

New Hampshire

UNIFORM APPLICATION

FY 2020/2021 Substance Abuse Prevention and Treatment Block Grant Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 03/31/2020 3.01.18 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State DUNS Number

Number 11040545

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name New Hampshire Department of Health and Human Services

Organizational Unit Bureau of Drug and Alcohol Services

Mailing Address 105 Pleasant St.

City Concord

Zip Code 03301

II. Contact Person for the Grantee of the Block Grant

First Name Annette

Last Name Escalante

Agency Name NH DHHS, Bureau of Drug and Alcohol Services

Mailing Address 105 Pleasant St. Main Bldg., 3rd Floor North

City Concord

Zip Code 03301

Telephone 603-271-6104

Fax 603-271-6105

Email Address annette.escalante@dhhs.nh.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 10/1/2019 1:02:05 PM

Revision Date 3/17/2020 12:37:25 PM

V. Contact Person Responsible for Application Submission

First Name Shannon

Last Name Quinn

Telephone 603-271-5889

Fax 603-271-6105

Email Address shannon.quinn@dhhs.nh.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2020

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Substance Abuse Prevention and Treatment Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52

Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: Annette Escalante, MSW, MLADC

Signature of CEO or Designee¹: _____

Title: Director, NH Bureau of Drug & Alcohol Services

Date Signed: _____

mm/dd/yyyy

_____ ¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:



**STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR**

CHRISTOPHER T. SUNUNU
Governor

September 19, 2017

Ms. Odessa Crocker, Branch Chief
Office of Financial Resources Formal Grants Branch Room
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 17E25D
Rockville, Maryland 20857

RE: Substance Abuse Prevention and Treatment Block Grant (SABG)

Dear Ms. Crocker:

As the Governor of the State of New Hampshire, for the duration of my tenure, I delegate authority to the New Hampshire Department of Health and Human Services, Bureau of Drug and Alcohol Services, or anyone officially acting in this role in the instance of a vacancy, for all transactions required to administer the Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SABG).

Sincerely,

A handwritten signature in blue ink that reads "Christopher T. Sununu".

Christopher T. Sununu
Governor



STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF LEGAL AND REGULATORY SERVICES
CLIENT AND LEGAL SERVICES

Jeffrey A. Meyers
Commissioner

Melissa A. St. Cyr., Esq.
Chief Legal Officer

105 PLEASANT STREET, CONCORD, NH 03301-3857
603-271-5144 1-800-852-3345 Ext. 5144
Fax: 603-271-5058 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

October 23, 2019

Odessa F. Crocker
Branch Chief, Formula Grants Branch
Division of Grants Management, Office of Financial Resources
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, 17E22
Rockville, MD 20857

Re: Attestation by NH STATE DEPT OF HEALTH AND HUMAN SERS for
Substance Abuse Prevention & Treatment Block Grant, 6B08TI010035-19M001

Dear Ms. Crocker:

I certify that the grantee organization/recipient, State of New Hampshire, Department of Health and Human Services, and all sub-recipients will comply with the following NoA language:

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. *See, e.g.*, 45 C.F.R. § 75.300(a) (requiring HHS to “ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements.”); 21 U.S.C. §§ 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

*The Department of Health and Human Services' Mission is to join communities and families
in providing opportunities for citizens to achieve health and independence.*

Sincerely,



Annette Escalante, MSW, MLADC
SSA & Director, Bureau of Drug & Alcohol
Services

Division for Behavioral Health
NH Dept. of Health & Human Services

105 Pleasant Street
Concord, NH 03301
Office 603-271-6104

Annette.Escalante@dhhs.nh.gov

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name

Shannon Quinn

Title

Program Specialist IV

Organization

NH Bureau of Drug & Alcohol Services

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

The NH Bureau of Drug & Alcohol Services does not utilize any funding for lobbying.

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

FFY 2020/21 SABG Application & Plan
NH Bureau of Drug & Alcohol Services

Step 1: Assess the strengths and capacity of the service system

The Bureau of Drug and Alcohol Services (BDAS) sits within the New Hampshire Department of Health and Human Services (DHHS), Division for Behavioral Health (DBH). Also included under the DBH umbrella are the Bureau of Children’s Behavioral Health, Bureau of Mental Health Services, and the Policy Section.

BDAS is responsible for managing the federal substance abuse prevention and treatment block grant (SABG), which is our primary funding source, as well as the administration of a full continuum of substance misuse services under contract with the NH DHHS that are supported by resources from SAMHSA (the SABG, MAT-PDOA, STR and SOR) and the Governor’s Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery. BDAS provides administrative / regulatory oversight, on behalf of NH DHHS, over the private for-profit methadone clinics (opioid treatment programs) and all impaired driving programs in the state. BDAS also serves as the NH DHHS’ subject matter resource for alcohol and drugs, for managing alcohol and drug-related public awareness efforts and training and technical assistance resources for prevention, treatment and recovery services.

BDAS has a primary role in representing NH DHHS, in concert with numerous stakeholders from the public and private sector at both the state and local level, that are working together to implement the Governor’s Commission plan for the state. This plan utilizes a comprehensive public health approach to address the misuse of alcohol and drugs in New Hampshire.

The following four units structure BDAS internally and work to carry out the mission of the Bureau; to join individuals, families and communities in reducing alcohol and other drug problems thereby increasing opportunities for citizens to achieve health and independence:

- Prevention Services
- Clinical Services, including Impaired Driver Services
- Resources and Development
- Business and Financial Services

Prevalence and Consequence of the misuse of alcohol and drugs in New Hampshire:

- NH has and continues to put forth many concerted efforts to address the opioid epidemic over the past few years, however opioid misuse and drug overdose continues to touch every community across NH. Since 2012, 1,900 NH residents have lost their lives as a result of opioid-related overdose deaths.
- Drug overdose deaths decreased 3.5% from 2017 to 2018 across NH. However, despite this decrease, 5 counties across NH experienced increases during the elapsed year¹.
- EMS Narcan administration incidents decreased by 19.5% from 2017 to 2018, significantly more than the 5% decrease from 2016 to 2017 ¹.
- Opioid/opiate, methamphetamine, and cocaine/crack treatment admissions decreased by 17.% from 2017 to 2018 ²
- In 2018, 82% of treatment admissions involved opioid/opiates ².
- There are approximately 110,000 people in New Hampshire that are misusing and or that meet the criteria of a substance use disorder (SUD)
- Admission rates for publically support treatment services for individuals with an opioid use disorder (OUD), that involves the Illicit use of any of the following; heroin , synthetic opioids (such as Fentanyl) and non-medical use or misuse of opioid based prescription medications, have increased from 17% a decade ago to more than 50% of admission is SFY-2019, 53.63%. Admission for alcohol use disorders continue to be the single second highest rate for admission, SFY2019 29.2%²

¹ NH Drug Monitoring Initiative (DMI), 2018 Overview Report

² NH Bureau of Drug and Alcohol Services

FFY 2020/21 SABG Application & Plan
NH Bureau of Drug & Alcohol Services

- There were 5,539 Opioid related emergency Department visits in 2018, a decrease of 17.6% from 2017 ¹.
- According to a report released by New Futures in May of 2017, [The Corrosive Effects of Alcohol and Drug Misuse on NH's Workforce and Economy](#), the misuse of alcohol and drugs cost the New Hampshire economy \$2.36 Billion in 2014 (Gottlob, 2017).

NH Governor's Commission on Alcohol and Other Drugs (the Commission)

The mission of the Governor's Commission on Alcohol and Other Drugs is to significantly reduce alcohol and drug problems and their behavioral, health and social consequences for the citizens of New Hampshire by advising the Governor regarding the delivery of effective and coordinated alcohol and drug abuse prevention, treatment and recovery services throughout the state. BDAS works closely with the Commission and external stakeholders to consider, within the context of a full continuum of strategies and services, what resources can support which elements of the continuum of care for particular populations.

The Commission was created by the NH Legislature in the year 2000 and revised in 2014. Its duties include:

- Developing and revising, as necessary, a statewide plan for the effective prevention of alcohol and drug abuse, particularly among youth; and a comprehensive system of treatment and recovery services for individuals and families affected by alcohol and drug abuse;
- Promoting collaboration between and among state agencies and communities to foster the development of effective community-based alcohol and drug abuse prevention programs;
- Promoting the development of treatment services to meet the needs of citizens addicted to alcohol or other drugs;
- Identifying unmet needs the resources required to reduce the incidence of alcohol and drug abuse in NH and to make recommendations to the Governor regarding legislation and funding to address such needs; and
- Authorizing the disbursement of moneys from the alcohol abuse and prevention and treatment fund, pursuant to RSA 176-A:1, III.

To assist in the performance of its duties, the Commission has 8 taskforces.

1. Data and Evaluation
2. Healthcare
3. Joint Military
4. Opioid
5. Perinatal Substance Exposure
6. Prevention
7. Recovery
8. Treatment

The Commission released its [2019-2022 Strategic Plan](#), which highlights progress, challenges, and opportunities for the Commission and its collective efforts to address the misuse of alcohol and other drugs, particularly opioids, and to promote treatment and recovery. The Director of BDAS serves as the Executive Director of the Commission and ensures that directives of the Commission and initiatives of the Bureau align efforts to mitigate substance use disorders for the citizens of NH.

For more information, please visit the Commission's webpage <https://nhcenterforexcellence.org/governors-commission/>.

FFY 2020/21 SABG Application & Plan
NH Bureau of Drug & Alcohol Services

Continuum of Care Facilitators

CoC development is a key component in NH DHHS/BDAS' and Regional Public Health Networks' efforts to create comprehensive, connected and coordinated substance misuse systems of care that coordinates with primary health and behavioral health services. CoC development work engages regional stakeholders in work that seek to

- Increase awareness of, and access to, substance misuse services,
- Increase communication and collaboration among providers,
- Increasing service capacity and service delivery quality

Data measures used to monitor the effectiveness of efforts include the number of call to 2-1-1 from people seeking help by region and by community, the number of admissions to BDAS substance misuse services by region and by community, and the number of people seeking services that were not available by region and by community.

To assist in this development, CoC Facilitators have been located in each of the 13 RPHNs and serve as a resource in each by facilitating a community/regional approach to address the misuse of alcohol and drugs utilizing a public health method. (<http://www.dhhs.nh.gov/dcbcs/bdas/continuum-of-care.htm>). CoC development activities include, but are not limited to:

- Engaging with regional stakeholders, and with other related initiatives, in an ongoing scan of substance misuse service assets, including those sited in primary health and behavioral health care settings,
- Engaging with regional stakeholders, and other related initiatives, in an ongoing update to, and implementation of, the regional CoC development plan, which identifies actions to maximize access to and connections between the existing service array, and high priority areas to be addressed and/or actions to be taken for each CoC component,
- Organizing and facilitating efforts to increase service capacity and/or develop new services,
- Coordinating with regional and state partners to distribute materials throughout regions that help individuals, families and communities become aware of and connect to services, materials that provide important information on SUD for special populations, and information on emerging substance-misuse threats.

Prevention Services

NH's prevention structures and efforts are supported by public and private partnership that provides additional funds toward prevention. The New Hampshire Charitable Foundation invests approximately \$3 million per year to "reduce the burden caused to the citizens of New Hampshire by alcohol, tobacco and other drugs". Core to the strategy is policy and advocacy to improve public financing, research and evaluation of best practices in substance use disorder services, as well as funding for proven strategies. In 2012, the foundation approved 10-year strategy dedicated to the prevention of substance use disorders. Approximately \$1.2 million dollars per year will be allocated from the portfolio in furtherance of this strategy. This strategy is implemented in close partnership with the DHHS. This includes strategic co-funding, integrated planning and reporting systems for grantees.

Like CoC Facilitators, Substance Misuse Prevention (SMP) Coordinators are also positioned within each of the 13 regions. SMP's utilize the Strategic Prevention Framework Model (assessment, capacity, planning, implementation and evaluation), a data driven public health approach, to address the misuse of alcohol and drugs in their area by convening and collaborating with the core sectors (local government, education, community organizations, safety, businesses, health/medical) to increase service capacity and to reduce "factors that put people, families and communities at risk" and increase "factors that protect people, families and communities" in the prevention of misuse of alcohol and drugs.

SMP Coordinators participate with the regions' Public Health Advisory Group, a high level leadership council, and their Community Health Improvement Plan (CHIP) to improve health outcomes and coordination with the IDN (Integrated Delivery Networks – NH's 1115 DSRIP Waiver) within their regions.

FFY 2020/21 SABG Application & Plan NH Bureau of Drug & Alcohol Services

Other BDAS funded Prevention activities include:

- **Public Awareness Campaigns** – through a contract with the NH Center for Excellence, we are developing evidence informed public awareness messaging targeting children, adolescents, adults and families for use in public awareness / social marketing campaigns utilizing a variety of media, including television, radio, newspapers, printed materials, social media.
- **Life of an Athlete** - a comprehensive multicomponent prevention program which empowers and motivates youth participating in athletics and leadership programs to make healthy choices and decisions by educating them on the impact alcohol and other drugs have on performance and development.
- **Referral, Education, Assistance Program (REAP) for Older Adults** - a community based statewide prevention education and early intervention program for individuals 60 years of age or older and their caregivers. The program is designed to provide brief screening to identify areas of concern related to mental well-being and substance misuse, brief counseling, prevention education and supportive referral to community based services. The goal is to provide the services, supports, and skill-building needed to help an older adult maintain their independent lifestyle and regain health and emotional wellbeing.
- **Student Assistance Programs (SAP)** - a school based program for middle and high schools as well as colleges and universities using trained SAP counselors to deliver the services. SAP services administered by the BDAS are based on the “*Project Success*” evidence based practice. The program is designed to prevent and reduce substance misuse among students 12 to 25 years of age. The school-based program combines school wide alcohol and other drug prevention awareness activities, classroom based prevention education, individual and group sessions for students, parent education and referral to community resources.
- **Young Adult Prevention Services** – Services began in Sept 2017 through the Partnership for Success 2015 grant. 10 of the 13 RPHN’s will be implementing evidenced-based or evidence-informed strategies targeted specifically for young adults 18 to 25 years of age and young adult social media campaign. The strategies range from SBIRT in community-health settings, healthy workforce initiatives, college-based prevention education, and peer leadership. The Young Adult Leadership Program is modeled after the evidenced-based National Alliance on Mental Illness-New Hampshire’s CONNECT program for youth.
- **Prevention Direct Services** – Services began in SFY 18 and are community-based. Not funded by the Block Grant, but important to mention, these interventions target youth and parents/caregivers within selective and indicated categories to reduce risk factors and increase protective factors to prevention or diminish the onset of substance using behaviors and progression of a SUD. Programming includes a variety of components including screening for substance misuse and/or mental health issues, prevention education, positive alternative activities, prevention counseling, and parent education.

Early Intervention

- **Juvenile Diversion Services** – although not funded through the Block Grant, the NH Juvenile Diversion programs are critical partners in the early intervention and identification of juveniles at risk of substance misuse disorders due to criminal behavior. The programs use restorative justice principals that divert juveniles otherwise headed to the NH court system by utilizing prevention and early intervention services that reduce the harm to the victim, decrease the impact and cost to the community, and restore the pathway of success for the juveniles participating in the program
- **Screening, Brief Intervention, Referral to Treatment** - Approximately \$1,000,000 of Federal Block Grant funding was made available for the development of SBIRT services in Community Health Center (CHCs) settings in SFY-16. All Community Health CHCs are currently providing SBIRT services to their clients.

Crisis Intervention

Since 2012, 1,900 NH residents have died as a result of opioid-related overdoses. As a response to this epidemic, the following services were initiated and continue to develop:

FFY 2020/21 SABG Application & Plan
NH Bureau of Drug & Alcohol Services

- **The Doorways** (<https://www.thedoorway.nh.gov/>) – The new hub and spoke system went live on January 1, 2019. The hubs, known as Doorways, serve as a comprehensive, 24/7 statewide access and referral hub with a minimum of nine physical locations situated to ensure that no one in NH has to travel more than sixty minutes to begin the process towards recovery. Doorways are responsible for providing screening, evaluation, closed loop referrals, and care coordination for the client throughout their experience along the continuum of care. In addition to the core services, some Doorways are also able to provide medication assisted treatment (MAT), peer recovery support services, and other supportive services.
- **Hospital Emergency Department SUD Care Coordination** - BDAS sub-contracts with 8 hospitals across the state to provide care coordination services for individuals transported to hospital ED as a result of a drug overdose or admitted to the hospital and suspected of misusing alcohol and drugs. The primary scope of this work is to recruit and support hospitals to conduct substance use screenings and to coordinate care for individuals transported to the hospital by EMS or otherwise admitted to the emergency department as a result a drug overdose, or patients admitted to the hospital due to acute medical conditions that are suspected of misusing alcohol and drugs. Care coordination includes facilitated referrals for full substance use disorder evaluation and to treatment or recovery support services.
- **Naloxone Administration / Department of Safety (DOS) EMS First Responder Training** - The New Hampshire Statewide Naloxone Distribution and Training initiative is jointly administered by a number of program areas within the New Hampshire Department of Health and Human Services, including BDAS, the Division of Public Health Services (DPHS) and the Emergency Services Unit, that coordinate with the Bureau of Emergency Medical Services (BEMS) at the Department of Safety (DOS).

This initiative makes Naloxone (Narcan) Kits and related instructions available free of charge to individuals at risk for opioid overdose, their families and friends that do not have insurance to cover the cost of a kit and that otherwise cannot afford to purchase one. DHHS makes Naloxone kits directly available to substance use disorder treatment providers, community health centers and other health and social services agencies that serve individuals at risk for opioid overdose, their families and friends. These kits are also available to agencies through the 13 RPHNs. Each of these networks have also held numerous public events in their area, where Naloxone Kits and related instructions are likewise made available to individuals at risk for opioid overdose, their families and friends that otherwise cannot afford one.

BEMS has developed a training of trainers program made available at a number of locations across the state for the administration of Naloxone and has made these and related First Aid/CPR training available to Law Enforcement personnel from agencies across the state, many of which become certified by BEMS to administer Naloxone (245 officers trained / 164 licensed). This initiative is particularly import for areas that don't have rapid response emergency medical services (EMS).

Impaired Driver Services

BDAS has oversight of the Impaired Driver Care Management Programs as well as the Impaired Driver Education Programs and Impaired Driver Services Providers. Work between BDAS, Department of Safety, Division of Motor Vehicles, and state police continues to refine and improve systems and update Impaired Driving State Policy.

SUD Treatment Services

BDAS provides treatment and recovery support services to individuals with a substance use disorder who are residents of or homeless in NH; are under 400% of Federal Poverty level; and who do not have public or private insurance that will pay for the required services. Contracted services include Outpatient, Intensive Outpatient, Partial Hospitalization, Transitional Living, Low and High Intensity Residential Treatment Services, withdrawal management and medication assisted treatment. These contracts also fund specialty outpatient, intensive outpatient, and residential services for pregnant and parenting women and their children. All treatment providers

FFY 2020/21 SABG Application & Plan NH Bureau of Drug & Alcohol Services

are strongly encouraged to enroll and credential with public and private insurers in an effort to better support patients and their ability to access available services.

New Hampshire boasts a very robust Medicaid benefit for substance use disorders treatment and recovery support services (<https://www.dhhs.nh.gov/ombp/sud/documents/sud-billable-services.pdf>). Previously, NH utilized a premium assistance program model that limited the access of some beneficiaries to these benefits; however, as of January 1, 2019 all beneficiaries either are in Medicaid managed care or fee for service models with access to the full range of SUD benefits. Furthermore, a new managed care contract was recently approved by Governor & Executive Council that makes significant improvements to the requirements for all behavioral health services, including SUD treatment, services for substance exposed infants and their caregivers, and social determinants of health. BDAS coordinates closely with the Division of Medicaid Services in the design and administration of the SUD benefit.

Regardless of the payor source, NH law requires all providers of SUD services to utilize American Society of Addiction Medicine (ASAM) criteria to determine the initial level of care for an individual as well as to make decisions about continuing care, transferring care, or discharging from care. When the identified level of care is not immediately available, contracted treatment providers are required to offer interim services to support the individual while they wait for the appropriate level of care. These services include group counseling, individual counseling, recovery support services and community based services. To assist providers with meeting these requirements as well as to improve overall client care, BDAS sponsors a community of practice for treatment providers to connect clinicians and other providers with the opportunity to gain knowledge and information and share experiences related to improving services for individuals with a substance use disorder.

Neo-Natal Taskforce

The Department worked with the Perinatal Substance Exposure Task Force of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery to bring physicians and the opiate treatment programs together to more effectively coordinate care for pregnant and post-partum women and their infants. Members of the Task Force to include BDAS staff held a summit Optimizing Care for Mothers and Babies Affected by Prenatal Substance Exposure to address Plan of Safe Care in January 2019. Representatives from local birthing hospitals, NH DCYF, SUD treatment providers and other stakeholders partners were provided the opportunity to learn about and discuss the Plan of Safe Care for infants who are born with substance exposure with the collective goal of ensuring women with a substance use disorder feel safe enough to access quality prenatal care (and treatment) and ensuring the safety of their infant. The Task Force completed the 2019-2022 Governor's Commission Plan/State Plan Recommendations in March 2018 for presentation at the Governor's Commission monthly meeting..

IVDUs

BDAS will continue to mandate priority admission for pregnant and parenting women and injection drug using individuals. NH takes a broad perspective in defining IDUs as those individuals with current or past history of injection drug use, preferring this term rather than only intravenous drug use. In addition, we have added individuals who have recently been administered Naloxone as a priority population for contracted treatment services.

Per NH law, RSA 318:52:C, persons over 18 years of age may legally purchase a hypodermic syringe or needle at a pharmacy without a prescription from a physician. Through the NH Division of Public Health Services, Bureau of Infection Disease Control, [Syringe Service Programs](#) in NH are community-based programs that provide access to sterile needles and syringes and facilitate safe disposal of used needles and syringes. As of 7/25/19, 5 organizations are registered with the NH DHHS as Syringe Services Programs. These programs are an effective component of a comprehensive, integrated approach to preventing infectious diseases among people who inject drugs.

FFY 2020/21 SABG Application & Plan
NH Bureau of Drug & Alcohol Services

Infectious Disease

BDAS takes a broad approach to infectious disease. In NH, the tuberculosis rate is relatively low and NH is not an HIV incidence state. However, various strains of hepatitis, particularly A, B, and C, are a concern. BDAS works closely with the Viral Hepatitis Unit of the NH Division of Public Health Services (DPHS) and routinely promotes their trainings as well as the NH Training Institute offers trainings throughout the year.

Infectious disease is addressed in Administrative Rule He-A 302.06 Clinical Manual. Providers are also referred to Treatment Improvement Protocol (TIP) #6, *Screening for Infectious Diseases Among Substance Abusers* and #11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases*, in developing their policies. Infectious disease policies are reviewed as part of provider site visits.

Medication-Assisted Treatment (MAT)

NH continues to help providers move toward integrating MAT with existing services. NH recently updated our Guidance Document on Best Practices for Delivering Community-Based MAT Services for Opioid Use Disorders in NH (<https://www.dhhs.nh.gov/dcbcs/bdas/documents/matguidancedoc.pdf>) based on advances in knowledge and understanding since the original publication.

BDAS is building infrastructure in Community Health Centers and Hospital-Based Primary Care Networks to develop their capacity to provide MAT fully integrated with primary care to their patients identified with a substance use disorder. These Health Centers and Hospitals are developing MAT services that meet the recommendations in the guidance document mentioned above, inclusive of retaining and training staff, modifying EHRs, developing and implementing policies, practices and workflow. As of 6/30/18, 20 practices associated with 10 hospitals and 7 Community Health Centers are providing MAT to patients. In addition, our MAT-PDOA grant funds two Federally Qualified Health Centers in the most populous counties that also have the highest overdose rates. Additional Hospitals and practices continue to build their capacities.

