STATE: New Hampshire

1. **Identify the needs and gaps of your state's mental health services continuum including prevention, intervention, access to crisis services, treatment, and recovery support services.**

New Hampshire has dedicated great efforts, with the assistance of Community Mental Health Block Grant funding, to establish a system of care that meets the needs of all New Hampshire citizens, and considers the unique demographics of the State and the respective challenges those demographics present. This demonstration of commitment to the timely and appropriate service of its residents has been demonstrated throughout many of its programs and initiatives successes, and drives forward the commitment of the Department to continue its work in expanding and growing this system.

In 2019, the New Hampshire Department of Health & Human Services submitted to the Governor, Senate President, and Speaker of the House a 10-Year Mental Health Plan (referenced as Plan hereafter) that provided goals of its mental health services system spread out through the next 10 years. These goals were developed by taking into considerations the recommendations that were made to bolster and expand the current system in order to address identified gaps. Areas of need identified in the Plan include:

Alternatives to Emergency Department and Centralize Access

New Hampshire has seen success in establishing crisis services in targeted regions of the state. A core goal of the Plan is to expand crisis intervention services and supports statewide and improve access to care through a centralized access point. Plans are underway to expand New Hampshire's mobile crisis services to be statewide and integrated (serving all ages with both mental health and substance use disorders). This expansion will also include the development of a single, statewide crisis access point that will serve as a single crisis call center that will provide phone based triage, intervention, and deployment of regional mobile crisis teams. The vision of this expansion is to align with the national 9-8-8 and Crisis Now model and will be implemented in a step-approach over the next 2 years to include the full continuum of call/text/chat, mobile, and location based crisis intervention. New Hampshire is still in the initial stage of implementation. Infrastructure investments are needed and it is evident that there is a need to expand stabilization services and develop a rural crisis response model for deployment and stabilization that will be practical and sustainable.

Suicide Prevention and Community Education

The Plan identified the need to coordinate suicide prevention efforts with the New Hampshire Suicide Prevention Council, the Department of Education (DOE), community mental health and substance use disorder service providers and advocacy organizations and be in line with the strategies outlined in the NH Suicide Prevention State Plan. Progress has been made but there is a significant need to conduct public outreach and education that follows national best practices of primary prevention. Additionally, as New Hampshire develops and expands services to meet the needs of its residents, we recognize that there has not been consistent marketing or advertising of such programs to aid residents in locating and accessing the services that they need. This is, in part, evidenced by the large numbers of individuals who first access the mental health system through hospital emergency rooms and/or the State hospital. With the promising growth of the service array, a messaging campaign has yet to be designed that will serve to alert and inform the public about what services are available and how to access them on a consistent basis. The Plan recognized this need in its goal of Community Education, focusing on ensuring that, as programs and initiatives develop, residents are

informed and know how to access those services. The goal includes launching a multi-media statewide campaign on what individuals can do to access services, recognize the signs of mental distress, suicide, and intervene. This also aligns with the goals established as part of the 9-8-8 implementation efforts to promote use of 9-8-8 and access to care.

Workforce Development & Infusion of Peers Throughout the System

Peers are essential to our system of care but New Hampshire does not have a robust peer workforce infrastructure or enough trained peers to meet the staffing demands. The Plan includes goals to integrate peers and natural supports through the continuum of care by expanding the availability of peers in practice settings through training and education. The Bureau worked with stakeholders to develop a Peer Advancement Work plan that outlines concrete recommendations needed to achieve this goal. The Workforce Advancement Plan was completed in May 2021 and an advisory board will convene in the fall 2021 to begin moving the recommendations forward.

Both the Bureau of Mental Health Services (Bureau) and The Bureau of Drug and Alcohol Services (BDAS) recognize that many of New Hampshire's residents experience mental illness with co-occurring substance use. To this address this reality, both Bureaus have historically worked in tandem to develop systems and services that meet the needs of all such residents experiencing co-occurring mental health and substance use disorders. Gaps continue to exist in large part due to workforce shortages and consequently strategies to cross-train the mental health and substance use workforce is needed. The Bureaus are committed to continuing this integrated work to develop systems and services that best serve the behavioral health needs of New Hampshire's citizens.

