

**GRANT AGREEMENT WITH PROVIDER
TO COMBAT OPIOID ABUSE IN HERNANDO COUNTY**

THIS GRANT AGREEMENT is entered into by and between HERNANDO COUNTY, a political subdivision of the State of Florida, with an address of 15470 Flight Path Drive, Brooksville, Florida 34604, by and through its Board of County Commissioners, herein referred to as the "COUNTY," and Premier Community HealthCare Group, Inc, a Florida not-for-profit corporation with an address of 3712 Church Avenue, Dade City, FL 33525, herein referred to as the "PROVIDER," to combat opioid abuse in Hernando County, Florida.

WITNESSETH:

WHEREAS, both the COUNTY and the State of Florida (the "State") filed lawsuits against certain opioid manufacturers and distributors and retail pharmacies seeking compensatory damages for the costs that the County and the State incurred combating opioid addiction; and,

WHEREAS, the State subsequently negotiated settlements on its own and local governments' behalf with the opioid manufacturers, distributors, and retail pharmacies that were named as defendants in the above-referenced lawsuits; and,

WHEREAS, the COUNTY subsequently approved the Florida Opioid Allocation and Statewide Response Agreement (the "Allocation Agreement"), a copy of which is attached hereto as Attachment "A," which establishes that the COUNTY shall receive an allocation of the settlement funds over an 18-year period; provided, that the COUNTY uses the funds for certain "Core Strategies" and "Approved Uses," as those terms are defined in the Allocation Agreement; and,

WHEREAS, on March 20, 2026, the Hernando County Housing and Supportive Services requested applications from community partners for grants, derived from the County's distribution from the City/County Fund, to combat opioid use in Hernando County; and,

WHEREAS, following a competitive process, the Hernando County Board of County Commissioners selected the Provider to receive a grant on July 14, 2026.

NOW, THEREFORE, in consideration of the mutual covenants, promises, and representations contained herein, the parties hereto agree as follows:

ARTICLE 1. INCORPORATION OF RECITALS

1. The above-stated recitals are incorporated herein by reference and made a part of this Grant Agreement.

ARTICLE 2. DEFINITIONS

The following definitions shall apply to this Grant Agreement.

2.1. Application means the application, and all materials attached thereto, submitted by the PROVIDER to the COUNTY associated with the PROVIDER seeking a Grant, including any and all verbal representations made by the PROVIDER in connection therewith. A copy of the Application is attached hereto as Attachment "B" and is incorporated into this Grant Agreement.

2.2. Contract Administrator means the Manager of the Hernando County Health and Human Services, or other person designated in writing by the County Administrator.

2.3. County Administrator means the administrative head of the County appointed by the Hernando County Board of County Commissioners.

2.4. Core Strategies and Approved Uses shall have meanings as is provided for the terms in the Allocation Agreement.

2.5. Grant Activities mean the Core Strategies and Approved Uses that the PROVIDER will undertake with the Grant Funds.

2.6. Grant Funds means the money that the COUNTY will provide to the PROVIDER pursuant to this Grant Agreement.

ARTICLE 3. ALLOCATION

3. The PROVIDER is allocated a total sum of **One Hundred Fifty Thousand and 00/100 Dollars (\$150,000.00)** herein referred to as the "Allocated Sum," by the COUNTY, in consideration for the performance of the duties as indicated in Articles 4 and 5.

ARTICLE 4. GRANT AWARD

4.1. Grant Award. The COUNTY shall provide the Grant Award to the PROVIDER for its use towards the Core Strategies and Approved Uses, as those terms are defined in the Allocation Agreement, as set forth in the Application.

4.2. Grant Award Uses; Recipient Application Accuracy. The PROVIDER shall only utilize the Grant Award, whether in whole or in part, for Core Strategies and Authorized Uses, as stated in the Application. The PROVIDER represents and warrants that all information included in the Application is true and correct, and that it is expressly prohibited from using any portion of the Grant Award for any purpose other than the uses stated in the Application.

ARTICLE 5. PERFORMANCE, SUBCONTRACTS, AND AMENDMENTS

5.1. Expenditure Deadline. The PROVIDER shall spend or commit all of the Grant Funds on or before (365 days) from the grant execution date (the "Expenditure Deadline"). Any

Grant Funds not spent or committed by the Expenditure Deadline shall revert to the COUNTY and this Grant Agreement shall terminate. An extension of the Expenditure Deadline may be requested in writing from the County Administrator at least (90) business days prior to the Expenditure Deadline. The County Administrator, at his or her discretion, may grant an extension of up to (60 days) from the Expenditure Deadline. Additional extensions may be authorized by the County Administrator if the PROVIDER can document in a written request sufficient cause for such an extension to be warranted.

5.2. Report Deadline. To demonstrate that the Grant Funds have been used in accordance with this Grant Agreement, the PROVIDER must submit to the County Administrator or their designee a written report documenting that the PROVIDER is meeting or has fulfilled all of the applicable financial, performance, and progress reports on the funded project. This report is to be received by the County Administrator or their designee monthly by the 15th of the month for activities conducted in the prior month from the date funds are distributed through the termination of the grant agreement. The PROVIDER shall also submit a written report to the County Administrator or their designee on or prior to September 30th of each year from the time of the execution of this Grant Agreement through the termination of this Grant Agreement demonstrating that the PROVIDER is fulfilling, or has fulfilled, its purpose, and has complied with all applicable Hernando County, state, and federal requirements. The County Administrator may also request that a compilation statement or independent financial audit and accounting for the expenditure of Grant Funds be prepared by an independent certified public accountant at the expense of the PROVIDER. In the event that the PROVIDER fails to submit the required reports as required above, the County Administrator may terminate this Grant Agreement in accordance with Article 7. Further, the County Administrator must approve these reports for the PROVIDER to be deemed to have met all conditions of this Grant Award.

5.3. Program Monitoring and Evaluation. The County Administrator, their designee, analyst, and Contract Administrator may monitor and conduct an evaluation of the PROVIDER's operations, which may include visits by County representatives to: PROVIDER's programs, procedures, and operations; discuss the PROVIDER's programs with the PROVIDER's personnel; and evaluate the public impact of the PROVIDER's programs. Upon request, the PROVIDER shall provide the County Administrator with notice of all meetings of its Board of Directors or governing board.

5.4. Payments. For its performance under this Grant Agreement, the Grant Funds shall be distributed to the PROVIDER in two equal payments, the first payment distribution within sixty (60) days of execution of this Grant Agreement, and the second payment distribution shall be made (6) months after the execution date of this Grant Agreement. Prior to the second payment, the PROVIDER shall provide the COUNTY a complete accounting as to how the first payment has been spent. The PROVIDER shall provide the COUNTY a complete accounting as to how the second payment has been spent within 30 days of the expenditure deadline.

5.5. Contracts and Subcontracts; Laws. The PROVIDER shall not enter into any contracts or subcontracts in the performance of this Grant Agreement that would affect the COUNTY's financial contribution without prior notice and written consent of the Contract Administrator. Notice and consent for such contracts and subcontracts may be provided through

electronic communications or United States Postal Service. All contracts or subcontracts made by the PROVIDER shall be made in accordance with all applicable Hernando County, State, and Federal laws, rules, and regulations stipulated in this Grant Agreement, and in strict accordance with all terms, covenants, and conditions in this Agreement.

5.6. Subcontract Monitoring. If applicable, the PROVIDER shall monitor all subcontracted services on a regular basis to assure compliance. Results of monitoring efforts shall be summarized in written reports and supported with documented evidence of follow-up actions taken to correct areas of noncompliance. Such summaries and documents shall be submitted to the COUNTY upon request.

5.7. Amendments. The COUNTY or the PROVIDER may amend this Grant Agreement provided that such amendments make specific reference to this Grant Agreement and are executed and approved in writing by the governing bodies of each party. Such amendments shall not invalidate this Grant Agreement, nor relieve or release the COUNTY or the PROVIDER from its obligations under this Grant Agreement or change the independent agency status of the PROVIDER. The COUNTY may, at its discretion, amend this Grant Agreement to conform with Hernando County, State, or Federal, guidelines or policies, available funding amounts, or for other reasons. If such amendment results in a change in the funding, the scope of services, or the schedule of activities to be undertaken as part of this Grant Agreement, such modifications will be incorporated only by written amendment signed by both the COUNTY and the PROVIDER.

ARTICLE 6. TERM

6. The term of this agreement is July 1, 2026, through June 30, 2027, at which time this Grant Agreement shall automatically terminate unless an extension is agreed upon by both parties in writing for an additionally agreed upon period. Failure to comply with the conditions set forth herein will result in a breach of contract and damages shall be payable to the COUNTY in the amount of the Grant Funds.

ARTICLE 7. TERMINATION AND SUSPENSION

7.1. Termination for Cause. Either party may terminate this Grant Agreement with cause. Cause shall include, but is not limited to, failure to strictly comply with all applicable Hernando County, State, and Federal rules and regulations, or any substandard performance as described herein. In the event of substandard performance, the COUNTY shall notify the PROVIDER in writing of such substandard performance, and the PROVIDER shall take corrective action within sixty (60) days from receipt of the notice from the COUNTY, which shall constitute the initial sixty (60) days cure period. If applicable, upon termination of this Grant Agreement for any reason, all Grant Funds that have been delivered to the PROVIDER by the COUNTY, but have not been expended, including any interest accrued from the effective date of this Grant Agreement until termination, must be returned to the COUNTY no later than ninety (90) days from delivery of the Notice of Termination of this Grant Agreement. The PROVIDER will be compensated for any work successfully completed prior to the Notice of Termination.

7.2. Suspension. In lieu of termination, upon a finding of cause, as defined in this article,

the COUNTY may suspend this Grant Agreement and withhold any payment of the Grant Funds until such time as the PROVIDER is found to be in compliance by the COUNTY.

7.3. Repayment. The Provider shall repay the COUNTY all or a portion of the Grant Funds if (a) the Provider fails to complete the Grant Activities or a portion of the Grant Activities in accordance with the terms and conditions of this Grant Agreement, (b) the COUNTY determines, in its sole discretion and judgment, that the PROVIDER has failed to maintain scheduled progress of the Grant Activities, thereby endangering the timely performance of this Grant Agreement, or (c) a provision or provisions of this Grant Agreement setting forth the requirements or expectations of a deliverable resulting from the Grant Activities is held to be invalid, illegal, or unenforceable during the term of this Grant Agreement, contingent upon processes followed under Article 15. Should any of the above conditions exist that require the PROVIDER to repay the COUNTY, this Grant Agreement shall terminate in accordance with the procedure set forth herein.

ARTICLE 8. NOTICES

8. All notices, consents, waivers, demands, requests or other instruments required or permitted by this Grant Agreement shall be deemed to have been sufficiently served if the same shall be in writing and placed in the United States mail, via certified mail or registered mail, return receipt requested, with proper postage prepaid and addressed to the other party hereto at the address shown on page 1 hereof.

ARTICLE 9. PROGRAM RECORDS, AUDIT, AND DOCUMENTS

9.1. Records Retention. Each party shall maintain all such records and documents for at least five (5) years following termination date of this Grant Agreement.

9.2. Public Records. The PROVIDER shall comply with the requirements of Florida's Public Records Act, Chapter 119, Florida Statutes. To the extent required by Section 119.0701, Florida Statutes, the PROVIDER shall (a) keep and maintain those public records required by the COUNTY hereunder to perform the service under the Agreement; (b) upon request from the COUNTY's custodian of public records, provide the COUNTY with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided for under Florida's Public Records law; (c) ensure that the public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the contract term and following completion of the contract if the PROVIDER does not transfer the records to the COUNTY; and (d) upon completion of the contract, transfer, at no cost to the COUNTY, all public records in possession of the PROVIDER. Upon transfer, the PROVIDER shall destroy any duplicate public records that are exempt or confidential and exempt from public records requirements. All records stored electronically must be provided to the COUNTY in a format that is compatible with the Information Technology systems of the COUNTY. All documentation produced as part of this Agreement will become the property of the COUNTY. This paragraph shall survive the expiration or termination of this Agreement.

IF THE PROVIDER HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, AS TO THE PROVIDER'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS AGREEMENT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS, OFFICE OF THE PUBLIC INFORMATION COORDINATOR, AT TELEPHONE NUMBER (352) 540-6426, E-MAIL ADDRESS: publicinformation@co.hernando.fl.us; 15470 FLIGHT PATH DRIVE, BROOKSVILLE, FLORIDA 34604.

Under Florida law, in the event that the PROVIDER fails to provide the public records to the COUNTY within a reasonable time, the PROVIDER may be subject to penalties under Section 119.10, Florida Statutes, and such non-compliance will constitute a breach of the Grant Agreement and may serve as grounds for termination of this Grant Agreement. Such records shall be and remain available at the PROVIDER's place of business at all reasonable times during the term of this Agreement and for five (5) years after Agreement termination.

9.3. Audit. Payments made to the PROVIDER under this Grant Agreement shall be refunded to the COUNTY for amounts found to be not allowable under this Grant Agreement by an audit.

9.4. Upon request by the COUNTY, the PROVIDER shall provide the COUNTY with electronic or hardcopies of all data, reports, models, studies, maps, or other documents that result from the Grant Activities or this Grant Agreement. This subparagraph shall survive the expiration or termination of this Grant Agreement.

