes measured by the allocation proportions set forth in **Exhibit G**.

3. Acknowledgement. The Parties acknowledge that this MOA is an effective and fair way to address the needs arising from the public health crisis due to the misconduct committed by the Pharmaceutical Supply Chain Participants.

4. When MOA is no longer in effect. This MOA is effective until one year after the last date on which any Opioid Settlement Funds are being spent by Local Governments pursuant to the National Settlement Agreement and any Bankruptcy Resolution.

5. Application of MOA to settlements and bankruptcy resolutions. This MOA applies to all settlements under the National Settlement Agreement with the Settling Defendants and any Bankruptcy Resolutions. The Parties agree to discuss the use, as the Parties may deem appropriate in the future, of the settlement terms set out herein (after any necessary

amendments) for resolutions with Pharmaceutical Supply Chain Participants not covered by the National Settlement Agreement or a Bankruptcy Resolution.

6. Applicable law and venue. Unless required otherwise by the National Settlement Agreement or a Bankruptcy Resolution, this MOA shall be interpreted using North Carolina law and any action related to the provisions of this MOA must be adjudicated by the Superior Court of Wake County. If any provision of this MOA is held invalid by any court of competent jurisdiction, this invalidity does not affect any other provision which can be given effect without the invalid provision.

7. Scope of MOA. The Parties acknowledge that this MOA does not excuse any requirements placed upon them by the terms of the National Settlement Agreement or any Bankruptcy Resolution, except to the extent those terms allow for a State-Subdivision Agreement to do so.

8. No third party beneficiaries. No person or entity is intended to be a third party beneficiary of this MOA.

9. No effect on authority of parties. Nothing in this MOA shall be construed to affect or constrain the authority of the Parties under law.

10. Signing and execution of MOA. This MOA may be signed and executed simultaneously in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same agreement. A signature transmitted by facsimile or electronic image shall be deemed an original signature for purposes of executing this MOA. Each person signing this MOA represents that he or she is fully authorized to enter into the terms and conditions of, and to execute, this MOA, and that all necessary approvals and conditions precedent to his or her execution have been satisfied.

(Signature pages follow.)

Signature pages will be structured as one page for the State of North Carolina, followed by separate signature pages for each county.

These signature pages will also include blanks for the county's municipalities.

To avoid having 101 signature pages in the middle of this file, the signature pages are in a separate document.

EXHIBIT A TO NC MOA:
HIGH-IMPACT OPIOID ABATEMENT STRATEGIES ("OPTION A" List)

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

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

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

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

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

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

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

6. **Early intervention.** Fund programs, services, or training to encourage early identification and intervention for children or adolescents who may be struggling with problematic use of drugs or mental health conditions, including Youth Mental Health

First Aid, peer-based programs, or similar approaches. Training programs may target parents, family members, caregivers, teachers, school staff, peers, neighbors, health or human services professionals, or others in contact with children or adolescents.

7. **Naloxone distribution.** Support programs or organizations that distribute naloxone to persons at risk of overdose or their social networks, such as Syringe Service Programs, post-overdose response teams, programs that provide naloxone to persons upon release from jail or prison, emergency medical service providers or hospital emergency departments that provide naloxone to persons at risk of overdose, or community-based organizations that provide services to people who use drugs. Programs or organizations involved in community distribution of naloxone may, in addition, provide naloxone to first responders.

8. **Post-overdose response team.** Support post-overdose response teams that connect persons who have experienced non-fatal drug overdoses to addiction treatment, recovery support, harm reduction services, primary healthcare, or other services or supports they need to improve their health or well-being.

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

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

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

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

EXHIBIT B TO NC MOA:

Additional Opioid Remediation Activities ("OPTION B" List)

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

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:[1]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

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

8. Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.

14. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in treatment for or recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved medication with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have – or at risk of developing – OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically-appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL-JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice

system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

a. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative (PAARI);

b. Active outreach strategies such as the Drug Abuse Response Team (DART) model;

c. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

d. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model;

e. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

f. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison, have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (NAS), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

6. Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Enhanced family supports and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including but not limited to parent skills training.

10. Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

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

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

1. Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:

a. Increase the number of prescribers using PDMPs;

b. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

c. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increase electronic prescribing to prevent diversion or forgery.

8. Educate Dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

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

1. Fund media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Fund community anti-drug coalitions that engage in drug prevention efforts.

6. Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

7. Engage non-profits and faith-based communities as systems to support prevention.

8. Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or other drug misuse.

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

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

1. Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, individuals at high risk of overdose, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities that provide free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Support screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

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

1. Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

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

1. Statewide, regional, local, or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services; to support training and technical assistance; or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to share reports, recommendations, or plans to spend Opioid Settlement Funds; to show how Opioid Settlement Funds have been spent; to report program or strategy outcomes; or to track, share, or visualize key opioid-related or health-related indicators and supports as identified through collaborative statewide, regional, local, or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

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

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

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

1. Monitoring, surveillance, data collection, and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g. Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

EXHIBIT C to NC MOA:
COLLABORATIVE STRATEGIC PLANNING PROCESS UNDER OPTION B

	ACTIVITY NAME	ACTIVITY DETAIL	CONTENT OF REPORT & RECOMMENDATIONS
A	Engage diverse stakeholders	Engage diverse stakeholders, per "ITEM A DETAIL" below, throughout the collaborative strategic planning process	Report on stakeholder engagement per "ITEM A DETAIL" below
B	Designate facilitator	Designate a person or entity to facilitate the strategic collaborative planning process. Consider a trained, neutral facilitator.	Identify the facilitator
C	Build upon any related planning	Build upon or coordinate with prior or concurrent planning efforts that address addiction, drug misuse, overdose, or related issues, including but not limited to community health assessments.	Report any related planning efforts you will build upon or coordinate with
D	Agree on shared vision	Agree on a shared vision for positive community change, considering how strategic investments of Opioid Settlement Funds have the potential to improve community health and well-being and address root causes of addiction, drug misuse, overdose, and related issues	Report on shared vision for positive community change
E	Identify key indicator(s)	Identify one or more population-level measures to monitor in order to gauge progress towards the shared vision. (The NC Opioid Action Plan Data Dashboard contains several such measures.)	Report on the key indicators selected
F	Identify and explore root causes	Explore root causes of addiction, drug misuse, overdose, and related issues in the community, using quantitative data as well as stakeholder narratives, community voices, the stories of those with lived experience, or similar qualitative information	Report on root causes as described
G	Identify and evaluate potential strategies	Identify potential strategies to address root causes or other aspects of the opioid epidemic; identify these strategies (by letter or number) on EXHIBIT A or EXHIBIT B, and consider the effectiveness of each strategy based on available evidence	Identify and evaluate potential strategies
H	Identify gaps in existing efforts	For each potential strategy identified (or for favored strategies), survey existing programs, services, or supports that address the same or similar issues; and identify gaps or shortcomings	Report on survey of and gaps in existing efforts
I	Prioritize strategies	Prioritize strategies, taking into account your shared vision, analysis of root causes, evaluation of each strategy, and analysis of gaps in existing efforts	Report on prioritization of strategies
J	Identify goals, measures, and evaluation plan	For each strategy (or favored strategy), develop goals and an evaluation plan that includes at least one process measure (How much did you do?), at least one quality measure (How well did you do it?), and at least one outcome measure (Is anyone better off?)	Report on goals, measures, and evaluation plan for each chosen strategy
K	Consider ways to align strategies	For each potential strategy identified (or for favored strategies), consider opportunities to braid Opioid Settlement Funds with other funding streams; develop regional solutions; form strategic partnerships; or to pursue other creative solutions	Report on opportunities to align strategies as described
L	Identify organizations	Identify organizations and agencies with responsibility to implement each strategy; and identify the human, material, and capital resources to implement each strategy	Identify organizations and needs to implement each strategy