Expansion of Community Services and Housing Options

Housing is a significant barrier to recovery for many served through New Hampshire's mental health system so there is a need to address gaps that exist for permanent affordable housing. The Plan calls for an increase in bed capacity for expanded populations, including supervised housing for transition age youth, peer respite beds, crisis apartments, transitional housing and additional slots for the Housing Bridge subsidy program. There is not a centralized application process for individuals seeking mental health supported housing. Specifically the State's Housing Bridge Subsidy program that provides housing vouchers and housing support services to up to 500 individuals with severe mental illness while they await enrollment in a permanent housing voucher. There is a need to create a more accessible way for applications for the Housing Bridge program to be submitted, review, and tracked in order to expedite enrollment and more efficiently track peoples housing status over time.

The development of a data infrastructure and dashboard can assist in tracking all housing data. NH has been undergoing a multi-year data system overhaul to support the ongoing development of consistent data points, reporting, and utilization to inform our system as a whole. By investing in these platforms we can more consistently and effectively manage a multitude of programs in centrally located locations leading to more reliable and informative data.

Prevention and Early Intervention

Currently Early Severe Mental Illness/First Episode Psychosis (ESMI/FEP) is offered in one region of the state. As part of the effort to best support individuals who might be experiencing ESMI/FEP, the Bureau recognizes that services need to be available statewide. Efforts are underway to expand ESMI/FEP services to three additional regions. Infrastructure investments are needed such as provider training, technical assistance for teams to start programs in line with evidence-based practices, and targeted components of the model such as availability of family psychoeducation

statewide. In tandem with treatment programs, educating the public on what services are available and how to access them, is a core need.

In an effort to further address prevention and early intervention initiatives, New Hampshire's Infant Mental Health Plan was developed as a result of stakeholder engagement and one of the prioritized recommendations includes developing a new level of care for infants from birth to age five to support caregiver connections to foster health attachments and early mental health.

NH utilizes the Praed Foundation, who provides staff certification and data tracking to the NH Child and Adolescent Needs and Strength Tool/ Adult Needs and Strength Assessment (CANS/ANSA). The Families First Preventive Services ACT (FFSPA) and 42 USC 675a (c) requires that there is an Assessment, documentation, and judicial determination requirements in place for placement in a qualified residential treatment program. In the case of any child who is placed in a qualified residential treatment program or is being considered for treatment, a process for a comprehensive assessment, using a standardized assessment tool, must be conducted. Additionally NH SB 14 was signed into law on 7/11/2019, which requires the DHHS to determine which tool is to be used as a standard assessment tool across the system for Children's Behavioral Health. The tool selected by DHHS is the Child and Adolescent Needs and Strength Tool (CANS) that is already in use in NH by some DHHS providers. The online system for this tool is already in place and utilized by the community mental health system in NH. Due to the system expansion of child and early intervention services, ongoing access dues and increased numbers of those utilize the system leads to a higher cost of maintenance. Funds will support the next year of this increased system access needs.

Enhanced Regional Delivery and Supported Transitions

The Plan has triggered some exciting system transformation in New Hampshire and as the crisis system, children's continuum of care, and integrated mental health and physical health initiatives roll out, it is evident that alternative models need to be examined. NH recognizes that the continuum of care is inclusive of the whole person needs both within mental health and substance use, and physical health. Often times those with mental health and substance use needs struggle to access necessary care where and when needed. Data solutions are being explored and models such as Certified Community Behavioral Health Clinics (CCBHC) are being contemplated. CCBHCs expand access to care through community locations that address the whole person approach. New Hampshire is in need of engaging with a subject matter expert to assess the feasibility to adopt this infrastructure throughout our state, how to meld with the currently established system, and establish a plan that considers the long-term Medicaid payment models to ensure success. These efforts support the goal to review system models to ensure that there is a centralized infrastructure in place to enable individuals with mental health and or substance use disorders to have immediate access to care and receive support as they transition through levels of care.