ARTICLE 10. RISK, LIABILITY, AND INDEMNITY

10.1. To the extent permitted by Florida law, the PROVIDER assumes all risks relating to the Grant Activities and agrees to be solely liable for and to indemnify and hold the COUNTY harmless from all claims, loss, damage, and other expenses, including attorneys' fees and costs and attorneys' fees and costs on appeal, arising from the operation or implementation of the Grant Activities; provided, however, that the PROVIDER shall not indemnify for that portion of any loss or damage proximately caused by the negligent act or omission of the COUNTY'S officers, employees, and agents. The acceptance of the COUNTY'S funding by the PROVIDER does not in any way constitute an agency relationship between the COUNTY and the PROVIDER.

10.2. The PROVIDER agrees to indemnify and hold the COUNTY harmless from all claims, loss, damage, and other expenses, including attorneys' fees and costs and attorneys' fees and costs on appeal, arising from the negligent acts or omissions of the PROVIDER's officers, employees, contractors, and agents related to its performance under this Grant Agreement.

10.3. This Risk, Liability and Indemnity Paragraph, including all subparagraphs, shall survive the expiration or termination of this Grant Agreement.

10.4. The PROVIDER shall at all times remain an independent agency and shall have no power, nor shall the PROVIDER represent that the PROVIDER has any power, to bind the COUNTY or to assume or to create any obligation expressed or implied on behalf of the COUNTY.

ARTICLE 11. RELEASE OF INFORMATION AND RECOGNITION

11.1. The parties agree not to initiate any oral or written media interviews or issue press releases on or about the Grant Activities without providing notices or copies to the other party.

11.2. The PROVIDER shall recognize the COUNTY's funding in any reports, studies, maps, marketing material, or other documents resulting from this Grant Agreement, and the form of said recognition shall be subject to the COUNTY's approval. The adopted COUNTY logo shall be used on all collateral materials where feasible.

ARTICLE 12. NO ASSIGNMENT

12. Except as otherwise provided in this Grant Agreement, no party may assign any of its rights or delegate any of its obligations under this Grant Agreement, including any operation or maintenance duties related to the Grant Activities, without the prior written consent of the other party. Any attempted assignment in violation of this provision is void. This Paragraph shall survive the expiration or termination of this Grant Agreement.

SECTION 13. APPLICABLE LAW; VENUE; ATTORNEY'S FEES; JURY TRIAL WAIVER

13.1. This Grant Agreement shall be governed by the laws of Florida and shall be deemed to have been prepared jointly by the PROVIDER and the COUNTY, and any uncertainty or ambiguity existing herein, if any, shall not be interpreted against either party, but shall be interpreted according to the application of the rules of interpretation for arm's-length agreements. Any dispute, claim, or action arising out of or related to this Agreement shall be brought solely in civil court located in Hernando County, Florida. Each party hereto shall bear their own attorneys' fees and costs in the event of any dispute, claim, action, or appeal arising out of or related to this Agreement.

13.2. EACH OF THE PARTIES HERETO HEREBY VOLUNTARILY AND IRREVOCABLY WAIVES TRIAL BY JURY IN ANY ACTION OR OTHER PROCEEDING BROUGHT IN CONNECTION WITH THIS GRANT AGREEMENT OR ANY OF THE TRANSACTIONS CONTEMPLATED HEREBY.

ARTICLE 14. SEVERABILITY

14. If any provision or provisions of this Grant Agreement shall be held to be invalid, illegal, or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. Notwithstanding the above, if a provision or provisions of this Grant Agreement setting forth the requirements or expectations of deliverables resulting from the Grant Activities are held to be invalid, illegal, or unenforceable during the term of this Grant Agreement, this Grant Agreement shall terminate in accordance with Article 7. This Paragraph shall survive the expiration or termination of this Agreement.

ARTICLE 15. DEFAULT

15. Either party may terminate this Grant Agreement upon the other party's failure to comply with any term or condition of this Grant Agreement, including the failure to meet task deadlines established in this Grant Agreement, as long as the terminating party is not in default of any term or condition of this Grant Agreement at the time of termination. To effect termination, the terminating party shall provide the defaulting party with a written "Notice of Termination" stating its intent to terminate and describing all terms and conditions with which the defaulting party has failed to comply. If the defaulting party has not remedied its default within sixty (60) days after receiving the Notice of Termination, this Grant Agreement shall automatically terminate. If a default cannot reasonably be cured in sixty (60) days, then the sixty (60) days may be extended for an additional thirty (30) days at the non-defaulting party's discretion if the defaulting party is pursuing a cure of the default with reasonable diligence. The rights and remedies in this provision are in addition to any other rights and remedies provided by law or this Grant Agreement.

ARTICLE 16. NO THIRD-PARTY BENEFICIARIES

16. This Grant Agreement is made for the sole benefit of the parties hereto and their respective successors, including any successor-in-interest to the PROVIDER's interest in the Grant Activities, and is not intended to and shall not benefit any third-party. No third-party shall have any rights hereunder or as a result of this Grant Agreement or any right to enforce any provisions of this Grant Agreement.

ARTICLE 17. ENTIRE AGREEMENT

17. This Grant Agreement and the attached documents listed below constitute the entire agreement between the parties and, unless otherwise provided herein, may be amended only in writing, signed by all parties to this Grant Agreement.

ARTICLE 18. DOCUMENTS

18. The following documents are attached and made a part of this Grant Agreement: the Allocation Agreement as Attachment "A," and the Application as Attachment "B." In the event of a conflict of contract terminology, priority shall first be given to the language in Attachment "A," then to the body of this Grant Agreement, and then to Attachment "B."

ARTICLE 19. MISCELLANEOUS

19.1. Neither the PROVIDER nor its employees may have or hold any continuing or frequently recurring employment or contractual relationship that is substantially antagonistic or incompatible with the PROVIDER's loyal and conscientious exercise of judgment and care related to its performance under the Grant Agreement. During the term of the Grant Agreement, none of the PROVIDER's officers or employees will serve as an expert witness against the COUNTY in any legal or administrative proceeding in which he, she, or the PROVIDER is not a party, unless compelled by court process. Further, such persons may not give sworn testimony or issue a report or writing as an expression of his or her expert opinion that is adverse or prejudicial to the interests

of the COUNTY in connection with any such pending or threatened legal or administrative proceeding unless compelled by court process. The limitations of this section do not preclude the PROVIDER or any persons in any way from representing themselves, including giving expert testimony in support of such representation, in any action or in any administrative or legal proceeding. If the PROVIDER is permitted in accordance with the Grant Agreement to utilize subcontractors in connection with the Grant Agreement, the PROVIDER must require the subcontractors, by written contract, to comply with the provisions of this section to the same extent as the PROVIDER.

19.2. Materiality and Waiver of Breach. Each requirement, duty, and obligation stated in the Grant Agreement was bargained for at arm's length and is agreed to by the parties. Each requirement, duty, and obligation stated in the Grant Agreement is substantial and important to the formation of the Grant Agreement, and each is, therefore, a material term of the Grant Agreement. The COUNTY's failure to enforce any provision of the Grant Agreement is not a waiver of such provision or modification of the Grant Agreement. A waiver of any breach of a provision of the Grant Agreement is not a waiver of any subsequent breach and is not to be constructed as a modification of the terms of the Grant Agreement. To be effective, any waiver must be in writing signed by an authorized signatory of the party.

19.3. Compliance with Laws. The PROVIDER and the Grant Activities must comply with all applicable federal, state, and local laws, codes, ordinances, rules, and regulations including, without limitation, the Americans with Disabilities Act, 42 U.S.C. § 12101, Section 504 of the Rehabilitation Act of 1973, and any related federal, state, or local laws, rules, and regulations.

19.4. Sovereign Immunity. Except to the extent sovereign immunity may be deemed to be waived by entering into the Grant Agreement, nothing in the Grant Agreement is intended to serve as a waiver of sovereign immunity by the COUNTY nor shall anything included therein be construed as consent by the COUNTY to be sued by third parties. The COUNTY is a political subdivision as defined in Section 768.28, Florida Statutes, and shall be responsible for the negligent or wrongful acts or omissions of its employees pursuant to Section 768.28, Florida Statutes.

19.5. Voluntary Execution; Role of Legal Counsel. The PROVIDER and the COUNTY acknowledge that the Grant Agreement is freely and voluntarily executed after the PROVIDER had an opportunity to review the Grant Agreement, and that the PROVIDER had adequate opportunity to consult with and receive the advice of counsel before entering into the Grant Agreement.

19.6. Interpretation. The titles and headings contained in this Grant Agreement are for reference purposes only and do not in any way affect the meaning or interpretation of the Grant Agreement. Terms such as "therein" and "thereof" refer to the Grant Agreement and/or Grant Program Terms as a whole and not to any particular sentence, paragraph, or section where they appear, unless the context otherwise requires. Whenever reference is made to a section or article of the Grant Award Terms and/or Grant Agreement, such reference is to the section or article, including all the subsections of such section, unless the reference is made to a particular subsection or subparagraph of such a section or article. Any reference to "days" means calendar days, unless otherwise expressly stated.

19.7. Prior Agreements. The Grant Agreement represents the final and complete understanding of the parties regarding the subject matter contained in the Grant Agreement and supersedes all prior and contemporaneous negotiations and discussions regarding that subject matter. There is no commitment, agreement, or understanding concerning the subject matter of the Grant Agreement that is not contained in the written document.

19.8. Payable Interest.

19.8.1. Payment of Interest. The COUNTY is not liable to pay any interest to the PROVIDER for any reason, whether as prejudgment interest or for any other purpose, and in furtherance of that purpose, the PROVIDER waives, rejects, disclaims, and surrenders any and all entitlement it has or may have to receive interest in connection with a dispute or claim arising from, related to, or in connection with the Grant Agreement. This section does not apply to any claim for interest, including for post judgment interest, if such application would be contrary to applicable law.

19.8.2. Rate of Interest. If the preceding section is inapplicable or is determined to be invalid or unenforceable by a court of competent jurisdiction, the annual rate of interest payable by the COUNTY under the Grant Agreement, whether as prejudgment interest or for any other purpose, will be, to the full extent permissible under applicable law, one quarter of one percent (0.25%) simple interest (uncompounded).

19.9. Representation of Authority. The PROVIDER represents and warrants that the Grant Agreement constitutes the legal, valid, binding, and enforceable obligation of the PROVIDER, and that neither the execution nor performance of the Grant Agreement constitutes a breach of any agreement that the PROVIDER has with any third party or violates any law, rule, regulation, or duty arising in law or equity applicable to the PROVIDER. The PROVIDER further represents and warrants that execution of the Grant Agreement is within the PROVIDER's legal powers, and each individual executing the Grant Agreement on behalf of the PROVIDER is duly authorized by all necessary and appropriate action to do so on behalf of the PROVIDER and does so with full legal authority.

19.10. Contingency Fee. The PROVIDER represents that it has not paid or agreed to pay any person or entity, other than a bona fide employee working solely for the PROVIDER, any fee, commission, percentage, gift, or other consideration contingent upon or resulting from the award or making of the Grant Agreement.

19.11. Nondiscrimination. The PROVIDER may not discriminate on the basis of race, color, sex, religion, national origin, disability, age, marital status, political affiliation, or pregnancy in the performance of the Grant Agreement. The PROVIDER will include the foregoing or similar language in its contracts with any Subcontractors, except that any project assisted by the U.S. Department of Transportation funds must comply with the nondiscrimination requirements in 49 C.F.R. Parts 23 and 26.

19.12. Remedies Cumulative. Failure by the PROVIDER to carry out any of the requirements of the Grant Agreement, or any documents incorporated into the Grant Agreement,

constitutes a material breach of the Grant Agreement, which will permit the COUNTY to terminate the Grant Agreement for cause or to exercise any other remedy provided under applicable law or the Hernando County Code of Ordinances, all such remedies being cumulative.

19.13. Force Majeure. If the COUNTY's performance of any obligation under the Grant Agreement (or any document incorporated therein) is prevented or delayed by reason of hurricane, earthquake, epidemic, pandemic, or other casualty caused by nature, or by labor strike, war, or by a law, order, proclamation, regulation, or ordinance of any governmental agency (including, without limitation, by the COUNTY), the COUNTY, upon giving prompt notice to the PROVIDER, will be excused from such performance to the extent of such prevention, if the COUNTY has first taken reasonable steps to avoid and remove the cause of nonperformance and continues to take reasonable steps to avoid and remove such cause, and promptly notify the PROVIDER in writing and resume performance in accordance with the Grant Agreement whenever such causes are removed; if such nonperformance exceeds sixty (60) days, the COUNTY shall have the right to terminate the Grant Agreement upon written notice to the PROVIDER, with the PROVIDER waiving any and all rights or claims associated therewith. This section does not supersede or prevent the exercise of any right the parties may otherwise have to terminate the Grant Agreement.

19.14. Regulatory Capacity. Notwithstanding that the COUNTY is a political subdivision with certain regulatory authority, the COUNTY's performance under the Grant Agreement is as a party to the Grant Agreement. If the COUNTY exercises its regulatory authority, the exercise of the authority and the enforcement of any rules, regulation, laws, and ordinances will have occurred in accordance with the COUNTY's regulatory authority as a governmental body separate and apart from the Grant Agreement and will not be attributable to the COUNTY as a party to the Grant Agreement.