BDAS funds MAT efforts and works in partnership with the New Hampshire Medical Society, the Foundation for Healthy Communities (FHC), the NH Center for Excellence at Community Health Institute and Bi-State Primary Care Association (BSPCA) to support training and learning opportunities for medical practices engaged in developing MAT services. This includes multiple free waiver trainings at which the NH Guidance Document is distributed to all participants.

Integration of Care & Addressing Social Determinants of Health

NH recognizes that outcomes for clients are improved when behavioral (mental health and SUD) and physical health services are coordinated and integrated and social determinants of health are addressed. To this end, contracted service providers are required to obtain consent from all willing clients to coordinate care with clients primary care providers; behavioral healthcare providers; medication assisted treatment providers; peer recovery programs; and other agencies involved in the client's care, including but not limited to MCOs, IDNs, private insurers, Doorways, DCYF and criminal justice agencies. In order to ensure that social determinants of health are being actively addressed clinical evaluations and treatment plans are required to address all ASAM domains either directly through the treatment provider or through referral to and coordination with community-based providers.

Recovery

BDAS continues to develop capacity for peer recovery support services provided by peer-led Recovery Community Organizations (RCOs). NH has developed a Medicaid benefit for certain Recovery Support Services and established a

FFY 2020/21 SABG Application & Plan NH Bureau of Drug & Alcohol Services

Certified Recovery Support Worker credential which meets, but is not limited to the requirement of IC&RC's Peer Recovery Support Specialist.

The state has funded the development of 11 RCOs with a total of 14 Recovery Centers. All funded RCOs are required to work toward meeting CAPRSS standards, help staff achieve Certified Recovery Support Worker status, open at least 1 Recovery Center, provide Recovery Coaching and Telephone Recovery Support Services and develop the capacity to bill third party payers for these services. RCOs are peer-led and peer-run and support all paths to recovery. In addition to providing the specified PRSS, Recovery Centers also provide a variety of workshops and activities to enhance recovery and host multiple mutual support groups. Some of them also contract with medical providers, hospital EDs, law enforcement, drug courts, correctional facilities and/or businesses to provide outreach and support.

Recovery Support Services, whether provided by peers or non-peer CRSWs, are provided by many of our contracted treatment providers.

Workforce Development

BDAS contracts with two state-level agencies to provide quality improvement toward best practices, evidence-based interventions and professional training for alcohol and other drug service professionals; certification standards; and recruitment and retention activities.

- **The NH Center for Excellence** (the Center) is a state-level contract that provides training, technical assistance, program evaluation and data analysis, interpretation and support to foster systems change and related professional development to support community level practitioners in implementing evidence-based interventions and improving their practices to address substance use issues through prevention, intervention, treatment, and recovery support services. (<https://nhcenterforexcellence.org/>)

The Center sub-contracts for training services with the NH Alcohol and Drug Counselors Association's (NHADACA) Training Institute on Addictive Disorders (NHTIAD). NHTIAD provides high quality training and workforce development activities to enhance the knowledge, skills, and abilities of the prevention, intervention, treatment and recovery supports services workforce. Training opportunities that meet requirements for licensure and certification are offered throughout the year and assist providers in applying outcome-supported policies, programs and practices. NHTIAD also offers cross-training opportunities that increase effective integration of services across the CoC. (<https://www.nhadaca.org/>)

- **The NH Prevention Certification Board's** primary purpose is to ensure high quality standards for NH's substance misuse prevention specialists by aligning with the International Certification & Reciprocity Consortium (IC&RC) credentialing. The Board also has the responsibility of reviewing and approving Continuing Education (CEUs) for Certified Prevention Specialists for various types of training events (workshops, webinars, trainings, conferences, etc). (<http://nhpreventcert.org/>)

The Department requires that all contracted prevention services have lead staff who are prevention specialist certified.

In further efforts to recruit and retain staff in SUD treatment agencies, BDAS has collaborated with the Division of Public Health Services to include Licensed Drug and Alcohol Counselors (LADCs), Master Licensed Drug and Alcohol Counselors (MLADCs) in the NH State Loan Repayment Program. This allows LADCs and MLADCs who work in approved agencies to be eligible for up to 5 years of educational loan repayment. All BDAS funded treatment contractors have been deemed as approved agencies. (<https://www.dhhs.nh.gov/dphs/bchs/rhpc/repayment.htm>)

Although not funded through SABG funding, statewide efforts are in place, working to build the behavioral health workforce capacity.

FFY 2020/21 SABG Application & Plan
NH Bureau of Drug & Alcohol Services

- **Integrated Delivery Networks (IDNs):** Sighting significant challenges in meeting the needs of individuals with mental health and substance use disorders (SUD), the DHHS began working on the Delivery System Reform Incentive Program (DSRIP) waiver to strengthen community-based mental health services, combat the opiate crisis, and drive delivery system reform. Through this process, 7, NH Integrated Delivery Networks (IDNs) were created (<https://www.dhhs.nh.gov/section-1115-waiver/index.htm>). These IDNs are regionally-based networks of physical and behavioral health providers, as well as social service organizations that can address social determinants of health. The focus of the IDNs is to improve care transitions, promote integration of physical and behavioral health, and to build mental health and SUD treatment capacity. Since 2017 the IDNs have been independently and collaboratively working on workforce development as part of their projects. Support for attracting, recruiting, hiring and retaining workforce through loan repayment, recruitment and retention efforts, supervision support and internship support have been key factors for this initiative.

A taskforce was created specifically for workforce development, which included representation from each IDN, partner agencies, and the Bureau of Drug and Alcohol Services (BDAS). Through the work of this taskforce, IDNs continue to offer a variety of training opportunities to their partners that include topics such as co-occurring disorders and SUDs. Several of the IDNs continue to collaborate on training opportunities, which provides not only a reduction in the cost but also a uniform dissemination of information across multiple regions. As part of this collaboration, the BDAS presented a free, 6-hour introductory workshop on addiction and recovery to all 7 IDNs and their partners. Workshops were held regionally with IDNs partnering with each other and their respective stakeholders in an effort to reach as many people as possible within each region. In total, 3 workshops were held, covering all 7 IDN regions and their stakeholder agencies. IDNs are also currently working together to develop a series of on-line trainings which would also decrease costs for the IDNs but also would address the burden on partners having to send their staff to off-site trainings. The development of a repository of trainings which would be available on-line is in the works and would reduce the burden on the IDNs as well as their partners.

- **Recovery Friendly Workplace Initiative:** Led by Governor Chris Sununu, New Hampshire's "Recovery Friendly Workplace Initiative" (<https://www.recoveryfriendlyworkplace.com/>) promotes individual wellness for Granite Staters by empowering workplaces to provide support for people recovering from substance use disorder. The Recovery Friendly Workplace Initiative gives business owners the resources and support they need to foster a supportive environment that encourages the success of their employees in recovery.

To assist companies in developing and sustaining the Recovery Friendly Workforce initiative in their organizations, Recovery Friendly Advisors (RFAs) support interested companies, at no cost, to find evidence-based practices to meet their individualized needs. To date, 51 NH workplaces have earned the Recovery Friendly Workplace designation from Governor Sununu.

Technical Assistance

1. Update on TA recommendations per our 2014 CSAT review:
 - a. Provider certification rules and process
 - i. The He-A 301 – 303 rules are currently expired and under revision based in part on technical assistance from CSAT. The He-A 304 rules were also revised as a result of this and took effect February 16, 2018.

Revision Request Response: NH BDAS works closely with the NH DHHS Office of Health Equity to ensure prevention services are addressing the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states. Together with guidance with the Office of Health equity, BDAS' prevention program strives to have a sustained focus on the provision of culturally and linguistically appropriate services to NH's residents and maintain communication with racial, ethnic and other medically underserved populations to create partnerships to enhance the overall health of the communities by developing combined opportunities and resources to address health disparities.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several [other data sets](#) that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁶ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁶ <http://www.healthypeople.gov/2020/default.aspx>

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

FFY 2020/21 SABG Application & Plan
NH Bureau of Drug & Alcohol Services

Step 2: Identify the unmet service needs and critical gaps within the current system.

Unmet Service Needs: State Specific Priority Populations

Sources of data used are: NSDUH, YRBS, BRFSS, health data sources as displayed by NH WISDOM, Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment Task Forces Identification of Funding Needs, NH Continuum of Care Assets and Gaps Assessment results and The Voice of NH's Young Adults: Results of the 2015 Young Adult Needs Assessment. This data indicates that the populations listed below experience the highest rates of use and the greatest consequence (physical, social and financial impacts to these individuals, their families and communities, as well as the cost to the state) from substance misuse and are therefore identified among the groups with the greatest need for services:

Youth, need to determine age group and data such as perception of risk

- Underage drinking (30 day use)
- Binge drinking
- Marijuana (30 day use)
- Non-Medical Prescription drug use (lifetime, perception of harm and 30 day use)*
- Opioid**
- Illicit Drug Use other than marijuana

Young Adults 18 to 25 years of age:

- Binge drinking
- Marijuana (30 day use)
- Non-Medical Prescription drug use (lifetime, perception of harm and 30 day use)*
- Opioid **
- Illicit Drug Use other than marijuana

Adults 26 years of age and older:

- Binge drinking
- Marijuana (30 day use)
- Prescription drug use (lifetime, perception of harm and 30 day use)*
- Opioid**
- Illicit Drug Use other than marijuana

* Includes opioids and non-opioid based prescription drugs

** Includes opioid based prescription drugs, heroin and other synthetic opioids

State Specific Priority Populations

- Pregnant women and women with dependent children, even if the children are not in their custody, as long as parental rights have not been terminated, including the provision of interim services within the required 48 hour timeframe.
- Individuals with a history of injection drug use; including the provision of interim services within 14 days.
- Individuals who have been administered Narcan to reverse the effects of an opioid overdose either in the 14 days prior to screening or in the period between screening and admission to the program.
- Parents and guardians involved with the Division of Children, Youth and Families (DCYF) identified with a substance use disorder or history of substance misuse and their dependent children
- Criminal justice involved individuals, including individuals convicted of an impaired driving offense.
- Individuals with substance use co-occurring mental health disorders.
- Individuals with Opioid Use Disorders.
- Veterans with substance use disorders.
- Young adults 18-25.

FFY 2020/21 SABG Application & Plan
NH Bureau of Drug & Alcohol Services

Step 2: Identify the unmet service needs and critical gaps within the current system

Gaps in Prevention Services

Although NH continues to strive to have capacity for community-based selective and indicated prevention services across the state, some progress has been made in developing programming in these areas. The NH Department of Health and Human Services (DHHS) has been awarded two SAMHSA Partnership for Success (PFS) grants; reallocated SABG funding to support original PFS Student Assistance Program (SAP) contractors; and in collaboration with New Hampshire's Governor's Commission has allocated more than \$1.5 M for services in these categories. While these strides have created better capacity for selective and indicated prevention services more work needs to be done to ensure all areas of the state have access to these much needed services.

The BDAS Prevention Services Unit will be holding listening sessions in communities across the state to inform strategic planning for prevention efforts in NH. BDAS will utilize these sessions to determine what is currently working well in communities across NH as well as gaps in services and gaps in data for specific at-risk populations,

Gaps in Identification, early intervention and crisis services

There are a number of gaps in the identification and early intervention system, including:

- Lack of comprehensive parent/caregiver education programs at the elementary, middle and high school levels to assist parents/caregivers in understanding the signs and symptoms of substance misuse and behavioral health issues and identifying the resources needed to intervene early.
- Need for more schools to adopt restorative justice policies and protocols for substance misuse infractions.
- Need for wider use of SBIRT among primary health and mental health providers.
- Need to train primary health and behavioral health providers in motivational interviewing and brief interventions.

Gaps in the treatment system

Great strides have been made in the past two years in addressing gaps in the SUD treatment system; however, there remains a great deal of work to be done. To ensure that individuals are getting the support that they require.

Workforce

While a tremendous amount of money has come into the state for treatment services over the past two years, this funding is essentially worthless if there is no one qualified to deliver the services. Developing a more effective pipeline and more attractive salary and benefit packages is part of the scope of a number of on-going efforts throughout the state; however, easing of restrictions on federal funds to allow for the use of funding to increase contract and Medicaid rates for individuals with all substance use disorders would be a critical additional step in developing workforce. Time and time again, we hear our providers saying that they just cannot hire qualified staff and/or provide quality programming for the rates paid by Medicaid and BDAS. It is the Department's belief that all of the gaps following would be significantly improved just through having an adequate workforce.

Crisis & Interim Services

A second gap is in crisis and interim services. Many individuals are motivated to seek treatment by some sort of crisis and the Doorways were established to provide a place for those individuals to get assistance in addressing that crisis as well as navigating the treatment system. A significant barrier for these individuals has been lack of safe, stable housing and interim support services. Being able to provide crisis respite shelter and interim supportive services to individuals with substance use disorders while they are working to get into on-going treatment and more permanent housing would significantly improve engagement and retention rates.

FFY 2020/21 SABG Application & Plan
NH Bureau of Drug & Alcohol Services

Program Capacity

Recent Federal funding has allowed the Department to develop capacity for specialty treatment for pregnant and parenting women, medication assisted treatment, and general substance use disorder treatment; however, restrictions on this funding to individuals with Opioid Use Disorder means that these services are not available to all clients with SUD and can make it difficult for programs that are not substance specific, which most of the programs in NH are not, to take advantage of the opportunities available. In addition, the focus on service delivery vs. workforce and infrastructure development further limits the utility of the funding currently available.

Appropriate Implementation of ASAM Guidelines

Research shows that engagement in the appropriate level of care for the correct length of time improves SUD treatment outcomes. Over the past few years, NH has worked to educate providers around the proper use of ASAM in initial level of care determination, treatment planning, and transfer/discharge decision-making. While we have seen some small shifts, particularly in regards to the initial level of care determination, this continues to be a significant weakness in the state.

Treatment for Incarcerated Populations

The NH Department of Corrections as well as many of the county DOC's have worked tirelessly to develop treatment services for incarcerated populations; however, these remain extremely limited resulting in individuals re-entering the community with the same set of issues that led them to incarceration in the first place, which are likely only exacerbated by the period of incarceration.

Gaps in the recovery support service system

There are a number of gaps in the recovery support service system, including:

- Need for continuing development and resources for operational support of Recovery Community Organizations (RCOs)
- Lack of sufficient Recovery Housing and certification processes
- Lack of community-based, school-based and college-based recovery supports for Youth
- Peer Recovery Support Services integrated into criminal correctional systems

Although the DHHS is now supporting 11 RCOs who offer services in 14 locations, services are not available in all regions of the state, so there continues to be a need for developing Recovery Centers. Most of the existing RCOs are providing supports to people involved with drug courts, law enforcement, criminal justice, medical practices, and/or businesses in their communities. While these contracted services bring additional funds into the RCOs, none of them supports the normal operations of the centers.

Limited Capacity to Collect / Analyze and Utilize Data

The state has had limited capacity for analyzing and utilizing data to inform programs, policies and practices to optimize limited resources and to monitor effectiveness and quality of services. Please reference efforts underway identified in the Quality Improvement section of this report.

NH SEOW

The NH State Epidemiological Workgroup (SEOW) is a multidisciplinary advisory group that works to improve the quality and efficiency of data systems and the availability and utility of data products that describe substance misuse and behavioral health issues in order to inform the full continuum of care for substance misuse policy, programs and services in the state. In recognition of the critical value that data has in informing effective decisions regarding substance misuse policies, programs, and practices the SEOW became a taskforce of the Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery. Specifically, the Data and Evaluation Task Force of the Governor's Commission also serves as the NH SEOW with concurrent membership and meeting schedule. The current co-chairs of the Task Force / SEOW are the President/CEO of the NH Hospital Association and the Chief Medical Officer of NH DHHS.

The SEOW meets bi-monthly with administrative support provided by contract with Community Health Institute under the direction of BDAS. In May 2019, the Data and Evaluation Task Force / SEOW adopted a revised charter as follows:

PURPOSE: The Data and Evaluation Task Force (Task Force) of the New Hampshire Governor's Commission on Alcohol and Other Drugs (Governor's Commission) works to improve the quality and efficiency of data systems and the availability and utility of data products that describe substance use and behavioral health issues and outcomes.

The Task Force also serves as the State Epidemiological Outcomes Workgroup (SEOW) advising the NH Department of Health and Human Services, Bureau of Drug and Alcohol Services on matters related to program evaluation and development of reports and other products to inform prevention, harm reduction, treatment and recovery policy, programs and services.

MEMBERSHIP: The Task Force is a multidisciplinary advisory group consisting of data stewards from state agencies providing programs and services related to behavioral health and other stakeholders who are knowledgeable about behavioral health and substance misuse prevention, intervention, harm reduction, treatment and recovery issues.

The Task Force shall have co-chairs at least one of whom shall be an official member of the Governor's Commission. Co-chairs shall invite individuals to be members of the Task Force. Official Task Force membership shall be renewed and confirmed by the Chair of the Governor's Commission annually.

GOALS:

Goal 1: Facilitate assembly, analysis and interpretation of data and reports to determine the scope and extent of substance use and behavioral health risks and related social determinants of health at the state and regional level.

Goal 2: Facilitate assembly, analysis, and interpretation of data and reports to characterize protective factors for mental, emotional, and behavioral health, and assets vital to the delivery of prevention, treatment, and recovery services.

Goal 3: Guide the development and dissemination of data products, including web-based data dashboards, to targeted audiences in the education, health, government, business and safety sectors to address questions of policy, increase awareness, and foster a sense of shared responsibility.

Goal 4: Provide technical assistance and recommendations for improving data sharing and use across state level systems to assess prevalence rates and financial impacts of alcohol and drug misuse, as well as outcomes of strategies being implemented to address alcohol or other drug misuse among populations served by state systems including evaluation results of the Partnership for Success Initiative.

Goal 5: Provide technical support to the Governor's Commission for data monitoring and reporting as required by NH RSA Title 1, Chapter 12-J (Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery) and to assess progress on the Governor's Commission 2019-2021 Action Plan to reduce substance misuse.

Goal 6: Observe trends and data gaps to help guide strategic thinking about emerging issues and future data and evaluation planning for the Governor's Commission and other data users.



DATA AND EVALUATION TASK FORCE

Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery

Name	Email	Organization
Steve Ahnen (Co-Chair)	sahnen@nhha.org	New Hampshire Hospital Association
Jonathan Ballard (Co-Chair)	Jonathan.ballard@dhhs.nh.gov	NH DHHS, Chief Medical Officer
Helene Anzalone	Helene.Anzalone@doe.nh.gov	NH Department of Education
Jill Burke	Jill.Burke@dhhs.nh.gov	NH DHHS, Bureau of Drug & Alcohol Services
Andrew Chalsma	andrew.chalsma@dhhs.nh.gov	NH DHHS, Office of Quality Assurance & Improvement
Benjamin Chan	benjamin.chan@dhhs.nh.gov	NH DHHS, Division of Public Health Services
Chiahui Chawla	Chiahui.Chawla@dhhs.nh.gov	NH DHHS, Division of Public Health Services
Mark Cioffi	Mark.Cioffi@oplc.nh.gov	NH Prescription Drug Monitoring Program
Chip Cooper	richard.cooper@dos.nh.gov	Department of Safety, Bureau of EMS
Amy Costello	Amy.Costello@unh.edu	UNH, Institute for Health Policy and Practice
Kim Fallon	kim.fallon@doj.nh.gov	Office of Chief Medical Examiner
Djelloul Fourar-Laidi	djelloul.fourar-laidi@doj.nh.gov	NH DHHS, Division of Public Health Services
Helen Hanks	helen.hanks@doc.nh.gov	Department of Corrections
Joe Harding	Joseph.Harding@dhhs.nh.gov	NH DHHS, Office of Quality Assurance & Improvement
Chris Keating	CKeating@courts.state.nh.us	Department of Justice, Administrative Office of the Courts
Rachel Kohn	rachel_kohn@jsi.com	Community Health Institute/Center for Excellence/Juvenile Diversion Network
Joanne Lahaie	Joanne.lahaie@dos.nh.gov	Department of Safety, Bureau of EMS
David Mara	David.Mara@nh.gov	Governor's Adviser on Addiction & Behavioral Health
Nick Mercuri	nick.mercuri@dos.nh.gov	Department of Safety, Bureau of EMS
JoAnne Miles Holmes	JoAnne.MilesHolmes@dhhs.nh.gov	NH DHHS, Division of Public Health Services
Kathleen Mullen	Kathleen.Mullen@dhhs.nh.gov	NH DHHS, Division of Public Health Services
Maureen Mustard	maureen.mustard@ins.nh.gov	NH Insurance Department
Allison Parent	Allison.Parent@dhhs.nh.gov	Division of Children, Youth and Families
Mike Rogers	Michael.Rogers@dhhs.nh.gov	NH DHHS, Bureau of Drug & Alcohol Services
Jonathan Stewart	jonathan_stewart@jsi.com	Community Health Institute/Center for Excellence
Neil Twitchell	ntwitchell@dhhs.nh.gov	NH DHHS, Division of Public Health Services
David Weiters	David.wieters@dhhs.nh.gov	NH DHHS, Bureau of Information Services

Version – January 2019



DATA AND EVALUATION TASK FORCE

Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment and Recovery

Name	Email	Organization
Steve Ahnen (Co-Chair)	sahnen@nhha.org	New Hampshire Hospital Association
Jonathan Ballard (Co-Chair)	Jonathan.ballard@dhhs.nh.gov	NH DHHS, Chief Medical Officer
Helene Anzalone	Helene.Anzalone@doe.nh.gov	NH Department of Education
Jill Burke	Jill.Burke@dhhs.nh.gov	NH DHHS, Bureau of Drug & Alcohol Services
Andrew Chalsma	andrew.chalsma@dhhs.nh.gov	NH DHHS, Office of Quality Assurance & Improvement
Benjamin Chan	benjamin.chan@dhhs.nh.gov	NH DHHS, Division of Public Health Services
Chiahui Chawla	Chiahui.Chawla@dhhs.nh.gov	NH DHHS, Division of Public Health Services
Mark Cioffi	Mark.Cioffi@oplc.nh.gov	NH Prescription Drug Monitoring Program
Chip Cooper	richard.cooper@dos.nh.gov	Department of Safety, Bureau of EMS
Amy Costello	Amy.Costello@unh.edu	UNH, Institute for Health Policy and Practice
Kim Fallon	kim.fallon@doj.nh.gov	Office of Chief Medical Examiner
Djelloul Fourar-Laidi	djelloul.fourar-laidi@doj.nh.gov	NH DHHS, Division of Public Health Services
Helen Hanks	helen.hanks@doc.nh.gov	Department of Corrections
Joe Harding	Joseph.Harding@dhhs.nh.gov	NH DHHS, Office of Quality Assurance & Improvement
Chris Keating	CKeating@courts.state.nh.us	Department of Justice, Administrative Office of the Courts
Rachel Kohn	rachel_kohn@jsi.com	Community Health Institute/Center for Excellence/Juvenile Diversion Network
Joanne Lahaie	Joanne.lahaie@dos.nh.gov	Department of Safety, Bureau of EMS
David Mara	David.Mara@nh.gov	Governor's Adviser on Addiction & Behavioral Health
Nick Mercuri	nick.mercuri@dos.nh.gov	Department of Safety, Bureau of EMS
JoAnne Miles Holmes	JoAnne.MilesHolmes@dhhs.nh.gov	NH DHHS, Division of Public Health Services
Kathleen Mullen	Kathleen.Mullen@dhhs.nh.gov	NH DHHS, Division of Public Health Services
Maureen Mustard	maureen.mustard@ins.nh.gov	NH Insurance Department
Allison Parent	Allison.Parent@dhhs.nh.gov	Division of Children, Youth and Families
Mike Rogers	Michael.Rogers@dhhs.nh.gov	NH DHHS, Bureau of Drug & Alcohol Services
Jonathan Stewart	jonathan_stewart@jsi.com	Community Health Institute/Center for Excellence
Neil Twitchell	ntwitchell@dhhs.nh.gov	NH DHHS, Division of Public Health Services
David Weiters	David.wieters@dhhs.nh.gov	NH DHHS, Bureau of Information Services

Version – January 2019

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,

etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?
Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

New Hampshire - FFY 2020-2021 SABG Plan

Quality and Data Collection Readiness

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

- The NH Web Information Technology System (WITS) provides a secure, 24/7 accessible web-based information technology system for the purpose of storing client demographic information (e.g. client first and last name, date of birth, address, phone numbers). WITS is a Stage 1 Ambulatory Meaningful Use Certified Electronic Health Record (EHR) originally built by SAMHSA and focused on Substance Use Disorder services. WITS assists in tracking and managing clients, staff, facilities, and agencies collecting treatment, prevention, and recovery data. WITS is also used also to capture the Treatment Episode Data Set (TEDS) required for Federal Block Grant reporting requirements and Centers for Disease Control (CDC) National Outcomes Measurement System data submission. WITS reports data on the client, program, and provider levels as needed.