Since the Plan's inception, New Hampshire has made ample progress in its work towards achieving these goals but remains focused on improving the system and addressing the gaps identified.

2. **Identify the needs and gaps of your state's mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and stabilization services.**

New Hampshire's 10 Year Mental Health Plan (Plan) calls for centralization of access to services, including crisis services, an expansion of the crisis continuum, including Mobile Crisis Response Teams (MCRTs), and a renewed focus on suicide prevention. Expansion initiatives are underway to develop a centralized crisis operations center, statewide mobile crisis response system, and a State suicide prevention coordinator.

The current delivery system is comprised of one national suicide prevention lifeline and ten regionally based community mental health centers (CMHCs) that each provide services in their designated community mental health region, each with unique crisis phone number(s). In sum, there are more than 20 crisis phone numbers statewide, which makes accessing crisis services for individuals and families extremely confusing. This identifies the need for a central call center that can be accessed anywhere in the state for those in a crisis and that central location can provide warm handoffs to and deployment of regionally based mobile teams.

Mobile Crisis Response Team services and apartments are only located in the three, more urban regions of Nashua, Manchester and Concord. However, New Hampshire is undergoing a system re-design to expand MCRTs and crisis stabilization services into all regions of the state. These efforts align with goals of the Plan and national roll-out of 9-8-8.

Specifically, there is a need to expand Children's Crisis Stabilization Services and the platform these are provided on. During the Covid-19 pandemic, it became very apparent that children's services did not match the need for those with significant mental illness. While office based services were established, the need for a robust crisis response system and community deployment became apparent. Additionally, these age groups communicate in many different ways on different platforms than most of the adults being served, making it hard to establish lines of communication that felt accessible and comfortable to this age group. New Hampshire does not currently have a chat/text service therefore the Plan proposes to develop and implement this with the ARP funds to allow for increased access for this age group.

New Hampshire has one walk-in behavioral health crisis treatment center located in Concord. Crisis respite centers provide individuals with access 24/7 either by walk-in, through MCRT, via first responders, or any other way that they arrive with a need. By not having a 24/7 walk in centers accessible, individuals experiencing a crisis often find themselves attempting to access mental health or substance use disorder care through their local emergency rooms. This leads to increased wait times for these individuals as well as those looking for urgent medical care. This is a critical component of the Crisis Now model and something that New Hampshire needs to explore to identify models that will be sustainable and accessible statewide. Models such as crisis apartments, in-home stabilization services, and additional stationary crisis centers all need to be explored as potential solutions.

Additionally, there exists a need to assess and develop a crisis model to meet New Hampshire's unique geographical needs. With a vast Northern region of the State, services can be a challenging to access due to geographical distance to service agencies and reduced or slower access to technology. A response model would look to break down those barriers, allowing residents in all regions immediate and appropriate supports during crisis, in addition to establishing a chat and text function. An

assessment will need to be completed to determine the unique needs of the more rural regions of the state, and the development of MCRT delivery options in rural New Hampshire communities.

As a part of the national roll-out of 9-8-8, New Hampshire's planning coalition has identified a need for public messaging, outreach, education, and training to inform the public about this service. Through public, first responders, and natural support system education and training, we can expect to see that those in crisis or who are experiencing mental illness receive support and services that are best suited to their individual needs, and connecting them to service agencies that can support them in the most informed way possible. It also expands the natural supports systems knowledge throughout the state allowing for more educated responses to mental illness needs and knowledge of supports available for those close to them and in their communities. A more robust messaging campaign also needs to be developed and implemented to ensure the public awareness of the 9-8-8 implementation is broadly heard and utilized throughout the state. In this same light, suicide prevention outreach and education have had minimal public messaging. This highlights another goal set in the Plan regarding Community Education. Additionally, in order to successfully implement the full vision of 9-8-8 in New Hampshire, which is inclusive of phone/text/chat, mobile, and location-based response, infrastructure investments are needed. For example, system-wide training of providers and partners; technology upgrades to enable community providers to interface with the centralized call center, law enforcement, and first responders; updates to electronic health records to improve documentation of crisis services; expanding capacity of our national suicide prevention lifeline to offer chat and text functionality; etc.