19.15. Truth-In-Negotiation Representation. The Grant Award awarded to the PROVIDER is based upon its representations to the COUNTY in, among other materials submitted to the COUNTY, financial documents and reports provided to the COUNTY as required by the Grant Agreement, as well as those contained in the PROVIDER's Application and statements made by the PROVIDER to the COUNTY during the application process. The PROVIDER certifies that all such information is accurate, complete, and current as of when the same is submitted to the COUNTY. The PROVIDER will promptly provide the COUNTY with written notice and details of any new information which renders any representations previously made by the PROVIDER inaccurate, out of date, or incomplete. The COUNTY reserves the right to reduce the Grant Funds based on updated information provided by the PROVIDER.

19.16. Use of Logo. Except as noted in the Grant Agreement, the PROVIDER may not use the COUNTY's name, logo, or otherwise refer to the Grant Agreement in any marketing or publicity materials without the prior written consent of the COUNTY.

19.17. Singular/Plural. Wherever used, the singular shall include the plural, the plural the singular, and the use of any gender shall include all genders.

19.18. Approval by Board. This Grant Agreement requires approval by the Hernando County Board of County Commissioners at a duly noticed public hearing as a condition precedent

to its execution by the County. At such meeting, the Board of County Commissioners reserves the right to approve, deny, or modify this Grant Agreement, in whole or part, for any reason or no reason. Furthermore, the failure of the Board of County Commissioners to act upon, or to act favorably on, this Grant Agreement shall not be actionable in any manner or grounds for any claim or dispute.

WHEREFORE, the Parties hereto have set their hands and seals on the dates so indicated below.

HERNANDO COUNTY,
a political subdivision of the State of Florida

ATTEST:

Doug A. Chorvat, Jr., Clerk

Jerry Campbell, Chairman

Date

Premier Community HealthCare Group, Inc.,
a Florida not-for-profit corporation

Signature

Name and title

Date

APPROVED AS TO FORM AND LEGAL
SUFFICIENCY

BY: _____

James J. Harrison

County Attorney's Office

Approved as to legal form and sufficiency for
the reliance of Hernando County only.
(LR 22-567-3)

FLORIDA OPIOID ALLOCATION AND
STATEWIDE RESPONSE
AGREEMENT

BETWEEN

STATE OF FLORIDA DEPARTMENT OF LEGAL AFFAIRS,
OFFICE OF THE ATTORNEY GENERAL

And

CERTAIN LOCAL GOVERNMENTS IN THE STATE OF FLORIDA

This Florida Opioid Allocation and Statewide Response Agreement (the "Agreement") is entered into between the State of Florida ("State") and certain Local Governments ("Local Governments" and the State and Local Governments are jointly referred to as the "Parties" or individually as a "Party"). The Parties agree as follows:

Whereas, the people of the State and its communities have been harmed by misfeasance, nonfeasance and malfeasance committed by certain entities within the Pharmaceutical Supply Chain; and

Whereas, the State, through its Attorney General, and certain Local Governments, through their elected representatives and counsel, are separately engaged in litigation seeking to hold many of the same Pharmaceutical Supply Chain Participants accountable for the damage caused by their misfeasance, nonfeasance and malfeasance as the State; and

Whereas, certain of the Parties have separately sued Pharmaceutical Supply Chain participants for the harm caused to the citizens of both Parties and have collectively negotiated settlements with several Pharmaceutical Supply Chain Participants; and

Whereas, the Parties share a common desire to abate and alleviate the impacts of that misfeasance, nonfeasance and malfeasance throughout the State; and

Whereas, it is the intent of the State and its Local Governments to use the proceeds from any Settlements with Pharmaceutical Supply Chain Participants to increase the amount of funding presently spent on opioid and substance abuse education, treatment, prevention and other related programs and services, such as those identified in Exhibits "A" and "B," and to ensure that the funds are expended in compliance with evolving evidence-based "best practices;" and

Whereas, the State and its Local Governments enter into this Agreement and agree to the allocation and use of the proceeds of any settlement described herein

Wherefore, the Parties each agree to as follows:

A. Definitions

As used in this Agreement:

1. “Approved Purpose(s)” shall mean forward-looking strategies, programming and services used to expand the availability of treatment for individuals impacted by substance use disorders, to: (a) develop, promote, and provide evidence-based substance use prevention strategies; (b) provide substance use avoidance and awareness education; (c) decrease the oversupply of licit and illicit opioids; and (d) support recovery from addiction. Approved Purposes shall include, but are not limited to, the opioid abatement strategies listed in Exhibits “A” and “B” which are incorporated herein by reference.

2. “Local Governments” shall mean all counties, cities, towns and villages located within the geographic boundaries of the State.

3. “Managing Entities” shall mean the corporations selected by and under contract with the Florida Department of Children and Families or its successor (“DCF”) to manage the daily operational delivery of behavioral health services through a coordinated system of care. The singular “Managing Entity” shall refer to a singular of the Managing Entities.

4. “County” shall mean a political subdivision of the state established pursuant to s. 1, Art. VIII of the State Constitution.

5. “Dependent Special District” shall mean a Special District meeting the requirements of Florida Statutes § 189.012(2).

6. “Municipalities” shall mean cities, towns, or villages located in a County within the State that either have: (a) a Population greater than 10,000 individuals; or (b) a Population equal to or less than 10,000 individuals and that has either (i) filed a lawsuit against one or more Pharmaceutical Supply Chain Participants; or (ii) executes a release in connection with a settlement with a Pharmaceutical Supply Chain participant. The singular “Municipality” shall refer to a singular city, town, or village within the definition of Municipalities.

7. “Negotiating Committee” shall mean a three-member group comprised by representatives of the following: (1) the State; and (2) two representatives of Local Governments of which one representative will be from a Municipality and one shall be from a County (collectively, “Members”) within the State. The State shall be represented by the Attorney General or her designee.

8. “Negotiation Class Metrics” shall mean those county and city settlement allocations which come from the official website of the Negotiation Class of counties and cities certified on September 11, 2019 by the U.S. District for the Northern District of Ohio in *In re National Prescription Opiate Litigation*, MDL No. 2804 (N.D. Ohio). The website is located at <https://allocationmap.iclaimsonline.com>.

9. “Opioid Funds” shall mean monetary amounts obtained through a Settlement.

10. “Opioid Related” shall have the same meaning and breadth as in the agreed Opioid Abatement Strategies attached hereto as Exhibits “A” or “B.”

11. “Parties” shall mean the State and Local Governments that execute this Agreement. The singular word “Party” shall mean either the State or Local Governments that executed this Agreement.

12. “PEC” shall mean the Plaintiffs’ Executive Committee of the National Prescription Opiate Multidistrict Litigation pending in the United States District Court for the Northern District of Ohio.

13. “Pharmaceutical Supply Chain” shall mean the entities, processes, and channels through which Controlled Substances are manufactured, marketed, promoted, distributed or dispensed.

14. “Pharmaceutical Supply Chain Participant” shall mean any entity that engages in, or has engaged in the manufacture, marketing, promotion, distribution or dispensing of an opioid analgesic.

15. “Population” shall refer to published U.S. Census Bureau population estimates as of July 1, 2019, released March 2020, and shall remain unchanged during the term of this Agreement. These estimates can currently be found at <https://www.census.gov>. *For purposes of Population under the definition of Qualified County, a County’s population shall be the greater of its population as of the July 1, 2019, estimates or its actual population, according to the official U.S. Census Bureau count, which was released by the U.S. Census Bureau in August 2021.*

16. “Qualified County” shall mean a charter or non-chartered County that has a Population of at least 300,000 individuals and: (a) has an opioid taskforce or other similar board, commission, council, or entity (including some existing sub-unit of a County’s government responsible for substance abuse prevention, treatment, and/or recovery) of which it is a member or it operates in connection with its municipalities or others on a local or regional basis; (b) has an abatement plan that has been either adopted or is being utilized to respond to the opioid epidemic; (c) is, as of December 31, 2021, either providing or is contracting with others to provide substance abuse prevention, recovery, and/or treatment services to its citizens; and (d) has or enters into an interlocal agreement with a majority of Municipalities (Majority is more than 50% of the Municipalities’ total Population) related to the expenditure of Opioid Funds. The Opioid Funds to be paid to a Qualified County will only include Opioid Funds for Municipalities whose claims are released by the Municipality or Opioid Funds for Municipalities whose claims are otherwise barred. For avoidance of doubt, the word “operate” in connection with opioid task force means to do at least one of the following activities: (1) gathers data about the nature, extent, and problems being faced in communities within that County; (2) receives and reports recommendations from other government and private entities about activities that should be undertaken to abate the opioid epidemic to a County; and/or (3) makes recommendations to a County and other public and private leaders about steps, actions, or plans that should be undertaken to abate the opioid epidemic. For avoidance of doubt, the Population calculation required by subsection (d) does not include Population in unincorporated areas.

17. "SAMHSA" shall mean the U.S. Department of Health & Human Services, Substance Abuse and Mental Health Services Administration.

18. "Settlement" shall mean the negotiated resolution of legal or equitable claims against a Pharmaceutical Supply Chain Participant when that resolution has been jointly entered into by the State and Local Governments or a settlement class as described in (B)(1) below.

19. "State" shall mean the State of Florida.

B. Terms

1. **Only Abatement** - Other than funds used for the Administrative Costs and Expense Fund as hereinafter described or to pay obligations to the United States arising out of Medicaid or other federal programs, all Opioid Funds shall be utilized for Approved Purposes. In order to accomplish this purpose, the State will either: (a) file a new action with Local Governments as Parties; or (b) add Local Governments to its existing action, sever any settling defendants. In either type of action, the State will seek entry of a consent judgment, consent order or other order binding judgment binding both the State and Local Governments to utilize Opioid Funds for Approved Purposes ("Order") from the Circuit Court of the Sixth Judicial Circuit in and for Pasco County, West Pasco Division New Port Richey, Florida (the "Court"), except as herein provided. The Order may be part of a class action settlement or similar device. The Order shall provide for continuing jurisdiction by the Court to address non-performance by any party under the Order.

2. **Avoid Claw Back and Recoupment** - Both the State and Local Governments wish to maximize any Settlement and Opioid Funds. In addition to committing to only using funds for the Expense Funds, Administrative Costs and Approved Purposes, both Parties will agree to utilize a percentage of funds for the Core Strategies highlighted in Exhibit A. Exhibit A contains the programs and strategies prioritized by the U.S. Department of Justice and/or the U.S. Department of Health & Human Services ("Core Strategies"). The State is trying to obtain the United States' agreement to limit or reduce the United States' ability to recover or recoup monies from the State and Local Government in exchange for prioritization of funds to certain projects. If no agreement is reached with the United States, then there will be no requirement that a percentage be utilized for Core Strategies.

3. **No Benefit Unless Fully Participating** - Any Local Government that objects to or refuses to be included under the Order or refuses or fails to execute any of documents necessary to effectuate a Settlement shall not receive, directly or indirectly, any Opioid Funds and its portion of Opioid Funds shall be distributed to, and for the benefit of, the Local Governments. Funds that were a for a Municipality that does not join a Settlement will be distributed to the County where that Municipality is located. Funds that were for a County that does not join a Settlement will be distributed pro rata to Counties that join a Settlement. For avoidance of doubt, if a Local Government initially refuses to be included in or execute the documents necessary to effectuate a Settlement and subsequently effectuates such documents necessary to join a Settlement, then that Local Government will only lose those payments made under a Settlement while that Local Government was not a part of the Settlement. If a Local Government

participates in a Settlement, that Local Government is thereby releasing the claims of its Dependent Special District claims, if any.

4. **Distribution Scheme** – If a Settlement has a National Settlement Administrator or similar entity, all Opioids Funds will initially go to the Administrator to be distributed. If a Settlement does not have a National Settlement Administrator or similar entity, all Opioid Funds will initially go to the State, and then be distributed by the State as they are received from the Defendants according to the following distribution scheme. The Opioid Funds will be divided into three funds after deducting any costs of the Expense Fund detailed below. Funds due the federal government, if any, pursuant to Section B-2, will be subtracted from only the State and Regional Funds below:

(a) City/County Fund- The city/county fund will receive 15% of all Opioid Funds to directly benefit all Counties and Municipalities. The amounts to be distributed to each County and Municipality shall be determined by the Negotiation Class Metrics or other metrics agreed upon, in writing, by a County and a Municipality, which are attached to this Agreement as Exhibit "C." In the event that a Municipality has a Population less than 10,000 people and it does not execute a release or otherwise join a Settlement that Municipalities share under the Negotiation Class Metrics shall be reallocated to the County where that Municipality is located.

(b) Regional Fund- The regional fund will be subdivided into two parts.

(i) The State will annually calculate the share of each County within the State of the regional fund utilizing the sliding scale in paragraph 5 of the Agreement, and according to the Negotiation Class Metrics.

(ii) For Qualified Counties, the Qualified County's share will be paid to the Qualified County and expended on Approved Purposes, including the Core Strategies identified in Exhibit A, if applicable.