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

ITEM A DETAIL: STAKEHOLDER INVOLVEMENT

	STAKE-HOLDERS	**DESCRIPTION**	**CONTENT OF REPORT & RECOMMENDATIONS**
A-1	Local officials	County and municipal officials, such as those with responsibility over public health, social services, and emergency services	Report stakeholder involvement (who and how involved in process)
A-2	Healthcare providers	Hospitals and health systems, addiction professionals and other providers of behavioral health services, medical professionals, pharmacists, community health centers, medical safety net providers, and other healthcare providers	same as above
A-3	Social service providers	Providers of human services, social services, housing services, and community health services such as harm reduction, peer support, and recovery support services	same
A-4	Education and employment service providers	Educators, such as representatives of K-12 schools, community colleges, and universities; and those providing vocational education, job skills training, or related employment services	same
A-5	Payers and funders	Health care payers and funders, such as managed care organizations, prepaid health plans, LME-MCOs, private insurers, and foundations	same
A-6	Law enforcement	Law enforcement and corrections officials	same
A-7	Employers	Employers and business leaders	same
A-8	Community groups	Community groups, such as faith communities, community coalitions that address drug misuse, groups supporting people in recovery, youth leadership organizations, and grassroots community organizations	same
A-9	Stakeholders with "lived experience"	Stakeholders with "lived experience," such as people with addiction, people who use drugs, people in medication-assisted or other treatment, people in recovery, people with criminal justice involvement, and family members or loved ones of the individuals just listed	same
A-10	Stakeholders reflecting diversity of community	Stakeholders who represent the racial, ethnic, economic, and cultural diversity of the community, such as people of color, Native Americans, members of the LGBTQ community, and members of traditionally unrepresented or underrepresented groups	same

EXHIBIT D TO NC MOA:
COORDINATION GROUP

COMPOSITION

The Coordination Group shall consist of the following twelve members:

Five Local Government Representatives

- Four appointed by the North Carolina Association of County Commissioners including:
  - One county commissioner
  - One county manager
  - One county attorney
  - One county local health director or consolidated human services director

- One municipal manager appointed by the North Carolina League of Municipalities

Four Experts Appointed by the Department of Health and Human Services

- Four appointed by the Secretary of the Department of Health and Human Services, having relevant experience or expertise with programs or policies to address the opioid epidemic, or with behavioral health, public health, health care, harm reduction, social services, or emergency services.

One Expert Appointed by the Attorney General

- One appointed by the Attorney General of North Carolina from the North Carolina Department of Justice or another state agency, having drug policy or behavioral health experience or expertise.

Two Experts Appointed by Legislative Leaders

- One representative from the University of North Carolina School of Government with relevant expertise appointed by the Speaker of the North Carolina House of Representatives.
- One representative from the board or staff of the North Carolina Institute of Medicine with relevant expertise appointed by the President Pro Tem of the North Carolina Senate.

The coordination group may appoint a non-voting administrator to convene meetings and facilitate the work of the coordination group. The administrator will not be paid from the Opioid Settlement Funds distributed under this MOA.

Appointees shall have relevant experience or expertise with programs or policies to address the opioid epidemic, behavioral health, public health, health care, social services, emergency services, harm reduction, management of local government, or other relevant areas.

Those responsible for making appointments to the coordination group are encouraged to appoint individuals who reflect the diversity of North Carolina, taking into consideration the need for geographic diversity; urban and rural perspectives; representation of people of color and

traditionally underrepresented groups; and the experience and perspective of persons with "lived experience." Those responsible for making appointments may appoint a successor or replace a member at any time. Members of the coordination group serve until they resign or are replaced by the appointer. Eight members of the coordination group constitutes a quorum.