3. **Describe your state's spending plan proposal, including a budget that addresses the needs and gaps related to crisis and services continuum.**

Mental Health Block Grant – Additional ARP Allocation
September 1, 2021 - September 30, 2025
Total allocation $5,083,896.74

Budget item	**Proposed spending for ARP**
Crisis Expansion & Infrastructure Investments - Expansion of crisis stabilization services via crisis apartments for adults w/SMI and in-home children's stabilization services for youth w/ SED and crisis stabilization centers - Development of a rural crisis response model for deployment and stabilization - Equity investments to ensure crisis system is accessible - Crisis training for providers, law enforcements, first responders, and peers - Expansion of infrastructure for implementation of statewide mobile crisis (e.g. needed technology upgrades such as data platforms, text/chat functionality, updates to EHRs, etc. - 9-8-8 & Crisis Expansion Planning Coalition; facilitate stakeholder and provider engagement for the early implementation phase of crisis system-transformation.	$2,363,432.25 2-4 year timeline
9-8-8 & Suicide Prevention Public Outreach & Education - 9-8-8 roll-out public messaging - Primary suicide prevention and access to care messaging	$400,000 3-4 year project
Peer Workforce Development - Implementation of the NH Peer Workforce Advancement Plan	$236,753 2 year project
Peer Support Services Infrastructure - Develop ethics and boundaries training curriculum - Deliver suicide prevention training - Define data requirements and platform needed for data tracking for peer delivered programs	$250,000 2 year project
Co-occurring disorder trainer - Work with MH providers to train and support the infrastructure for the provision of co-occurring disorder treatment	$250,000 4 year PT position
CANS/ANSA Assessment Access & Training for CMHC providers	$13,500
MH Housing Data Infrastructure & Dashboard - Development of a data system to input and track all MH housing data (Bridge & 811 PRA & Mainstream)	$150,000
CCBHC Enrollment Assessment - Conduct an assessment to determine feasibility for NH to adopt Certified Community Behavioral Health Clinic model of care.	$250,000
Early Serious Mental Illness/First Episode Psychosis (ESMI/FEP) Set-Aside (required) - Funds will support training and technical assistance for providers and family members	$866,216

- Conduct outreach efforts regarding availability of ESMI/FEP services - Provide technical assistance to expansion sites	
Administration Set-Aside -Program Specialist II to provide oversight of implementation and reporting for grant deliverables.	$251,573.75
Mental Health ARP Allocation	**$5,031,475.00**

4. Describe how the state will advance the development of crisis and other needed prevention, intervention, treatment and recovery support services so that your state's system is responsive to the needs of your residents with SMI and SED. Refer to the Guidebook on crisis services.

Following the distribution of the New Hampshire 10 Year Mental Health Plan (Plan), a request for information was published to garner input about how to design a comprehensive, accessible, responsive, and sustainable crisis system to meet the needs of both individuals with SMI and SED. Information gained from the more than 15 responses nationwide was used to inform the crisis transformation work that began in early 2020.

On the June 30, 2021 the New Hampshire Governor and Executive Council approved a new contract for the NH Rapid Response Access Point. This agreement, will provide the centralized crisis call center that will also dispatch and deploy Mobile Crisis Teams statewide; the population served includes individuals across the age continuum who experience a behavioral health crisis including individuals with SMI and SED. It is also anticipated that the Access Point will connect with the new national 9-8-8-crisis line and include phone, text and chat functionality. Also on June 30, 2021 Governor and Executive Council approved contracts with all 10 community mental health centers to begin planning for implementation of mobile crisis in all 10 regions. This will integrate crisis services for the general population and individuals with SMI/SED currently served through the community mental health system. New Hampshire's 9-8-8 planning coalition is also working to address access and collaboration efforts between the Access Point and Department of Safety.