(iii) For all other Counties, the State will appropriate the regional share for each County and pay that share through DCF to the Managing Entities providing service for that County. The Managing Entities will be required to expend the monies on Approved Purposes, including the Core Strategies as directed by the Opioid Abatement Task Force or Council. The Managing Entities shall expend monies from this Regional Fund on services for the Counties within the State that are non-Qualified Counties and to ensure that there are services in every County. To the greatest extent practicable, the Managing Entities shall endeavor to expend monies in each County or for citizens of a County in the amount of the share that a County would have received if it were a Qualified County.

(c) State Fund - The remainder of Opioid Funds will be expended by the State on Approved Purposes, including the provisions related to Core Strategies, if applicable.

(d) To the extent that Opioid Funds are not appropriated and expended in a year by the State, the State shall identify the investments where settlement funds will be

deposited. Any gains, profits, or interest accrued from the deposit of the Opioid Funds to the extent that any funds are not appropriated and expended within a calendar year, shall be the sole property of the Party that was entitled to the initial amount.

(e) To the extent a County or Municipality wishes to pool, comingle, or otherwise transfer its share, in whole or part, of Opioid Funds to another County or Municipality, the comingling Municipalities may do so by written agreement. The comingling Municipalities shall provide a copy of that agreement to the State and any settlement administrator to ensure that monies are directed consistent with such agreement. The County or Municipality receiving any such Opioid Funds shall assume the responsibility for reporting how such Opioid Funds were utilized under this Agreement.

5. Regional Fund Sliding Scale- The Regional Fund shall be calculated by utilizing the following sliding scale of the Opioid Funds available in any year after deduction of Expenses and any funds due the federal government:

- A. Years 1-6: 40%
- B. Years 7-9: 35%
- C. Years 10-12: 34%
- D. Years 13-15: 33%
- E. Years 16-18: 30%

6. Opioid Abatement Taskforce or Council - The State will create an Opioid Abatement Taskforce or Council (sometimes hereinafter "Taskforce" or "Council") to advise the Governor, the Legislature, DCF, and Local Governments on the priorities that should be addressed by expenditure of Opioid Funds and to review how monies have been spent and the results that have been achieved with Opioid Funds.

(a) Size - The Taskforce or Council shall have ten Members equally balanced between the State and the Local Government representatives.

(b) Appointments Local Governments - Two Municipality representatives will be appointed by or through Florida League of Cities. Two county representatives, one from a Qualified County and one from a county within the State that is not a Qualified County, will be appointed by or through the Florida Association of Counties. The final representative will alternate every two years between being a county representative (appointed by or through Florida Association of Counties) or a Municipality representative (appointed by or through the Florida League of Cities). One Municipality representative must be from a city of less than 50,000 people. One county representative must be from a county of less than 200,000 people and the other county representative must be from a county whose population exceeds 200,000 people.

(c) Appointments State -

- (i) The Governor shall appoint two Members.
 - (ii) The Speaker of the House shall appoint one Member.
 - (iii) The Senate President shall appoint one Member.
 - (iv) The Attorney General or her designee shall be a Member.
- (d) Chair - The Attorney General or designee shall be the chair of the Taskforce or Council.
- (e) Term - Members will be appointed to serve a four-year term and shall be staggered to comply with Florida Statutes § 20.052(4)(c).
- (f) Support - DCF shall support the Taskforce or Council and the Taskforce or Council shall be administratively housed in DCF.
- (g) Meetings - The Taskforce or Council shall meet quarterly in person or virtually using communications media technology as defined in section 120.54(5)(b)(2), Florida Statutes.
- (h) Reporting - The Taskforce or Council shall provide and publish a report annually no later than November 30th or the first business day after November 30th, if November 30th falls on a weekend or is otherwise not a business day. The report shall contain information on how monies were spent the previous fiscal year by the State, each of the Qualified Counties, each of the Managing Entities, and each of the Local Governments. It shall also contain recommendations to the Governor, the Legislature, and Local Governments for priorities among the Approved Purposes or similar such uses for how monies should be spent the coming fiscal year to respond to the opioid epidemic. Prior to July 1st of each year, the State and each of the Local Governments shall provide information to DCF about how they intend to expend Opioid Funds in the upcoming fiscal year.
- (i) Accountability - The State and each of the Local Governments shall report its expenditures to DCF no later than August 31st for the previous fiscal year. The Taskforce or Council will set other data sets that need to be reported to DCF to demonstrate the effectiveness of expenditures on Approved Purposes. In setting those requirements, the Taskforce or Council shall consider the Reporting Templates, Deliverables, Performance Measures, and other already utilized and existing templates and forms required by DCF from Managing Entities and suggest that similar requirements be utilized by all Parties to this Agreement.
- (j) Conflict of Interest - All Members shall adhere to the rules, regulations and laws of Florida including, but not limited to, Florida Statute §112.311, concerning the disclosure of conflicts of interest and recusal from discussions or votes on conflicted matters.

7. **Administrative Costs-** The State may take no more than a 5% administrative fee from the State Fund and any Regional Fund that it administers for counties that are not Qualified Counties. Each Qualified County may take no more than a 5% administrative fee from its share of the Regional Funds. Municipalities and Counties may take no more than a 5% administrative fee from any funds that they receive or control from the City/County Fund.

8. **Negotiation of Non-Multistate Settlements** - If the State begins negotiations with a Pharmaceutical Supply Chain Participant that is separate and apart from a multi-state negotiation, the State shall include Local Governments that are a part of the Negotiating Committee in such negotiations. No Settlement shall be recommended or accepted without the affirmative votes of both the State and Local Government representatives of the Negotiating Committee.

9. **Negotiation of Multistate or Local Government Settlements** - To the extent practicable and allowed by other parties to a negotiation, both Parties agree to communicate with members of the Negotiation Committee regarding the terms of any other Pharmaceutical Supply Chain Participant Settlement.

10. **Program Requirements-** DCF and Local Governments desire to make the most efficient and effective use of the Opioid Funds. DCF and Local Governments will work to achieve that goal by ensuring the following requirements will be minimally met by any governmental entity or provider providing services pursuant to a contract or grant of Opioid Funds:

a. In either performing services under this Agreement or contracting with a provider to provide services with the Opioid Funds under this Agreement, the State and Local Governments shall be aware of and comply with all State and Federal laws, rules, Children and Families Operating Procedures (CFOPs), and similar regulations relating to the substance abuse and treatment services.

b. The State and Local Governments shall have and follow their existing policies and practices for accounting and auditing, including policies relating to whistleblowers and avoiding fraud, waste, and abuse. The State and Local Governments shall consider additional policies and practices recommended by the Opioid Abatement Taskforce or Council. c. In any award or grant to any provider, State and Local Governments shall ensure that each provider acknowledges its awareness of its obligations under law and shall audit, supervise, or review each provider's performance routinely, at least once every year.

d. In contracting with a provider, the State and Local Governments shall set performance measures in writing for a provider.

e. The State and Local Governments shall receive and report expenditures, service utilization data, demographic information, and national outcome measures in a similar fashion as required by the 42.U.S.C. s. 300x and 42 U.S.C. s. 300x-21.

f. The State and Local Governments, that implement evidenced based practice models will participate in fidelity monitoring as prescribed and completed by the originator of the model chosen..

g. The State and Local Governments shall ensure that each year, an evaluation of the procedures and activities undertaken to comply with the requirements of this Agreement are completed.

h. The State and Local Governments shall implement a monitoring process that will demonstrate oversight and corrective action in the case of non-compliance, for all providers that receive Opioid Funds. Monitoring shall include:

- (i) Oversight of the any contractual or grant requirements;
- (ii) Develop and utilize standardized monitoring tools;
- (iii) Provide DCF and the Opioid Abatement Taskforce or Council with access to the monitoring reports; and
- (iv) Develop and utilize the monitoring reports to create corrective action plans for providers, where necessary.

11. **Reporting and Records Requirements-** The State and Local Governments shall follow their existing reporting and records retention requirements along with considering any additional recommendations from the Opioid Abatement Taskforce or Council. Local Governments shall respond and provide documents to any reasonable requests from the State or Opioid Abatement Taskforce or Council for data or information about programs receiving Opioid Funds. The State and Local Governments shall ensure that any provider or sub-recipient of Opioid Funds at a minimum does the following:

(a) Any provider shall establish and maintain books, records and documents (including electronic storage media) sufficient to reflect all income and expenditures of Opioid Funds. Upon demand, at no additional cost to the State or Local Government, any provider will facilitate the duplication and transfer of any records or documents during the term that it receives any Opioid Funds and the required retention period for the State or Local Government. These records shall be made available at all reasonable times for inspection, review, copying, or audit by Federal, State, or other personnel duly authorized by the State or Local Government.

(b) Any provider shall retain and maintain all client records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to the use of the Opioid Funds during the term of its receipt of Opioid Funds and retained for a period of six (6) years after its ceases to receives Opioid Funds or longer when required by law. In the event an audit is required by the State of Local Governments, records shall be retained for a minimum period of six (6) years after the audit report is issued or until resolution of any audit findings or litigation based on the terms of any award or contract.

(c) At all reasonable times for as long as records are maintained, persons duly authorized by State or Local Government auditors shall be allowed full access to and the right to examine any of the contracts and related records and documents, regardless of the form in which kept.

(d) A financial and compliance audit shall be performed annually and provided to the State.

(e) All providers shall comply and cooperate immediately with any inspections, reviews, investigations, or audits deemed necessary by The Office of the Inspector General (section 20.055, F.S.) or the State.

(f) No record may be withheld nor may any provider attempt to limit the scope of any of the foregoing inspections, reviews, copying, transfers or audits based on any claim that any record is exempt from public inspection or is confidential, proprietary or trade secret in nature; provided, however, that this provision does not limit any exemption to public inspection or copying to any such record.

12. **Expense Fund** - The Parties agree that in any negotiation every effort shall be made to cause Pharmaceutical Supply Chain Participants to pay costs of litigation, including attorneys' fees, in addition to any agreed to Opioid Funds in the Settlement. To the extent that a fund sufficient to pay the full contingent fees of Local Governments is not created as part of a Settlement by a Pharmaceutical Supply Chain Participant, the Parties agree that an additional expense fund for attorneys who represent Local Governments (herein "Expense Fund") shall be created out of the City/County fund for the purpose of paying the hard costs of a litigating Local Government and then paying attorneys' fees.

(a) The Source of Funds for the Expense Fund- Money for the Expense Fund shall be sourced exclusively from the City/County Fund.

(b) The Amount of the Expense Fund- The State recognizes the value litigating Local Governments bring to the State in connection with the Settlement because their participation increases the amount of Incentive Payments due from each Pharmaceutical Supply Chain Participant. In recognition of that value, the amount of funds that shall be deposited into the Expense Fund shall be contingent upon on the percentage of litigating Local Government participation in the Settlement, according to the following table:

Litigating Local Government Participation in the Settlement (by percentage of the population)	Amount that shall be paid into the Expense Fund from (and as a percentage of) the City/County fund
96 to 100%	10%
91 to 95%	7.5%
86 to 90%	5%
85%	2.5%
Less than 85%	0%

If fewer than 85% percent of the litigating Local Governments (by population) participate, then the Expense Fund shall not be funded, and this Section of the Agreement shall be null and void.

(c) The Timing of Payments into the Expense Fund- Although the amount of the Expense Fund shall be calculated based on the entirety of payments due to the City/County fund over a ten-to-eighteen-year period, the Expense Fund shall be funded entirely from payments made by Pharmaceutical Supply Chain Participants during the first two payments of the Settlement. Accordingly, to offset the amounts being paid from the City/County Fund to the Expense Fund in the first two years, Counties or Municipalities may borrow from the Regional Fund during the first two years and pay the borrowed amounts back to the Regional Fund during years three, four, and five.

For the avoidance of doubt, the following provides an illustrative example regarding the calculation of payments and amounts that may be borrowed under the terms of this MOU, consistent with the provisions of this Section:

Opioid Funds due to State of Florida and Local Governments (over 10 to 18 years):	\$1,000
Litigating Local Government Participation:	100%
City/County Fund (over 10 to 18 years):	\$150
Expense Fund (paid over 2 years):	\$15
Amount Paid to Expense Fund in 1st year:	\$7.5
Amount Paid to Expense Fund in 2nd year:	\$7.5
Amount that may be borrowed from Regional Fund in 1st year:	\$7.5
Amount that may be borrowed from Regional Fund in 2nd year:	\$7.5
Amount that must be paid back to Regional Fund in 3rd year:	\$5
Amount that must be paid back to Regional Fund in 4th year:	\$5
Amount that must be paid back to Regional Fund in 5th year:	\$5

(d) Creation of and Jurisdiction over the Expense Fund- The Expense Fund shall be established, consistent with the provisions of this Section of the Agreement, by order of the Court. The Court shall have jurisdiction over the Expense Fund, including authority to allocate and disburse amounts from the Expense Fund and to resolve any disputes concerning the Expense Fund.

(e) Allocation of Payments to Counsel from the Expense Fund- As part of the order establishing the Expense Fund, counsel for the litigating Local Governments shall seek to have the Court appoint a third-neutral to serve as a special master for purposes of allocating the Expense Fund. Within 30 days of entry of the order appointing a special master for the Expense Fund, any counsel who intend to seek an award from the Expense Fund shall provide the copies of their contingency fee contracts to the special master. The special master shall then build a mathematical model, which shall be based on each litigating Local Government's share under the Negotiation Class Metrics and the rate set forth in their contingency contracts, to calculate a proposed award for each litigating Local Government who timely provided a copy of its contingency contract.