NH WITS is also utilized by State Opioid Response (SOR) grantees to capture GPRA data for grant reporting purposes.

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

- The Web Information and Technology System are specific to clients with substance use disorders for the State of New Hampshire current data collection and reporting systems.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

- The State of New Hampshire Bureau of Drug and Alcohol Services WITS system has the ability to collect and report measures at the individual client level without client identifying information (i.e. aggregate data).

4. If not, what changes will the state need to make to be able to collect and report on these measures?

- N/A

Please indicate areas of technical assistance needed related to this section.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Peer Recovery Support Services (PRSS)
Priority Type: SAT
Population(s): Other (Persons in Recovery)

Goal of the priority area:

More people with substance use disorders will have access to affordable peer recovery support services.

Objective:

Increase the number of state-funded Recovery Community Organizations (RCOs) providing Peer Recovery Coaching (PRC), Telephone Recovery Support Services (TRSS) and other activities to support recovery across the state.

Strategies to attain the objective:

Additional funding streams to pay for PRSS will be identified; and funding and Technical Assistance will be provided to Recovery Organizations to initiate Peer Recovery Coaching and Telephone Recovery Support Services according to standards.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of state-funded RCOs and Recovery Centers providing Peer Recovery Coaching and Telephone Recovery Support Services (TRSS)
Baseline Measurement: 11 state-funded RCOs with 14 Recovery Centers providing PRSS
First-year target/outcome measurement: 13 state-funded RCOs with 16 Recovery Centers providing PRSS and reporting data on people receiving PRSS.
Second-year target/outcome measurement: 13 state-funded RCOs maintaining provision of PRSS, increasing numbers of people served and reporting outcomes for people receiving PRC and TRSS.

Data Source:

quarterly and annual reports submitted by contracted providers

Description of Data:

BDAS Recovery Support contractors are required to submit quarterly and annual reports delineating progress on required activities.

Data issues/caveats that affect outcome measures:

State-funded RCOs began using the Recovery Data Platform to collect data during SFY19. The data is incomplete for that year, so we cannot establish a baseline. Demographic and outcome data will be established in the first year. Increases in numbers served and outcome data will be reported in the second year.

Priority #: 2
Priority Area: Young Adult Misuse of Alcohol, Marijuana, Non-Medical Prescription Drugs
Priority Type: SAP
Population(s): PP

Goal of the priority area:

Reduce misuse of Alcohol, Marijuana, Non-Medical Prescription Drugs

Objective:

Changes in 3 risk factors: reduce access to substances, increase perception of risk / harm, increase peer and parental disapproval as measured by NSDUH and compared with similar data sets within the YRBS.

Strategies to attain the objective:

Through the Regional Public Health Network's (RPHN) concerted effort to employ a variety of strategies and activities that increases family and community communication and monitoring of underage and high risk drinking as well as the negative health outcomes of misuse of marijuana and non-medical prescription drugs, the intended impact would be a reduction in 30-day use of the targeted substances.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Alcohol - past 30-day Binge Alcohol use as reported by young adults surveyed
Baseline Measurement: 46.36%
First-year target/outcome measurement: 46%
Second-year target/outcome measurement: 45%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

NSDUH - annual nationwide survey - NH state estimates are based on interviews of about 300 individuals of each population group identified through a random sampling process. Table 70 Percentages, Annual Averages based on 2016-2017

Data issues/caveats that affect outcome measures::

Samples are combined over a two year period and overlap from one year to another.

Indicator #: 2
Indicator: Marijuana - past 30 day use as reported by young adults surveyed
Baseline Measurement: 28.93%
First-year target/outcome measurement: 28.80%
Second-year target/outcome measurement: 28.25%

Data Source:

NSDUH

Description of Data:

NSDUH - annual nationwide survey - NH state estimates are based on interviews of about 300 individuals of each population group identified through a random sampling process. Table 70 Percentages, Annual Averages based on 2016-2017

Data issues/caveats that affect outcome measures::

Samples are combined over a two year period and overlap from one year to another.

Indicator #: 3
Indicator: Pain Relievers-past year mis use as reported by young adults surveyed.
Baseline Measurement: 7.06%
First-year target/outcome measurement: 7%
Second-year target/outcome measurement: 6.5%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

NSDUH - annual nationwide survey - NH state estimates are based on interviews of about 300 individuals of each population group identified through a random sampling process. Table 70 Percentages, Annual Averages based on 2016-2017

Data issues/caveats that affect outcome measures::

Samples are combined over a two year period and overlap from one year to another.

Priority #: 3
Priority Area: Youth Misuse of Alcohol, Marajuana, Non-Medical Use of Prescriptoin Drugs
Priority Type: SAP
Population(s): PP

Goal of the priority area:

Reduce Alcohol, Marijuana, non-medical use of prescription drugs among Youth

Objective:

Changes in 3 risk factors: reduce access to substances, increase perception of risk / harm, increase peer and parental disapproval as measured by NSDUH and compared with similar data sets within the YRBS.

Strategies to attain the objective:

Through the Regional Public Health Network's (RPHN) concerted effort to employ a variety of strategies and activities that increases family and community communication and monitoring of underage and high risk drinking as well as the negative health outcomes of misuse of marijuana and non-medical prescription drugs, the intended impact would be a reduction in 30-day use of the targeted substances. Additional strategies include implementation and expansion Student Assistance Programs based on the evidenced-based Project Success in New Hampshire middle and high schools

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Alcohol - past 30 day use as reported by youth surveyed
Baseline Measurement: 11.30%
First-year target/outcome measurement: 11.10%
Second-year target/outcome measurement: 11.00%

Data Source:

National Survey on Drug Use and Health (NSDUH)

Description of Data:

NSDUH - annual nationwide survey - NH state estimates are based on interviews of about 300 individuals of each population group identified through a random sampling process. Table 70 Percentages, Annual Averages Based on 2016-2017

Data issues/caveats that affect outcome measures::

Samples are combined over a two year period and overlap from one year to another.

Indicator #: 2
Indicator: Marijuana - past 30 day use as reported by youth surveyed
Baseline Measurement: 8.64%
First-year target/outcome measurement: 8.50%

Second-year target/outcome measurement: 8.25%

Data Source:

National Survey for Drug Use and Health (NSDUH)

Description of Data:

NSDUH - annual nationwide survey - NH state estimates are based on interviews of about 300 individuals of each population group identified through a random sampling process. Table 69 Percentages, Annual Averages Based on 2016-2017

Data issues/caveats that affect outcome measures::

Samples are combined over a two year period and overlap from one year to another.

Indicator #:

3

Indicator:

Misuse of Pain Relievers - past year use as reported by youth surveyed

Baseline Measurement:

3.0%

First-year target/outcome measurement:

2.75%

Second-year target/outcome measurement:

2.25%

Data Source:

National Survey for Drug Use and Health (NSDUH)

Description of Data:

NSDUH - annual nationwide survey - NH state estimates are based on interviews of about 300 individuals of each population group identified through a random sampling process. Table 70 Percentages, Annual Averages Based on 2016-2017

Data issues/caveats that affect outcome measures::

Samples are combined over a two year period and overlap from one year to another.

Priority #:

4

Priority Area:

Facilitating Coordination between SUD treatment and primary care; including behavioral health. (MAT to be included in this area)

Priority Type:

SAT

Population(s):

Other (All clients who receive services through BDAS contracted treatment providers)

Goal of the priority area:

All contracted providers will coordinate with client's physical health, behavioral health, and MAT providers as applicable.

Objective:

To increase coordination between treatment providers and physical health, behavioral health, and MAT providers.

Strategies to attain the objective:

Provider contracts include a requirement for coordination with these providers and the state will monitor client progress notes to ensure that this coordination is taking place.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Encounter notes indicate referral to, where appropriate, and coordination with the client's physical health provider.

Baseline Measurement:

1% of files reviewed during annual site visits indicate referral to, where appropriate, and coordination with clients physical health provider.

First-year target/outcome measurement: 5% of files reviewed during annual site visits indicate referral to, where appropriate, and coordination with the client's physical health provider.

Second-year target/outcome measurement: 10% of files reviewed during annual site visits indicate referral to, where appropriate, and coordination with the client's physical health provider

Data Source:

Client encounter notes

Description of Data:

data entered into WITS via encounter notes dropdown menu - "Billed for Coordination of Care" note type

Data issues/caveats that affect outcome measures::

Historically, providers have struggled with this level of coordination. Continuing technical assistance and training in this area will be critical. To clarify what is being asked, BDAS will be adding new choices to the dropdown menu in the client encounter notes within our WTIS system.

Indicator #: 2

Indicator: For clients with a co-occurring mental health disorder, encounter notes indicate referral to, where appropriate, and coordination with the client's behavioral health provider.

Baseline Measurement: 1% of files reviewed during annual site visits indicate referral to, where appropriate, and coordination with the client's BH provider.

First-year target/outcome measurement: 5% of files reviewed during annual site visits indicate referral to, where appropriate, and coordination with the client's behavioral health provider.

Second-year target/outcome measurement: 10% of files reviewed during annual site visits indicate referral to, where appropriate, and coordination with the client's behavioral health provider

Data Source:

client progress notes

Description of Data:

data entered into WITS via encounter notes dropdown menu - "Billed for Coordination of Care" note type

Data issues/caveats that affect outcome measures::

Historically, providers have struggled with this level of coordination. Continuing technical assistance and training in this area will be critical. To clarify what is being asked, BDAS will be adding new choices into the dropdown menu in the client encounter notes within our WTIS system.

Indicator #: 3

Indicator: For clients receiving MAT outside of the treatment program, encounter notes indicate referral to, where appropriate, and coordination with the client's physical health provider

Baseline Measurement: 1% of files reviewed during annual site visits indicate referral to, where appropriate, and coordination with clients MAT provider

First-year target/outcome measurement: 5% of files reviewed during annual site visits indicate referral to, where appropriate, and coordination with the client's MAT provider.

Second-year target/outcome measurement: 10% of files reviewed during annual site visits indicate referral to, where appropriate, and coordination with the client's MAT provider

Data Source:

client encounter notes

Description of Data:

data entered into WITS via encounter notes dropdown menu "Billed for Coordination of Care" note type

Data issues/caveats that affect outcome measures::

Historically, providers have struggled with this level of coordination. Continuing technical assistance and training in this area will be critical. To clarify what is being asked, BDAS will be adding new choices to the dropdown menu in the client encounter notes within our WITS system.

Priority #: 5
Priority Area: TB
Priority Type: SAT
Population(s): TB

Goal of the priority area:

All clients who receive services through BDAS contracted providers will receive education about TB

Objective:

Raise client awareness about infectious diseases, including TB, what it is, and how to prevent the spread of the disease.

Strategies to attain the objective:

BDAS contracted treatment providers will educate clients about infectious diseases, including TB, what it is, and how to prevent the spread of the disease. This can be done through conversation in group or individual counseling as well as through the provision of educational material such as pamphlets and videos.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Encounter notes will indicate infectious disease educational material, including TB has been provided to clients receiving services through BDAS contracted treatment providers.
Baseline Measurement: 0 - This information is not currently captured by BDAS.
First-year target/outcome measurement: 25% of files reviewed during annual site visits indicate the provision of educational materials on infectious diseases including TB
Second-year target/outcome measurement: 50% of files reviewed during annual site visits indicate the provision of educational materials on infectious diseases including TB

Data Source:

client encounter notes

Description of Data:

data entered into WITS via encounter notes dropdown menu

Data issues/caveats that affect outcome measures::

BDAS does not currently capture this information, therefore BDAS needs to create a dropdown menu option within our WITS system which will allow a space for contracted providers to enter the data into the system. Because this is a new ask of our providers, BDAS contract managers will work with providers to ensure the new information is captured accurately and consistently.

Indicator #: 2
Indicator: Encounter notes indicate referral to TB testing, as appropriate.
Baseline Measurement: 0 - this informatino is not currently captured by BDAS
First-year target/outcome measurement: 25% of files reviewed during annual site visits indicate referral to TB testing, as appropriate.
Second-year target/outcome measurement: 50% of files reviewed during annual site visits indicate referral to TB testing, as appropriate.

Data Source:

client encounter notes

Description of Data:

data entered into WITS via encounter notes dropdown menu.

Data issues/caveats that affect outcome measures::

BDAS does not currently capture this information, therefore BDAS needs to create a dropdown menu option within our WTIS system which will allow a space for contracted providers to enter the data into the system. Because this is a new ask for our providers, BDAS contract managers will work with providers to ensure the new information is captured accurately and consistently.

Priority #: 6
Priority Area: Pregnant and Parenting Women
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:

Increase the percentage of pregnant and parenting women served.

Objective:

- 1) Increase the percentage of pregnant and parenting women admitted to treatment.
- 2) Increase percentage of referrals of pregnant and parenting women from medical providers.

Strategies to attain the objective:

- 1) Continue to fund specialty treatment for pregnant and parenting women.
- 2) Continue to prioritize admission for pregnant women into contracted treatment services.
- 3) Outreach to medical providers regarding treatment services for PPW.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Percentage of pregnant and parenting women admissions per total clients served.
Baseline Measurement: SFY19: 1.21% of PPW admissions per total clients served (20/1649 x 100)
First-year target/outcome measurement: SFY20: 1.5% of PPW admissions per total clients served
Second-year target/outcome measurement: SFY21: 1.75% of PPW admissions per total clients served

Data Source:

WITS admission data report

Description of Data:

percentage of women who reported being pregnant per the WITS admission module

Data issues/caveats that affect outcome measures::

none

Indicator #: 2
Indicator: Referral of PPW to contracted treatment providers from medical providers
Baseline Measurement: SFY19: 1.76% of PPW referred out of total unduplicated clients (29/1649)
First-year target/outcome measurement: SFY20: 2% of PPW referred out of total unduplicated clients
Second-year target/outcome measurement: SFY21: 2.25% of PPW referred out of total unduplicated clients.

Data Source:

WITS SSRS: home-my reports-ppw screening data

Description of Data:

Percentage of women who reported being pregnant per the WITS detox screener

Data issues/caveats that affect outcome measures::

Providers may not choose the appropriate referral source for clients. On-going provider training is being done to address this.

Priority #: 7
Priority Area: PWID
Priority Type: SAT
Population(s): PWID

Goal of the priority area:

All contracted provider staff will participate in training on public health strategies that reduce the harm associated with injection drug use.

Objective:

To increase staff awareness of public health strategies that reduce the harm associated with injection drug use.

Strategies to attain the objective:

Through our contracted training provider, BDAS will create a webinar on strategies that reduce the harm associated with injection drug use and will require that all contracted provider staff view and obtain a certificate of completion for viewing the webinar.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Provider reporting of staff who have successfully completed training on public health strategies that reduce the harm associated with injection drug use.
Baseline Measurement: 0 - the webinar does not currently exist
First-year target/outcome measurement: 25% of provider staff will have successfully completed training.
Second-year target/outcome measurement: 50% of provider staff will have successfully completed training

Data Source:

provider submission of certificates of completion for staff participation in the training.

Description of Data:

certificates of training completion

Data issues/caveats that affect outcome measures::

The webinar does not currently exist. BDAS will work with their training provider to create the webinar. Our target to have the training created by is 6/30/20. After which time, BDAS contract managers will notify contracted providers of the training and the requirement to view/participate. BDAS treatment and training contracts will be going out to bid in 2020. This requirement will be added to new contract language.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Due to unforeseen circumstances and with permission from Spencer Clark, our Project Officer, NH will be adding priority areas for PPWDC and PWID into this table at a later date.

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$9,344,979		\$60,722,000	\$48,628,246	\$18,660,560	\$0	\$0
a. Pregnant Women and Women with Dependent Children**	\$825,780		\$0	\$0	\$308,313	\$0	\$0
b. All Other	\$8,519,199		\$60,722,000	\$48,628,246	\$18,352,247	\$0	\$0
2. Primary Prevention	\$0		\$0	\$0	\$0	\$0	\$0
a. Substance Abuse Primary Prevention	\$3,894,550		\$21,424,000	\$5,648,569	\$4,803,425	\$0	\$50,000
b. Mental Health Primary Prevention							
3. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
4. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
5. Early Intervention Services for HIV	\$0		\$0	\$0	\$0	\$0	\$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	\$696,817		\$0	\$1,148,461	\$2,202,741	\$0	\$0
10. Total	\$13,936,346	\$0	\$82,146,000	\$55,425,276	\$25,666,726	\$0	\$50,000

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	504	41
2. Women with Dependent Children	1617	428
3. Individuals with a co-occurring M/SUD	33784	2397
4. Persons who inject drugs	3360	1271
5. Persons experiencing homelessness	4013	655

Please provide an explanation for any data cells for which the state does not have a data source.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Pregnant Women: 504

Data Source: <https://www.nhbar.org/publications/display-news-issue.asp?id=8377>

Women with Dependent Children: 1617

of women with dependent children <18 ; 29,399 * 5.5% = 1617

Data Source: <https://www.nh.gov/osi/data-center/census/>

https://www.samhsa.gov/sites/default/files/family_treatment_paper508v.pdf

Individuals with co-occurring M/SUD: 33,784

Population of NH 18 and older multiplied by 3.28%: 1,030,000 x 3.28% = 33,784

Data Source: <https://www.samhsa.gov/disorders>

<https://www.nh.gov/osi/data-center/documents/2016-state-county-projections-final-report.pdf>

Persons who inject drugs: 3360

Population of NH 13 and older multiplied by 0.30%; $1,120,000 \times .30\% = 3360$

Data Source: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4026524/>

Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rates

<https://www.nh.gov/osi/data-center/documents/2016-state-county-projections-final-report.pdf>

Persons experiencing homelessness: 4013

Data source: <https://www.dhhs.nh.gov/dcbcs/bhhs/documents/2016-bhhs-report.pdf>

Report of Bureau of Homelessness & Housing Services, State of New Hampshire

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment *	\$4,672,490
2 . Primary Substance Abuse Prevention	\$1,947,275
3 . Early Intervention Services for HIV **	
4 . Tuberculosis Services	
5 . Administration (SSA Level Only)	\$348,408
6. Total	\$6,968,173

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Strategy	A	B
	IOM Target	FFY 2020 SA Block Grant Award
1. Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
2. Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
3. Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
	Universal	

5. Community-Based Process	Selective	
	Indicated	
	Unspecified	
	Total	\$0
6. Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
7. Section 1926 Tobacco	Universal	\$50,000
	Selective	
	Indicated	
	Unspecified	
	Total	\$50,000
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	\$0
Total Prevention Expenditures		\$50,000
Total SABG Award*		\$6,968,173
Planned Primary Prevention Percentage		0.72 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

\$50,000 is Synar funding

REVISION REQUEST RESPONSE: Per request, please see the following:

Amount of SABG Primary Prevention funds (from Table 4, Row 2) to be used for Non-Direct-Services/System Development Activities for SABG

Prevention, Column B, and/or SABG Combined, Column C = \$ \$511,228.

Amount of SABG Administration funds (from Table 4, Row 5) to be used for Non-Direct-Services/System Development Activities for SABG Prevention, Column B, and/or SABG Combined, Column C = \$0

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	\$359,011
Universal Indirect	\$718,024
Selective	\$223,111
Indicated	\$135,901
Column Total	\$1,436,047
Total SABG Award*	\$6,968,173
Planned Primary Prevention Percentage	20.61 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

REVISION REQUEST RESPONSE: Per request, please see the following:

Amount of SABG Primary Prevention funds (from Table 4, Row 2) to be used for Non-Direct-Services/System Development Activities for SABG Prevention, Column B, and/or SABG Combined, Column C = \$ 511,228.

Amount of SABG Administration funds (from Table 4, Row 5) to be used for Non-Direct-Services/System Development Activities for SABG Prevention, Column B, and/or SABG Combined, Column C = \$0

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>
Cocaine	<input type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>
Inhalants	<input type="checkbox"/>
Methamphetamine	<input checked="" type="checkbox"/>
Synthetic Drugs (i.e. Bath salts, Spice, K2)	<input type="checkbox"/>
Targeted Populations	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input checked="" type="checkbox"/>
LGBTQ	<input type="checkbox"/>
American Indians/Alaska Natives	<input type="checkbox"/>
African American	<input type="checkbox"/>
Hispanic	<input type="checkbox"/>
Homeless	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input type="checkbox"/>
Asian	<input type="checkbox"/>
Rural	<input type="checkbox"/>
Underserved Racial and Ethnic Minorities	<input type="checkbox"/>

Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

FY 2020			
Activity	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems			
2. Infrastructure Support	\$401,670		
3. Partnerships, community outreach, and needs assessment		\$511,228	
4. Planning Council Activities (MHBG required, SABG optional)			
5. Quality Assurance and Improvement	\$174,606		
6. Research and Evaluation	\$48,253		
7. Training and Education	\$69,007		
8. Total	\$693,536	\$511,228	\$0

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

0930-0169 Approved: 07/17/2017 Expires: 07/30/2020

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²² Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²³ It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.²⁴

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.²⁵ SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.²⁶ For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.²⁷

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.²⁸

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.²⁹ The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.³⁰ Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³¹ and ACOs³² may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.³³ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.³⁴

One key population of concern is persons who are dually eligible for Medicare and Medicaid.³⁵ Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.³⁶ SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.³⁷ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.³⁸ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.³⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁴⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.⁴¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

²² BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102-123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52-77

²³ Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/health-care-health-systems-integration>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

²⁴ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

²⁵ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchstp/socialdeterminants/index.html>

²⁶ <http://www.samhsa.gov/health-disparities/strategic-initiatives>

²⁷ <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

²⁸ Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, http://books.nap.edu/openbook.php?record_id=11470&page=210; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

²⁹ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁰ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, <https://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/home>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>;

³¹ Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

³² New financing models, <https://www.integration.samhsa.gov/financing>

³³ Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

³⁴ What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

³⁵ Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

³⁶ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

³⁷ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

³⁸ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

³⁹ Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

⁴⁰ About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

⁴¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.
 - a. DHHS continues to include resources for enhanced recovery support services, ancillary services, such as childcare, transportation and care coordination in contracts designed to augment resources and foster integrated SUD/COD and primary care services.
 - b. Through our technical assistance contractor, DHHS hosts bi-monthly Communities of Practice for staff working in an agency or practice providing MAT or interested in providing MAT, including practices/agencies who offer integrated care.
 - c. DHHS contracts with the Foundation for Healthy Communities to recruit and provide technical assistance to hospitals and their networked medical practices to initiate and implement MAT.
 - d. Prevention Services addresses integration through our Juvenile Diversion, Student Assistance and REAP programs by providing screening, brief intervention, and referral to treatment (SBIRT), which addresses mental health, SUD, and primary care concerns.
 - e. DHHS is involved in a Legislative Commission on Primary Care Workforce issues.
 - f. HB 1692, Chapter 114:2, authorizes the State Office of Rural Health to collect primary care workforce supply and capacity data. The Division of Public Health Services has developed the Health Professions Data Center (HPDC) (<https://www.dhhs.nh.gov/dphs/bchs/rhpc/data-center.htm>) to collect and store key practice and capacity data from all practicing, licensed providers in NH. Data will be used for healthcare access planning and workforce assessment and will ultimately lead to:
 - i. Federal shortage designations, which brings providers and grant funding to underserved areas of the state;
 - ii. Strengthened recruitment/retention initiatives including scholarships, loan repayment, and waiver programs;
 - iii. expansion of existing educational programs and employment training programs; and
 - iv. Stronger emergency preparedness
 - g. Through the continued implementation of the 1115 Transformation Waiver, funding to support delivery system transformation—rather than to cover the costs of specific services rendered by providers—the waiver enables health care providers and community partners within a region to form relationships focused on transforming care. This funding also provides prompt resources for combating the opioid crisis and strengthening the state's strained mental health delivery system. More information can be found at <https://www.dhhs.nh.gov/section-1115-waiver/index.htm> and <https://www.dhhs.nh.gov/dphs/oqai/dsrip-quality-perf.htm>.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.
- a. Continued implementation of the state's 1115 Transformation Waiver supports each of the state's 7 Integrated Delivery Networks (IDNs) to organize health care providers and community partners within a region to form relationships focused on the integration and transformation of care.
 - b. DHHS continues to utilize MAT PDOA funding to support the provision of integrated MAT, SUD, and COD treatment and primary care services in FQHCs in Manchester and Nashua, our state's largest 2 cities.
 - c. DHHS funds prevention activities to address integration through our Juvenile Diversion, Student Assistance and REAP programs by providing screening, brief intervention, and referral to treatment (SBIRT), which addresses mental health, SUD, and primary care concerns.
 - d. DHHS created and continues to support (with BG funding) Continuum of Care Facilitators within our Regional Public Health Networks (RPHNs) to create comprehensive, connected and coordinated substance misuse systems of care that coordinates with primary health and behavioral health services. CoC development work engages regional stakeholders in work that seek to
 - i. Increase awareness of, and access to, substance misuse services,
 - ii. Increase communication and collaboration among providers,
 - iii. Increasing service capacity and service delivery quality

CoC Facilitators have been located in each of the 13 RPHNs and serve as a resource in each by facilitating a community/regional approach to address the misuse of alcohol and drugs utilizing a public health method. CoC development activities include, but are not limited to: (<http://www.dhhs.nh.gov/dcbcs/bdas/continuum-of-care.htm>).