Through expansion and infrastructure investments in current initiatives to address the crisis continuum, the State proposes to increase availability and accessibility to crisis apartments for adults with SMI and in-home children's stabilization services for youth with SED and crisis stabilization centers. Additionally, the State plans to explore alternative rural crisis response model(s) for deployment and stabilization while making investments in building equity to ensure the crisis system is accessible to all residents.

New Hampshire's 9-8-8 Planning Coalition guides and informs the implementation of the crisis transformation work that is underway. This multi-sector stakeholder group (as described below) is integral to informing the development of a system that is comprehensive and accessible.

In an effort to further address prevention and early intervention initiatives, New Hampshire's Infant Mental Health Plan was developed as a result of stakeholder engagement and one of the prioritized recommendations includes developing a new level of care for infants from birth to age five to support caregiver connections to foster healthy attachments early mental health. Young children birth to age five (5) can receive a mental health diagnosis and be considered SED if the DC 0-5 Manual (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and

Early Childhood) is used. DC 0-5 allows clinicians to diagnose infants and young children with mental health disorders and/or developmental disorders-which then allows clinicians to crosswalk the DC 0-5 with the DSM V. DC 0-5 also shows functional impairments, which aligns diagnostically with DSM 5, as well as the designation of SED. The CANS tool will be utilized to help determine eligibility for the proposed program. The CANS is the tool NH's community mental health centers use to determine SED for their eligibility. In addition, parent/caregiver with SMI/SED, along with their child/ren, will also be served under this program.

This service array (programming, services, and support) is prevention in that early identification and treatment of young children's SED can help prevent worsening and/or chronicity of the SED. In addition, the service array aims to improve family function and reduce adverse childhood experiences in order to prevent the development of additional SED diagnoses later on in childhood or adulthood, such as PTSD, mood and anxiety disorders. This service array is treatment in that the service array also aims to directly address the current SED in a person- and family-centered approach. This programming would include services and supports to children and their primary caregiver, once screened and found eligible using the CANS tool, and DC 0-5. The screening and eligibility process will not be included in this funding request. The services then delivered once the child is found to be eligible either through their own diagnosis and needs that indicate that they are SED, or if their primary caregiver is considered to have his/her own SED, SMI eligibility. The treatment and supportive services involved in this programming are;

- Treatment using evidences based modalities such as Child and Parent Psychotherapy
- Intensive in home services using a home visiting model.
- Peer support
- Respite- in home

New Hampshire has also expanded its efforts to increase awareness and reduce stigma related to mental illness in young people generally, and first episode psychosis specifically. We have implemented learning and education models such as Mental Health First Aid statewide. These programs have planted the seeds of awareness about mental illness and how to recognize early signs. We recognize that stigma reduction aids the general public in recognizing early symptoms, referring to appropriate services, and understanding the value in engaging treatment. As part of NH's 10-year mental health plan, early treatment models, including FEP were highlighted and identified by stakeholders as foundational recommendations in areas to address.

New Hampshire has been working on a plan to expand FEP services statewide. During SFY 2019-21, the State carried out a stakeholder engagement process to identify, propose, and develop an implementation strategy for a statewide ESMI or FEP treatment model using the 10% set aside Block Grant funds. The initiative included two components; proposing a treatment model that we can scale to provide ESMI/FEP services statewide, and developing a public awareness campaign that focuses on the importance in, and availability of, early interventions.

The State is fortunate to have a national expert on our staff. Mary Brunette, MD, who serves as our Medical Director, is an Associate Professor of Psychiatry at Dartmouth-Hitchcock. Dr. Brunette has worked on the RAISE NAVIGATE research team from its inception. Dr. Brunette provides expertise to the FEP/ESMI BMHS project management team.

5. Explain how your state plans to collaborate with other departments or agencies to address crisis, treatment, and recovery support services.

New Hampshire's 9-8-8 Planning Coalition guides and informs the development of the New Hampshire 9-8-8 Implementation Plan. The Coalition is specifically tasked with the following responsibilities:

- Developing clear roadmaps for how to address key coordination, capacity, funding, and communication strategies that are foundational to the launching of 9-8-8, and
- Plan for the long-term improvement of in-state answer rates for 9-8-8 calls.