13. **Dispute resolution-** Any one or more of the Local Governments or the State may object to an allocation or expenditure of Opioid Funds solely on the basis that the allocation or expenditure at issue (a) is inconsistent with the Approved Purposes; (b) is inconsistent with the distribution scheme as provided in paragraph;; (c) violates the limitations set forth herein with respect to administrative costs or the Expense Fund; or (d) to recover amounts advanced from the Regional Fund for the Expense Fund. There shall be no other basis for bringing an objection to the approval of an allocation or expenditure of Opioid Funds. In the event that there is a National Settlement Administrator or similar entity, the Local Governments sole action for non-payment of amounts due from the City/County Fund shall be against the particular settling defendant and/or the National Settlement Administrator or similar entity.

C. Other Terms and Conditions

1. **Governing Law and Venue:** This Agreement will be governed by the laws of the State of Florida. Any and all litigation arising under the Agreement, unless otherwise specified in this Agreement, will be instituted in either: (a) the Court that enters the Order if the matter deals with a matter covered by the Order and the Court retains jurisdiction; or (b) the appropriate State court in Leon County, Florida.

2. **Agreement Management and Notification:** The Parties have identified the following individuals as Agreement Managers and Administrators:

a. State of Florida Agreement Manager:

Greg Slempp

PL-01, The Capitol, Tallahassee, FL 32399

850-414-3300

Greg.slempp@myfloridalegal.com

b. State of Florida Agreement Administrator

Janna Barineau

PL-01, The Capitol, Tallahassee, FL 32399

850-414-3300

Janna.barineau@myfloridalegal.com

c. Local Governments Agreement Managers and Administrators are listed on Exhibit C to this Agreement.

Changes to either the Managers or Administrators may be made by notifying the other Party in writing, without formal amendment to this Agreement.

3. **Notices.** All notices required under the Agreement will be delivered by certified mail, return receipt requested, by reputable air courier, or by personal delivery to the designee identified in paragraphs C.2., above. Either designated recipient may notify the other, in writing, if someone else is designated to receive notice.

4. **Cooperation with Inspector General:** Pursuant to section 20.055, Florida Statutes, the Parties, understand and will comply with their duty to cooperate with the Inspector General in any investigation, audit, inspection, review, or hearing.

5. **Public Records:** The Parties will keep and maintain public records pursuant to Chapter 119, Florida Statutes and will comply will all applicable provisions of that Chapter.

6. **Modification:** This Agreement may only be modified by a written amendment between the appropriate parties. No promises or agreements made subsequent to the execution of this Agreement shall be binding unless express, reduced to writing, and signed by the Parties.

7. **Execution in Counterparts:** This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument.

8. **Assignment:** The rights granted in this Agreement may not be assigned or transferred by any party without the prior written approval of the other party. No party shall be permitted to delegate its responsibilities or obligations under this Agreement without the prior written approval of the other parties.

9. **Additional Documents:** The Parties agree to cooperate fully and execute any and all supplementary documents and to take all additional actions which may be reasonably necessary or appropriate to give full force and effect to the basic terms and intent of this Agreement.

10. **Captions:** The captions contained in this Agreement are for convenience only and shall in no way define, limit, extend or describe the scope of this Agreement or any part of it.

11. **Entire Agreement:** This Agreement, including any attachments, embodies the entire agreement of the parties. There are no other provisions, terms, conditions, or obligations. This Agreement supersedes all previous oral or written communications, representations or agreements on this subject.

12. **Construction:** The parties hereto hereby mutually acknowledge and represent that they have been fully advised by their respective legal counsel of their rights and responsibilities under this Agreement, that they have read, know, and understand completely the contents hereof, and that they have voluntarily executed the same. The parties hereto further hereby mutually acknowledge that they have had input into the drafting of this Agreement and that, accordingly, in any construction to be made of this Agreement, it shall not be construed for or against any party, but rather shall be given a fair and reasonable interpretation, based on the plain language of the Agreement and the expressed intent of the parties.

13. **Capacity to Execute Agreement:** The parties hereto hereby represent and warrant that the individuals signing this Agreement on their behalf are duly authorized and fully competent to do so.

14. **Effectiveness:** This Agreement shall become effective on the date on which the last required signature is affixed to this Agreement.

IN WITNESS THEREOF, the parties hereto have caused the Agreement to be executed by their undersigned officials as duly authorized.

STATE OF FLORIDA

Jeffrey W. Rogers 12/3/2021

Jeffrey W. Rogers

County Administrator

By: _____
Its: _____

11/15/2021

DATED

14. **Effectiveness:** This Agreement shall become effective on the date on which the last required signature is affixed to this Agreement.

IN WITNESS THEREOF, the parties hereto have caused the Agreement to be executed by their undersigned officials as duly authorized.

STATE OF FLORIDA

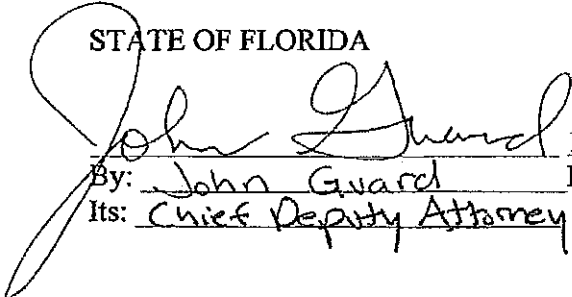

By: John Guard 11/15/2021
Its: Chief Deputy Attorney General DATED

EXHIBIT A

Schedule A

Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies (“**Core Strategies**”)[, such that a minimum of __% of the [aggregate] state-level abatement distributions shall be spent on [one or more of] them annually].¹

A. Naloxone or other FDA-approved drug to reverse opioid overdoses

1. Expand training for first responders, schools, community support groups and families; and
2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. Medication-Assisted Treatment (“MAT”) Distribution and other opioid-related treatment

1. Increase distribution of MAT to non-Medicaid eligible or uninsured individuals;
2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;
3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and
4. Treatment and Recovery Support Services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication with other support services.

C. Pregnant & Postpartum Women

1. Expand Screening, Brief Intervention, and Referral to Treatment (“SBIRT”) services to non-Medicaid eligible or uninsured pregnant women;
2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder (“OUD”) and other Substance Use Disorder (“SUD”)/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and
3. Provide comprehensive wrap-around services to individuals with Opioid Use Disorder (OUD) including housing, transportation, job placement/training, and childcare.

D. Expanding Treatment for Neonatal Abstinence Syndrome

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

¹ As used in this Schedule A, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the Term Sheet.

E. Expansion of Warm Hand-off Programs and Recovery Services

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;
2. Expand warm hand-off services to transition to recovery services;
3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions. ;
4. Provide comprehensive wrap-around services to individuals in recovery including housing, transportation, job placement/training, and childcare; and
5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. Treatment for Incarcerated Population

1. Provide evidence-based treatment and recovery support including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and
2. Increase funding for jails to provide treatment to inmates with OUD.

G. Prevention Programs

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);
2. Funding for evidence-based prevention programs in schools.;
3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);
4. Funding for community drug disposal programs; and
5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. Expanding Syringe Service Programs

1. Provide comprehensive syringe services programs with more wrap-around services including linkage to OUD treatment, access to sterile syringes, and linkage to care and treatment of infectious diseases.
- I. Evidence-based data collection and research analyzing the effectiveness of the abatement strategies within the State.

EXHIBIT B

Schedule B

Approved Uses

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:²

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.
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,

² As used in this Schedule B, words like “expand,” “fund,” “provide” or the like shall not indicate a preference for new or existing programs. Priorities will be established through the mechanisms described in the Term Sheet.

scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. [Intentionally Blank – to be cleaned up later for numbering]

13. 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.

14. 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.

15. 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 of 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 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 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

County	Allocated Subdivisions	Regional % by County for Abatement Fund	City/County Fund %
Alachua		1.241060164449%	
	Alachua County		0.821689546303%
	Alachua		0.013113332457%
	Archer		0.000219705515%
	Gainesville		0.381597611347%
	Hawthorne		0.000270546460%
	High Springs		0.011987568663%
	La Crosse		0.000975056706%
	Micanopy		0.002113530737%
	Newberry		0.006102729215%
	Waldo		0.002988721299%
Baker		0.193173804130%	
	Baker County		0.169449240037%
	Glen St. Mary		0.000096234647%
	Maccleenny		0.023628329446%
Bay		0.839656373312%	
	Bay County		0.508772605155%
	Callaway		0.024953825527%
	Lynn Haven		0.039205632015%
	Mexico Beach		0.005614292988%
	Panama City		0.155153855596%
	Panama City Beach		0.080897023117%
	Parker		0.008704696178%
	Springfield		0.016354442736%
Bradford		0.189484204081%	
	Bradford County		0.151424309090%
	Brooker		0.000424885045%
	Hampton		0.002839829959%
	Lawtey		0.003400896108%
	Starke		0.031392468132%
Brevard		3.878799180444%	
	Brevard County		2.323022668525%
	Cape Canaveral		0.045560750209%

	Cocoa		0.149245411423%
	Cocoa Beach		0.084363286155%
	Grant-Valkaria		0.000321387406%
	Indianalantic		0.024136738902%
	Indian Harbour Beach		0.021089913665%
	Malabar		0.002505732317%
	Melbourne		0.383104682233%
	Melbourne Beach		0.012091066302%
	Melbourne Village		0.003782203200%
	Palm Bay		0.404817397481%
	Palm Shores		0.000127102364%
	Rockledge		0.096603243798%
	Satellite Beach		0.035975416224%
	Titusville		0.240056418924%
	West Melbourne		0.051997577066%
Broward		9.057962672578%	
	Broward County		3.966403576878%
	Coconut Creek		0.101131719448%
	Cooper City		0.073935445073%
	Coral Springs		0.323406517664%
	Dania Beach		0.017807041180%
	Davie		0.266922227153%
	Deerfield Beach		0.202423224725%
	Fort Lauderdale		0.830581264531%
	Hallandale Beach		0.154950491814%
	Hillsboro Beach		0.012407006463%
	Hollywood		0.520164608456%
	Lauderdale-By-The-Sea		0.022807611325%
	Lauderdale Lakes		0.062625150435%
	Lauderhill		0.144382838130%
	Lazy Lake		0.000021788977%
	Lighthouse Point		0.029131861803%
	Margate		0.143683775129%
	Miramar		0.279280208419%
	North Lauderdale		0.066069624496%

	Oakland Park		0.100430840699%
	Ocean Breeze		0.005381877237%
	Parkland		0.045804060448%
	Pembroke Park		0.024597938908%
	Pembroke Pines		0.462832363603%
	Plantation		0.213918725664%
	Pompano Beach		0.335472163493%
	Sea Ranch Lakes		0.005024174870%
	Southwest Ranches		0.025979723178%
	Sunrise		0.286071106146%
	Tamarac		0.134492458472%
	Weston		0.138637811283%
	West Park		0.029553115352%
	Wilton Manors		0.031630331127%
Calhoun		0.047127740781%	
	Calhoun County		0.038866087128%
	Altha		0.000366781107%
	Blountstown		0.007896688293%
Charlotte		0.737346233376%	
	Charlotte County		0.690225755587%
	Punta Gorda		0.047120477789%
Citrus		0.969645776606%	
	Citrus County		0.929715661117%
	Crystal River		0.021928789266%
	Inverness		0.018001326222%
Clay		1.193429461456%	
	Clay County		1.055764891131%
	Green Cove Springs		0.057762577142%
	Keystone Heights		0.000753535443%
	Orange Park		0.078589207339%
	Penney Farms		0.000561066149%
Collier		1.551333376427%	
	Collier County		1.354673336030%
	Everglades		0.000148891341%
	Marco Island		0.062094952003%

	Naples		0.134416197054%
Columbia		0.446781150792%	
	Columbia County		0.341887201373%
	Fort White		0.000236047247%
	Lake City		0.104659717920%
DeSoto		0.113640407802%	
	DeSoto County		0.096884684746%
	Arcadia		0.016755723056%
Dixie		0.103744580900%	
	Dixie County		0.098822087921%
	Cross City		0.004639236282%
	Horseshoe Beach		0.000281440949%
Duval		5.434975156935%	
	Jacksonville		5.270570064997%
	Atlantic Beach		0.038891507601%
	Baldwin		0.002251527589%
	Jacksonville Beach		0.100447182431%
	Neptune Beach		0.022814874318%
Escambia		1.341634449244%	
	Escambia County		1.005860871574%
	Century		0.005136751249%
	Pensacola		0.330636826421%
Flagler		0.389864712244%	
	Flagler Counry		0.279755934409%
	Beverly Beach		0.000154338585%
	Bunnell		0.009501809575%
	Flagler Beach		0.015482883669%
	Marineland		0.000114392127%
	Palm Coast		0.084857169626%
Franklin		0.049911282550%	
	Franklin County		0.046254365966%
	Apalachicola		0.001768538606%
	Carabelle		0.001888377978%
Gadsden		0.123656074077%	
	Gadsden County		0.090211810642%