- i. Engaging with regional stakeholders, and with other related initiatives, in an ongoing scan of substance misuse service assets, including those sited in primary health and behavioral health care settings,
- ii. Engaging with regional stakeholders, and other related initiatives, in an ongoing update to, and implementation of, the regional CoC development plan, which identifies actions to maximize access to and connections between the existing service array, and high priority areas to be addressed and/or actions to be taken for each CoC component,
- iii. Organizing and facilitating efforts to increase service capacity and/or develop new services,
- iv. Coordinating with regional and state partners to distribute materials throughout regions that help individuals, families and communities become aware of and connect to services, materials that provide important information on SUD for special populations, and information on emerging substance-misuse threats.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? Yes No
- b)** and Medicaid? Yes No
4. Who is responsible for monitoring access to M/SUD services by the QHP?
Combined responsibility of the Division for Behavioral Health, the Division of Public Health, and the Office of Quality Assurance and Improvement.
5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? Yes No
6. Do the M/SUD providers screen and refer for:
- a)** Prevention and wellness education Yes No
 - b)** Health risks such as
 - ii)** heart disease Yes No
 - iii)** hypertension Yes No
 - iv)** high cholesterol Yes No
 - v)** diabetes Yes No
 - c)** Recovery supports Yes No
7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? Yes No
8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? Yes No
9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?
10. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁴², [Healthy People, 2020](#)⁴³, [National Stakeholder Strategy for Achieving Health Equity](#)⁴⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for [Culturally and Linguistically Appropriate Services in Health and Health Care](#) (CLAS)⁴⁵.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁴⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status⁴⁷. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations⁴⁸. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

⁴² http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁴³ <http://www.healthypeople.gov/2020/default.aspx>

⁴⁴ https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

⁴⁵ <http://www.ThinkCulturalHealth.hhs.gov>

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
 - a) Race Yes No
 - b) Ethnicity Yes No
 - c) Gender Yes No
 - d) Sexual orientation Yes No
 - e) Gender identity Yes No
 - f) Age Yes No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? Yes No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? Yes No
4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? Yes No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? Yes No
6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? Yes No
7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,⁴⁹ The New Freedom Commission on Mental Health,⁵⁰ the IOM,⁵¹ NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).⁵² The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁵³ SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (**TIPS**)⁵⁴ are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (**KIT**)⁵⁵ was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

⁴⁹ United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁵⁰ The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁵¹ Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

⁵² National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

⁵³ <http://psychiatryonline.org/>

⁵⁴ <http://store.samhsa.gov>

⁵⁵ <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? Yes No

2. Which value based purchasing strategies do you use in your state (check all that apply):
 - a) Leadership support, including investment of human and financial resources.
 - b) Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c) Use of financial and non-financial incentives for providers or consumers.
 - d) Provider involvement in planning value-based purchasing.
 - e) Use of accurate and reliable measures of quality in payment arrangements.
 - f) Quality measures focus on consumer outcomes rather than care processes.
 - g) Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
 - h) The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? Yes No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? Yes No
3. Does the state have any activities related to this section that you would like to highlight?

BDAS contract managers and program staff visit each contracted provider annually to ensure compliance with both federal program requirements as well as contract requirements and scope of work deliverables. Contract managers and program staff have also implemented orientation meetings for each Vendor, upon contract approval, to discuss all contract requirements

The NH DHHS is conducting contract compliance site reviews of all of its SUD providers (<https://www.dhhs.nh.gov/dcbcs/bdas/site-reviews.htm>). Each site review includes a team of staff from the NH DHHS Bureau of Improvement and Integrity (BII) and Bureau of Drug and Alcohol Services (BDAS). The compliance reviews expand the regular, program area site reviews, by incorporating more HR and administrative policy review as well as expenditure and payroll testing.

Additionally, DHHS has recently hired a Grants Administrator. This individual will be responsible for assuring all required information be communicated to those recipients sub-awarded Federal funds.

Please indicate areas of technical assistance needed related to this section

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁵⁶ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

⁵⁶ <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?
3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? Yes No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) Yes No
 - a) Data on consequences of substance-using behaviors
 - b) Substance-using behaviors
 - c) Intervening variables (including risk and protective factors)
 - d) Other (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
 - Children (under age 12)
 - Youth (ages 12-17)
 - Young adults/college age (ages 18-26)
 - Adults (ages 27-54)
 - Older adults (age 55 and above)
 - Cultural/ethnic minorities
 - Sexual/gender minorities
 - Rural communities
 - Others (please list)
4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- Archival indicators (Please list)
- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

NH Hospital discharge data set, NH Division of Vital Records Administration Death Certificate Data, NH County Health Rankings, and Drug Monitoring Initiative (Surveillance Data)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? Yes No

If yes, (please explain)

Data is collected and assessed from NSDUH, BRFSS, YRBS, and other data sets to determine communities of highest risk and highest need. While SABG Primary PX funding is allocated statewide, the criteria of high risk and high need is used to determine the level of funding that is distributed.

If no, (please explain) how SABG funds are allocated:

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? Yes No

If yes, please describe

The NH Prevention Specialist Certification Board supports and certifies NH's prevention workforce using IC&RC standards. The Certification Board developed and implemented a mentoring program which pairs newer professionals with more seasoned professionals to enhance knowledge and skills of new professionals as well as advance the overall prevention workforce within NH. (<http://nhpreventcert.org/>)

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? Yes No

If yes, please describe mechanism used

The Bureau of Drug and Alcohol Services (BDAS) contracts with JSI Research and Training Institute for the NH Center for Excellence. The Center for Excellence provides training and technical assistance to the alcohol and other drug continuum of care system across NH. For the NH Prevention workforce, services includes targeted prevention trainings and professional development, as well as a Prevention Community of Practice that brings together the state's prevention field to join in shared learning experience to elevate the knowledge and skills of preventionists and advance the science of prevention within NH. (<https://nhcenterforexcellence.org/>)

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? Yes No

If yes, please describe mechanism used

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? Yes No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan
The NH Governor's Commission on Alcohol and Other Drugs Three Year Action Plan is attached.
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) Yes No N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
 - a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
 - b) Timelines
 - c) Roles and responsibilities
 - d) Process indicators
 - e) Outcome indicators
 - f) Cultural competence component
 - g) Sustainability component
 - h) Other (please list):
 - i) Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? Yes No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? Yes No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

NH contracts with the JSI Research and Training Institute, Center for Excellence, to establish and maintain a process for identifying, selecting, guiding, and supporting promising programs and practices in becoming a NH-endorsed, evidence-informed prevention process. The NH Service to Science process is aligned with SAMHSA's process to determine the strength of theoretical frameworks used in the development of the intervention; feasibility of determining and evaluating intermediate outcomes relevant for the intervention's intended purpose; and to address the risk and protective factors and cultural context influencing alcohol and other drug behaviors in NH.

(<https://nhcenterforexcellence.org/resources/best-practices/>)

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
 - a) SSA staff directly implements primary prevention programs and strategies.
 - b) The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
 - c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
 - d) The SSA funds regional entities that provide training and technical assistance.
 - e) The SSA funds regional entities to provide prevention services.
 - f) The SSA funds county, city, or tribal governments to provide prevention services.
 - g) The SSA funds community coalitions to provide prevention services.
 - h) The SSA funds individual programs that are not part of a larger community effort.
 - i) The SSA directly funds other state agency prevention programs.
 - j) Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
 - a) Information Dissemination:
 - Student Assistance Programs
 - Social Media
 - Community Forums
 - Speaker Panels
 - Health Promotion Events
 - Promotion of Resource Lines, Resource Hubs, and Community Supports and Services
 - b) Education:
 - Student Assistance Programs
 - Support and Promotion of Local Community Prevention Coalitions
 - Sector Specific Education
 - Community Education and Training
 - Mental Health First Aid - used for professional development services
 - Suicide Prevention Education - used for professional development services
 - Youth Leadership
 - c) Alternatives:

Student Assistance Programs
Promotion of Life of an Athlete
Promotion of Youth Leadership and Empowerment Programs

d) Problem Identification and Referral:

Student Assistance Programs
Referral, Education, Assistance, Prevention (REAP) Program

e) Community-Based Processes:

Strategic Prevention Framework (Implementing ACPIE steps)
Appreciative Inquiry
Support and Promotion of community Prevention Coalitions
Regional Network Facilitation

f) Environmental:

Student Assistance Programs
Prescription Drug Drop Boxes and Take Back Days
Promotion of Prescription Drug Monitoring Program
Education and Policy Change Technical Assistance per sector

- 3.** Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? Yes No

If yes, please describe

Service providers are provided guidance and written instructions on Block Grant requirements. These requirements are reviewed at our Substance Misuse Prevention Coordinators bi-monthly meetings, documents are posted to the BDAS web page, and strategic planning templates are provided to ensure CSAP and IOM components are being met and are appropriately aligned.

3-year Prevention Plans and annual work plan (derived from the 3-year plan) are submitted for review and preapproval before service providers can begin implementation.

a) Both BDAS and Center for Excellence staff review prevention plans to ensure the plan meets a level of evidence-based standards as outlined by SAMHSA and the plans are data-driven, goals and objectives are measurable and feasible, and it aligns with Block Grant requirements.

b) Service providers record monthly implementation data (process/short-term outcomes) into the state's data system (WITS). BDAS staff reviews this data weekly to ensure there is quality data and Block Grant NOMs are being appropriately recorded.

c) WITS monthly progress reports are drawn and reviewed to ensure accuracy. The reports are filed on BDAS shared drive and sent to the service provider contract administrator.

d) Quarterly Block Grant tables are retrieved per service provider to ensure all appropriate data is being collected.

e) Additionally, semiannual site visits are conducted per service provider, to assess any concerns and to offer technical assistance when needed. If additional TA is needed, a request is made to the Center for Excellence.

f) BDAS Prevention Staff maintain contract monitoring documentation to track contract monitoring issues per service provider; tracking site visits, communications, WITS monitoring, actions taken, and follow up needed.

g) for non-compliance issues:

- BDAS contract manager sends an email to the service provider and;
- follows up with a phone call, and;
- offers TA to help remedy the non-compliance issue, and;
- as appropriate refers to the Center for Excellence
- a deadline is given for the corrective action plan
- follow up to ensure service provider is on track
- track all actions and information in the contract monitoring document

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? Yes No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- a) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b) Includes evaluation information from sub-recipients
- c) Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d) Establishes a process for providing timely evaluation information to stakeholders
- e) Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f) Other (please list:)
- g) Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a) Numbers served
- b) Implementation fidelity
- c) Participant satisfaction
- d) Number of evidence based programs/practices/policies implemented
- e) Attendance
- f) Demographic information
- g) Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a) 30-day use of alcohol, tobacco, prescription drugs, etc
- b) Heavy use
- Binge use
- Perception of harm
- c) Disapproval of use

- d)** Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e)** Other (please describe):

Footnotes:

Expanding Our Response

The NH Governor's Commission on Alcohol and other Drugs Action Plan

January 1, 2019 – December 31, 2021



Dedication

New Hampshire families and communities have lost hundreds of parents, children, friends, co-workers, and neighbors to addiction. This plan is dedicated to those who we mourn, to those who are not yet in recovery, and to those who live in recovery from alcohol and other drug use disorders every day.

Message from the Governor and Commission Chair

We are pleased to present the 2019-2022 Governor’s Commission on Alcohol and Other Drugs Strategic Plan. This plan highlights the key actions to be taken over the next three years to comprehensively address our state’s addiction crisis. This plan has been developed with input and expertise provided by Commission members, Commission Task Force members, and other key stakeholders. This plan serves as a blueprint for our shared efforts, with a focus on alignment, coordination, innovation, and accountability.

We face significant challenges in our state concerning substance misuse. Families, communities, and workplaces have been severely impacted by opioid-related overdoses, resulting in over 1,900 deaths of NH residents since 2012. Over that time first responders and emergency medical providers have seen sharp increases in cases involving the misuse of opioids, alcohol, and other drugs.

To address these challenges, we have engaged people from all regions of the state and are putting forth new ideas and increased resources to build a coordinated system of care in NH. The Commission’s Task Forces have worked to identify data-driven priorities in partnership with service providers and community members. We are starting to see positive results from our collective efforts, including the first decline in overdose deaths in the past six years, the launch of the nation’s first Recovery Friendly Workplace Initiative and the development of The Doorway, an innovative “hub and spoke” model of substance use disorder services that ensure no one in NH has to travel more than sixty minutes to begin the process towards recovery.

To be effective, we need to work together and create strategic partnerships across state government, not for profits and the business community. We need to build a well-coordinated effort across all systems and create an outcomes-based approach that ensures we understand what is working and what needs to change. The actions identified in this plan provide a framework to move us forward in that direction. Included in this strategic plan are the recommend priorities from the Governor’s Commission on Alcohol and other Drugs. We would like to thank the numerous task force volunteers, service providers, the faith community, first responders, state employees and elected officials for their commitment to the creation of this strategic plan and its priorities.

Sincerely,



Christopher T. Sununu
Governor



Patrick M. Tufts
Chair

COMMISSION MEMBERS

Legislative Members

Senator Jeb Bradley

Senator Martha Hennessey

Representative William Hatch

Representative Sherman Packard

Public Members

*Patrick Tufts, Commission Chairman
Prevention Professional*

Timothy Lena – Prevention Professional

Keith Howard – Recovery Representative

Monica Edgar – Treatment Professional

Stephanie Savard – Treatment Professional

Stephen Ahnen – Non-Professional Public Member

Chris Placy – Non-Professional Public Member

Designated Members

*Annette Escalante, Commission Executive Director
Director, NH Bureau of Drug and Alcohol Services*

Gordon MacDonald – Attorney General, NH Department of Justice

David Mikolaities – Adjutant General, NH National Guard

Tina Nadeau – Designee, Administrative Judge of the NH District and Municipal Courts

Joseph Mollica – Chairman, NH Liquor Commission

Jeffrey A. Meyers – Commissioner, NH Department of Health & Human Services

Joseph Ribsam – Director, NH Division for Children, Youth & Families

Frank Edelblut – Commissioner, NH Department of Education

Helen Hanks – Commissioner, NH Department of Corrections

John J. Barthelmes – Commissioner, NH Department of Safety

John Elias – Commissioner, NH Insurance Department

Cheryl Ann Coletti-Lawson – NH Business and Industry Association

Seddon Savage – NH Medical Society

Ross Gittell – Chancellor, Community College System of NH

Daniel Potenza – Chairman, NH Suicide Prevention Council

Kate Thompson – NH Nurses Association

Timothy Rourke – NH Charitable Foundation



The New Hampshire Governor's Commission on Alcohol and other Drugs

The New Hampshire Governor's Commission on Alcohol and other Drugs (Commission), created by the New Hampshire Legislature in 2000 is legislatively mandated to reduce alcohol and drug problems and their behavioral, health and social consequences for the citizens of New Hampshire by advising the Governor and Legislature. The Commission is represented by members of the legislature, the public, designated organizations and state government.

For more information please visit the Commission's webpage nhcenterforexcellence.org/governors-commission.

COMMISSION PURPOSE

VISION	<p>The Commission envisions a New Hampshire in which all people live healthy and meaningful lives free from harm related to alcohol and other drug use.</p>
MISSION	<p>The Commission will work to significantly reduce alcohol and drug problems and their behavioral, health and social consequences for the citizens of New Hampshire by advising the Governor and Legislature regarding the delivery of effective and coordinated substance misuse prevention, treatment, and recovery services throughout the state.</p>
CORE FUNCTIONS	<p>The Commission will work towards its mission by:</p> <ul style="list-style-type: none"> • Developing and revising, as necessary, a statewide plan for the effective prevention of alcohol and drug misuse, particularly among youth; and a comprehensive system of treatment and recovery services for individuals and families affected by alcohol and other drug use; • Promoting collaboration between and among state agencies and communities to foster the development of effective community-based alcohol and drug misuse prevention programs; • Promoting the development of treatment services to meet the needs of citizens addicted to alcohol or other drugs; • Identifying unmet needs and the resources required to reduce the incidence of alcohol and drug misuse in New Hampshire and to make recommendations to the Governor and Legislature regarding legislation and funding to address such needs; and • Authorizing the disbursement of monies from the “alcohol abuse and prevention and treatment fund”, pursuant to RSA 176-A:1, III.
VALUES	<p>The Commission supports alcohol and other drug use related policies, programs and services that:</p> <ul style="list-style-type: none"> • Honor the complex biopsychosocial nature of alcohol and other drug misuse, unique to each individual; • Respect the human rights, cultural values, beliefs, and dignity of all people; • Are evidence informed, pragmatic, non-coercive, and non-discriminatory; • Are continuously improved with timely and available data; • Are trauma informed; • Are resilience and recovery oriented; • Are informed by the wisdom of lived experience; and • Are equally accessible to all.

COMMISSION TASK FORCES

To assist in the performance of its duties, the Commission has eight task forces. Task force memberships, work plans, recommendations, meeting schedules and minutes are available through the Commission's webpage nhcenterforexcellence.org/governors-commission.



Data and Evaluation Task Force

This task force is a multidisciplinary group which works to improve the quality and efficiency of data systems and the availability and utility of data products in order to inform alcohol and other drug policy, programs and services in New Hampshire.



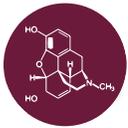
Healthcare Task Force

This task force engages healthcare personnel and health systems in New Hampshire in preventing substance-related harm and effectively addressing substance misuse and substance use disorders.



Joint Military Task Force

This task force enhances awareness and advocacy as well as improves access to affordable, relevant alcohol and other drug services for service members, veterans and their families through education and collaboration.



Opioid Task Force

This task force focuses on high-priority concerns relative to opioid misuse, identifying and recommending needs and strategies for addressing the problem. This Task Force is made up of members representing business, education, government, health care, emergency services, law enforcement, and community supports.



Perinatal Substance Exposure Task Force

This task force identifies and recommends needs and opportunities related to perinatal substance exposure: including ways to lessen barriers pregnant and parenting women face when seeking quality healthcare; aligning state policy and activities with best medical practices for pregnant and newly parenting women and their children; and increasing public awareness about the risks of exposure during pregnancy.



Prevention Task Force

This task force identifies data trends related to substance misuse; related to substance misuse to understand the impact of emerging trends; identifies and takes action to address the gaps in the current prevention system; and recommends strategies.



Recovery Task Force

This task force supports services and systems related to the advancement of recovery support services in New Hampshire. The Task Force includes many active leaders, members and advocates involved in the recovery movement.



Treatment Task Force

This task force makes recommendations regarding policies, practices, and unmet needs to ensure accessible, high-quality services for New Hampshire residents experiencing substance use disorders.

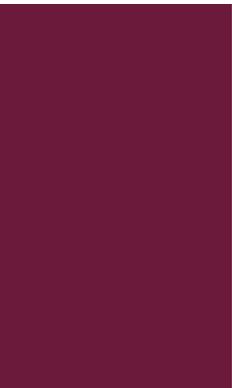
SNAPSHOT OF CURRENT ALCOHOL AND OTHER DRUG MISUSE IN NH

The epidemic of opioid misuse and drug overdose in New Hampshire is a public health crisis devastating families and touching every community across our state. Since 2012, the number of drug overdose deaths has increased 200%, claiming the lives of over 1,900 NH residents. Use of illicit opioids, fentanyl in particular, accounts for the vast majority of drug overdoses and deaths caused by drug overdose.

The unprecedented escalation of opioid misuse, combined with existing challenges of broader substance misuse and addiction, is overwhelming community and state systems of care, from emergency rooms and law enforcement to child protection and treatment services. In 2017, Emergency Medical Service (EMS) providers across the state responded to 5,940 cases where the working diagnosis was drug overdose or misuse of medications. An additional 4,360 EMS cases involved a working diagnosis of “alcohol abuse” and effects.

New Hampshire hospitals also saw a total of 6,684 emergency department visits related to opioid use in 2017. During that year, more than half of new cases opened by the NH Division for Children, Youth and Families for child protection services were determined to include substance misuse as a risk factor.

As a result of strategic efforts toward curtailing the epidemic, a substantially lower number of drug related overdose deaths is projected for 2018, which will be the first decline in drug-related deaths in the past six years. This plan aims to build on the significant efforts that have been made to address the epidemic of substance misuse and addiction and to accelerate progress on prevention, harm reduction, treatment and recovery for individuals, families and communities throughout New Hampshire.



COMMISSION STRATEGIC PLAN

This three-year (January 1, 2019 to December 31, 2021) strategic plan is based on recommendations made by the Governor’s Commission and Task Force members and other key stakeholders. In developing this plan each Task Force reviewed relevant alcohol and drug related data and engaged in a structured process to prioritize the strategies. State-level plans such as the NH Department of Health and Human Services (DHHS) Strategic Opioid Response Plan were cross-referenced and used to inform strategy decisions and to guide the activity of the Commission’s Task Forces.

GOAL: To reduce the misuse of alcohol and other drugs across the lifespan through the implementation of effective programs, practices and policies.

OBJECTIVE 1

Reduce the number of lives lost to drug and alcohol use.

TARGET 1.1: Decrease the number of drug overdose deaths by 25% by 2021.

TARGET 1.2: Decrease the number of alcohol-induced deaths by 15% by 2021.

OBJECTIVE 2

Reduce the incidence of negative health consequences of alcohol and other drug use.

TARGET 2.1: Reduce the number of drug overdose EMS cases by 15% by 2021.