Members of the New Hampshire 9-8-8 Planning Coalition are diverse stakeholders in NH's behavioral health system including: Individuals with lived experience, Lifeline crisis center staff, NH's State suicide prevention coordinator, Law enforcement leaders, 9-1-1/PSAP leaders and major state mental health and suicide prevention advocacy groups like NAMI and AFSP, as well as staff from NH's Department of Health and Human Services, Department of Safety, Department of Justice and the Governor's Office.

The New Hampshire 9-8-8 Planning Coalition also formed subcommittees to meet more frequently on specific goals of the Implementation plan and process. These goals are focused on: Sustainable funding, Volume Forecasting and Projections, Public Messaging and Communications, Coordinating with First Responders, and Operational Capacity. The subcommittees expanded membership to include members of the public who are investing in making change to the NH crisis system. This allows for deeper participation and robust dialogue outside of traditional planning meetings.

A specific focus of NH's 9-8-8 planning coalition is through the Law Enforcement subcommittee which has representation from the Office of the Governor, Department of Safety, and Department of Justice, local first responders in both urban and rural regions, 9-1-1 and Bureau of EMS in addition to several other stakeholders. This subcommittee has identifies this need and is committed to working with the Bureau to increase first responder training.

Many of the New Hampshire's mental health system initiatives are the result of a collaborative effort between the Bureau of Mental Health Services, Bureau of Drug and Alcohol Services and the Bureau for Children's Behavioral Health. The crisis continuum and support services are designed to be an integration of services to address both mental health and substance use concerns. This spending plan reflects that New Hampshire believes in the importance of ensuring services meet the need of the client presentation to allow for a more robust delivery of services, as well as addressing workforce shortages in the field.

New Hampshire has been consistent in considering the cross-section of the Mental Health and SUD systems in the work that has been done and is currently ongoing. New Hampshire recognizes that many of its residents experience both mental health and substance use co-occurring disorders which produce needs that are best met and addressed by dually diagnosed trained staff and initiatives that are developed with this ideology in mind.

Approximately half of people with SMI/SPMI develop a co-occurring substance use disorder during their lifetime. Alcohol is the most common substance followed by cannabis, opioids and then stimulants. This rate is three times higher than general population rates of substance use disorder.

People with co-occurring SMI/SPMI and substance use disorders have higher rates of treatment nonadherence, experience a worse course of illness, utilize emergency rooms and hospitals at higher rates, and experience premature mortality.

Conversely, about a third people with substance use disorders have higher rates of co-occurring mental illnesses during their lifetime; among people in treatment settings, two-thirds have co-occurring mental illnesses with the substance use disorder. Mood disorders, post-traumatic stress disorder and anxiety disorders are common. People with these co-occurring disorders also experience worse outcomes.

Due to the high rates of co-occurring disorders among people receiving treatment in New Hampshire, clinicians need the knowledge and skills to help service recipients manage both illnesses – the substance use disorder and the mental illness - in order to achieve recovery and return to community functioning. Over the past five years, the Bureau of Mental Health Services has documented that our mental health centers have consistently lacked skills in the area of co-occurring disorders treatment. Our service providers have requested training and technical assistance in this area to help their existing employees gain the necessary knowledge and skills for evidence-based co-occurring disorders treatment.

As New Hampshire assesses and redesigns our behavioral health system of care, it is clear that additional training is required for mental health professionals in the area of substance misuse and for substance misuse professionals in the area of mental health. This funding would support a full time trainer to address these needs across the behavioral health continuum of care.

6. **Describe how the state plans to spend the ten percent set aside for first-episode psychosis/early SMI and, if applicable, the five percent set aside for crisis services.**

Currently, one FEP program is operational in New Hampshire. Starting in July 2021, three additional providers will begin to implement FEP/ESMP coordinated specialty care (CSC) teams. These providers requested training and funds to implement these teams in their region in order to meet the increased demand for FEP/ESMI services in their region of the state.