	Chattahoochee		0.004181667772%
	Greensboro		0.000492067723%
	Gretna		0.002240633101%
	Havana		0.005459954403%
	Midway		0.001202025213%
	Quincy		0.019867915223%
Gilchrist		0.064333769355%	
	Gilchrist County		0.061274233881%
	Bell		0.000099866143%
	Fanning Springs		0.000388570084%
	Trenton		0.002571099247%
Glades		0.040612836758%	
	Glades County		0.040420367464%
	Moore Haven		0.000192469294%
Gulf		0.059914238588%	
	Gulf County		0.054715751905%
	Port St. Joe		0.004817179591%
	Wewahitchka		0.000381307092%
Hamilton		0.047941195910%	
	Hamilton County		0.038817061931%
	Jasper		0.004869836285%
	Jennings		0.002623755940%
	White Springs		0.001630541754%
Hardee		0.067110048132%	
	Hardee County		0.058100306280%
	Bowling Green		0.001797590575%
	Wauchula		0.006667426860%
	Zolfo Springs		0.000544724417%
Hendry		0.144460915297%	
	Hendry County		0.122147187443%
	Clewiston		0.017589151414%
	LaBelle		0.004724576440%
Hernando		1.510075949110%	
	Hernando County		1.447521612849%
	Brooksville		0.061319627583%

	Weeki Wachee		0.001234708678%
Highlands		0.357188510237%	
	Highlands County		0.287621754986%
	Avon Park		0.025829016090%
	Lake Placid		0.005565267790%
	Sebring		0.038172471371%
Hillsborough		8.710984113657%	
	Hillsborough County		6.523111204400%
	Plant City		0.104218491142%
	Tampa		1.975671881253%
	Temple Terrace		0.107980721113%
Holmes		0.081612427851%	
	Holmes County		0.066805002459%
	Bonifay		0.006898026863%
	Esto		0.006269778036%
	Noma		0.001278286631%
	Ponce de Leon		0.000179759057%
	Westville		0.000179759057%
Indian River		0.753076058781%	
	Indian River County		0.623571460217%
	Fellsmere		0.004917045734%
	Indian River shores		0.025322422382%
	Orchid		0.000306861421%
	Sebastian		0.038315915467%
	Vero Beach		0.060642353558%
Jackson		0.158936058795%	
	Jackson County		0.075213731704%
	Alford		0.000303229925%
	Bascom		0.000061735434%
	Campbellton		0.001648699234%
	Cottdale		0.001093080329%
	Graceville		0.002794436257%
	Grandridge		0.000030867717%
	Greenwood		0.001292812616%
	Jacob City		0.000481173235%

	Malone		0.000092603151%
	Marianna		0.073519638768%
	Sneads		0.002404050426%
Jefferson		0.040821647784%	
	Jefferson County		0.037584169001%
	Monticello		0.003237478783%
Lafayette		0.031911772076%	
	Lafayette County		0.031555885457%
	Mayo		0.000355886619%
Lake		1.139211224519%	
	Lake County		0.757453827343%
	Astatula		0.002727253579%
	Clermont		0.075909163209%
	Eustis		0.041929254098%
	Fruitland Park		0.008381493024%
	Groveland		0.026154034992%
	Howey-In-The-Hills		0.002981458307%
	Lady Lake		0.025048244426%
	Leesburg		0.091339390185%
	Mascotte		0.011415608025%
	Minneola		0.016058475803%
	Montverde		0.001347285057%
	Mount Dora		0.041021380070%
	Tavares		0.031820984673%
	Umatilla		0.005623371728%
Lee		3.325371883359%	
	Lee County		2.115268407509%
	Bonita Springs		0.017374893143%
	Cape Coral		0.714429677167%
	Estero		0.012080171813%
	Fort Myers		0.431100350585%
	Fort Myers Beach		0.000522935440%
	Sanibel		0.034595447702%
Leon		0.897199244939%	
	Leon County		0.471201146391%

	Tallahassee		0.425998098549%
Levy		0.251192401748%	
	Levy County		0.200131750679%
	Bronson		0.005701448894%
	Cedar Key		0.005180329202%
	Chiefland		0.015326729337%
	Fanning Springs		0.000808007885%
	Inglis		0.004976965420%
	Otter Creek		0.000408543312%
	Williston		0.017774357715%
	Yankeetown		0.000884269303%
Liberty		0.019399452225%	
	Liberty County		0.019303217578%
	Bristol		0.000096234647%
Madison		0.063540287455%	
	Madison County		0.053145129837%
	Greenville		0.000110760631%
	Lee		0.000019973229%
	Madison		0.010264423758%
Manatee		2.721323346235%	
	Manatee County		2.201647174006%
	Anna Maria		0.009930326116%
	Bradenton		0.379930754632%
	Bradenton Beach		0.014012127744%
	Holmes Beach		0.028038781473%
	Longboat Key		0.034895046131%
	Palmetto		0.052869136132%
Marion		1.701176168960%	
	Marion County		1.303728892837%
	Belleview		0.009799592256%
	Dunnellon		0.018400790795%
	McIntosh		0.000145259844%
	Ocala		0.368994504094%
	Reddick		0.000107129135%
Martin		0.869487298116%	

	Martin County		0.750762795758%
	Jupiter Island		0.020873839646%
	Ocean Breeze Park		0.008270732393%
	Sewall's Point		0.008356072551%
	Stuart		0.081223857767%
Miami-Dade		5.232119784173%	
	Miami-Dade County		4.282797675552%
	Aventura		0.024619727885%
	Bal Harbour		0.010041086747%
	Bay Harbor Islands		0.004272455175%
	Biscayne Park		0.001134842535%
	Coral Gables		0.071780152131%
	Cutler Bay		0.009414653668%
	Doral		0.013977628531%
	El Portal		0.000924215760%
	Florida City		0.003929278792%
	Golden Beach		0.002847092951%
	Hialeah		0.098015895785%
	Hialeah Gardens		0.005452691411%
	Homestead		0.024935668046%
	Indian Creek		0.002543863026%
	Key Biscayne		0.013683477346%
	Medley		0.008748274131%
	Miami		0.292793005448%
	Miami Beach		0.181409572478%
	Miami Gardens		0.040683650932%
	Miami Lakes		0.007836768608%
	Miami Shores		0.006287935516%
	Miami Springs		0.006169911893%
	North Bay Village		0.005160355974%
	North Miami		0.030379280717%
	North Miami Beach		0.030391990953%
	Opa-locka		0.007847663096%
	Palmetto Bay		0.007404620570%
	Pinecrest		0.008296152866%

	South Miami		0.007833137111%
	Sunny Isles Beach		0.007693324511%
	Surfside		0.004869836285%
	Sweetwater		0.004116300842%
	Virginia Gardens		0.001172973244%
	West Miami		0.002654623657%
Monroe		0.476388738585%	
	Monroe County		0.330124785469%
	Islamorada		0.022357305808%
	Key Colony Beach		0.004751812661%
	Key West		0.088087385417%
	Layton		0.000150707089%
	Marathon		0.030916742141%
Nassau		0.476933463002%	
	Nassau County		0.392706357951%
	Callahan		0.000225152759%
	Fernandina Beach		0.083159445195%
	Hillard		0.000842507098%
Okaloosa		0.819212865955%	
	Okaloosa County		0.612059617545%
	Cinco Bayou		0.000733562214%
	Crestview		0.070440130066%
	Destin		0.014678507281%
	Fort Walton Beach		0.077837487644%
	Laurel Hill		0.000079892914%
	Mary Esther		0.009356549730%
	Niceville		0.021745398713%
	Shalimar		0.001824826796%
	Valparaiso		0.010456893052%
Okeechobee		0.353495278692%	
	Okeechobee County		0.314543851405%
	Okeechobee		0.038951427287%
Orange		4.671028214546%	
	Orange County		3.063330386979%
	Apopka		0.097215150892%

	Bay Lake		0.023566594013%
	Belle Isle		0.010798253686%
	Eatonville		0.008325204835%
	Edgewood		0.009716067845%
	Lake Buena Vista		0.010355211161%
	Maitland		0.046728276209%
	Oakland		0.005429086686%
	Ocoee		0.066599822928%
	Orlando		1.160248481490%
	Windemere		0.007548064667%
	Winter Garden		0.056264584996%
	Winter Park		0.104903028159%
Osceola		1.073452092940%	
	Osceola County		0.837248691390%
	Kissimmee		0.162366006872%
	St. Cloud		0.073837394678%
Palm Beach		8.601594372053%	
	Palm Beach County		5.552548475026%
	Atlantis		0.018751230169%
	Belle Glade		0.020828445945%
	Boca Raton		0.472069073961%
	Boynton Beach		0.306498271771%
	Briny Breezes		0.003257452012%
	Cloud Lake		0.000188837798%
	Delray Beach		0.351846579457%
	Glen Ridge		0.000052656694%
	Golf		0.004283349663%
	Greenacres		0.076424835657%
	Gulf Stream		0.010671151322%
	Haverhill		0.001084001589%
	Highland Beach		0.032510968934%
	Hypoluxo		0.005153092982%
	Juno Beach		0.016757538804%
	Jupiter Island		0.125466374888%
	Jupiter Inlet Colony		0.005276563849%

	Lake Clarke Shores		0.007560774903%
	Lake Park		0.029433275980%
	Lake Worth		0.117146617298%
	Lantana		0.024507151505%
	Loxahatchee Groves		0.002531152789%
	Manalapan		0.021632822333%
	Mangonia Park		0.010696571795%
	North Palm Beach		0.044349646256%
	Ocean Ridge		0.012786497807%
	Pahokee		0.004018250447%
	Palm Beach		0.185476848123%
	Palm Beach Gardens		0.233675880257%
	Palm Beach Shores		0.014135598612%
	Palm Springs		0.038021764282%
	Riviera Beach		0.163617057282%
	Royal Palm Beach		0.049295743959%
	South Bay		0.001830274040%
	South Palm Beach		0.005866681967%
	Tequesta		0.031893614595%
	Wellington		0.050183644758%
	West Palm Beach		0.549265602541%
Pasco		4.692087260494%	
	Pasco County		4.319205239813%
	Dade City		0.055819726723%
	New Port Richey		0.149879107494%
	Port Richey		0.049529975458%
	San Antonio		0.002189792155%
	St. Leo		0.002790804761%
	Zephyrhills		0.112672614089%
Pinellas		7.934889816777%	
	Pinellas County		4.546593184553%
	Belleair		0.018095745121%
	Belleair Beach		0.004261560686%
	Belleair Bluffs		0.007502670965%
	Belleair Shore		0.000439411029%

	Clearwater		0.633863120196%
	Dunedin		0.102440873796%
	Gulfport		0.047893986460%
	Indian Rocks Beach		0.008953453662%
	Indian Shores		0.011323004874%
	Kenneth City		0.017454786058%
	Largo		0.374192990777%
	Madeira Beach		0.022616957779%
	North Reddington Beach		0.003820333909%
	Oldsmar		0.039421706033%
	Pinellas Park		0.251666311991%
	Redington Beach		0.003611522882%
	Redington Shores		0.006451352841%
	Safety Harbor		0.038061710740%
	Seminole		0.095248695748%
	South Pasadena		0.029968921656%
	St. Pete Beach		0.071791046619%
	St. Petersburg		1.456593090134%
	Tarpon Springs		0.101970595050%
	Treasure Island		0.040652783215%
Polk		2.150483025298%	
	Polk County		1.558049828484%
	Auburndale		0.028636162584%
	Bartow		0.043971970660%
	Davenport		0.005305615818%
	Dundee		0.005597951255%
	Eagle Lake		0.002580177987%
	Fort Meade		0.007702403251%
	Frostproof		0.005857603227%
	Haines City		0.047984773863%
	Highland Park		0.000063551182%
	Hillcrest Heights		0.000005447244%
	Lake Alfred		0.007489960729%
	Lake Hamilton		0.002540231530%
	Lakeland		0.294875668468%

	Lake Wales		0.036293172134%
	Mulberry		0.005414560702%
	Polk City		0.001080370093%
	Winter Haven		0.097033576087%
Putnam		0.384893194068%	
	Putnam County		0.329225990182%
	Crescent City		0.005561636294%
	Interlachen		0.001877483489%
	Palatka		0.046955244716%
	Pomona Park		0.000379491344%
	Welaka		0.000893348043%
Santa Rosa		0.701267319513%	
	Santa Rosa County		0.592523984216%
	Gulf Breeze		0.061951507906%
	Jay		0.000159785829%
	Milton		0.046632041562%
Sarasota		2.805043857579%	
	Sarasota County		1.924315263251%
	Longboat Key		0.044489458856%
	North Port		0.209611771277%
	Sarasota		0.484279979635%
	Venice		0.142347384560%
Seminole		2.141148264544%	
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	Altamonte Springs		0.081305566430%
	Casselberry		0.080034542791%
	Lake Mary		0.079767627827%
	Longwood		0.061710013415%
	Oviedo		0.103130858057%
	Sanford		0.164243490362%
	Winter Springs		0.062262000824%
St. Johns		0.710333349554%	
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	Hastings		0.000010894488%
	Marineland		0.000000000000%