RESPONSIBILITIES

a. As provided in **Section F.2** of the MOA, where no compliance audit would be required under the Federal Single Audit Act of 1984 for expenditures of Opioid Settlement Funds, a compliance audit shall be required under a compliance supplement established by a vote of at least 8 members of the coordination group. The compliance supplement shall address, at least, procedures for determining:

    i. Whether the Local Government followed the procedural requirements of the MOA in ordering the expenditures.

    ii. Whether the Local Government's expenditures matched one of the types of opioid-related expenditures listed in **Exhibit A** of the MOA **(**if the Local Government selected Option A) or **Exhibit B** of the MOA (if the Local Government selected Option B).

    iii. Whether the Local Government followed the reporting requirements in the MOA.

    iv. Whether the Local Government (or sub-recipient of any grant or loan, if applicable) utilized the awarded funds for their stated purpose, consistent with this MOA and other relevant standards.

    v. Which processes (such as sampling) shall be used:
        i. To keep the costs of the audit at reasonable levels; and
        ii. Tailor audit requirements for differing levels of expenditures among different counties.

b. The coordination group may, by a vote of at least 8 members, propose amendments to the MOA as discussed in **Section H** of the MOA or modify any of the following:

    i. The high-impact strategies discussed in **Section E.5** of the MOA and described in **Exhibit A** to the MOA;

    ii. The collaborative strategic planning process discussed in **Section E.5** of the MOA and described in **Exhibit C** to the MOA;

    iii. The annual financial report discussed in **Section F.4** of the MOA and described in **Exhibit E** to the MOA;

    iv. The impact information discussed in **Section F.4** of the MOA and described in **Exhibit F** to the MOA; or

    v. Other information reported to the statewide opioid dashboard.

c. The coordination group may, by consensus or by vote of a majority of members present and voting, work with the parties to this MOA, the North Carolina Association of County Commissioners, the North Carolina League of Municipalities, other associations, foundations, non-profits, and other government or nongovernment entities to provide support to Local Governments in their efforts to effectuate the goals and implement the terms of this MOA. Among other activities, the coordination group may coordinate, facilitate, support, or participate in any of the following activities:

   i. Providing assistance to Local Governments in identifying, locating, collecting, analyzing, or reporting data used to help address the opioid epidemic or related challenges, including data referred to in **Exhibit F**;

   ii. Developing resources or providing training or technical assistance to support Local Governments in addressing the opioid epidemic and carrying out the terms of this MOA;

   iii. Developing pilot programs, trained facilitators, or other resources to support the collaborative strategic planning process described in this MOA;

   iv. Developing and implementing a voluntary learning collaborative among Local Governments and others to share best practices in carrying out the terms of this MOA and addressing the opioid epidemic, including in-person or virtual convenings or connections;

   v. Developing voluntary leadership training programs for local officials on strategies to address the opioid epidemic, opportunities for Local Governments to harness the ongoing transition to value-based healthcare, and other relevant topics;

   vi. Taking other actions that support Local Governments in their efforts to effectuate the goals and implement the terms of this MOA but do not in any way change the terms of this MOA or the rights or obligations of parties to this MOA.

EXHIBIT E TO NC MOA:
ANNUAL FINANCIAL REPORT

Each annual financial report must include the following financial information:

1. The amount of Opioid Settlement Funds in the special revenue fund at the beginning of the fiscal year (July 1).
2. The amount of Opioid Settlement Funds received during the fiscal year.
3. The amount of Opioid Settlement Funds disbursed or applied during the fiscal year, broken down by funded strategy (with any permissible common costs prorated among strategies).
4. The amount of Opioid Settlement Funds used to cover audit costs as provided in Section F.3 of this MOA.
5. The amount of Opioid Settlement Funds in the special revenue fund at the end of the fiscal year (June 30).

All Local Governments that receive two-tenths of one percent (0.2 percent) or more of the total Local Government Allocation as listed in **Exhibit G** shall provide the following additional information:

6. For all Opioid Settlement Funds disbursed or applied during the fiscal year as reported in item 3 above, a single breakdown of the total amount disbursed or applied for all funded strategies during the fiscal year into the following categories:
   a. Human resource expenditures.
   b. Subcontracts, grants, or other payments to sub-recipients involved in implementing of the funded strategies listed item 4 above.
   c. Operational expenditures.
   d. Capital expenditures.
   e. Other expenditures.