TARGET 2.2: Reduce the number of alcohol misuse EMS cases by 10% by 2021.

TARGET 2.3: Reduce the number of emergency department visits related to opioid use by 25% by 2021.

OBJECTIVE 3

Decrease the number of NH residents who need, but are not receiving substance use treatment services.

TARGET 3.1: Increase the number of individuals engaged in substance use disorder treatment by 25% by 2021.

TARGET 3.2: Decrease the number of individuals who need, but are not receiving treatment for substance use by 10% by 2021.

OBJECTIVE 4

Reduce the prevalence of alcohol and other drug misuse across the lifespan.

TARGET 4.1: Decrease the proportion of NH residents ages 12+ who report current binge alcohol use by 2.5% by 2021.

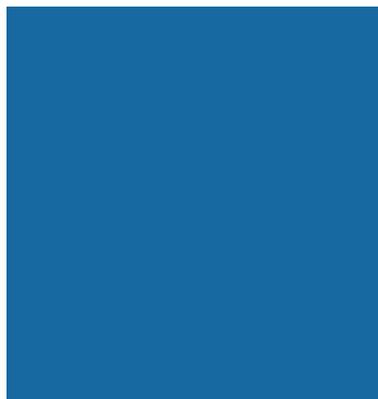
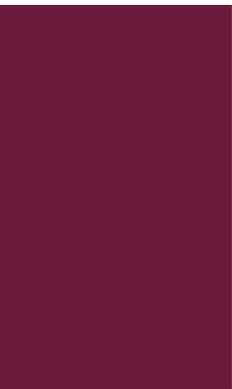
TARGET 4.2: Decrease current marijuana use among NH high school students by 10% by 2021

TARGET 4.3: Decrease the proportion of NH residents ages 12+ who report recent illicit drug use other than marijuana by 0.5% by 2021.

Guiding Principles

The Commission and its task forces followed the fundamental principles below to design the goals, objectives, and strategies outlined in this plan. These core principles shall continue to guide actions as the Commission and its task forces work toward implementation.

- Base decisions on the prevalence of substance use and mental health disorders
- Ensure that strategies are data driven and on the continuum of research from evidence-informed to evidence-based. Reduce stigma and discrimination associated with substance use disorder
- Align with other state-level plans including the 10 year Mental Health Plan, the State Opioid Response Plan and the Children’s Behavioral Health Plan, by addressing common priorities, implementing joint strategies and focusing on shared outcomes
- Address the social determinants of health including education, health and healthcare, social and community context, economic stability, neighborhood and built environment
- Align with harm reduction principles
- Address co-occurring mental health and substance use disorders
- Ensure all strategies are delivered in a culturally appropriate manner
- Preserve and build the funding, stability and sustainability for equitable quality services across the continuum of care





LAW ENFORCEMENT

- A. Continue to coordinate and support enforcement actions of agencies and departments working in New Hampshire to combat the supply of illegal drugs (Operation Granite Hammer)
- B. Support and expand the availability of law enforcement drug expertise through the Department of Safety, State Police, Mobile Enforcement Teams
- C. Continue to pursue the prosecution of drug related offense and drug overdose death cases
- D. Continue to expand the number of local law enforcement officers trained and supported through the AG’s Drug Task Force to enforce drug laws from the initial investigation to the prosecution of cases

PREVENTION



- A. Identify and invest in new programs, policies, and practices to:
 - Support individuals and families who have experienced adverse childhood experiences
 - Ensure young adults feel connected to their communities
 - Support young adults in gaining meaningful employment
- B. Expand the implementation and coordination of existing prevention programs including youth leadership programs, Life of an Athlete, the Referral Education and Assistance Program (REAP), court diversion and restorative justice programs, the Recovery Friendly Workplace initiative, local community-based coalitions and Student Assistance Programs (SAP)
- C. Develop systems to improve prescription drug storage and disposal
- D. Create a Multi-Tiered System of Support for Behavior and Wellness through the development of Community Management Teams in New Hampshire school districts



SUBSTANCE USE DISORDER DELIVERY SYSTEM & EARLY IDENTIFICATION

- A. Create The Doorway, a hub and spoke model, for access to delivery of substance use disorder services
- B. Implement a “one-stop shop” model to manage crisis calls and promote information access through a centralized website
- C. Create mobile crisis response teams
- D. Expand behavioral health telehealth services
- E. Implement screening protocols or Screening, Brief Intervention, and Referral to Treatment (SBIRT) in multiple settings to identify problematic alcohol and other drug use



HARM REDUCTION

- A. Develop and implement syringe service programs
- B. Expand availability of free naloxone in settings such as hospitals, churches, schools, jails, prisons and shelters
- C. Distribute naloxone to providers and peers interacting with individuals at greatest risk of overdose including citizens returning to the community from incarceration



TREATMENT

- A. Support practice change to integrate substance use disorder services with mental health services in general healthcare settings including emergency rooms, primary care offices, inpatient medical settings and OB practices
- B. Support practice change and implementation of best practices to increase the availability and effective use of medication assisted treatment (MAT)
- C. Expand access to medication assisted treatment (MAT) in multiple settings and with various specialty populations including Opioid Treatment Programs, emergency departments, hospital based primary care offices, and office and community based MAT providers for the general population as well as specialty programs for pregnant women and citizens returning to the community from incarceration
- D. Utilize technology and innovative practices to provide treatment in limited resource areas
- E. Develop a mechanism for obtaining real-time treatment vacancy data
- F. Expand access to extended-release injectable naltrexone for citizens returning to the community from incarceration
- G. Increase specialized treatment services for specific populations (e.g. veterans, youth, pregnant/parenting women and their families, individuals with co-occurring substance use disorder and mental health disorders and citizens returning to the community from incarceration)
- H. Expand services and increase care coordination for citizens returning to the community from incarceration
- I. Expand services and increase care coordination for pregnant and newly parenting women
- J. Increase the availability and utilization of juvenile diversion programs and adult drug court

RECOVERY SUPPORT SERVICES



- A. Integrate recovery-oriented principles into policies and practices across public and private sectors (i.e. Law Enforcement, Health Care, Social Services, Business Sector, Faith-based communities)
- B. Enhance recovery housing availability and promote quality standards to increase opportunities for special populations, including citizens returning to the community from incarceration, women and their children, and individuals leaving treatment
- C. Increase access to transitional living
- D. Increase access to non-clinical recovery support services (e.g. housing, childcare, transportation)
- E. Invest in vocational training and workforce readiness initiatives for individuals in recovery moving towards employment
- F. Promote and support the Recovery Friendly Workplace initiative
- G. Increase peer recovery support service referrals including in healthcare settings and OB practices
- H. Increase engagement of healthcare providers and health systems in supporting patient recovery

SYSTEMS SUPPORTS ACROSS THE CONTINUUM OF CARE



FAMILY SUPPORTS AND SERVICES

- A. Increase supports and services for families such as home visiting services
- B. Provide support for children who are impacted by substance use disorder (i.e. children who have a loved one or caregiver with a substance use disorder)
- C. Provide support for older adults who are parenting a second time around or are custodial parents



REIMBURSEMENT

- A. Assess and address insurance barriers to allow for easier patient access into treatment
- B. Engage payors to support best practices and services such as screening (for example, SBIRT), case management and the integration of recovery support services
- C. Maintain and expand access to residential treatment services through room and board reimbursements for Medicaid eligible individuals
- D. Increase reimbursement rates across all payors to strengthen the financial stability of organizations and providers
- E. Establish training regarding reimbursement across all payors

WORKFORCE CAPACITY AND PROFESSIONAL DEVELOPMENT



- A. Provide training and technical assistance in support of strategies listed throughout the plan
- B. Provide no cost buprenorphine waiver trainings to physicians, nurse practitioners and physician assistants
- C. Increase training for the Drug Addiction Treatment Act of 2000 (DATA 2000) waived prescribers
- D. Promote core competency training to engage qualified mental health clinicians including social workers in the treatment of persons with substance use disorder
- E. Include training on substance use and substance use disorders in undergraduate and graduate professional education programs
- F. Actively work with employers to recruit and retain experienced addiction specialists in each of the major hospital systems
- G. Align training and support with standards for peer recovery support services (PRSS) and Recovery Community Organizations
- H. Increase provider awareness of non-clinical support services (e.g. housing, childcare, transportation, domestic violence, sexual violence, legal services)
- I. Provide training to all providers and service professionals related to trauma-informed best practices and harm reduction strategies
- J. Address compassion fatigue among all providers including healthcare providers, first responders, and substance use disorder treatment providers
- K. Promote and advocate for military culture trainings across all sectors
- L. Increase provider awareness of the importance of medication assisted treatment to support recovery



PUBLIC AWARENESS

- A. Increase the awareness of substance use disorder service access hubs, treatment and recovery support resources
- B. Develop population-specific awareness campaigns for pregnant and parenting women, emerging adults and individuals who use substances
- C. Increase understanding of medication assisted treatment as best practice in the support of recovery from opioid use disorders
- D. Target specific prevention messaging for children and young adults



DATA UTILIZATION

- A. Collect, analyze and utilize existing and new data sets to inform efforts to address substance misuse including risk factors across the life span, adverse childhood experiences (ACEs) indicators, Middle School Youth Risk Behavior Survey (YRBS), Pregnancy Risk Assessment Monitoring System (PRAMS), Prescription Drug Monitoring Program (PDMP) data
- B. Conduct a statewide assessment of the impact of substance misuse on older adults
- C. Centralize, standardize and enhance police drug enforcement data
- D. Improve data acquisition and sharing of information related to opioid prescribing, naloxone dispensing and to promote better collaboration between pharmacists and other professionals
- E. Establish a tracking system for the Drug Addiction Treatment Act of 2000 (DATA 2000) waived prescribers to determine if buprenorphine is prescribed to patients following training
- F. Establish a surveillance system to collect the incidence of Hepatitis B and C, STDs and HIV

COMMISSION COMMITMENT TO ACTION

The NH Governor's Commission on Alcohol and other Drugs is committed to the continued development of a robust continuum of care for alcohol and other drug misuse. The Commission will ensure that the system focuses on all alcohol and other drug use disorders while ensuring that the current opioid crisis continues to be urgently addressed using effective, evidence-informed strategies. Through the engagement of numerous, active members, Task Forces will recommend annual strategy and funding priorities to the Commission providing both momentum and oversight for this plan. As continued and new resources, such as federal funding, are made available to the State, the Commission will seek to ensure that strategies are appropriately resourced and fully implemented to fill current gaps in the system.

The Commission is dedicated to actions that are evidence-informed and evidence-based and to building on existing positive outcomes of strategy investments. This approach will support the Commission's vision of a New Hampshire in which all people live healthy and meaningful lives free from harm related to alcohol and other drug use.



Compiled by the Community Health Institute/Center for Excellence with support from the New Hampshire Charitable Foundation





Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- i) Screening Yes No
- ii) Education Yes No
- iii) Brief Intervention Yes No
- iv) Assessment Yes No
- v) Detox (inpatient/social) Yes No
- vi) Outpatient Yes No
- vii) Intensive Outpatient Yes No
- viii) Inpatient/Residential Yes No
- ix) Aftercare; Recovery support Yes No

b) Services for special populations:

- Targeted services for veterans? Yes No
- Adolescents? Yes No
- Other Adults? Yes No
- Medication-Assisted Treatment (MAT)? Yes No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? Yes No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? Yes No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? Yes No
4. Does your state have an arrangement for ensuring the provision of required supportive services? Yes No
5. Has your state identified a need for any of the following:
 - a) Open assessment and intake scheduling Yes No
 - b) Establishment of an electronic system to identify available treatment slots Yes No
 - c) Expanded community network for supportive services and healthcare Yes No
 - d) Inclusion of recovery support services Yes No
 - e) Health navigators to assist clients with community linkages Yes No
 - f) Expanded capability for family services, relationship restoration, and custody issues? Yes No
 - g) Providing employment assistance Yes No
 - h) Providing transportation to and from services Yes No
 - i) Educational assistance Yes No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

All SAPTBG requirements relative to PWWDC are included in the BDAS treatment contracts and monitored as a part of that process. At this time, this is limited to annual audits as well as responses to complaints and/or requests for technical assistance; however, the goal is to shift our quality monitoring to include more on-going review over the course of the year. This is currently on hold due to staffing. When issues are identified, providers are required to submit and regularly report of corrective action plans utilizing SMART goals and objectives.

Criterion 4,5&6**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
 - a) 90 percent capacity reporting requirement Yes No
 - b) 14-120 day performance requirement with provision of interim services Yes No
 - c) Outreach activities Yes No
 - d) Syringe services programs Yes No
 - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation Yes No
2. Has your state identified a need for any of the following:
 - a) Electronic system with alert when 90 percent capacity is reached Yes No
 - b) Automatic reminder system associated with 14-120 day performance requirement Yes No
 - c) Use of peer recovery supports to maintain contact and support Yes No
 - d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)? Yes No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

All SAPTBG requirements relative to PWID are included in the BDAS treatment contracts and monitored as a part of that process. At this time, this is limited to annual audits as well as responses to complaints and/or requests for technical assistance; however, the goal is to shift our quality monitoring to include more on-going review over the course of the year. This is currently on hold due to staffing. When issues are identified, providers are required to submit and regularly report of corrective action plans utilizing SMART goals and objectives.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? Yes No
2. Has your state identified a need for any of the following:
 - a) Business agreement/MOU with primary healthcare providers Yes No
 - b) Cooperative agreement/MOU with public health entity for testing and treatment Yes No
 - c) Established co-located SUD professionals within FQHCs Yes No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

All SAPTBG requirements relative to TB are included in the BDAS treatment contracts and monitored as a part of that process. At this time, this is limited to annual audits as well as responses to complaints and/or requests for technical assistance; however, the goal is to shift our quality monitoring to include more on-going review over the course of the year. This is currently on hold due to staffing. When issues are identified, providers are required to submit and regularly report of corrective action plans utilizing SMART goals and objectives.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? Yes No
2. Has your state identified a need for any of the following:
 - a) Establishment of EIS-HIV service hubs in rural areas Yes No
 - b) Establishment or expansion of tele-health and social media support services Yes No

- c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS Yes No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C.Â§ 300x-31(a)(1)F)? Yes No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? Yes No
3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? Yes No
- If yes, please provide a brief description of the elements and the arrangement

Criterion 8,9&10**Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement? Yes No
2. Has your state identified a need for any of the following:
 - a) Workforce development efforts to expand service access Yes No
 - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services Yes No
 - c) Establish a peer recovery support network to assist in filling the gaps Yes No
 - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities) Yes No
 - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations Yes No
 - f) Explore expansion of services for:
 - i) MAT Yes No
 - ii) Tele-Health Yes No
 - iii) Social Media Outreach Yes No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? Yes No
2. Has your state identified a need for any of the following:
 - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services Yes No
 - b) Establish a program to provide trauma-informed care Yes No
 - c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education Yes No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? Yes No
2. Does your state provide any of the following:
 - a) Notice to Program Beneficiaries Yes No
 - b) An organized referral system to identify alternative providers? Yes No
 - c) A system to maintain a list of referrals made by religious organizations? Yes No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? Yes No
2. Has your state identified a need for any of the following:
 - a) Review and update of screening and assessment instruments Yes No
 - b) Review of current levels of care to determine changes or additions Yes No
 - c) Identify workforce needs to expand service capabilities Yes No

- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background Yes No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? Yes No
2. Has your state identified a need for any of the following:
- a) Training staff and community partners on confidentiality requirements Yes No
 - b) Training on responding to requests asking for acknowledgement of the presence of clients Yes No
 - c) Updating written procedures which regulate and control access to records Yes No
 - d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure Yes No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? Yes No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

one (1) program per SFY

3. Has your state identified a need for any of the following:
- a) Development of a quality improvement plan Yes No
 - b) Establishment of policies and procedures related to independent peer review Yes No
 - c) Development of long-term planning for service revision and expansion to meet the needs of specific populations Yes No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? Yes No

If Yes, please identify the accreditation organization(s)

- i) Commission on the Accreditation of Rehabilitation Facilities
- ii) The Joint Commission
- iii) Other (please specify)

Criterion 7&11**Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? Yes No
2. Has your state identified a need for any of the following:
 - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service Yes No
 - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing Yes No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
 - a) Recent trends in substance use disorders in the state Yes No
 - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services Yes No
 - c) Performance-based accountability Yes No
 - d) Data collection and reporting requirements Yes No
2. Has your state identified a need for any of the following:
 - a) A comprehensive review of the current training schedule and identification of additional training needs Yes No
 - b) Addition of training sessions designed to increase employee understanding of recovery support services Yes No
 - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services Yes No
 - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort Yes No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
 - a) Prevention TTC? Yes No
 - b) Mental Health TTC? Yes No
 - c) Addiction TTC? Yes No
 - d) State Targeted Response TTC? Yes No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
 - a) Allocations regarding women Yes No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
 - a) Tuberculosis Yes No
 - b) Early Intervention Services Regarding HIV Yes No
3. Additional Agreements
 - a) Improvement of Process for Appropriate Referrals for Treatment Yes No
 - b) Professional Development Yes No

c) Coordination of Various Activities and Services

Yes No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Other than the OTP rules (http://www.gencourt.state.nh.us/rules/state_agencies/he-a300.html) they are expired and under revision. To cover for this we added Exhibit A-1 to our contracts. Please see attached contract documents for example: Greater Nashua Council on Alcoholism Exhibit A Amendment #2 w SOR Final & Greater Nashua Council on Alcoholism Exhibit B Amendment #2 w SOR final.

Footnotes:

Targeted services for veterans: services are available, although not through BDAS contracts at this time.

TB Q1: If an individual were positive for TB, we would assist them with accessing services through their healthcare provider and/or with obtaining insurance and a healthcare provider if one was not already in place.

SSP Q2: The answer to this questions is unknown, these programs are very new in NH.

Charitable Choice: NH BDAS does not currently contract with any religious organizations. Should the NH BDAS contract with any religious organizations, we will use the model notice provided in final, federal regulation as notice to individuals receiving substance use disorder services.

For referrals to alternative services, NH utilizes SAMHSA's Behavioral Health Treatment Locator as well as the following other assistance and referral options:

- NH Alcohol and Drug Treatment Locator: <https://nhtreatment.org/>, a NH specific website which lists treatment agencies and individual practitioners offering substance use disorder services, including evaluation, withdrawal management, outpatient counseling, residential treatment, and recovery supports.
- The NH Doorway website and Hub Locator Map: <https://www.thedoorway.nh.gov/hubmap>, a NH specific, website and map, that allows people to locate the NH Doorway nearest to them. NH has developed 9 hub locations, called Doorways, which offer screening and evaluation; referral to treatment, including Medication-Assisted Treatment; prevention, including Naloxone; as well as supports and services to assist in long-term recovery. Each Doorway has been specifically located as to enable NH citizens to be 1 hour or less away from services, no matter where they live in our state.
- 2-1-1: <https://www.211nh.org/>, a statewide, comprehensive, information and referral service, allowing NH residents to be connected, at no cost, with trained Information and Referral Specialists who can provide them with the health and human service, including substance use disorder services, information they need to get help, give help or discover options.



New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services

Exhibit A, Amendment #2

Scope of Services

1. Provisions Applicable to All Services

- 1.1. The Contractor agrees that, to the extent future legislative action by the New Hampshire General Court or federal or state court orders may have an impact on the Services described herein, the State Agency has the right to modify Service priorities and expenditure requirements under this Agreement so as to achieve compliance therewith.
- 1.2. For the purposes of this Contract, the Department has identified the Contractor as a Subrecipient in accordance with the provisions of 2 CFR 200 et seq.
- 1.3. The Contractor shall provide Substance Use Disorder Treatment and Recovery Support Services to any eligible client, regardless of where the client lives or works in New Hampshire.

1.4. Standard Compliance

1.4.1. The Contractor shall meet all information security and privacy requirements as set by the Department.

1.4.2. State Opioid Response (SOR) Grant Standards

1.4.2.1. The Contractor shall establish formal information sharing and referral agreements with the Regional Hubs for Substance Use Services, compliant with all applicable confidentiality laws, including 42 CFR Part 2 in order to receive payments for services funded with SOR resources.

1.4.2.2. The Department shall be able to verify that client referrals to the Regional Hub for Substance Use Services have been completed by Contractor prior to accepting invoices for services provided through SOR funded initiatives.

1.4.2.3. The Contractor shall only provide Medication Assisted Treatment (MAT) with FDA-approved MAT for Opioid Use Disorder (OUD). FDA-approved MAT for OUD includes:

1.4.2.3.1. Methadone.

1.4.2.3.2. Buprenorphine products, including:

1.4.2.3.2.1. Single-entity buprenorphine products.

1.4.2.3.2.2. Buprenorphine/naloxone tablets,

1.4.2.3.2.3. Buprenorphine/naloxone films.

1.4.2.3.2.4. Buprenorphine/naloxone buccal



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

preparations.

- 1.4.2.3.3. Long-acting injectable buprenorphine products.
- 1.4.2.3.4. Buprenorphine implants.
- 1.4.2.3.5. Injectable extended-release naltrexone.
- 1.4.2.4. The Contractor shall not provide medical withdrawal management services to any individual supported by SOR Funds, unless the withdrawal management service is accompanied by the use of injectable extended-release naltrexone, as clinically appropriate.
- 1.4.2.5. The Contractor shall ensure that clients receiving financial aid for recovery housing utilizing SOR funds shall only be in a recovery housing facility that is aligned with the National Alliance for Recovery Residences standards and registered with the State of New Hampshire, Bureau of Drug and Alcohol Services in accordance with current NH Administrative Rules.
- 1.4.2.6. The Contractor shall assist clients with enrolling in public or private health insurance, if the client is determined eligible for such coverage.
- 1.4.2.7. The Contractor shall accept clients on MAT and facilitate access to MAT on-site or through referral for all clients supported with SOR Grant funds, as clinically appropriate.
- 1.4.2.8. The Contractor shall coordinate with the NH Ryan White HIV/AIDs program, for clients identified as at risk of or with HIV/AIDs.
- 1.4.2.9. The Contractor shall ensure that all clients are regularly screened for tobacco use, treatment needs and referral to the QuitLine as part of treatment planning.
- 1.4.3. The Contractor shall submit a plan for Department approval no later than 30 days from the date of Governor & Executive Council approval that specifies actions to be taken in the event that the Contractor ceases to provide services. The Contractor shall ensure the plan includes, but is not limited to:
 - 1.4.3.1. A transition action plan that ensures clients seamlessly transition to alternative providers with no gap in services.
 - 1.4.3.2. Where and how client records will be transferred to ensure no gaps and services, ensuring the Department is not identified as the entity responsible for client records; and
 - 1.4.3.3. Client notification processes and procedures for 1.5.3.1 and 1.5.3.2.

2. Scope of Services

2.1. Covered Populations

2.1.1. The Contractor shall provide services to eligible individuals who:



New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services

Exhibit A, Amendment #2

- 2.1.1.1. Are age 12 or older or under age 12, with required consent from a parent or legal guardian to receive treatment, and
- 2.1.1.2. Have income below 400% Federal Poverty Level, and
- 2.1.1.3. Are residents of New Hampshire or homeless in New Hampshire, and
- 2.1.1.4. Are determined positive for substance use disorder.

2.2. Resiliency and Recovery Oriented Systems of Care

2.2.1. The Contractor shall provide substance use disorder treatment services that support the Resiliency and Recovery Oriented Systems of Care (RROSC) by operationalizing the Continuum of Care Model (<http://www.dhhs.nh.gov/dcbcs/bdas/continuum-of-care.htm>).