	St. Augustine		0.046510386442%
	St. Augustine Beach		0.007477250493%
St. Lucie		1.506627843552%	
	St. Lucie County		0.956156584302%
	Fort Pierce		0.159535255654%
	Port St. Lucie		0.390803453989%
	St. Lucie Village		0.000132549608%
Sumter		0.326398870459%	
	Sumter County		0.302273026046%
	Bushnell		0.006607507174%
	Center Hill		0.001312785844%
	Coleman		0.000748088199%
	Webster		0.001423546476%
	Wildwood		0.014033916721%
Suwannee		0.191014879692%	
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	Branford		0.000929663004%
	Live Oak		0.029057416132%
Taylor		0.092181897282%	
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	Perry		0.022212045963%
Union		0.065156303224%	
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	Lake Butler		0.001398126003%
	Raiford		0.000012710236%
	Worthington Springs		0.000116207876%
Volusia		3.130329674480%	
	Volusia County		1.708575342287%
	Daytona Beach		0.447556475212%
	Daytona Beach Shores		0.039743093439%
	DeBary		0.035283616215%
	DeLand		0.098983689498%
	Deltona		0.199329190038%
	Edgewater		0.058042202343%
	Flagler Beach		0.000223337011%

	Holly Hill		0.031615805143%
	Lake Helen		0.004918861482%
	New Smyrna Beach		0.104065968306%
	Oak Hill		0.004820811087%
	Orange City		0.033562287058%
	Ormond Beach		0.114644516477%
	Pierson		0.002333236251%
	Ponce Inlet		0.023813535748%
	Port Orange		0.177596501562%
	South Daytona		0.045221205323%
Wakulla		0.115129321208%	
	Wakulla County		0.114953193647%
	Sopchoppy		0.000107129135%
	St. Marks		0.000068998426%
Walton		0.268558216151%	
	Walton County		0.224268489581%
	DeFuniak Springs		0.017057137234%
	Freeport		0.003290135477%
	Paxton		0.023942453860%
Washington		0.120124444109%	
	Washington County		0.104908475404%
	Caryville		0.001401757499%
	Chipley		0.012550450560%
	Ebro		0.000221521263%
	Vernon		0.000361333863%
	Wausau		0.000680905521%
		100.00%	100.00%

Applicant Information

Organization Name: Premier Community HealthCare Group, Inc.	Authorized Organization Representative Name/Title: Joseph D. Resnick, President and CEO
Address: 37912 Church Avenue	Telephone: jresnick@HCNetwork.org 352.518.2000 x9013 (Main) 813. 484.9431 (Mobile)
City, State, ZIP: Dade City, FL 33525	Organization Website: www.premierhc.org
Contact Person Name and Title: Yvonne Kelly Montell Senior Manager of Grants	Federal ID Number: 59-1964612
Contact Person Email: ymontell@HCNetwork.org 813.364.2665 (Mobile)	DUNS # (Not required):

3. Certification

To the best of my knowledge, I certify that the information in this application is true and correct and that the document has been duly authorized by the governing body of the applicant. I also certify that I am aware that providing false information on the application can subject the individual signing such application to criminal sanctions. I further certify that I am authorized to submit this application and have followed all policies and procedures of my agency regarding grant application submissions.

Authorized Organization Representative: Joseph D. Resnick

Signature: *Joseph Resnick*

Typed Name: Joseph D. Resnick

Title: President and CEO Date: 4/20/26

Project Description and Narrative

SECTION A: Population of Focus and Statement of Need

Premier Community HealthCare Group, Inc. (Premier) is requesting funding to maintain and support access to substance use disorder (SUD), opioid use disorder (OUD), and co-occurring mental health services across its Hernando County health center locations. The population of focus includes medically underserved, uninsured, underinsured, and low-income individuals, including vulnerable populations such as veterans, older adults, individuals experiencing homelessness, and those with complex behavioral health conditions. This population spans all ages, ethnicities, and socioeconomic backgrounds, reflecting the continued and evolving impact of the opioid crisis within Hernando County.

Hernando County has an estimated population of approximately 205,000 residents (U.S. Census Bureau, American Community Survey, 2023). Despite population growth, economic and healthcare access challenges persist. Approximately 12.5% of residents live below the federal poverty level, and an estimated 13.8% of individuals under age 65 are uninsured, reinforcing the continued need for affordable and accessible healthcare services. Additionally, Hernando County continues to have a higher proportion of veterans compared to the state average, further emphasizing the need for targeted behavioral health and substance use services within this population.

Premier continuously evaluates community need through multiple data sources, including the U.S. Census Bureau, UDS Mapper, internal utilization data, and formal Community Health Needs Assessments conducted in collaboration with hospitals, the Florida Department of Health, and community-based partners. In addition to these data sources, Premier reviewed the Social Vulnerability Index (SVI) framework referenced in the most recent community assessment process to better understand the social and economic conditions that affect access to care in Hernando County. This lens further reinforces that many residents face heightened vulnerability related to factors such as income, transportation, housing stability, and other social determinants that can delay or prevent access to behavioral health and substance use treatment services.

Behavioral health and substance use remain among the most critical health challenges facing Hernando County. According to Florida CHARTS (2024), non-fatal overdose emergency department visit rates exceed 200 per 100,000 residents, surpassing state benchmarks and reflecting a sustained burden on emergency services, with opioids, particularly fentanyl, continuing to drive overdose-related incidents. These findings align with the Hernando County Community Health Improvement Plan, which identifies substance misuse and mental health as priority areas requiring expanded intervention, prevention, and treatment services.

Access to behavioral health providers remains a significant barrier. Hernando County is designated as a Mental Health Professional Shortage Area (HPSA) with a score of 21 out of 25 (HRSA, 2024). The provider-to-population ratio remains approximately 1,000:1, significantly exceeding state and national benchmarks (County Health Rankings, 2024). These shortages are further compounded by limited providers accepting Medicaid or offering sliding fee scales, creating additional barriers for vulnerable populations.

Premier's integrated model of care is uniquely positioned to address these challenges. By co-locating behavioral health, primary care, and care coordination services, Premier ensures that patients are screened, diagnosed, and connected to treatment in a timely and coordinated manner. Services include outpatient therapy, medication management utilizing FDA-approved medications such as Suboxone, Vivitrol, and naltrexone, medication-assisted treatment (MAT), and recovery support services. Telehealth services further expand access for patients experiencing transportation or socioeconomic barriers.

In 2025, Premier provided a total of 2,542 behavioral health visits to 679 unduplicated patients in Hernando County, representing a 46.3% increase in visits and a 54.0% increase in unduplicated patients over the prior year. These services included 1,173 therapy visits, 813 medication management visits, and 556 psychiatric evaluations, demonstrating both the breadth of service need and the intensity of care required across the continuum of behavioral health services. This growth reflects both increased community demand and Premier's expanded capacity to identify and engage patients in care through its integrated service model.

Of those visits, 279 were SUD/ODU related, benefiting 111 unduplicated patients. This data further demonstrates the continued need to sustain access to integrated behavioral health, substance use disorder, and medication-assisted treatment services for community members in need.

The sustained volume of services delivered demonstrates both the effectiveness of Premier's integrated model of care and the complexity of the population served, where patients often require multiple visits, medication management, and coordinated support services over time. Despite this capacity, demand continues to exceed available resources, particularly for individuals requiring timely intake, assessment, and initiation of treatment. These delays can result in worsening health outcomes, increased emergency department utilization, and a heightened risk of overdose. This level of demand reflects both the effectiveness of Premier's integrated model of care and the continued gap in available behavioral health and substance use services within Hernando County.

The target population served through this initiative faces significant social determinants of health, including limited access to stable housing, transportation, employment opportunities, and healthy food options. These barriers directly impact an individual's ability to access and sustain behavioral health and substance use treatment. As a result, integrated, accessible, and patient-centered care is essential to addressing both the clinical and social needs of this population.

Premier remains committed to serving the community's most vulnerable populations by reducing barriers to care and ensuring equitable access to services. Through its sliding fee discount program, Premier ensures that cost is not a barrier to treatment, enabling patients to access services based on income and household size.

This request directly aligns with Hernando County's Opioid Settlement Response Plan, including core strategies focused on expanding access to treatment, increasing medication-assisted treatment availability, and improving recovery outcomes for individuals impacted by opioid use disorder.

SECTION B: Proposed Implementation Approach

There is a critical shortage of behavioral health and opioid prevention services in Hernando County, as identified in the Community Health Needs Assessment and Community Health Improvement Plan. One of the primary goals of CHIP is to improve access to mental health and substance misuse services, particularly for underserved and vulnerable populations. As a safety-net provider, Premier is well positioned to address these service gaps and reduce health disparities by maintaining access to outpatient therapy, medication-assisted treatment (MAT), and integrated behavioral health services.

Based on the Hernando County Community Health Needs Assessment conducted by WellFlorida Council in collaboration with the Florida Department of Health and over twenty community-based partners, opioid-related morbidity and mortality remain a significant concern. Prior data identified opioid overdose deaths and substantial rates of opioid-involved emergency department visits and hospitalizations, and more recent findings confirm that these trends persist, with non-fatal overdose events and behavioral health-related emergency utilization continuing to exceed state benchmarks. These indicators, along with findings from the Hernando County Community Health Improvement Plan (2024–2026), highlight the continued and urgent need for expanded behavioral health and substance use treatment services in the community.

Substance misuse and mental health were identified as the top two priority health issues by both community members and healthcare providers through the Hernando County Community Health Needs Assessment and Community Health Improvement Plan (2024–2026).

The primary goal of this program is to maintain and support opioid use disorder (OUD) services while broadening recovery support services to address co-occurring substance use and mental health conditions, directly addressing the gap in integrated SUD-MH services available in Hernando County.

Support from Hernando County's Opioid Settlement funding will enable Premier to maintain this vital service capacity through the strategic support of existing clinical staff, including a Licensed Clinical Social Worker (LCSW) and a psychiatric Advanced Practice Registered Nurse (APRN) specializing in medication-assisted treatment (MAT). These providers are already onboard and fully integrated within Premier's model of care and will be dedicated to increasing access to services in Hernando County, particularly in high-need areas such as Spring Hill.

Within Premier's patient population, there are hundreds of individuals with SUD/OUD and co-occurring mental health conditions requiring assessment and treatment. Current demand has resulted in extended wait times for intake and initiation of services, historically reaching several months. In some cases, patients have experienced wait times up to three to four months for intake and initiation of services, further emphasizing the importance of sustaining current clinical capacity. Sustaining this capacity will help preserve access to care, significantly reduce these delays, allowing patients to access Screening, Brief Intervention, Referral to Treatment (SBIRT), therapy, and medication-assisted treatment in a more timely and coordinated manner.

From an operational perspective, a Licensed Clinical Social Worker can provide an average of 6 patient visits per day for therapy and counseling services, while an APRN providing MAT services can see approximately 12–14 patients per day. This continued service capacity will

directly improve access to care, reduce wait times, and increase patient throughput for individuals requiring behavioral health and substance use treatment.

The proposed project budget is designed to maximize direct patient care and support continued service delivery. Funding will support approximately 54% of a Licensed Clinical Social Worker and 60% of an APRN, ensuring that resources are focused on high-impact clinical services. By allocating the LCSW to SBIRT screenings, intake, and therapy services, licensed providers are able to operate at the top of their scope, while the APRN focuses on psychiatric evaluation and medication-assisted treatment. This coordinated, team-based approach improves efficiency, strengthens care delivery, and expands access for individuals with OUD and co-occurring conditions. This model minimizes bottlenecks in the intake and treatment process while maximizing provider productivity and patient throughput.

The proposed number of patients to be served through this project will reflect a realistic and data-driven approach based on current utilization, provider productivity, and service demand. This project period goal is to serve an additional 125 unduplicated patients over the prior year.

While the number of unduplicated patients served is a key measure, this program recognizes that behavioral health and substance use treatment require multiple encounters over time. As a result, success will also be measured by total encounters, continuity of care, and patient engagement in treatment. These measures ensure that both access and quality of care are evaluated, aligning with best practices in behavioral health performance management.

Premier's integrated model of care will serve as the foundation for implementation. Services will include outpatient therapy, psychiatric evaluation, medication management, medication-assisted treatment (MAT), SBIRT screenings, and care coordination. Patients will be assessed using standardized tools such as SBIRT and PHQ-9, with results documented in Premier's electronic health record system (EPIC). Patients will be reassessed throughout treatment to monitor progress, identify barriers, and adjust care plans as needed.

Program Goal

To expand access to integrated behavioral health, substance use disorder, and opioid use disorder services for medically underserved and high-risk populations in Hernando County.

Objectives

- Increase the number of SUD/OUD/MH patients served over the prior year, with a project period goal of an additional 125 unduplicated patients
- Ensure 100% of patients are screened using SBIRT and/or PHQ-9
- Reduce wait times for intake and initiation of treatment
- Achieve at least 50% of patients progressing toward stabilization or recovery

Key Performance Indicators (KPIs)

- Number of visits/encounters provided
- Patient engagement and retention in treatment
- Appointment outcomes (scheduled, completed, canceled, no-show rates)
- Patient demographics and payer mix
- Diagnosis and treatment categories
- Number of uninsured, underinsured, and low-income patients served

Implementation will begin immediately upon award, with Premier positioned to maintain and support continued delivery of these services within 45–60 days, as this project builds upon existing infrastructure and staffing.

The proposed services align directly with Hernando County’s Opioid Settlement Response Plan, including maintaining access to treatment, sustaining availability of medication-assisted treatment, improving recovery outcomes, and strengthening coordination of care for individuals impacted by opioid use disorder.