7. With respect to item 6.b above, the Local Government shall provide the following information for any sub-recipient that receives ten percent or more of the total amount that the Local Government disbursed or applied during the fiscal year:
   a. The name of the sub-recipient.
   b. The amount received by the sub-recipient during the fiscal year.
   c. A very brief description of the goods, services, or other value provided by the sub-recipient (for example, “addiction treatment services” or “peer-support services” or “syringe service program” or “naloxone purchase”).

The coordination group may clarify or modify specifications for this annual financial report as provided in Exhibit D.

EXHIBIT F TO NC MOA:
IMPACT INFORMATION

Within 90 days of the end of any fiscal year in which a Local Government expends Opioid Settlement Funds, the Local Government shall report impact information for each strategy that it funded with Opioid Settlement Funds during that fiscal year ("funded strategy"), using the STANDARD FORM or the SHORT FORM for each funded strategy.

The STANDARD FORM is recommended to all Local Governments for all funded strategies. However, Local Governments may use the SHORT FORM as follows:

- All Local Governments that receive less than 0.2 percent (two-tenths of one percent) of the total Local Government Allocation as shown on **Exhibit G** may use the SHORT FORM for all funded strategies.

- All Local Governments that receive 0.2 percent (two-tenths of one percent) or more but less than 0.3 percent (three-tenths of one percent) of the total Local Government Allocation as shown on **Exhibit G** must use the STANDARD FORM for the funded strategy that received the largest amount of settlement funds during the fiscal year and may use the SHORT FORM for all other funded strategies.

- All Local Governments that receive 0.3 percent (three-tenths of one percent) or more but less than 0.4 percent (four-tenths of one percent) of the total Local Government Allocation as shown on **Exhibit G** must use the STANDARD FORM for the two funded strategies that received the largest amount of settlement funds during the fiscal year and may use the SHORT FORM for all other funded strategies.

STANDARD FORM

1. County or municipality and fiscal year covered by this report.

2. Name, title, and organization of person completing this report.

3. Name of funded strategy, letter and/or number of funded strategy on **Exhibit A** or **Exhibit B** to the MOA, and number and date of resolution(s) authorizing expenditure of settlement funds on funded strategy.

4. **Brief progress report** describing the funded strategy and progress made during the fiscal year. Recommended length: approximately one page (250 words).

5. **Brief success story** from a person who has benefitted from the strategy (de-identified unless the person has agreed in writing to be identified). Recommended length: approximately one page (250 words).

6. **One or more process measures,** addressing the question, "How much did you do?" Examples: number of persons enrolled, treated, or served; number of participants trained; units of naloxone or number of syringes distributed.

7. **One or more quality measures,** addressing the question, "How well did you do it?" Examples: percentage of clients referred to care or engaged in care; percentage of staff with

certification, qualification, or lived experience; level of client or participant satisfaction shown in survey data.

8. **One or more outcome measures,** addressing the question, "Is anyone better off?" Examples: number or percentage of clients with stable housing or employment; self-reported measures of client recovery capital, such as overall well-being, healthy relationships, or ability to manage affairs; number or percentage of formerly incarcerated clients receiving community services or supports within X days of leaving jail or prison.

9. In connection with items 6, 7, and 8 above, **demographic information** on the participation or performance of people of color and other historically marginalized groups.

The State will provide counties and municipalities with recommended measures and sources of data for common opioid remediation strategies such as those listed in **Exhibit A**.

Counties or municipalities that have engaged in collaborative strategic planning are encouraged to use the measures for items 6 through 8 above identified through that process.

SHORT FORM

1. County or municipality and fiscal year covered by this report.

2. Name, title, and organization of person completing this report.

3. Name of funded strategy, letter and/or number of funded strategy on **Exhibit A** or **Exhibit B** to the MOA, and number and date of resolution(s) authorizing expenditure of settlement funds on strategy.

4. **Brief progress report** describing the funded strategy and progress made on the funded strategy during the fiscal year. Recommended length: approximately one-half to one page (125-250 words).

EXHIBIT G TO NC MOA:
LOCAL GOVERNMENT ALLOCATION PROPORTIONS

Counties:

Alamance	1.378028967612490%
Alexander	0.510007879580514%
Alleghany	0.149090598929352%
Anson	0.182192960366522%
Ashe	0.338639188321974%
Avery	0.265996766935006%
Beaufort	0.477888434887858%
Bertie	0.139468575095652%
Bladen	0.429217809476617%
Brunswick	2.113238507591200%
Buncombe	2.511587857322730%
Burke	2.090196827047270%
Cabarrus	1.669573446626000%
Caldwell	1.276301146194650%
Camden	0.073036400412663%
Carteret	1.128465593852300%
Caswell	0.172920237524674%
Catawba	2.072695222699690%
Chatham	0.449814383077585%
Cherokee	0.782759152904478%
Chowan	0.113705596126821%
Clay	0.224429948904576%
Cleveland	1.119928027749120%
Columbus	1.220936938986050%
Craven	1.336860190247190%
Cumberland	2.637299659634610%
Currituck	0.186778551294444%
Dare	0.533126731273811%
Davidson	1.940269530393250%
Davie	0.513147526867745%
Duplin	0.382785147396895%
Durham	1.797994362444460%
Edgecombe	0.417101939026669%
Forsyth	3.068450809484740%
Franklin	0.500503643290578%
Gaston	3.098173886907710%
Gates	0.079567516632414%
Graham	0.183484561708488%
Granville	0.590103409340146%

Greene	0.123274818647799%
Guilford	3.375015231147900%
Halifax	0.453161173976264%
Harnett	0.988980772198890%
Haywood	0.803315110111045%
Henderson	1.381595087040930%
Hertford	0.206843050128754%
Hoke	0.332485804570157%
Hyde	0.027237354085603%
Iredell	2.115931374540020%
Jackson	0.507757731330674%
Johnston	1.250887468217670%
Jones	0.087966986994631%
Lee	0.653115683614534%
Lenoir	0.604282592625687%
Lincoln	0.926833627125253%
Macon	0.466767666100745%
Madison	0.237776496104888%
Martin	0.232882220579515%
McDowell	0.587544576492856%
Mecklenburg	5.038301259920550%
Mitchell	0.309314151564137%
Montgomery	0.226050543041193%
Moore	0.971739112775481%
Nash	0.845653639635102%
New Hanover	2.897264892001010%
Northampton	0.120996238921878%
Onslow	1.644001364710850%
Orange	1.055839419023090%
Pamlico	0.119936151028001%
Pasquotank	0.374816210815334%
Pender	0.585749331860312%
Perquimans	0.111833180344914%
Person	0.403024296727131%
Pitt	1.369008066415930%
Polk	0.266142985954851%
Randolph	1.525433986174180%
Richmond	0.749132839979529%
Robeson	1.359735343574080%
Rockingham	1.365368837477560%
Rowan	2.335219287913370%
Rutherford	0.928941617994687%
Sampson	0.619513740526226%
Scotland	0.449148274209402%

Stanly	0.724974208589555%
Stokes	0.623953112434303%
Surry	1.410826706091650%
Swain	0.281162928604502%
Transylvania	0.497595509451435%
Tyrrell	0.041440907207785%
Union	1.466702679869700%
Vance	0.536258255282162%
Wake	4.902455667205510%
Warren	0.106390583495122%
Washington	0.074770720453604%
Watauga	0.469675799939888%
Wayne	0.970699333078804%
Wilkes	1.997177160589100%
Wilson	0.646470841490459%
Yadkin	0.562147145073638%
Yancey	0.382114976889272%

Municipalities:

Asheville	0.235814724255298%
Canton	0.011453823221205%
Cary	0.144151645370137%
Charlotte	1.247483814366830%
Concord	0.227455870287483%
Durham	0.380405026684971%
Fayetteville	0.309769055181433%
Gastonia	0.257763823789835%
Greensboro	0.527391696384329%
Greenville	0.162656474659432%
Henderson	0.032253478794181%
Hickory	0.094875835682315%
High Point	0.206428762905859%
Jacksonville	0.095009869783840%
Raleigh	0.566724612722679%
Wilmington	0.119497493968465%
Winston-Salem	0.494459923803644%