2.2.2. RROSC supports person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families and communities to take responsibility for their sustained health, wellness and recovery from alcohol and drug problems. At a minimum, the Contractor shall:

- 2.2.2.1. Inform the Integrated Delivery Network(s) (IDNs) of services available in order to align this work with IDN projects that may be similar or impact the same populations.
- 2.2.2.2. Inform the Regional Public Health Networks (RPHN) of services available in order to align this work with other RPHN projects that may be similar or impact the same populations.
- 2.2.2.3. Coordinate client services with other community service providers involved in the client’s care and the client’s support network
- 2.2.2.4. Coordinate client services with the Department’s Doorway contractors including, but not limited to:
 - 2.2.2.4.1. Ensuring timely admission of clients to services
 - 2.2.2.4.2. Referring any client receiving room and board payment to the Doorway;
 - 2.2.2.4.3. Coordinating all room and board client data and services with the clients’ preferred Doorway to ensure that each room and board client served has a GPRA interview completed at intake, three (3) months, six (6) months, and discharge.
 - 2.2.2.4.4. Referring clients to Doorway services when the Contractor cannot admit a client for services within forty-eight (48) hours; and
 - 2.2.2.4.5. Referring clients to Doorway services at the time of discharge when a client is in need of Hub services
- 2.2.2.5. Be sensitive and relevant to the diversity of the clients being served.



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

2.2.2.6. Be trauma informed; i.e. designed to acknowledge the impact of violence and trauma on people's lives and the importance of addressing trauma in treatment.

2.3. Substance Use Disorder Treatment Services

2.3.1. The Contractor shall provide one or more of the following substance use disorder treatment services:

2.3.1.1. Individual Outpatient Treatment as defined as American Society of Addiction Medicine (ASAM) Criteria, Level 1. Outpatient Treatment services assist an individual to achieve treatment objectives through the exploration of substance use disorders and their ramifications, including an examination of attitudes and feelings, and consideration of alternative solutions and decision making with regard to alcohol and other drug related problems.

2.3.1.2. Group Outpatient Treatment as defined as ASAM Criteria, Level 1. Outpatient Treatment services assist a group of individuals to achieve treatment objectives through the exploration of substance use disorders and their ramifications, including an examination of attitudes and feelings, and consideration of alternative solutions and decision making with regard to alcohol and other drug related problems.

2.3.1.3. Intensive Outpatient Treatment as defined as ASAM Criteria, Level 2.1. Intensive Outpatient Treatment services provide intensive and structured individual and group alcohol and/or other drug treatment services and activities that are provided according to an individualized treatment plan that includes a range of outpatient treatment services and other ancillary alcohol and/or other drug services. Services for adults are provided at least 9 hours a week. Services for adolescents are provided at least 6 hours a week.

2.3.1.4. Partial Hospitalization as defined as ASAM Criteria, Level 2.5. Partial Hospitalization services provide intensive and structured individual and group alcohol and/or other drug treatment services and activities to individuals with substance use and moderate to severe co-occurring mental health disorders, including both behavioral health and medication management (as appropriate) services to address both disorders. Partial Hospitalization is provided to clients for at least 20 hours per week according to an individualized



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- treatment plan that includes a range of outpatient treatment services and other ancillary alcohol and/or other drug services.
- 2.3.1.5. Ambulatory Withdrawal Management services as defined as ASAM Criteria, Level 1-WM as an outpatient service. Withdrawal Management services provide a combination of clinical and/or medical services utilized to stabilize the client while they are undergoing withdrawal.
- 2.3.1.6. Transitional Living Services provide residential substance use disorder treatment services according to an individualized treatment plan designed to support individuals as they transition back into the community. Transitional Living Services are not defined by ASAM. Transitional Living services shall include at least 3 hours of clinical services per week of which at least 1 hour shall be delivered by a Licensed Counselor or unlicensed Counselor working under the supervision of a Licensed Supervisor and the remaining hours shall be delivered by a Certified Recovery Support Worker (CRSW) working under a Licensed Supervisor or a Licensed Counselor. The maximum length of stay in this service is six (6) months. Adult residents typically work in the community and may pay a portion of their room and board.
- 2.3.1.7. Low-Intensity Residential Treatment as defined as ASAM Criteria, Level 3.1 for adults. Low-Intensity Residential Treatment services provide residential substance use disorder treatment services designed to support individuals that need this residential service. The goal of low-intensity residential treatment is to prepare clients to become self-sufficient in the community. Adult residents typically work in the community and may pay a portion of their room and board.
- 2.3.1.8. High-Intensity Residential Treatment for Adults as defined as ASAM Criteria, Level 3.5. This service provides residential substance use disorder treatment designed to assist individuals who require a more intensive level of service in a structured setting.
- 2.3.1.9. Specialty Residential Treatment for Pregnant and Parenting Women as defined as ASAM Criteria, Level 3.1 and above. This service provides residential substance use disorder treatment to pregnant women and their children when appropriately designed to assist individuals who require a more intensive level of service in a structured setting.
- 2.3.2. The Contractor may provide Integrated Medication Assisted Treatment only in coordination with providing at least one of the services in Section 2.3.1.1 through 2.3.1.9 to a client.



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

2.3.2.1. Integrated Medication Assisted Treatment services provide for medication prescription and monitoring for treatment of opiate and other substance use disorders. The Contractor shall provide non-medical treatment services to the client in conjunction with the medical services provided either directly by the Contractor or by an outside medical provider. The Contractor shall be responsible for coordination of care and meeting all requirements for the service provided. The Contractor shall deliver Integrated Medication Assisted Treatment services in accordance with guidance provided by the Department, "Guidance Document on Best Practices: Key Components for Delivery Community-Based Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire."

2.4. Recovery Support Services

2.4.1. Upon approval of the Department, the Contractor shall provide recovery support services that will remove barriers to a client's participation in treatment or recovery, or reduce or remove threats to an individual maintaining participation in treatment and/or recovery.

2.4.2. The Contractor shall provide recovery support services only in coordination with providing at least one of the services in Section 2.3.1.1 through 2.3.1.9 to a client, as follows:

2.4.2.1. Intensive Case Management

2.4.2.1.1. The Contractor may provide individual or group Intensive Case Management in accordance with SAMHSA TIP 27: Comprehensive Case Management for Substance Abuse Treatment (<https://store.samhsa.gov/product/TIP-27-Comprehensive-Case-Management-for-Substance-Abuse-Treatment/SMA15-4215>) and which exceed the minimum case management expectations for the level of care.

2.4.2.2. Transportation for Pregnant Women and Parenting Men and Women:

2.4.2.2.1. The Contractor may provide transportation services to pregnant women and parenting men and women to and from services as required by the client's treatment plan.



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

2.4.2.2.2. The Contractor may use Contractor’s own vehicle, and/or purchase public transportation passes and/or pay for cab fare. The Contractor shall:

2.4.2.2.2.1. Comply with all applicable Federal and State Department of Transportation and Department of Safety regulations.

2.4.2.2.2.2. Ensure that all vehicles are registered pursuant to New Hampshire Administrative Rule Saf-C 500 and inspected in accordance with New Hampshire Administrative Rule Saf-C 3200, and are in good working order.

2.4.2.2.2.3. Ensure all drivers are licensed in accordance with New Hampshire Administrative Rules, Saf-C 1000, drivers licensing, and Saf-C 1800 Commercial drivers licensing, as applicable.

2.4.2.3. Child Care for Parenting Clients:

2.4.2.3.1. The Contractor may provide child care to children of parenting clients while the individual is in treatment and case management services.

2.4.2.3.2. The Contractor may directly provide child care and/or pay for childcare provided by a licensed childcare provider.

2.4.2.3.3. The Contractor shall comply with all applicable Federal and State childcare regulations such as but not limited to New Hampshire Administrative Rule He-C 4002 Child Care Licensing.

2.5. Enrolling Clients for Services

2.5.1. The Contractor shall determine eligibility for services in accordance with Section 2.1 above and with Sections 2.5.2 through 2.5.4 below:

2.5.2. The Contractor shall complete intake screenings as follows:



New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services

Exhibit A, Amendment #2

- 2.5.2.1. Have direct contact (face to face communication by meeting in person, or electronically, or by telephone conversation) with an individual (defined as anyone or a provider) within two (2) business days from the date that individual contacts the Contractor for Substance Use Disorder Treatment and Recovery Support Services. All attempts at contact shall be documented in the client record or call log.
- 2.5.2.2. Complete an initial Intake Screening within two (2) business days from the date of the first direct contact with the individual, using the eligibility module in Web Information Technology System (WITS) to determine probability of being eligible for services under this contract and for probability of having a substance use disorder. All attempts at contact shall be documented in the client record or call log.
- 2.5.2.3. Assess clients' income prior to admission using the WITS fee determination model and
 - 2.5.2.3.1. Assure that clients' income information is updated as needed over the course of treatment by asking clients about any changes in income no less frequently than every 4 weeks. Inquiries about changes in income shall be documented in the client record
- 2.5.3. The Contractor shall complete an ASAM Level of Care Assessment for all services in Sections 2.3.1.1 through 2.3.1.2 within two (2) days of the initial Intake Screening in Section 2.5.2 above using the ASI Lite module, in Web Information Technology System (WITS) or other method approved by the Department when the individual is determined probable of being eligible for services.
 - 2.5.3.1. The Contractor shall make available to the Department, upon request, the data from the ASAM Level of Care Assessment in Section 2.5.3 in a format approved by the Department.
- 2.5.4. The Contractor shall use the clinical evaluations completed by a Licensed or unlicensed Counselor from a referring agency.
- 2.5.5. If the client does not present with an evaluation completed by a licensed or unlicensed counselor, the Contractor shall, for all services provided, complete a clinical evaluation utilizing CONTINUUM or an alternative method approved by the Department that includes DSM 5 diagnostic information and a recommendation for a level of care based on the ASAM Criteria, published in October, 2013. The Contractor shall complete a clinical evaluation, for each client:
 - 2.5.5.1. Prior to admission as a part of interim services or within three (3) business days following admission.
 - 2.5.5.2. During treatment only when determined by a Licensed Counselor.
- 2.5.6. The Contractor shall either complete clinical evaluations in Section 2.5.4, above before admission **or** Level of Care Assessments in Section 2.5.3, above before admission along with a clinical evaluation in Section 2.5.4, above after admission.



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- 2.5.7. The Contractor shall provide eligible clients the substance use disorder treatment services in Section 2.3 determined by the client's clinical evaluation in Section 2.5.4 unless:
- 2.5.7.1. The client chooses to receive a service with a lower intensity ASAM Level of Care; or
 - 2.5.7.2. The service with the needed ASAM level of care is unavailable at the time the level of care is determined in Section 2.5.3, in which case the client may choose:
 - 2.5.7.2.1. A service with a lower Intensity ASAM Level of Care;
 - 2.5.7.2.2. A service with the next available higher intensity ASAM Level of Care;
 - 2.5.7.2.3. Be placed on the waitlist until their service with the assessed ASAM level of care becomes available as in Section 2.5.3; or
 - 2.5.7.2.4. Be referred to another agency in the client's service area that provides the service with the needed ASAM Level of Care.
- 2.5.8. The Contractor shall enroll eligible clients for services in order of the priority described below:
- 2.5.8.1. Pregnant women and women with dependent children, even if the children are not in their custody, as long as parental rights have not been terminated, including the provision of interim services within the required 48-hour time frame. If the Contractor is unable to admit a pregnant woman for the needed level of care within 24 hours, the Contractor shall:
 - 2.5.8.1.1. Contact the Doorway of the client's choice to connect the client with substance use disorder treatment services; or
 - 2.5.8.1.2. If the client refuses referral in 2.5.8.1.1., assist the pregnant woman with identifying alternative providers and with accessing services with these providers. This assistance shall include actively reaching out to identify providers on the behalf of the client; and
 - 2.5.8.1.3. Provide interim services until the appropriate level of care becomes available at either the Contractor agency or an alternative provider. Interim services shall include:
 - 2.5.8.1.3.1. At least one 60-minute individual or group outpatient session per week;
 - 2.5.8.1.3.2. Recovery support services as needed by the client;



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- 2.5.8.1.3.3. Daily calls to the client to assess and respond to any emergent needs.
- 2.5.8.2. Individuals who have been administered naloxone to reverse the effects of an opioid overdose either in the 14 days prior to screening or in the period between screening and admission to the program.
- 2.5.8.3. Individuals with a history of injection drug use including the provision of interim services within 14 days.
- 2.5.8.4. Individuals with substance use and co-occurring mental health disorders.
- 2.5.8.5. Individuals with Opioid Use Disorders.
- 2.5.8.6. Veterans with substance use disorders
- 2.5.8.7. Individuals with substance use disorders who are involved with the criminal justice and/or child protection system.
- 2.5.8.8. Individuals who require priority admission at the request of the Department.
- 2.5.9. The Contractor shall obtain consent in accordance with 42 CFR Part 2 for treatment from the client prior to receiving services for individuals whose age is 12 years and older.
- 2.5.10. The Contractor shall obtain consent in accordance with 42 CFR Part 2 for treatment from the parent or legal guardian when the client is under the age of twelve (12) prior to receiving services.
- 2.5.11. The Contractor shall include in the consent forms language for client consent to share information with other social service agencies involved in the client's care, including but not limited to:
- 2.5.11.1. The Department's Division of Children, Youth and Families (DCYF)
- 2.5.11.2. Probation and parole
- 2.5.11.3. Doorways
- 2.5.12. The Contractor shall not prohibit clients from receiving services under this contract when a client does not consent to information sharing in Section 2.5.11 above except that clients who refuse to consent to information sharing with the Doorways shall not receive services utilizing State Opioid Response (SOR) funding.
- 2.5.13. The Contractor shall notify the clients whose consent to information sharing in Section 2.5.11 above that they have the ability to rescind the consent at any time without any impact on services provided under this contract except that clients who rescind consent to information sharing with the Regional Hub shall not receive any additional services utilizing State Opioid Response (SOR) funding.
- 2.5.14. The Contractor shall not deny services to an adolescent due to:



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- 2.5.14.1. The parent's inability and/or unwillingness to pay the fee;
 - 2.5.14.2. The adolescent's decision to receive confidential services pursuant to RSA 318-B:12-a.
 - 2.5.15. The Contractor shall provide services to eligible clients who:
 - 2.5.15.1. Receive Medication Assisted Treatment services from other providers such as a client's primary care provider;
 - 2.5.15.2. Have co-occurring mental health disorders; and/or
 - 2.5.15.3. Are on medications and are taking those medications as prescribed regardless of the class of medication.
 - 2.5.16. The Contractor shall provide substance use disorder treatment services separately for adolescent and adults, unless otherwise approved by the Department. The Contractor agrees that adolescents and adults do not share the same residency space, however, the communal space such as kitchens, group rooms, and recreation may be shared but at separate times.
- 2.6. Waitlists
- 2.6.1. The Contractor shall maintain a waitlist for all clients and all substance use disorder treatment services including the eligible clients being served under this contract and clients being served under another payer source.
 - 2.6.2. The Contractor shall track the wait time for the clients to receive services, from the date of initial contact in Section 2.5.2.1 above to the date clients first received substance use disorder treatment services in Sections 2.3 and 2.4 above, other than Evaluation in Section 2.5.4
 - 2.6.3. The Contractor shall report to the Department monthly:
 - 2.6.3.1. The average wait time for all clients, by the type of service and payer source for all the services.
 - 2.6.3.2. The average wait time for priority clients in Section 2.5.8 above by the type of service and payer source for the services.
- 2.7. Assistance with Enrolling in Insurance Programs
- 2.7.1. The Contractor shall assist clients and/or their parents or legal guardians, who are unable to secure financial resources necessary for initial entry into the program, with obtaining other potential sources for payment, such as:
 - 2.7.1.1. Enrollment in public or private insurance, including but not limited to New Hampshire Medicaid programs within fourteen (14) days after intake.
 - 2.7.1.2. Assistance with securing financial resources or the clients' refusal of such assistance shall be clearly documented in the client record
- 2.8. Service Delivery Activities and Requirements



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- 2.8.1. The Contractor shall assess all clients for risk of self-harm at all phases of treatment, such as at initial contact, during screening, intake, admission, on-going treatment services and at discharge.
- 2.8.2. The Contractor shall assess all clients for withdrawal risk based on ASAM (2013) standards at all phases of treatment, such as at initial contact, during screening, intake, admission, on-going treatment services and stabilize all clients based on ASAM (2013) guidance and shall:
 - 2.8.2.1. Provide stabilization services when a client's level of risk indicates a service with an ASAM Level of Care that can be provided under this Contract; If a client's risk level indicates a service with an ASAM Level of Care that can be provided under this contract, then the Contractor shall integrate withdrawal management into the client's treatment plan and provide on-going assessment of withdrawal risk to ensure that withdrawal is managed safely.
 - 2.8.2.2. Refer clients to a facility where the services can be provided when a client's risk indicates a service with an ASAM Level of Care that is higher than can be provided under this Contract; Coordinate with the withdrawal management services provider to admit the client to an appropriate service once the client's withdrawal risk has reached a level that can be provided under this contract. and
- 2.8.3. The Contractor shall complete individualized treatment plans for all clients based on clinical evaluation data within three (3) days or three (3) sessions, whichever is longer of the clinical evaluation in Section 2.5.4 above, that address problems in all ASAM (2013) domains which justified the client's admittance to a given level of care, that are in accordance the requirements in Exhibit A-1 and that:
 - 2.8.3.1. Include in all individualized treatment plan goals, objectives, and interventions written in terms that are:
 - 2.8.3.1.1. Specific, clearly defining what shall be done.
 - 2.8.3.1.2. Measurable, including clear criteria for progress and completion.
 - 2.8.3.1.3. Attainable, within the individual's ability to achieve.
 - 2.8.3.1.4. Realistic, the resources are available to the individual.
 - 2.8.3.1.5. Timely, something that needs to be completed within a stated period for completion that is reasonable.
 - 2.8.3.2. Include the client's involvement in identifying, developing, and prioritizing goals, objectives, and interventions.
 - 2.8.3.3. Are update based on any changes in any American Society of Addiction Medicine Criteria (ASAM) domain and no less frequently than every 4 sessions or every 4 weeks, whichever is less frequent. Treatment plan updates shall include:



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- 2.8.3.3.1. Documentation of the degree to which the client is meeting treatment plan goals and objectives;
- 2.8.3.3.2. Modification of existing goals or addition of new goals based on changes in the clients functioning relative to ASAM domains and treatment goals and objectives.
- 2.8.3.3.3. The counselor's assessment of whether or not the client needs to move to a different level of care based on changes in functioning in any ASAM domain and documentation of the reasons for this assessment.
- 2.8.3.3.4. The signature of the client and the counselor agreeing to the updated treatment plan, or if applicable, documentation of the client's refusal to sign the treatment plan.
- 2.8.3.4. Track the client's progress relative to the specific goals, objectives, and interventions in the client's treatment plan by completing encounter notes in WITS.
- 2.8.4. The Contractor shall refer clients to and coordinate a client's care with other providers.
 - 2.8.4.1. The Contractor shall obtain in advance if appropriate, consents from the client, including 42 CFR Part 2 consent, if applicable, and in compliance with state, federal laws and state and federal rules, including but not limited to:
 - 2.8.4.1.1. Primary care provider and if the client does not have a primary care provider, the Contractor shall make an appropriate referral to one and coordinate care with that provider if appropriate consents from the client, including 42 CFR Part 2 consent, if applicable, are obtained in advance in compliance with state, federal laws and state and federal rules.
 - 2.8.4.1.2. Behavioral health care provider when serving clients with co-occurring substance use and mental health disorders, and if the client does not have a mental health care provider, then the Contractor shall make an appropriate referral to one and coordinate care with that provider if appropriate consents from the client, including 42 CFR Part 2 consent, if applicable, are obtained in advance in compliance with state, federal laws and state and federal rules.
 - 2.8.4.1.3. Medication assisted treatment provider.
 - 2.8.4.1.4. Peer recovery support provider, and if the client does not have a peer recovery support provider, the Contractor shall make an appropriate referral to one and coordinate care with that provider if appropriate consents from the client,



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

including 42 CFR Part 2 consent, if applicable, are obtained in advance in compliance with state, federal laws and state and federal rules.

2.8.4.1.5. Coordinate with local recovery community organizations (where available) to bring peer recovery support providers into the treatment setting, to meet with clients to describe available services and to engage clients in peer recovery support services as applicable.

2.8.4.1.6. Coordinate with case management services offered by the client’s managed care organization, Doorway, third party insurance or other provider, if applicable. If appropriate consents from the client, including 42 CFR Part 2 consent, if applicable, are obtained in advance in compliance with state, federal laws and state and federal rules.

2.8.4.2. Coordinate with other social service agencies engaged with the client, including but not limited to the Department’s Division of Children, Youth and Families (DCYF), probation/parole, and the Doorways as applicable and allowable with consent provided pursuant to 42 CFR Part 2. The Contractor shall clearly document in the client’s file if the client refuses any of the referrals or care coordination in Section 2.8.4, above.

2.8.5. The Contractor shall complete continuing care, transfer, and discharge plans for all Services in Section 2.3, except for Transitional Living, in Section 2.3.1.1, that address all ASAM (2013) domains, that are in accordance with the requirements in Exhibit A-1 and that:

2.8.5.1. Include the process of transfer/discharge planning at the time of the client’s intake to the program.

2.8.5.2. Include at least one (1) of the three (3) criteria for continuing services when addressing continuing care as follows:

2.8.5.2.1. Continuing Service Criteria, A: The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals; or

2.8.5.2.2. Continuing Service Criteria B: The patient is not yet making progress, but has the capacity to resolve his or her problems. He/she is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his/her treatment goals; and /or



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- 2.8.5.2.3. Continuing Service Criteria C: New problems have been identified that are appropriately treated at the present level of care. The new problem or priority requires services, the frequency and intensity of which can only safely be delivered by continued stay in the current level of care. The level of care which the patient is receiving treatment is therefore the least intensive level at which the patient's problems can be addressed effectively
- 2.8.5.3. Include at least one (1) of the four (4) criteria for transfer/discharge, when addressing transfer/discharge that include:
 - 2.8.5.3.1. Transfer/Discharge Criteria A: The Patient has achieved the goals articulated in the individualized treatment plan, thus resolving the problem(s) that justified admission to the present level of care. Continuing the chronic disease management of the patient's condition at a less intensive level of care is indicated; or
 - 2.8.5.3.2. Transfer/Discharge Criteria B: The patient has been unable to resolve the problem(s) that justified the admission to the present level of care, despite amendments to the treatment plan. The patient is determined to have achieved the maximum possible benefit from engagement in services at the current level of care. Treatment at another level of care (more or less intensive) in the same type of services, or discharge from treatment, is therefore indicated; or
 - 2.8.5.3.3. Transfer/Discharge Criteria C: The patient has demonstrated a lack of capacity due to diagnostic or co-occurring conditions that limit his or her ability to resolve his or her problem(s). Treatment at a qualitatively different level of care or type of service, or discharge from treatment, is therefore indicated; or
 - 2.8.5.3.4. Transfer/Discharge Criteria D: The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively at a more intensive level of care.
- 2.8.5.4. Include clear documentation that explains why continued services/transfer/ or discharge is necessary for Transitional Living.
- 2.8.6. The Contractor shall deliver all services in this Agreement using evidence based practices as demonstrated by meeting one of the following criteria:
 - 2.8.6.1. The service shall be included as an evidence-based mental health and substance abuse intervention on the SAMHSA Evidence-Based Practices Resource Center <https://www.samhsa.gov/ebp-resource-center>;



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- 2.8.6.2. The services shall be published in a peer-reviewed journal and found to have positive effects; or
- 2.8.6.3. The service is based on a theoretical perspective that has validated research.
- 2.8.7. The Contractor shall deliver services in this Contract in accordance with:
 - 2.8.7.1. The ASAM Criteria (2013). The ASAM Criteria (2013) can be purchased online through the ASAM website at: <http://www.asamcriteria.org/>
 - 2.8.7.2. The Substance Abuse Mental Health Services Administration (SAMHSA) Treatment Improvement Protocols (TIPs) available at <http://store.samhsa.gov/list/series?name=TIP-Series-Treatment-Improvement-Protocols-TIPS->
 - 2.8.7.3. The SAMHSA Technical Assistance Publications (TAPs) available at <http://store.samhsa.gov/list/series?name=Technical-Assistance-Publications-TAPs-&pageNumber=1>
 - 2.8.7.4. The Requirements in Exhibit A-1.
- 2.9. Client Education
 - 2.9.1. The Contractor shall offer to all eligible clients receiving services under this contract, individual or group education on prevention, treatment, and nature of:
 - 2.9.1.1. Hepatitis C Virus (HCV).
 - 2.9.1.2. Human Immunodeficiency Virus (HIV).
 - 2.9.1.3. Sexually Transmitted Diseases (STD).
 - 2.9.1.4. Tobacco Treatment Tools that include:
 - 2.9.1.4.1. Assessing clients for motivation in stopping the use of tobacco products;
 - 2.9.1.4.2. Offering resources such as but not limited to the Department's Tobacco Prevention & Control Program (TPCP) and the certified tobacco cessation counselors available through the QuitLine.
- 2.10. Tobacco Free Environment
 - 2.10.1. The Contractor shall ensure a tobacco-free environment by having policies and procedures that at a minimum:
 - 2.10.1.1. Include the smoking of any tobacco product, the use of oral tobacco products or "spit" tobacco, and the use of electronic devices;
 - 2.10.1.2. Apply to employees, clients and employee or client visitors;
 - 2.10.1.3. Prohibit the use of tobacco products within the Contractor's facilities at any time.