Premier is fully engaged in the Hernando County Public Safety Coordinating Council and works collaboratively with community-based organizations to ensure warm handoffs and coordinated referrals. Outreach, education, and engagement efforts are ongoing to connect individuals to care and support recovery. With over forty-six years of service, Premier has a demonstrated history of grant compliance, strong fiscal stewardship, and the ability to leverage public and private funding to sustain services beyond the grant period.

SECTION C: Evidence-Based Service/Practice

Premier Community HealthCare Group, Inc. (Premier) delivers behavioral health and substance use disorder services using evidence-based practices that are clinically proven to improve outcomes for individuals with opioid use disorder (OUD), substance use disorders (SUD), and co-occurring mental health conditions.

The primary modality utilized by Premier’s licensed behavioral health providers is Cognitive Behavioral Therapy (CBT), a widely recognized evidence-based practice. CBT is a goal-oriented, structured therapeutic approach that enables patients to understand the relationship between thoughts, emotions, and behaviors. Through this approach, patients develop coping strategies, reduce harmful behaviors, and improve emotional regulation. Interventions include motivational interviewing, relapse prevention strategies, contingency management, and cognitive restructuring techniques tailored to each patient’s individual needs, culture, and preferences.

In addition to CBT, Premier maintains Medication-Assisted Treatment (MAT) as a core component of care for individuals with opioid use disorder. MAT utilizes FDA-approved medications such as Suboxone, Vivitrol, and naltrexone in combination with behavioral therapy to support recovery, reduce cravings, and decrease the risk of relapse and overdose. The

integration of MAT with behavioral health services reflects best practices and national standards, including SAMHSA and CDC guidelines for the treatment of opioid use disorder.

Premier's integrated model of care ensures that behavioral health, primary care, and psychiatric services are delivered in a coordinated and patient-centered manner. Patients are routinely screened using validated tools such as SBIRT (Screening, Brief Intervention, and Referral to Treatment) and PHQ-9, with results documented in Premier's electronic health record system (EPIC). Patients are reassessed throughout treatment to monitor progress, identify barriers, and adjust care plans as needed.

This integrated approach is directly aligned with the priorities outlined in the Hernando County Community Health Needs Assessment and Community Health Improvement Plan (2024–2026), which designate substance misuse and mental health as top priority health issues and emphasize the need for expanded access to integrated behavioral health and medication-assisted treatment services.

To ensure fidelity to evidence-based practices, clinicians receive ongoing supervision from licensed clinical leadership and participate in peer review and case consultation. Collaboration among providers supports continuous learning and the consistent application of best practices across the care team. Clinicians utilize established treatment protocols and conduct self-assessments, making adjustments as needed to ensure fidelity and effectiveness in service delivery.

Since 1979, Premier has served as a Federally Qualified Health Center (FQHC), providing comprehensive primary, preventive, and behavioral health services to medically underserved populations in Pasco and Hernando counties. In 2025, Premier provided healthcare services to over 44,000 community members across multiple service lines, demonstrating both capacity and experience in delivering integrated, high-quality care.

Premier reduces barriers to care through its Sliding Fee Discount Program, which determines patient financial responsibility based on federal poverty level guidelines, ensuring that cost is not a barrier to accessing needed services. In addition, Premier operates an in-house pharmacy, enabling patients to access medications at the lowest possible cost, which is particularly critical for individuals receiving medication-assisted treatment. This access significantly reduces barriers to medication adherence, a key factor in successful recovery outcomes. For patients with minimal financial resources, Premier maintains the capacity to provide care regardless of ability to pay, supported in part by ongoing fundraising efforts that help offset costs not covered through federal or third-party funding sources. Premier has expanded its services over the past decade to meet the evolving needs of the community while remaining committed to its mission “to provide accessible healthcare services for all.”

Premier also addresses barriers to care through financial counselors and referral partnerships that support patients in accessing coverage and assistance programs. Patients may be referred to external community-based enrollment support, including DCF Hope Florida Office of Community Services and other third-party entities that provide Medicaid application assistance at no cost, ensuring a comprehensive approach to care and access to needed services.

Premier is committed to delivering culturally competent, patient-centered services that respect the diverse backgrounds and needs of the communities it serves. Providers and staff reflect the

populations served and offer bilingual services in English and Spanish. Interpretation services are available for additional languages through contracted third-party translation services, and accommodation is made for individuals who are deaf or hard of hearing. All patient education materials, forms, and communications are available in accessible and bilingual formats to support patient understanding and engagement.

All services are delivered by licensed, highly skilled professionals in a respectful, non-judgmental, and patient-centered environment of care. Premier actively engages the community to better understand the unique needs of its patient population and continuously adapts services to improve access, engagement, and outcomes.

Premier is committed to fostering a supportive and patient-centered environment of care where individuals feel respected, valued, and empowered throughout their treatment journey. This commitment is reflected in a culture of professionalism, collaboration, and continuous improvement, ensuring that patients receive high-quality, coordinated care that supports long-term recovery and improved health outcomes.

SECTION D: Staff and Organizational Experience and Expertise

Premier Community HealthCare Group, Inc. (Premier) has a highly qualified leadership and clinical team with extensive experience in implementing and managing behavioral health and substance use disorder programs.

Jesse Dang, Associate Vice President of Operations, will be responsible for overall project implementation and operational oversight. Jesse joined Premier in August 2021 and brings a strong background in healthcare leadership and process improvement. He holds undergraduate degrees in Biomedical Sciences and graduate degrees in Health Administration and Business Administration from the University of South Florida. He is a Certified Project Management Professional (PMP), Certified Lean Six Sigma Black Belt, and Certified Professional in Healthcare Management Systems. Jesse oversees clinic operations across service lines and focuses on optimizing performance, improving patient access, and supporting Premier's continued growth to meet community needs.

Larry Legg, LCSW, CCM, serves as the Clinical Director of Behavioral Health Services and provides direct supervision and clinical oversight for all behavioral health providers. Larry joined Premier in August 2021 and was promoted to Clinical Director in 2024. He has over 25 years of experience as a licensed clinical social worker, specializing in co-occurring substance use and mental health disorders. His experience includes family preservation, outpatient treatment, intensive outpatient programs, and partial hospitalization programs. Larry holds both his bachelor's and master's degrees in social work from West Virginia University and brings a strong, patient-centered approach to care.

Behavioral Health practitioners Nany Peña, LCSW, and Yaima Rodriguez, APRN, serve as key clinical providers for this initiative. Collectively, they bring over 20 years of experience in treating individuals with opioid use disorder, substance use disorders, and co-occurring mental health conditions. These providers are already integrated into Premier's care model and will be strategically allocated to support expanded services in Hernando County. Peña provides therapy

services both in-clinic and via telehealth, ensuring continuity and accessibility of care. Rodriguez, as an APRN specializing in medication-assisted treatment, provides psychiatric evaluation and medication management services critical to patient stabilization and recovery.

All clinical staff operate within Premier's integrated care model, collaborating closely with primary care providers, care coordinators, and support staff to ensure comprehensive, whole-person care. Existing and new health center patients benefit from Premier's integrated Substance Use Disorder (SUD) program, which follows a structured and coordinated care process. Intake by a licensed therapist or behavioral health provider is a required first step before a patient can begin receiving OUD or co-occurring SUD/MH services. To further optimize integrated care and ensure patient safety, each patient is required to have a physical examination on file within the last six months. Each patient's OUD/SUD plan of care is individualized and tailored to their specific clinical and social needs, ensuring a patient-centered approach to treatment and recovery. Behavioral Health and Substance Use Disorder services have progressively expanded over the past five years in response to increasing community demand and the complexity of patient needs. This sustained growth demonstrates Premier's ability to scale services in response to increasing demand while maintaining quality and continuity of care.

To ensure fidelity to evidence-based practices, clinicians receive ongoing supervision from licensed clinical leadership and participate in peer review and case consultation. Collaboration among providers supports continuous learning and the consistent application of best practices across the care team. Clinicians utilize established treatment protocols and conduct self-assessments, making adjustments as needed to ensure fidelity and effectiveness in service delivery.

The personnel structure for this project aligns with the proposed budget and supports direct patient care through the allocation of clinical staff, including a Licensed Clinical Social Worker and a psychiatric provider specializing in medication-assisted treatment. These roles are critical in expanding access to screening, intake, therapy, and medication management services for individuals with OUD and co-occurring conditions.

Premier has extensive experience successfully implementing and managing projects of similar scope and complexity. With supplemental funding through the Health Resources and Services Administration (HRSA), Premier launched integrated substance use disorder services in 2018 and has continued to expand these services in response to increasing community needs.

Premier has been awarded numerous federal, state, and local grants over its forty-six-year history and has demonstrated strong performance in achieving program goals, maintaining compliance, and managing funds responsibly. The organization maintains transparent grant management practices and consistently delivers timely, accurate reporting for all funded programs.

Through its longstanding presence in the community, Premier has developed strong partnerships with healthcare providers, community-based organizations, and local coalitions throughout Hernando County. These partnerships support coordinated referrals, warm handoffs, and expanded access to services for individuals with opioid use disorder and co-occurring conditions.

Premier's experienced leadership, skilled clinical team, and strong organizational infrastructure position the organization to successfully implement and sustain the proposed project, ensuring expanded access to high-quality behavioral health and substance use services for the community.

SECTION E: Data Collection and Performance Management

Premier Community HealthCare Group, Inc. (Premier) utilizes a comprehensive and integrated approach to data collection, performance management, and quality improvement to ensure effective program implementation and measurable outcomes.

All program data will be collected, tracked, and reported through Premier's electronic health record (EHR) system, EPIC, which is fully implemented across all service lines. EPIC provides robust functionality for patient-level, provider-level, and population-level reporting, enabling Premier to monitor service utilization, clinical outcomes, and program performance in real time. The system supports both standard and customized reporting, allowing staff to generate dashboards specific to behavioral health, substance use disorder services, and grant-funded programs.

EPIC enables the tracking of key data elements including patient demographics, diagnoses, screenings, treatment plans, encounters, and outcomes. Clinical quality measures are integrated into the system and aligned with Centers for Medicare and Medicaid Services (CMS) reporting requirements, Patient-Centered Medical Home (PCMH) standards, and other regulatory benchmarks. The PCMH report calculates, measures, and exports data so health center staff can easily submit performance measures to payers, ensuring compliance and supporting value-based care initiatives.

Patients are actively engaged in their care through EPIC's patient portal, formerly known as MyChart, which allows access to post-visit summaries, appointment scheduling, and communication with providers. Patients can also self-schedule appointments via Premier's website and renew prescriptions through Premier's pharmacy application, RX365. The addition of prescription delivery services has been well received by patients in Hernando County, improving access and medication adherence; however, controlled substances are excluded from delivery in accordance with regulatory requirements. These tools support continuity of care and improve patient engagement, particularly for individuals managing behavioral health and substance use conditions. These tools also support improved adherence to treatment plans and reduce missed appointments, particularly among high-risk populations.

Premier maintains a structured Quality Improvement/Quality Assurance (QI/QA) process to support ongoing performance management. The QI/QA committee, led by clinical leadership with oversight from the Chief Medical Officer, meets regularly to review performance metrics, monitor progress toward clinical quality goals, and identify opportunities for improvement. The quality improvement process includes four key steps: identification of areas for improvement, analysis of data, development of targeted interventions, and implementation of corrective actions. This framework ensures continuous monitoring and improvement of patient outcomes and program effectiveness.

As it relates to program-specific performance, data will be collected and monitored for key indicators including patient volume, encounters, screening completion (SBIRT and PHQ-9), treatment engagement, and continuity of care. Additional performance measures will include appointment adherence, no-show rates, patient demographics, diagnosis categories, and payer mix, including the number of uninsured and underinsured patients served.

All clinicians are required to document patient encounters, screenings, assessments, and treatment plans within EPIC at the time of service. Documentation is reviewed to ensure completeness, accuracy, and compliance with clinical and reporting standards. Consent forms and supporting documentation are securely maintained within the EHR system. For patients with literacy or language barriers, care team members provide assistance to ensure comprehension and informed consent.

Program data will be used to evaluate progress toward established goals and objectives, inform program adjustments, and support required reporting to Hernando County. Premier has a demonstrated history of utilizing data to improve clinical outcomes, reduce health disparities, and ensure accountability for grant-funded services.

Through its use of EPIC, structured quality improvement processes, and commitment to data-driven decision-making, Premier ensures that program performance is continuously monitored, evaluated, and strengthened to achieve meaningful and measurable outcomes for the community.

SECTION F: Detailed Budget, Budget Narrative, and Justification

(See attached spreadsheet)

Premier Community HealthCare Group, Inc.

Expanding Access to Care: Combating Opioid Use in Hernando County

SECTION F: Budget 2026-2027

Item	Hernando Opioid Funding Request	Premier Matching Funds	Total	Budget Narrative
Provision of outpatient therapy or counseling for SUD, OUD and Co-Occurring Mental Health Services	\$50,826	\$43,281	\$94,107	54% of 1 FTE Licensed Clinical Social Worker (Salary, Taxes and Benefits)
Provision of Medication-Assisted Treatment	\$99,174	\$66,116	\$165,290	60% of 1 FTE Psychiatric Advanced Practice Registered Nurse (Salary, Taxes and Benefits)
Total	\$150,000	\$109,397	\$259,397	