The State will use the ten percent set aside on the expansion of services and workforce development, to aide in the delivery of FEP/ESMI services. New Hampshire is in the process of expanding teams to three additional regions, and the funds will support a learning community, provider and family member training, professional development, expansion of core elements such as family psychoeducation, and infrastructure improvements needed to implement ESMI/FEP services in all regions.

7. **Describe other state priorities or activities that the state plans to fund during the performance period using ARPA funds, with consideration given to disproportionately high rates of MH/SUD in certain communities and disparities in COVID-19 BH-related outcomes by race, ethnicity, and other factors.**

By expanding the crisis continuum of care, NH is providing assistance to the most vulnerable populations as they attempt to avoid a psychiatric hospital stay or transition from institutional to community-based care. Additionally by lowering the emergency department utilization among individuals with co-occurring disorders and immediately connecting them with community based

providers will address the ongoing high rates of mental health and substance use concerns in New Hampshire. Studies show that the use of Peer Support Specialists are very effective for this group and increase engagement and access to services in times of need. By further educated the peer workforce throughout our state and integrating them further into all care settings, there is a higher likelihood that individuals will reach out to and engage in established services.

By recognizing the need to establish a more interlocking system of care to address more comprehensively the current challenges experienced by patients, families and providers resulting from fragmented care through multiple mental health and substance use disorder service agencies, New Hampshire hopes to reduce the high rates of mental health and substance use.

As a result of school and college closures due to the Covid-19 pandemic, many youth and young adults spent extensive periods of time at home and socially isolated. Consequently, New Hampshire is experiencing an increased demand for children's behavioral health services and specifically an increased need for specialty services to treat youth who are experiencing FEP/ESMI. The usage of the identified FEP/ESMI 10% set aside further supports the development and establishments of programs to address these needs.

The Office of Health Equity (OHE) assures equitable access to effective, quality programs and services across all populations, with specialized focus on racial, ethnic, language, gender and sexual minorities, and individuals with disabilities. OHE provides coaching and TA to the Bureau as well as external organizations to improve systems and practices for organizations to be able to serve all people with high quality care and services. These include effective strategies for communication access, cultural competence, data collection to identify disparities, community engagement, CLAS Standards implementation, gender identity 101, immigrant/refugee integration, and more. The Bureau often partners with OHE on data collection standards, training of providers, and technical assistance needed to ensure programs and services are meeting the needs of all populations in our state.

Specifically, the OHE has worked with NH's 9-8-8 planning coalition to provide an equity foundation across the work of all subcommittees and prioritized a resident centric approach to building a system that is community driven and community informed and inclusive of voice of underserved and unserved populations including those with lived experience, people who use drugs, immigrant and refugee communities, deaf and hard of hearing residents, and voices of youth being prioritized in the planning.

8. **Describe how the state will use, or consider, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support behavioral health clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (**https://www.healthit.gov/isa/ **), including but not limited to those standards described in the, the "Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data" section and the "Social Determinants of Health" section.**

The MH Housing Data Infrastructure and Dashboard planned for implementation will be a cloud hosted solution leveraging a HIPAA compliant platform and will not employ

interoperability functions and as a result there are no plans at the moment to employ health IT standards as it relates to connecting systems together. The planned effort is goaled at streamlining services by replacing a legacy system requiring manual processing with the cloud accessible system for providers and state employees to utilize. The system will not be connected to other systems at this time.

The Department of Health and Human Services leverages National Institute of Standards and Technology (NIST) standards, NIST is a supporting collaborator for the Office of the National Coordinator certification criteria in health IT products. These standards describe the security requirements surrounding the data and systems that are utilized by the department to include the data classification, data sharing, information risk management, disposition of data and incident management. As part of the implementation if the scope changes the department will update the scope for approval (as applicable) along with a comprehensive review and update of any standards in accordance with the Office of the National Coordinator certification criteria in 45 C.F.R 170 as well as consider standards identified in the Interoperability Standards Advisory.