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- 2.10.1.4. Prohibit the use of tobacco in any Contractor owned vehicle.
- 2.10.1.5. Include whether or not use of tobacco products is prohibited outside of the facility on the grounds.
- 2.10.1.6. Include the following if use of tobacco products is allowed outside of the facility on the grounds:
 - 2.10.1.6.1. A designated smoking area(s) which is located at least twenty (20) feet from the main entrance.
 - 2.10.1.6.2. All materials used for smoking in this area, including cigarette butts and matches, shall be extinguished and disposed of in appropriate containers.
 - 2.10.1.6.3. Ensure periodic cleanup of the designated smoking area.
 - 2.10.1.6.4. If the designated smoking area is not properly maintained, it can be eliminated at the discretion of the Contractor.
- 2.10.1.7. Prohibit tobacco use in any company vehicle.
- 2.10.1.8. Prohibit tobacco use in personal vehicles when transporting people on authorized business.
- 2.10.2. The Contractor shall post the tobacco free environment policy in the Contractor's facilities and vehicles and included in employee, client, and visitor orientation.
- 2.10.3. The Contractor shall not use tobacco use, in and of itself, as grounds for discharging clients from services being provided under this contract.

3. Staffing

- 3.1. The Contractor shall meet the minimum staffing requirements to provide the scope of work in this contract as follows:
 - 3.1.1. At least one licensed supervisor, defined as:
 - 3.1.1.1. Masters Licensed Alcohol and Drug Counselor (MLADC);
 - 3.1.1.2. Licensed Alcohol and Drug Counselor (LADC) who also holds the Licensed Clinical Supervisor (LCS) credential; or
 - 3.1.1.3. Licensed mental health provider.
 - 3.1.2. Sufficient staffing levels that are appropriate for the services provided and the number of clients served including but not limited to:
 - 3.1.2.1. Licensed counselors defined as MLADCS, LADCs and individuals licensed by the Board of Mental Health Practice or Board of Psychology. Licensed counselors may deliver any clinical or recovery support services within their scope of practice.
 - 3.1.2.2. Unlicensed counselors defined as individuals who have completed the required coursework for licensure by the Board of Alcohol and Other



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- Drug Use Providers, Board of Mental Health Practice or Board of Psychology and are working to accumulate the work experience required for licensure. Unlicensed counselors may deliver any clinical or recovery support services within their scope of knowledge provided that they are under the direct supervision of a licensed supervisor.
- 3.1.2.3. Certified Recovery Support workers (CRSWs) who may deliver intensive case management and other recovery support services within their scope of practice provided that they are under the direct supervision of a licensed supervisor.
 - 3.1.2.4. Uncertified recovery support workers defined as individuals who are working to accumulate the work experience required for certification as a CRSW who may deliver intensive case management and other recovery support services within their scope of knowledge provided that they are under the direct supervision of a licensed supervisor.
- 3.1.3. No licensed supervisor shall supervise more than twelve staff unless the Department has approved an alternative supervision plan (See Exhibit A-1 Section 8.1.2).
- 3.1.4. Provide ongoing clinical supervision that occurs at regular intervals in accordance with the Operational Requirements in Exhibit A-1. and evidence based practices, at a minimum:
- 3.1.4.1. Weekly discussion of cases with suggestions for resources or therapeutic approaches, co-therapy, and periodic assessment of progress;
 - 3.1.4.2. Group supervision to help optimize the learning experience, when enough candidates are under supervision;
- 3.2. The Contractor shall provide training to staff on:
- 3.2.1. Knowledge, skills, values, and ethics with specific application to the practice issues faced by the supervisee;
 - 3.2.2. The 12 core functions;
 - 3.2.3. The Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice, available at <http://store.samhsa.gov/product/TAP-21-Addiction-Counseling-Competencies/SMA15-4171> and
 - 3.2.4. The standards of practice and ethical conduct, with particular emphasis given to the counselor's role and appropriate responsibilities, professional boundaries, and power dynamics and appropriate information security and confidentiality practices for handling protected health information (PHI) and substance use disorder treatment records as safeguarded by 42 CFR Part 2.
- 3.3. The Contractor shall notify the Department, in writing of changes in key personnel and provide, within five (5) working days to the Department, updated resumes that clearly indicate the staff member is employed by the Contractor. Key personnel are those staff



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

for whom at least 10% of their work time is spent providing substance use disorder treatment and/or recovery support services.

- 3.4. The Contractor shall notify the Department in writing within one month of hire when a new administrator or coordinator or any staff person essential to carrying out this scope of services is hired to work in the program. The Contractor shall provide a copy of the resume of the employee, which clearly indicates the staff member is employed by the Contractor, with the notification.
- 3.5. The Contractor shall notify the Department in writing within 14 calendar days, when there is not sufficient staffing to perform all required services for more than one month.
- 3.6. The Contractor shall have policies and procedures related to student interns to address minimum coursework, experience and core competencies for those interns having direct contact with individuals served by this contract. Additionally, The Contractor shall have student interns complete an approved ethics course and an approved course on the 12 core functions and the Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice in Section 3.2.2, and appropriate information security and confidentiality practices for handling protected health information (PHI) and substance use disorder treatment records as safeguarded by 42 CFR Part 2 prior to beginning their internship.
- 3.7. The Contractor shall have unlicensed staff complete an approved ethics course and an approved course on the 12 core functions and the Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice in Section 3.2.2, and information security and confidentiality practices for handling protected health information (PHI) and substance use disorder treatment records as safeguarded by 42 CFR Part 2 within 6 months of hire.
- 3.8. The Contractor shall ensure staff receives continuous education in the ever changing field of substance use disorders. and state and federal laws, and rules relating to confidentiality
- 3.9. The Contractor shall provide in-service training to all staff involved in client care within 15 days of the contract effective date or the staff person’s start date, if after the contract effective date, and at least annually thereafter on the following:
 - 3.9.1. The contract requirements.
 - 3.9.2. All other relevant policies and procedures provided by the Department.
- 3.10. The Contractor shall provide in-service training or ensure attendance at an approved training by the Department to clinical staff on hepatitis C (HCV), human immunodeficiency virus (HIV), tuberculosis (TB) and sexually transmitted diseases (STDs) annually. The Contractor shall provide the Department with a list of trained staff.

4. Facilities License

- 4.1. The Contractor shall be licensed for all residential services provided with the Department’s Health Facilities Administration.



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- 4.2. The Contractor shall comply with the additional licensing requirements for medically monitored, residential withdrawal management services by the Department's Bureau of Health Facilities Administration to meet higher facilities licensure standards.
- 4.3. The Contractor is responsible for ensuring that the facilities where services are provided meet all the applicable laws, rules, policies, and standards.

5. Web Information Technology

- 5.1. The Contractor shall use the Web Information Technology System (WITS) or an alternative electronic health record approved by the Department to record all client activity and client contact within (3) days following the activity or contact as directed by the Department.
- 5.2. The Contractor shall, before providing services, obtain written informed consent from the client on the consent form provided by the Department.
 - 5.2.1. Any client refusing to sign the informed consent in 5.2:
 - 5.2.1.1. Shall not be entered into the WITS system; and
 - 5.2.1.2. Shall not receive services under this contract.
 - 5.2.1.2.1. Any client who cannot receive services under this contract pursuant to Section 5.2.4. shall be assisted in finding alternative payers for the required services.
- 5.3. The Contractor agrees to the Information Security Requirements Exhibit K.
- 5.4. The WITS system shall only be used for clients who are in a program that is funded by or under the oversight of the Department.

6. Reporting

- 6.1. The Contractor shall report on the following:
 - 6.1.1. National Outcome Measures (NOMs) data in WITS for:
 - 6.1.1.1. 100% of all clients at admission
 - 6.1.1.2. 100% of all clients who are discharged because they have completed treatment or transferred to another program
 - 6.1.1.3. 50% of all clients who are discharged for reasons other than those specified above in Section 6.1.1.2.
 - 6.1.1.4. The above NOMs in Section 6.1.1.1 through 6.1.1.3 are minimum requirements and the Contractor shall attempt to achieve greater reporting results when possible.
 - 6.1.2. Monthly and quarterly contract compliance reporting no later than the 10th day of the month following the reporting month or quarter;



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- 6.1.3. All critical incidents to the bureau in writing as soon as possible and no more than 24 hours following the incident. The Contractor agrees that:
 - 6.1.3.1. “Critical incident” means any actual or alleged event or situation that creates a significant risk of substantial or serious harm to physical or mental health, safety, or well- being, including but not limited to:
 - 6.1.3.1.1. Abuse;
 - 6.1.3.1.2. Neglect;
 - 6.1.3.1.3. Exploitation;
 - 6.1.3.1.4. Rights violation;
 - 6.1.3.1.5. Missing person;
 - 6.1.3.1.6. Medical emergency;
 - 6.1.3.1.7. Restraint; or
 - 6.1.3.1.8. Medical error.
- 6.1.4. All contact with law enforcement to the bureau in writing as soon as possible and no more than 24 hours following the incident;
- 6.1.5. All Media contacts to the bureau in writing as soon as possible and no more than 24 hours following the incident;
- 6.1.6. Sentinel events to the Department as follows:
 - 6.1.6.1. Sentinel events shall be reported when they involve any individual who is receiving services under this contract;
 - 6.1.6.2. Upon discovering the event, the Contractor shall provide immediate verbal notification of the event to the bureau, which shall include:
 - 6.1.6.2.1. The reporting individual’s name, phone number, and agency/organization;
 - 6.1.6.2.2. Name and date of birth (DOB) of the individual(s) involved in the event;
 - 6.1.6.2.3. Location, date, and time of the event;
 - 6.1.6.2.4. Description of the event, including what, when, where, how the event happened, and other relevant information, as well as the identification of any other individuals involved;
 - 6.1.6.2.5. Whether the police were involved due to a crime or suspected crime; and
 - 6.1.6.2.6. The identification of any media that had reported the event;



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- 6.1.6.3. Within 72 hours of the sentinel event, the Contractor shall submit a completed "Sentinel Event Reporting Form" (February 2017), available at <https://www.dhhs.nh.gov/dcbcs/documents/reporting-form.pdf> to the bureau
 - 6.1.6.4. Additional information on the event that is discovered after filing the form in Section 6.1.6.3. above shall be reported to the Department, in writing, as it becomes available or upon request of the Department; and
 - 6.1.6.5. Submit additional information regarding Sections 6.1.6.1 through 6.1.6.4 above if required by the department; and
 - 6.1.6.6. Report the event in Sections 6.1.6.1 through 6.1.6.4 above, as applicable, to other agencies as required by law.
- 6.2. For room and board payments associated with Medicaid clients with OUD, the Contractor shall coordinate client data and services with the Doorways to ensure that each client served has a Government Performance and Results Modernization Act (GPRA) interview completed at intake, three (3) months, six (6) months, and discharge.
- 6.3. The Contractor shall coordinate all services delivered to Medicaid clients with OUD for whom the contractor is receiving room and board payments for with the Doorways including, but not limited to accepting referrals and clinical evaluation results for level of care placement directly from the Doorways.

7. Quality Improvement

- 7.1. The Contractor shall participate in all quality improvement activities to ensure the standard of care for clients, as requested by the Department, such as, but not limited to:
- 7.1.1. Participation in electronic and in-person client record reviews
 - 7.1.2. Participation in site visits
 - 7.1.3. Participation in training and technical assistance activities as directed by the Department.
- 7.2. The Contractor shall monitor and manage the utilization levels of care and service array to ensure services are offered through the term of the contract to:
- 7.2.1. Maintain a consistent service capacity for Substance Use Disorder Treatment and Recovery Support Services statewide by:
 - 7.2.1.1. Monitoring the capacity such as staffing and other resources to consistently and evenly deliver these services; and
 - 7.2.1.2. Monitoring no less than monthly the percentage of the contract funding expended relative to the percentage of the contract period that has elapsed. If there is a difference of more than 10% between expended funding and elapsed time on the contract the Contractor shall notify the Department within 5 days and submit a plan for correcting the discrepancy within 10 days of notifying the Department.



New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services

Exhibit A, Amendment #2

8. Maintenance of Fiscal Integrity

8.1. In order to enable DHHS to evaluate the Contractor's fiscal integrity, the Contractor agrees to submit to DHHS monthly, the Balance Sheet, Profit and Loss Statement, and Cash Flow Statement for the Contractor. The Profit and Loss Statement shall include a budget column allowing for budget to actual analysis. Statements shall be submitted within thirty (30) calendar days after each month end. The Contractor shall be evaluated on the following:

8.1.1. Days of Cash on Hand:

8.1.1.1. Definition: The days of operating expenses that can be covered by the unrestricted cash on hand.

8.1.1.2. Formula: Cash, cash equivalents and short term investments divided by total operating expenditures, less depreciation/amortization and in-kind plus principal payments on debt divided by days in the reporting period. The short-term investments as used above shall mature within three (3) months and should not include common stock.

8.1.1.3. Performance Standard: The Contractor shall have enough cash and cash equivalents to cover expenditures for a minimum of thirty (30) calendar days with no variance allowed.

8.1.2. Current Ratio:

8.1.2.1. Definition: A measure of the Contractor's total current assets available to cover the cost of current liabilities.

8.1.2.2. Formula: Total current assets divided by total current liabilities.

8.1.2.3. Performance Standard: The Contractor shall maintain a minimum current ratio of 1.5:1 with 10% variance allowed.

8.1.3. Debt Service Coverage Ratio:

8.1.3.1. Rationale: This ratio illustrates the Contractor's ability to cover the cost of its current portion of its long-term debt.

8.1.3.2. Definition: The ratio of Net Income to the year to date debt service.

8.1.3.3. Formula: Net Income plus Depreciation/Amortization Expense plus Interest Expense divided by year to date debt service (principal and interest) over the next twelve (12) months.

8.1.3.4. Source of Data: The Contractor's Monthly Financial Statements identifying current portion of long-term debt payments (principal and interest).

8.1.3.5. Performance Standard: The Contractor shall maintain a minimum standard of 1.2:1 with no variance allowed.

8.1.4. Net Assets to Total Assets:



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- 8.1.4.1. Rationale: This ratio is an indication of the Contractor's ability to cover its liabilities.
 - 8.1.4.2. Definition: The ratio of the Contractor's net assets to total assets.
 - 8.1.4.3. Formula: Net assets (total assets less total liabilities) divided by total assets.
 - 8.1.4.4. Source of Data: The Contractor's Monthly Financial Statements.
 - 8.1.4.5. Performance Standard: The Contractor shall maintain a minimum ratio of .30:1, with a 20% variance allowed.
- 8.2. In order to enable DHHS to evaluate the Contractor's fiscal integrity, the Contractor agrees to submit to DHHS monthly, the Balance Sheet, the Profit and Loss statement for the month and year-to-date for the agency and the Profit and Loss statement for the month and year-to-date for the program being funded with this contract.
- 8.3. In the event that the Contractor does not meet either:
- 8.3.1. The standard regarding Days of Cash on Hand and the standard regarding Current Ratio for two (2) consecutive months; or
 - 8.3.2. Three (3) or more of any of the Maintenance of Fiscal Integrity standards for three (3) consecutive months, then
 - 8.3.3. The Department may require that the Contractor meet with Department staff to explain the reasons that the Contractor has not met the standards.
 - 8.3.4. The Department may require the Contractor to submit a comprehensive corrective action plan within thirty (30) calendar days of notification that 8.2.1 and/or 8.2.2 have not been met.
 - 8.3.4.1. The Contractor shall update the corrective action plan at least every thirty (30) calendar days until compliance is achieved.
 - 8.3.4.2. The Contractor shall provide additional information to assure continued access to services as requested by the Department. The Contractor shall provide requested information in a timeframe agreed upon by both parties.
- 8.4. The Contractor shall inform the Department by phone and by email within twenty-four (24) hours of when any key Contractor staff learn of any actual or likely litigation, investigation, complaint, claim, or transaction that may reasonably be considered to have a material financial impact on and/or materially impact or impair the ability of the Contractor to perform under this Agreement with the Department.
- 8.5. The monthly Balance Sheet, Profit & Loss Statement, Cash Flow Statement, and all other financial reports shall be based on the accrual method of accounting and include the Contractor's total revenues and expenditures whether or not generated by or resulting from funds provided pursuant to this Agreement. These reports are due within thirty (30) calendar days after the end of each month.

9. Performance Measures



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

The following performance measures are required for client services rendered from SOR funding only.

- 9.1. The Contractor shall ensure that 100% of clients receiving room and board payments under this contract that enter care directly through the Contractor who consent to information sharing with the Doorways receive a Hub referral for ongoing care coordination.
- 9.2. The Contractor shall ensure that 100% of clients referred to them by the Doorways who shall be covered by room and board payments under this contract have proper consents in place for transfer of information for the purposes of data collection between the Doorways and the Contractor.

The following performance measures are required for client services rendered from all sources of funds.

- 9.3. The Contractor’s contract performance shall be measured as in Section 9.5 below to evaluate that services are mitigating negative impacts of substance misuse, including but not limited to the opioid epidemic and associated overdoses.
- 9.4. For the first year of the contract only, the data, as collected in WITS, shall be used to assist the Department in determining the benchmark for each measure below. The Contractor agrees to report data in WITS used in the following measures:
 - 9.4.1. Initiation: % of clients accessing services within 14 days of screening;
 - 9.4.2. Engagement: % of clients receiving 3 or more eligible services within 34 days;
 - 9.4.3. Retention: % of clients receiving 6 or more eligible services within 60 days;
 - 9.4.4. Clinically appropriate services: % of clients receiving ASAM level of care within 30 days;
 - 9.4.5. Treatment completion: % of clients completing treatment; and
 - 9.4.6. National Outcome Measures (NOMS) The % of clients out of all clients discharged meeting at least 3 out of 5 NOMS outcome criteria:
 - 9.4.6.1. Reduction in /no change in the frequency of substance use at discharge compared to date of first service
 - 9.4.6.2. Increase in/no change in number of individuals employed or in school at date of last service compared to first service
 - 9.4.6.3. Reduction in/no change in number of individuals arrested in past 30 days from date of first service to date of last service
 - 9.4.6.4. Increase in/no change in number of individuals that have stable housing at last service compared to first service
 - 9.4.6.5. Increase in/no change in number of individuals participating in community support services at last service compared to first service

10. Contract Compliance Audits



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit A, Amendment #2

- 10.1. In the event that the Contractor undergoes an audit by the Department, the Contractor agrees to provide a corrective action plan to the Department within thirty (30) days from the date of the final findings which addresses any and all findings.
- 10.2. The Contractor shall ensure the corrective action plan shall include:
 - 10.2.1. The action(s) that shall be taken to correct each deficiency;
 - 10.2.2. The action(s) that shall be taken to prevent the reoccurrence of each deficiency;
 - 10.2.3. The specific steps and time line for implementing the actions above;
 - 10.2.4. The plan for monitoring to ensure that the actions above are effective; and
 - 10.2.5. How and when the vendor shall report to the Department on progress on implementation and effectiveness.



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit B, Amendment #2

Method and Conditions Precedent to Payment

1. The State shall pay the Contractor an amount not to exceed the Price Limitation, Block 1.8, of the General Provisions, for the services provided by the Contractor pursuant to Exhibit A, Scope of Services.
2. This Agreement is funded by:
 - 2.1. New Hampshire General Funds;
 - 2.2. Governor's Commission on Alcohol and Drug Abuse Prevention, Treatment, and Recovery Funds;
 - 2.3. Federal Funds from the United States Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration, Substance Abuse Prevention and Treatment Block Grant (CFDA #93.959);
 - 2.4. Federal funds from the United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration State Opioid Response Grant (CFDA #93.788) and
 - 2.5. The Contractor agrees to provide the services in Exhibit A, Scope of Services in compliance with the federal funding requirements.
3. Non Reimbursement for Services
 - 3.1. The State shall not reimburse the Contractor for services provided through this contract when a client has or may have an alternative payer for services described the Exhibit A, Scope of Work, such as but not limited to:
 - 3.1.1. Services covered by any New Hampshire Medicaid programs for clients who are eligible for New Hampshire Medicaid
 - 3.1.2. Services covered by Medicare for clients who are eligible for Medicare
 - 3.1.3. Services covered by the client's private insurer(s) at a rate greater than the Contract Rate in Exhibit B-1 Amendment #2, Service Fee set by the Department.
 - 3.2. Notwithstanding Section 3.1 above, the Contractor may seek reimbursement from the State for services provided under this contract when a client needs a service that is not covered by the payers listed in Section 3.1.
 - 3.3. Payments **may** be withheld until the Contractor submits accurate required monthly and quarterly reporting.
 - 3.4. Notwithstanding Section 3.1 above, when payment of the deductible or copay would constitute a financial hardship for the client, the Contractor must seek reimbursement from the State for that deductible based on the sliding fee scale, not to exceed \$4,000 per client per treatment episode.



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit B, Amendment #2

3.4.1. For the purposes of this section, financial hardship is defined as the client's monthly household income being less than the deductible plus the Federally-defined monthly cost of living (COL).

3.4.1.1. If the individual owns a vehicle:

	Family Size				
	1	2	3	4	5+
Monthly COL	\$ 3,119.90	\$ 3,964.90	\$ 4,252.10	\$ 4,798.80	\$ 4,643.90

3.4.1.2. If the individual does not own a vehicle:

	Family Size				
	1	2	3	4	5
Monthly COL	\$ 2,570.90	\$ 3,415.90	\$ 3,703.10	\$ 4,249.80	\$ 4,643.90

4. The Contractor shall bill and seek reimbursement for actual services delivered by fee for services in Exhibit B-1, Amendment #2 Service Fee Table, unless otherwise stated. The Contractor agrees:

4.1. The fees for services, excluding Clinical Evaluation, are all-inclusive contract rates to deliver the services and are the maximum allowable charge in calculating the amount to charge the Department for services delivered as part of this Agreement (See Section 5 below).

4.2. To bill for Clinical Evaluation services separately from all other per day units of services.

4.3. Payments may be withheld until the Contractor submits accurate required monthly and quarterly reporting.

5. Calculating the Amount to Charge the Department Applicable to All Services in Exhibit B-1, Amendment #2 Service Fee Table.

5.1. The Contractor shall:

5.1.1. Directly bill and receive payment for services and/or transportation provided under this contract from public and private insurance plans, the clients, and the Department

5.1.2. Assure a billing and payment system that enables expedited processing to the greatest degree possible in order to not delay a client's admittance into the program and to immediately refund any overpayments.

5.1.3. Maintain an accurate accounting and records for all services billed, payments received and overpayments (if any) refunded.



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit B, Amendment #2

- 5.2. The Contractor shall determine and charge accordingly for services provided to an eligible client under this contract, as follows:
- 5.2.1. First: Charge the client's private insurance up to the Contract Rate, in Exhibit B-1, Amendment #2 when the insurers' rates meet or are lower than the Contract Rate in Exhibit B-1 Amendment #2.
 - 5.2.2. Second: Charge the client according to Exhibit B, Amendment #3, Section 9, Sliding Fee Scale, when the Contractor determines or anticipates that the private insurer shall not remit payment for the full amount of the Contract Rate in Exhibit B-1, Amendment #2.
 - 5.2.3. Third: If, any portion of the Contract Rate in Exhibit B-1 Amendment #2 remains unpaid, after the Contractor charges the client's insurer, if applicable, and the client then the Contractor shall charge the Department the balance, which is the Contract Rate in Exhibit B-1 Amendment #2, Service Fee Table less the amount paid by private insurer and the amount paid by the client, unless the client's copay or deductible is charged to the Department in accordance with 3.3 above.
- 5.3. The Contractor agrees the amount charged to the client shall not exceed the Contract Rate in Exhibit B-1, Amendment #2 Service Fee Table multiplied by the corresponding percentage stated in Exhibit B, Amendment #3, Section 9 Sliding Fee Scale for the client's applicable income level.
- 5.4. The Contractor shall assist clients who are unable to secure financial resources necessary for initial entry into the program by developing payment plans.
- 5.5. The Contractor shall not deny, delay or discontinue services for enrolled clients who do not pay their fees in Section 5.2.2 above, until after working with the client as in Section 5.4 above, and only when the client fails to pay their fees within thirty (30) days after being informed in writing and counseled regarding financial responsibility and possible sanctions including discharge from treatment.
- 5.6. The Contractor shall provide to clients, upon request, copies of their financial accounts.
- 5.7. The Contractor shall not charge the combination of the public or private insurer, the client and the Department an amount greater than the Contract Rate in Exhibit B-1, Amendment #2 except for:
- 5.7.1. Transitional Living, See Section 7 below and
 - 5.7.2. Low-Intensity Residential Treatment as defined as ASAM Criteria, Level 3.1. See Section 7 below.
- 5.8. In the event of an overpayment, wherein the combination of all payments received by the Contractor for a given service (except in Exhibit B, Amendment #3, Section 5.7.1 and 5.7.2) exceeds the Contract Rate stated in Exhibit B-1 Amendment #2, Service Fee Table, the Contractor shall refund the parties in the reverse order, unless the overpayment was due to insurer, client or Departmental error.



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit B, Amendment #2

- 5.9. In instances of payer error, the Contractor shall refund the party who erred, and adjust the charges to the other parties, according to a correct application of the Sliding Fee Schedule.
- 5.10. In the event of overpayment as a result of billing the Department under this contract when a third party payer would have covered the service, the Contractor must repay the state in an amount and within a timeframe agreed upon between the Contractor and the Department upon identifying the error.
6. Additional Billing information for: Room and Board for Medicaid clients with Opioid Use Disorder (OUD) in residential level of care.
- 6.1. The Contractor shall invoice the Department for Room and Board payments up to \$100/day for Medicaid clients with OUD in residential level of care.
- 6.2. With the exception of room and board payments for transitional living, the Contractor shall not bill the Department for Room and Board payments in excess of **\$826,000**.
- 6.3. The Contractor shall maintain documentation of the following:
- 6.3.1. Medicaid ID of the Client;
 - 6.3.2. WITS ID of the Client (if applicable)
 - 6.3.3. Period for which room and board payments cover;
 - 6.3.4. Level of Care for which the client received services for the date range identified in 6.3.3
 - 6.3.5. Amount being billed to the Department for the service
- 6.4. The Contractor shall submit an invoice by the twentieth (20th) day of each month, which identifies and requests reimbursement for authorized expenses incurred for room and board in the prior month. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice for Contractor services provided pursuant to this Agreement. Invoices must be submitted in a Department approved manner.
- 6.5. The Contractor shall ensure that clients receiving services rendered from SOR funds have a documented history of/or current diagnoses of Opioid Use Disorder.
- 6.6. The Contractor shall coordinate ongoing client care for all clients with documented history of/or current diagnoses of Opioid Use Disorder, receiving services rendered from SOR funds, with Doorways in accordance with 42 CFR Part 2.
7. Charging the Client for Room and Board for Transitional Living and Low Intensity Residential Services
- 7.1. The Contractor may charge the client fees for room and board, in addition to:
- 7.1.1. The client's portion of the Contract Rate in Exhibit B-1, Amendment #2 using the sliding fee scale
 - 7.1.2. The charges to the Department



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit B, Amendment #2

7.2. The Contractor may charge the client for Room and Board, inclusive of lodging and meals offered by the program according to the Table A below:

Table A	
If the percentage of Client's income of the Federal Poverty Level (FPL) is:	Then the Contractor may charge the client up to the following amount for room and board per week:
0%-138%	\$0
139% - 149%	\$8
150% - 199%	\$12
200% - 249%	\$25
250% - 299%	\$40
300% - 349%	\$57
350% - 399%	\$77

7.3. The Contractor shall hold 50% of the amount charged to the client that shall be returned to the client at the time of discharge.

7.4. The Contractor shall maintain records to account for the client's contribution to room and board.

8. Charging for Clinical Services under Transitional Living

8.1. The Contractor shall charge for clinical services separately from this contract to the client's other third party payers such as Medicaid, NHHPP, Medicare, and private insurance. The Contractor shall not charge the client according to the sliding fee scale.

8.2. Notwithstanding Section 8.1 above, the Contractor may charge in accordance with Sections 5.2.2 and 5.2.3 above for clinical services under this contract only when the client does not have any other payer source other than this contract.

9. Additional Billing Information: Intensive Case Management Services:

9.1. The Contractor shall charge in accordance with Section 5 above for intensive case management under this contract only for clients who have been admitted to programs in accordance to Exhibit A, Scope of Services and after billing other public and private insurance.

9.2. The Department will not pay for intensive case management provided to a client prior to admission.

9.3. The Contractor will bill for intensive case management only when the service is authorized by the Department.



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit B, Amendment #2

-
10. Additional Billing Information: Transportation
- 10.1. The Contractor will seek reimbursement in accordance with Section 5 above and upon prior approval of the Department for Transportation provided in Exhibit A Scope of Services Section 2.4.2.2 as follows:
- 10.1.1. At Department's standard per mile rate plus an hourly rate in accordance with Exhibit B-1 Service Fee Table for Contractor's staff driving time, when using the Contractor's own vehicle for transporting clients to and from services required by the client's treatment plan. If the Contractor's staff works less than a full hour, then the hourly rate will be prorated at fifteen (15) minute intervals for actual work completed; or.
- 10.1.2. 9.1.2. At the actual cost to purchase transportation passes or to pay for cab fare, in order for the client to receive transportation to and from services required by the client's treatment plan.
- 10.2. The Contractor shall keep and maintain records and receipts to support the cost of transportation and provide said records and receipts to the Department upon request.
- 10.3. The Contractor will invoice the Department according to Department instructions.
11. Additional Billing Information: Child Care
- 11.1. The Contractor shall seek reimbursement upon prior approval of the Department for Childcare provided in Exhibit A Scope of Services, Section 2.4.2.3 as follows:
- 11.1.1. At the hourly rate in Exhibit B-1 Service Fee Table for when the Contractor's staff provides child care while the client is receiving treatment or recovery support services, or
- 11.1.2. At the actual cost to purchase childcare from a licensed child care provider.
- 11.2. The Contractor shall keep and maintain records and receipts to support the cost of childcare and provide these to the Department upon request.
- 11.3. The Contractor will invoice the Department according to Department instructions.
12. Additional Billing Information for: Integrated Medication Assisted Treatment (MAT)
- 12.1. The Contractor shall invoice the Department for Integrated Medication Assisted Treatment Services for Medication and Physician Time as in Section 5 above and as follows:



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit B, Amendment #2

12.2. Medication:

- 12.2.1. The Contractor shall seek reimbursement for the Medication Assisted Treatment medication based on the Contractor's usual and customary charges according to Revised Statutes Annotated (RSA) 126-A:3 III. (b), except for Section 6.2.2 below.
- 12.2.2. The Contractor will be reimbursed for Medication Assisted Treatment with Methadone or Buprenorphine in a certified Opiate Treatment Program (OTP) per New Hampshire Administrative Rule He-A 304 as follows:
 - 12.2.2.1. The Contractor shall seek reimbursement for Methadone or Buprenorphine based on the Medicaid rate, up to 7 days per week. The code for Methadone in an OTP is H0020, and the code for buprenorphine in an OTP is H0033.
- 12.2.3. The Contractor shall seek reimbursement for up to 3 doses per client per day.
- 12.2.4. The Contractor shall maintain documentation of the following:
 - 12.2.4.1. WITS Client ID #;
 - 12.2.4.2. Period for which prescription is intended;
 - 12.2.4.3. Name and dosage of the medication;
 - 12.2.4.4. Associated Medicaid Code;
 - 12.2.4.5. Charge for the medication.
 - 12.2.4.6. Client cost share for the service; and
 - 12.2.4.7. Amount being billed to the Department for the service.

12.3. Physician Time:

- 12.3.1. Physician Time is the time spent by a physician or other medical professional to provide Medication Assisted Treatment Services, including but not limited to assessing the client's appropriateness for a medication, prescribing and/or administering a medication, and monitoring the client's response to a medication.
- 12.3.2. The Contractor shall seek reimbursement according to Exhibit B-1 Service Fee Table.



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit B, Amendment #2

12.3.3. The Contractor shall maintain documentation of the following:

- 12.3.3.1. WITS Client ID #;
- 12.3.3.2. Date of Service;
- 12.3.3.3. Description of service;
- 12.3.3.4. Associated Medicaid Code;
- 12.3.3.5. Charge for the service;
- 12.3.3.6. Client cost share for the service; and
- 12.3.3.7. Amount being billed to the Department for the service.

12.3.4. The Contractor will submit an invoice by the twentieth (20th) day of each month, which identifies and requests reimbursement for authorized expenses incurred for medication assisted treatment in the prior month.

12.3.5. The State shall make payment to the Contractor within thirty (30) days of receipt of each invoice for Contractor services provided pursuant to this Agreement. Invoices must be submitted utilizing the WITS system.

13. Sliding Fee Scale

13.1. The Contractor shall apply the sliding fee scale in accordance with Exhibit B, Amendment #3, Section 5, above.

13.2. The Contractor shall adhere to the sliding fee scale as follows:

Percentage of Client's income of the Federal Poverty Level (FPL)	Percentage of Contract Rate in Exhibit B-1 to Charge the Client
0%-138%	0%
139% - 149%	8%
150% - 199%	12%
200% - 249%	25%
250% - 299%	40%
300% - 349%	57%
350% - 399%	77%



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit B, Amendment #2

- 13.3. The Contractor shall not deny a child under the age of 18 services because of the parent's unwillingness to pay the fee or the minor child's decision to receive confidential services pursuant to RSA 318-B:12-a.
14. Submitting Charges for Payment
- 14.1. The Contractor shall submit billing through the Website Information Technology System (WITS) for services listed in Exhibit B-1, Amendment #2 Service Fee Table. The Contractor shall:
- 14.1.1. Enter encounter note(s) into WITS no later than three (3) days after the date the service was provided to the client
 - 14.1.2. Review the encounter notes no later than twenty (20) days following the last day of the billing month, and notify the Department that encounter notes are ready for review.
 - 14.1.3. Correct errors, if any, in the encounter notes as identified by the Department no later than seven (7) days after being notified of the errors and notify the Department the notes have been corrected and are ready for review.
 - 14.1.4. Batch and transmit the encounter notes upon Department approval for the billing month.
 - 14.1.5. Submit separate batches for each billing month.
- 14.2. The Contractor agrees that billing submitted for review after sixty (60) days of the last day of the billing month may be subject to non-payment.
- 14.3. To the extent possible, the Contractor shall bill for services provided under this contract through WITS. For any services that are unable to be billed through WITS, the contractor shall work with the Department to develop an alternative process for submitting invoices.
- 14.4. The Contractor shall only bill room and board for SUD clients with Opioid Use Disorder that are Medicaid coded for both residential and transitional living services.
15. Funds in this contract may not be used to replace funding for a program already funded from another source.
16. The Contractor shall keep detailed records of their activities related to Department-funded programs and services.
17. Notwithstanding anything to the contrary herein, the Contractor agrees that funding under this agreement may be withheld, in whole or in part, in the event of non-compliance with any Federal or State law, rule or regulation applicable to the services provided, or if the said services or products have not been satisfactorily completed in accordance with the terms and conditions of this agreement.
18. The Contractor shall submit final invoices to the Department no later than forty-five (45) days after the contract completion date.



**New Hampshire Department of Health and Human Services
Substance Use Disorder Treatment and Recovery Support Services**

Exhibit B, Amendment #2

-
19. The Contractor shall ensure any adjustments to a prior invoices are submitted with the original invoice, adjusted invoice and supporting documentation to justify the adjustment.
20. Limitations and restrictions of federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds
- 20.1. The Contractor agrees to use the SAPT funds as the payment of last resort.
- 20.2. The Contractor agrees to the following funding restrictions on SAPT Block Grant expenditures to:
- 20.2.1. Make cash payments to intended recipients of substance abuse services.
- 20.2.2. Expend more than the amount of Block Grant funds expended in Federal Fiscal Year 1991 for treatment services provided in penal or correctional institutions of the State.
- 20.2.3. Use any federal funds provided under this contract for the purpose of conducting testing for the etiologic agent for Human Immunodeficiency Virus (HIV) unless such testing is accompanied by appropriate pre and post-test counseling.
- 20.2.4. Use any federal funds provided under this contract for the purpose of conducting any form of needle exchange, free needle programs or the distribution of bleach for the cleaning of needles for intravenous drug abusers.
- 20.3. The Contractor agrees to the Charitable Choice federal statutory provisions as follows:

Federal Charitable Choice statutory provisions ensure that religious organizations are able to equally compete for Federal substance abuse funding administered by SAMHSA, without impairing the religious character of such organizations and without diminishing the religious freedom of SAMHSA beneficiaries (see 42 USC 300x-65 and 42 CFR Part 54 and Part 54a, 45 CFR Part 96, Charitable Choice Provisions and Regulations). Charitable Choice statutory provisions of the Public Health Service Act enacted by Congress in 2000 are applicable to the SAPT Block Grant program. No funds provided directly from SAMHSA or the relevant State or local government to organizations participating in applicable programs may be expended for inherently religious activities, such as worship, religious instruction, or proselytization. If an organization conducts such activities, it must offer them separately, in time or location, from the programs or services for which it receives funds directly from SAMHSA or the relevant State or local government under any applicable program, and participation must be voluntary for the program beneficiaries.

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? Yes No

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma⁵⁷ is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁵⁸ paper.

⁵⁷ Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

⁵⁸ *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? Yes No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? Yes No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? Yes No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? Yes No
5. Does the state have any activities related to this section that you would like to highlight.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁵⁹

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.⁶⁰

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

⁵⁹ Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Ren?e L. Binder. [OJJDP Model Programs Guide](#)

⁶⁰ <http://csgjusticecenter.org/mental-health/>

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? Yes No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? Yes No
3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? Yes No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? Yes No
5. Does the state have any activities related to this section that you would like to highlight?

NH's Juvenile Diversion Network has been successfully implementing a universal evidenced-based SBIRT process for all first-time offenders under the age of 17 who have been referred to the program. In calendar year 2017 New Hampshire diversion programs served 218 youth between the ages of 12-18 all of whom were screened for substance use and mental health, and received educational information, a brief intervention or a referral to other services if warranted (SBIRT). Using the Screening to Brief Intervention (S2BI) screening tool, over seventy percent (72.4%) screened positive for substance use; of those who screened positive, 55.6% were referred to primary care or other provider for additional substance misuse assessment. Without the SBIRT protocol in place these youth would not have been identified as needing additional services at this early stage in their substance misuse. For more information visit: <http://nhcourtdiversion.org/>

MAT for inmates in NHDOC paid by SOR funds. This includes care coordinators both for men and women to assist with integration back into the community. Naloxone kits have been provided by SOR funding to inmates being released out in the community.

The NH Governor's Commission on Alcohol and Other Drugs, through BDAS, funds community housing for criminal justice

involved individuals, as well as SUD services for juvenile justice-involved NH youth between 13 and 17 years of age who are placed at the Sununu Youth Services Center.

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? Yes No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? Yes No
3. Does the state purchase any of the following medication with block grant funds? Yes No
 - a) Methadone
 - b) Buprenorphine, Buprenorphine/naloxone
 - c) Disulfiram
 - d) Acamprosate
 - e) Naltrexone (oral, IM)
 - f) Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? Yes No

5. Does the state have any activities related to this section that you would like to highlight?

In 2016, we developed and published Guidance Document on Best Practices: Key Components for Delivering Community-Based Medication Assisted Treatment Services for Opioid Use Disorders in New Hampshire. In April of 2018, we published the updated second edition of this guidebook. <https://www.dhhs.nh.gov/dcbcs/bdas/documents/matguidancedoc.pdf>. We have widely distributed it and we provide it to all participants in waiver trainings. We also frequently reference it.

Bi-monthly MAT Community of Practice for staff working in an agency or practice providing MAT or interested in providing MAT.

Multiple practices have been involved in MAT ECHO projects.

The state contracts with the Foundation for Healthy Communities (an arm of the NH Hospital Association) to recruit and provide technical assistance to hospitals and their networked medical practices to initiate and implement MAT. They also provide quality assurance to the practices for the first year of their MAT implementation.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.⁶¹ SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)⁶²,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

⁶¹<http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

⁶²Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- a) Wellness Recovery Action Plan (WRAP) Crisis Planning
- b) Psychiatric Advance Directives
- c) Family Engagement
- d) Safety Planning
- e) Peer-Operated Warm Lines
- f) Peer-Run Crisis Respite Programs
- g) Suicide Prevention

2. Crisis Intervention/Stabilization

- a) Assessment/Triage (Living Room Model)
- b) Open Dialogue
- c) Crisis Residential/Respite
- d) Crisis Intervention Team/Law Enforcement
- e) Mobile Crisis Outreach
- f) Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- a) Peer Support/Peer Bridgers
- b) Follow-up Outreach and Support
- c) Family-to-Family Engagement
- d) Connection to care coordination and follow-up clinical care for individuals in crisis
- e) Follow-up crisis engagement with families and involved community members

f) Recovery community coaches/peer recovery coaches

g) Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? Yes No
- b) Required peer accreditation or certification? Yes No
- c) Block grant funding of recovery support services. Yes No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? Yes No

2. Does the state measure the impact of your consumer and recovery community outreach activity? Yes No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Please see NH's MHBG application for answers regarding SME and SED.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

NH subscribes to the SAMHSA definition of recovery and embraces all pathways to recovery. Recovery support services are available at many of our treatment centers. The state has 11 established Recovery Community Organizations (RCO) providing services at 14 Recovery Centers throughout the state with additional RCOs in development stages. These RCOs either meet CAPRSS standards or are in the process of meeting them. They are all peer-led and peer-run and locally governed. They all provide low barrier accessible PRSS, including Recovery Coaching and Telephone Recovery Support Services. New Hampshire's vibrant recovery community and growing capacity to deliver Peer-based Recovery Support Services are building bridges and saving lives. Recovery Coaches and RCO volunteers are helping people who have precious few resources available to them, assisting them in navigating toward self-directed lives in sustained recovery. Recovery Community Centers are proving to be valuable meeting places and offer a variety of wellness activities and connections to various communities of recovery. They also provide coaching and support to impacted family members and help them to connect to community Family Support Groups. Many of the RCOs also contract with local service organizations to provide outreach and peer recovery supports in a variety of settings, including medical practices, drug courts, treatment agencies, jails and businesses.

5. Does the state have any activities that it would like to highlight?

We have a credential for Certified Recovery Support Worker (CRSW) and provide frequent affordable training opportunities to achieve and maintain it as well as providing Recovery Coach trainings.

We support a quarterly PRSS Community of Practice that is open to anyone who provides or who would like to provide PRSS.

The state contracts with a Facilitating Organization who has made immense strides in developing a statewide system of RCOs, providing them with training and technical assistance, and assuring quality services.

The Recovery Task Force of the Governor's Commission (with significant representation of the recovery community) has input on state policy and funding decisions related to recovery.

Please indicate areas of technical assistance needed related to this section.

Practical approaches to providing PRSS for adolescents.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

- Does the state's Olmstead plan include :
 - Housing services provided. Yes No
 - Home and community based services. Yes No
 - Peer support services. Yes No
 - Employment services. Yes No
- Does the state have a plan to transition individuals from hospital to community settings? Yes No
- What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.⁶³ Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁶⁴ For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.⁶⁵

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁶⁶ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.⁶⁷

According to data from the 2015 Report to Congress⁶⁸ on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

⁶³Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

⁶⁴Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁶⁵Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁶⁶The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁶⁷Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

⁶⁸http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
 - a) The recovery and resilience of children and youth with SED? Yes No
 - b) The recovery and resilience of children and youth with SUD? Yes No
2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
 - a) Child welfare? Yes No
 - b) Juvenile justice? Yes No
 - c) Education? Yes No
3. Does the state monitor its progress and effectiveness, around:
 - a) Service utilization? Yes No
 - b) Costs? Yes No
 - c) Outcomes for children and youth services? Yes No
4. Does the state provide training in evidence-based:
 - a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Yes No
 - b) Mental health treatment and recovery services for children/adolescents and their families? Yes No
5. Does the state have plans for transitioning children and youth receiving services:
 - a) to the adult M/SUD system? Yes No
 - b) for youth in foster care? Yes No
6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)
7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
 State Vocational Rehabilitation Agency
 State Criminal Justice Agency
 State Housing Agency
 State Social Services Agency
 State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Melinda Bellanti	Others (Advocates who are not State employees or providers)			
Robin Brenner	Others (Advocates who are not State employees or providers)			
Kathleen Chambers	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Sandra Davidson	State Employees	NH DHHS Office of Medicaid Services		
Scott Garnett	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Molly Gray	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Deb Green	State Employees	NH Department of Corrections		
Denise Green	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Thomas Grinley	State Employees	NH DHHS BMHS Office of Client & Family Services		
Laura Harwood	Others (Advocates who are not State employees or providers)			
Martha Hewitt	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Brian Huckins	Others (Advocates who are not State employees or providers)	NAMI-NH		
Ken Lewis	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Lisa McCann	Others (Advocates who are not State employees or providers)			
Michelle Myler	State Employees	NH Dept. of Education		

Amy Parece-Grogan	State Employees	NH DHHS Office of Health Equity		
Sharon Reynolds	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Nicole Robbins	State Employees	NH DHHS Bureau of Homeless & Housing		
Ann Strachan	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Daryll Tenney	State Employees	NH DHHS DBH Bureau of Children's Behavioral Health		
Richard Wiggins	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	21	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	2	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	5	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	14	66.67%
State Employees	7	
Providers	0	
Vacancies	0	
Total State Employees & Providers	7	33.33%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
 - a) Public meetings or hearings? Yes No
 - b) Posting of the plan on the web for public comment? Yes No
If yes, provide URL:
Posted on the DHHS, Bureau of Drug and Alcohol Services website: <https://www.dhhs.nh.gov/dcbcs/bdas/sapt-grant.htm>
Posted in the Center for Excellence e-Newsletter: <http://nhcenterforexcellence.org/resources/newsletters/>
 - c) Other (e.g. public service announcements, print media) Yes No

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes: