DOORWAY PROGRAM EVALUATION

FINAL REPORT - September 29, 2023

New Hampshire Department of Health and Human Services
State Opioid Response (SOR) Grant

Pacific Health Policy Group

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ABBREVIATIONS AND ACRONYMS

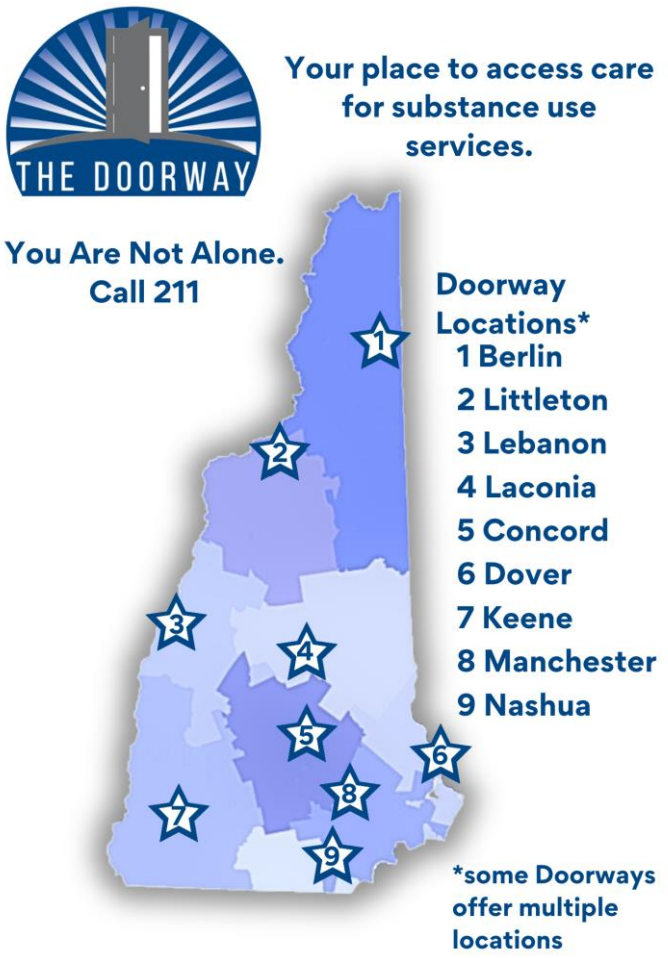
Acronym	Description	Acronym	Description
AOD	Alcohol and Other Drug	MCO	Managed Care Organization
ASAM	American Society of Addiction Medicine	MH	Mental Health
BDAS	Bureau of Drug and Alcohol Services	MLADC	Master Licensed Alcohol & Drug Counselor
BH	Behavioral Health	MMIS	Medicaid Management Information System
CCBHC	Certified Community Behavioral Health Clinic	MOUD	Medications for Opioid Use Disorder
CRSW	Certified Recovery Social Worker	NPI	National Provider Identifier
CY	Calendar Year	OUD	Opioid Use Disorder
DHHS	New Hampshire Department of Health and Human Services	PHE	Public Health Emergency
DOC	Department of Corrections	PHPG	Pacific Health Policy Group
ED	Emergency Department	ROI	Release of Information
Flex	Flexible Needs Fund	SAMHSA	Substance Abuse and Mental Health Services Administration
G&A	Grievances and Appeals	SFY	State Fiscal Year
GPRA	Government Performance and Results Act	SOR	State Opioid Response
ID	Identification	SUD	Substance Use Disorder
IP	Inpatient	TA	Technical Assistance
LADC	Licensed Alcohol and Drug Counselor	VA	Veterans Administration
MAT	Medication Assisted Treatment	WITS	Web Information Technology System

EXECUTIVE SUMMARY

Doorway Program Objectives

Funded through federal State Opioid Response (SOR) awards from the Substance Abuse and Mental Health Services Administration (SAMHSA) since 2019 to ensure:

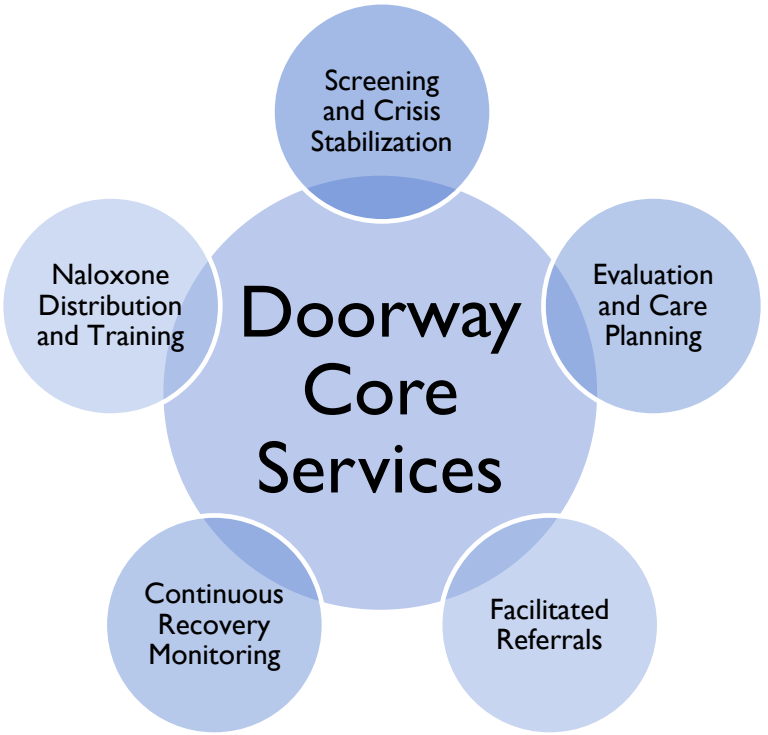
- Access to Opioid Use Disorder (OUD) treatment through the creation of local access points (expanded in 2020 to include stimulant use disorders)
- Individuals seeking Substance Use Disorder treatment and recovery support never have to drive more than 60 minutes to get help



EXECUTIVE SUMMARY (CONTINUED)

Doorway Program Design

- Non-profit hospitals were asked by DHHS to host Doorway programs
- Nine sites, plus statewide after-hours coverage and 211-referral agreements; DHHS also contracts for statewide respite capacity in two locations
- Doorway sites are responsible for providing Core Services and administering a:
  - Flexible Fund program to address social determinants of health/barriers to care
  - Respite Voucher program to provide safe housing for clients awaiting treatment
- Doorway site reimbursement is based on costs; Doorway sites submit monthly invoices based on costs incurred



EXECUTIVE SUMMARY (CONTINUED)

Summary of Key Findings

- Doorways serve as essential and immediate access points for SUD/OUD recovery planning and treatment, including after-hours coverage 24/7
- The following Doorway services promote success and should be maintained as a standard for care management, absent federal funding:
  - *Immediate screening and evidenced based (ASAM) assessment* (i.e., 24/7) is vital in engaging hard-to-reach clients
  - Mechanisms to *immediately transport* someone to *safe housing* while awaiting treatment
  - *Facilitated referrals* and *case management* to navigate the treatment system
- Doorway intake and engagement processes are more similar than different
- Doorways promote a face-to-face assessment and care management model that should be adopted as a standard of care across the system

EXECUTIVE SUMMARY (CONTINUED)

Summary of Key Findings (continued)

Doorways enhance the delivery system by:

- **Destigmatizing OUD**: Providing education and awareness to break down barriers/stigma in working with clients with OUD in ED, inpatient, PCP and FQHC settings
- **Enhancing Access to MOUD**: Doorways have filled gaps by:
  - Working with EDs to support induction and provide bridge prescriptions
  - Having MOUD prescribers available onsite or co-locating with existing programs
  - Partnering with other community-based providers (e.g., center and office-based addiction treatment programs)
- **Collaboration**: Working with community partners and other Doorways to wrap services around individuals to support engagement and recovery

EXECUTIVE SUMMARY (CONTINUED)

Summary of Key Findings (continued)

- Doorways served an average of 370 new clients per month since November 2019, including the during the PHE. In CY2022, Doorways served an average of 403 new clients and 761 established clients per month
- The largest portion of clients served by Doorways are Medicaid members (approximately 60-70%)
- Rapid implementation of the SOR program was immediately followed by the novel coronavirus Public Health Emergency (PHE), slowing the integration of programs into the overall DHHS system of care for SUD/OUD
- DHHS respite programs are essential, however were under utilized and difficult are to reach for residents in rural areas
- There are opportunities to maximize current and future Medicaid revenues
- Medicaid reform and alternative delivery system models could be explored absent federal SOR funds

EXECUTIVE SUMMARY (CONTINUED)

Key Recommendations

This section provides a summary of key opportunities to enhance operations and support sustainability in the following domains:

- System of Care: Defining and aligning roles and creating incentives for collaboration across the system of care
  - Standardize Doorway Model of Care
  - Define and Align State Priorities, and Initiatives and Incentivize Collaboration
- Quality Framework, Benchmarks and Monitoring: Defining data and quality standards
  - Develop Monitoring and Performance Improvement Framework
  - Standardize Data Collection and Establish Benchmarks
- Financing and Sustainability: Enhancing the current financing model and promoting sustainability
  - Enhance Third Party Revenue, Including Medicaid
  - Clarify Medicaid MCO Obligations
  - Centralize Management of Flexible Needs Fund
  - Enhance SOR and Medicaid Transportation
  - Enhance Access and Utilization of DHHS Respite Services
  - Enhance Medicaid Authorities and Multi-payer Approaches
  - Explore Alternative Delivery System Models

EXECUTIVE SUMMARY (CONTINUED)

Key Recommendations (Continued)

1. System of Care: Defining and aligning roles and creating incentives for collaboration across the publicly funded system of care for SUD/OUD

Key Recommendations	
Enhance Doorway policies to support a seamless statewide model of care	• Develop uniform model of care standards, including communication and collaboration across Doorways, respite and treatment providers • Enhance web-based technology to support coordination and care planning

Enhance and align DHHS policies, oversight, funding and initiatives across publicly funded behavioral health programs (BDAS, SOR, MH, Medicaid, Health Facilities Licensing)	• Develop or enhance interagency mechanisms in DHHS to:
	  • Define roles and create incentives for treatment providers to work with Doorways (e.g., define Hub and Spoke roles)
	  • Minimize funding gaps (e.g., funding for alcohol use disorder, Medicaid)
	  • Limit duplication (e.g., multiple client assessments across Doorways and/or treatment providers)
	  • Align communication and care planning requirements across providers
	• Define provider standards, client rights, and grievance and appeals policies across the system of care

Improve access to care for Doorway clients	• Amend Medicaid MCO contract requirements to eliminate prior authorizations relative to Doorway referrals

EXECUTIVE SUMMARY (CONTINUED)

Key Recommendations (Continued)

2. Quality Framework, Benchmarks and Monitoring: Defining quality monitoring and data standards

Key Recommendation	
Create a quality monitoring and improvement framework and standardize data reporting	• Create quality benchmarks and monitor trends (e.g., performance standards, client satisfaction, complaints, grievance/appeals, and outcome measures) • Create standardized data definitions, cell formats and templates for reporting across Doorway and SOR grants (including for vendors with multiple SAMHSA awards) • Adopt common IDs across datasets • Establish a process for reporting Medicaid enrollment

EXECUTIVE SUMMARY (CONTINUED)

Key Recommendations (Continued)

3. Financing and Sustainability: Enhancing the current financing model and promoting sustainability

Key Recommendations	
Enhance third-party revenues for Doorway services, including Medicaid	• Advance legislation to include a full array of SUD provider types (e.g., LADC, MLADC, CRSW) and services in commercial plans • Create a Doorway-specific coverage rules and rate structure for current Medicaid services provided by Doorways
Clarify and recognize Doorways as part of Medicaid MCO care management obligations	• The State could require MCOs to recognize Doorways as a specialized care management provider under the contract • Transition to an all-inclusive Medicaid rate or capacity-based agreement to fund Doorway services
Improve access and enhance utilization management of DHHS respite services	• Establish a reimbursement approach for capacity-based contracts that adjust payment rates for utilization (e.g., risk corridor, tiered payment rates based on occupancy) • Require respite programs to distribute real-time bed availability information to Doorways • Prioritize the use of contracted respite when clinically appropriate
Improve flexibility of flex fund allocation methods and maximize Medicaid revenues for transportation services	• Centralize management of the fund through DHHS (or another entity) while maintaining the immediacy of local decision-making regarding eligibility and needs • Explore options to include specialized transportation services in Medicaid or SOR program • Require Medicaid MCOs to reimburse Doorways for transportation under the "Family and Friends Mileage Reimbursement Program" when a covered service is arranged by a Doorway

EXECUTIVE SUMMARY (CONTINUED)

Key Recommendations (Continued)

3. Financing and Sustainability: Enhancing the current financing model and promoting sustainability (continued)

Key Recommendations	
Explore a bundled rate that establishes a population based and/or multi-payer approach to funding as part of a Medicaid reform model	• Explore a bundled rate that establishes a population based and/or multi-payer approach to funding as part of a Medicaid reform model • Participation in funding could be based on members served by payer or overall health plan enrollment in each region or statewide • New state plan authorities such as targeted case management, crisis stabilization programs, specialized health homes or an 1115 Demonstration project could be explored
Expand Medicaid eligibility for low-income individuals in need of SUD treatment (e.g., 200% of the federal poverty level)	• Eligibility expansion for SUD/OUD could be supported as part of an 1115 Demonstration and address gaps in Doorway funding for members with alcohol use disorder

EXECUTIVE SUMMARY (CONTINUED)

Key Recommendations (Continued)

3. Financing and Sustainability: Enhancing the current financing model and promoting sustainability (continued)

Key Recommendations	
Explore alternative delivery system structure for Doorway services	Two potential models include a: • Statewide Doorway: Single lead entity with nine or more regional satellite locations and management of flex funds and naloxone • Statewide Facilitating Organization: Non-profit entity with responsibility to coordinate across current and future Doorway locations and manage flex funds and naloxone

EXECUTIVE SUMMARY (CONTINUED)

Conclusions

- The face-to-face nature and immediacy of the Doorway response (including after-hours) is a preferred standard of care for working with hard-to-reach clients struggling with OUD and other addictions (e.g., stimulant use, other drug, alcohol)
- The majority of clients that present at the Doorways are enrolled in, or eligible for, Medicaid
- Existing Medicaid State Plan and MCO obligations include coverage for: screening, brief intervention and referral to treatment; crisis stabilization; screening; assessment; on-going care management; and non-emergency medical transportation. However, Medicaid claiming is limited
- Existing Medicaid coverage policies and payment models could be clarified and enhanced to support Doorway services (including transportation) as the standard of care for members with OUD and other addictions. This would preserve SOR funds for uninsured members and address gaps in the system of care that are not Medicaid reimbursable
- Absent federal funds, a multi-payer model with Medicaid reform as its foundation (including new or enhanced state plan services) could be explored
- Alternative delivery systems, including a Statewide Doorway Model or Statewide Facilitating Organization, may offer more flexibility for funding and service delivery

DOORWAY PROGRAM OVERVIEW

OPERATIONS, STAFFING, COMMUNITY PARTNERS

DOORWAY PROGRAM OVERVIEW

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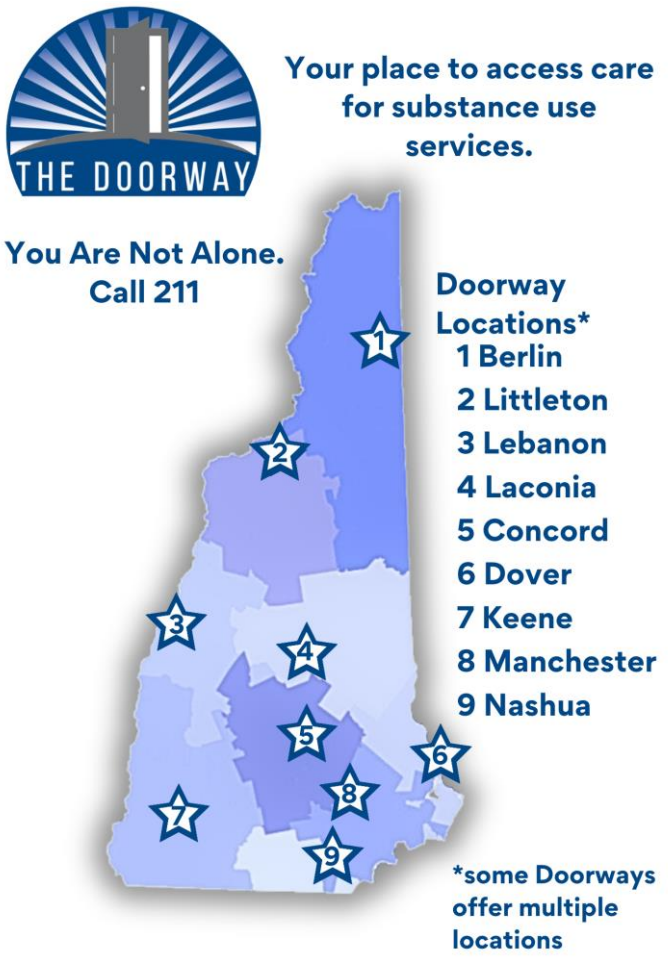

DOORWAY PROGRAM OVERVIEW (CONTINUED)

Doorway Program Design

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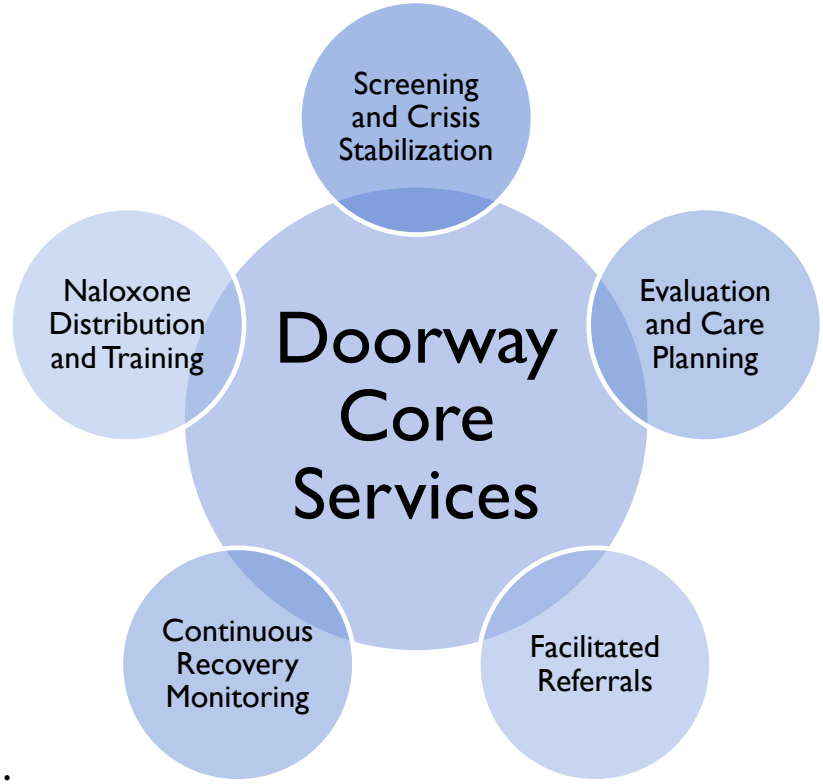


DOORWAY PROGRAM OVERVIEW (CONTINUED)

Doorway Operating Structure and Local Contracts

Operational Model	Doorway (Operated By)	Population	# of sites	Local Contracts
Five operated directly by SOR awardee	Dover (Wentworth Douglas Hospital)	231,319	2*	▪ N/A
	Keene (Cheshire Medical Center)	98,377	1	▪ 4 local respite beds**
	Lebanon (Dartmouth Hitchcock Medical Center)	85,501	1	▪ 3 local respite beds**
	Littleton (Littleton Regional Hospital)	38,102	1	▪ MAT/Medical Director
	Laconia (Concord Hospital)	128,764	1	▪ 1 FTE peer recovery
Three subcontracted to a single entity in SOR awardee's health system	Berlin (Weeks Medical Center)	34,538	4*	▪ N/A
	Concord (Riverbend CMHC)	134,447	1	▪ 2 local respite beds**
	Nashua (Foundation Medical Partners)	249,393	1	▪ .5 FTE peer recovery ▪ Afterhours screening and respite (flat rate/month)
One subcontracted to multiple entities	Manchester (Catholic Medical Center and contracted community partners)	359,271	1	▪ Assessments, as needed ▪ 10 local respite beds**† ▪ Afterhours staffing on respite unit for 24/7 coverage

* Dover recently opened a second site for MAT related to all SUD diagnostic groups; Berlin, offers clients teleconferences with Doorway staff from three outreach locations

** All local respite arrangements are capacity-based agreements whereby payment is made to hold a bed open until 5-7pm each day, regardless of whether it is used by a Doorway client

† Originally planned as a DHHS contract with Farnum Center, CMC agreed to implement the contract as local agreement; Manchester assessments are currently contracted w/two providers; a partnership with a third vendor is in process

DOORWAY PROGRAM OVERVIEW (CONTINUED)

Doorway Integration with Host (SOR Awardee)

Doorway	Setting	Co-located w/Other Svs	Supports provided by SOR Awardee		
			Invoicing DHHS	Fully Integrated*	Notes
Berlin	Community	SUD/MOUD	✓		Hospital ED and inpatient units refer to Doorway
Concord	Community	SUD/MOUD & Drug Court			Concord Hospital's only function is receiving DHHS payments; VP for BH at Hospital is Riverbend's CEO;
Dover	Community	Across from hospital	✓	✓	Doorway staff complete assessments and provide case management in the hospital (inpatient and ED)
Keene	Community	N/A	✓	✓	Hospital ED and inpatient units refer to Doorway
Laconia	Hospital	N/A	✓	✓	Doorway recovery coaches are available to hospital 24/7 (ED and inpatient units)
Lebanon	Community	Addiction treatment program	✓	✓	Addiction treatment staff, ED, Pharmacy and nursing staff are available to Doorway, as needed,
Littleton	Community	N/A	✓	✓	Doorway is a department of the hospital
Manchester	Community	N/A	✓	✓	CMC offers business supports, apart from EMR and provides access to specialized services for pregnant women, veterans, and integrated PCP/BH services for homeless clients
Nashua	Community	Daily outreach/street work	✓	✓	Doorway staff run groups onsite and meet with individuals who are in hospital as needed

* Includes use of EMRs, business office, payroll/HR, legal, policy, and clinical supports

DOORWAY PROGRAM OVERVIEW (CONTINUED)

Doorway Client Access to Medications for OUD

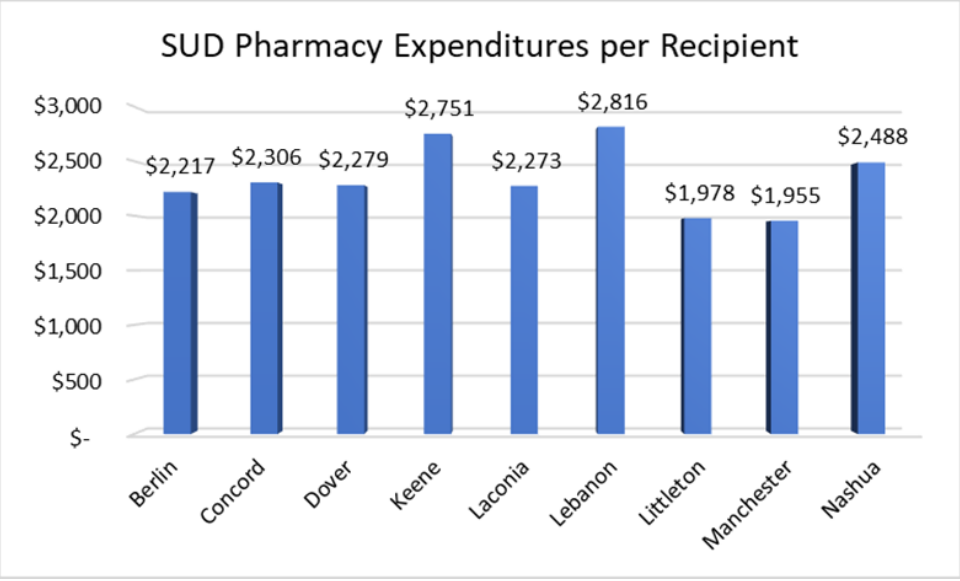
Doorway	Access to Medications for OUD			Estimated Wait for MOUD†	Number of Other MOUD Providers in Region/Accessible to Doorway Clients		
	Onsite*	Partner Agency	Induction in the ED		1-2	3-4	4 or More
Berlin	✓	✓		90% - 1-2 weeks	✓		
Concord	✓	✓	✓	100% - 0-72 hours			✓
Dover	✓	✓	✓	100% - 0-24 hours			✓††
Keene	✓	✓	✓	100% - 0-48 hours			✓
Laconia	✓**	✓	✓	100% - 0-24 hours		✓	
Lebanon	✓	✓	✓	90% - 0-24 hours		✓	
Littleton	✓	✓	✓	100% - 0-24 hours		✓	
Manchester		✓	✓	95% - 0-24 hours			✓
Nashua		✓	✓	100% - 0-24 hours			✓

* Onsite access refers to MOUD by Doorway staff or through co-location with an existing program
** Laconia MOUD program is one mile away
† Wait times are staff estimates
† † access to some providers is challenging

DOORWAY PROGRAM OVERVIEW (CONTINUED)

Doorway SUD Pharmacy-Related Medicaid Expenditures, SFY2022

- A total of 1,716 of 2,972 Medicaid members received SUD pharmacy in SFY2022, representing 57.8% of the Medicaid sample population
- Average Medicaid expenditures per recipient in SFY2022 equaled $2,308
- Expenditures per recipient were relatively similar across Doorway sites, ranging from $1,955 to $2,816



DOORWAY PROGRAM OVERVIEW (CONTINUED)

Community Partners

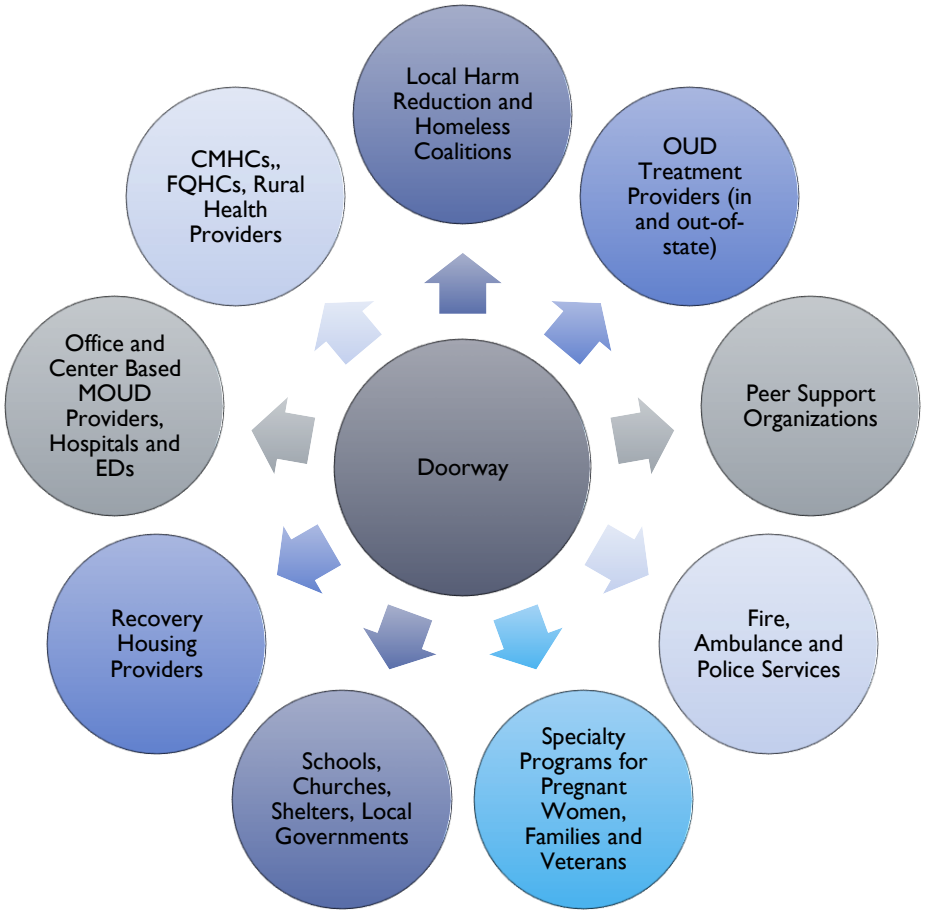
All Doorways support community partnerships through informal collaborations

Five Doorways have formal operating agreements with partners for:

- Client referral and treatment
- Naloxone distribution and training
- General education and awareness trainings related to evidenced-based OUD treatment
- Flexible Needs Fund Disbursements

Monthly activity reports show:

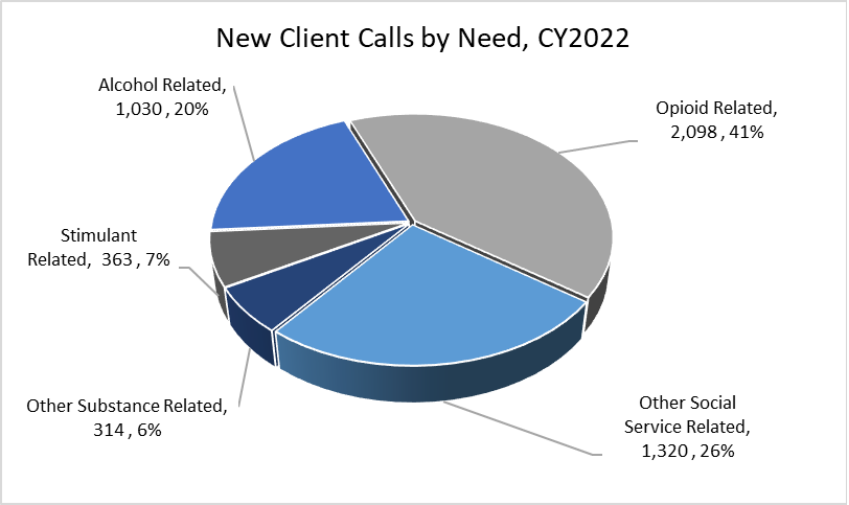
- Calls related to social service needs more than doubled between CY2020 and 2022
- In CY2022, Doorway sites initiated nearly 4,000 referrals for SUD treatment and more than 10,400 referrals for other services



DOORWAY PROGRAM OVERVIEW (CONTINUED)

New Client Calls

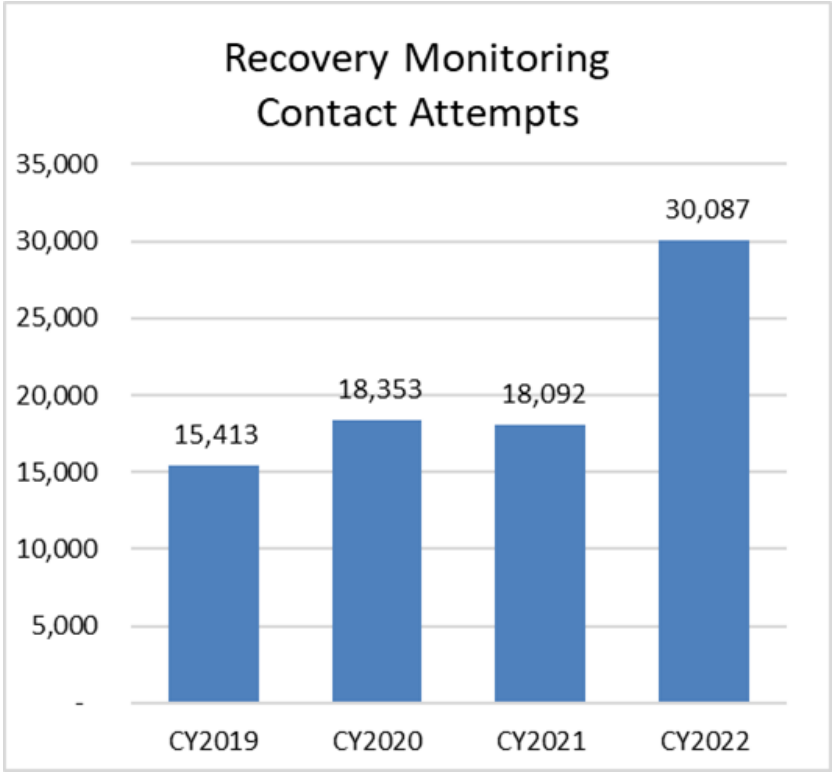
- Between April 2019 and December 2022, Doorway sites received nearly18,000 new client calls
- The average number of monthly calls increased by approximately 71% from CY2019 to CY2022
- The average number of monthly calls consistently averaged approximately 425 calls in CY2020, 2021 and 2022
- In CY2022:
  - Nearly half (48%) of new client calls were related to opioid and stimulant use
  - Approximately one-fourth (26%) of new client calls were related to social service needs
  - Approximately 20% of new client calls were related to alcohol use



DOORWAY PROGRAM OVERVIEW (CONTINUED)

Recovery Monitoring

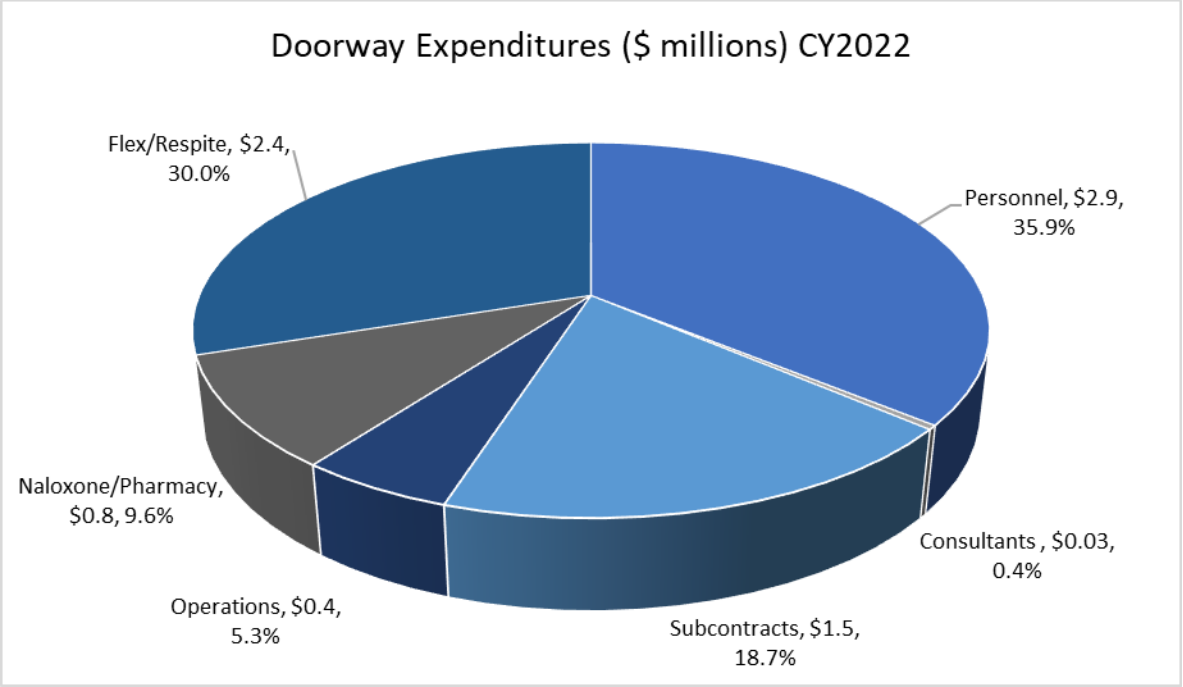
- Doorway sites reported an average of approximately 2,500 recovery monitoring contact attempts each month in CY2022
- Recovery monitoring contact attempts increased significantly from approximately 18,000 total calls in CY2021 to more than 30,000 in CY2022



DOORWAY PROGRAM OVERVIEW (CONTINUED)

Doorway Program Expenditures, CY2022

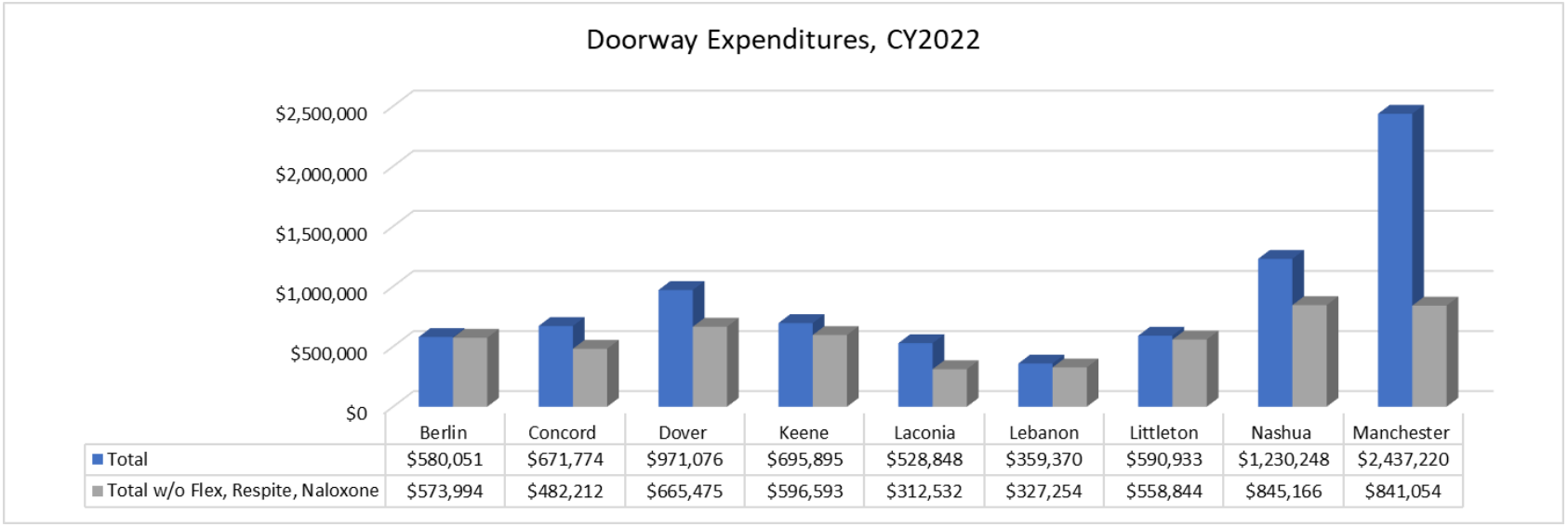
- DHHS-SOR invoices for CY2022 totaled $8,065,415 for Doorway programs



DOORWAY PROGRAM OVERVIEW (CONTINUED)

Doorway Program Expenditures by Site, CY2022

- Absent Flexible Needs, Respite and Naloxone, annual expenditures per site range from $312k to $845k
- The two Doorways with the most populated service areas (Manchester and Nashua) represent the largest expenditures

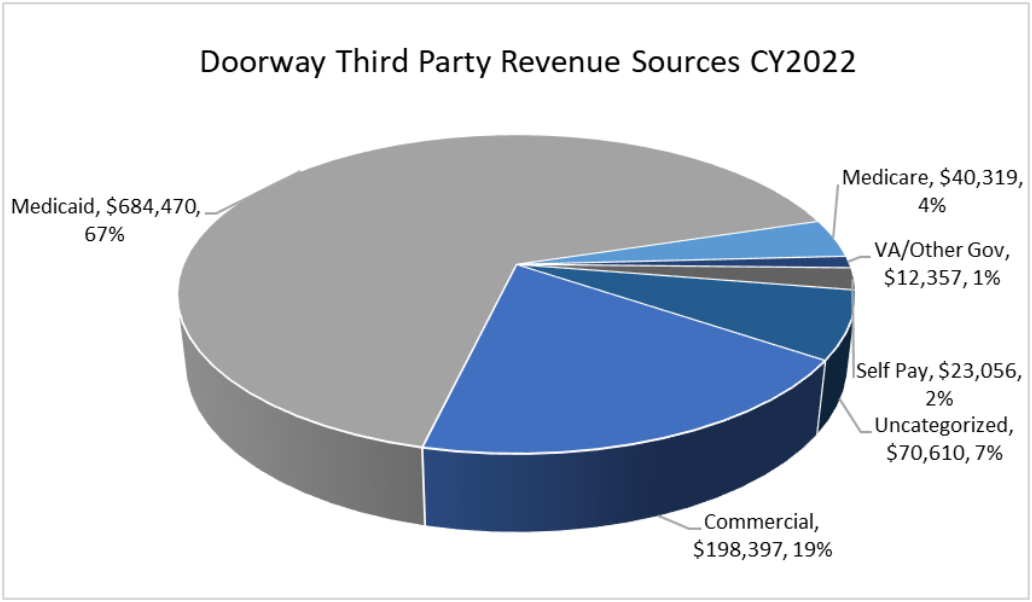


	Berlin	Concord	Dover	Keene	Laconia	Lebanon	Littleton	Nashua	Manchester
Total	$580,051	$671,774	$971,076	$695,895	$528,848	$359,370	$590,933	$1,230,248	$2,437,220
Total w/o Flex, Respite, Naloxone	$573,994	$482,212	$665,475	$596,593	$312,532	$327,254	$558,844	$845,166	$841,054

DOORWAY PROGRAM OVERVIEW (CONTINUED)

Doorway Third-Party Revenues

- Medicaid represents 67% of third-party revenues, followed by commercial plans with 19%
- One site (Manchester) does not have third party revenue offsets; evaluations are provided at partner agencies and case management provided by the Doorway staff is not billed
- Methodologies for revenue offsets vary:
  - 100% of collections
  - Allocation of clinician salary expenses based on the amount of time clinicians spent providing services covered by third parties



DOORWAY PROGRAM OVERVIEW (CONTINUED)

Local Flex Fund Utilization – Allowable Uses

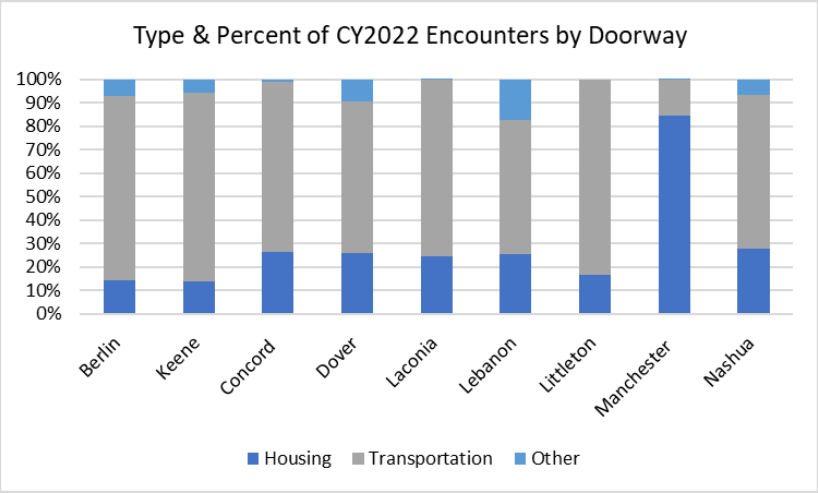
The Flexible Needs Fund (Flex Funds) may be used for supports that promote access to care not otherwise covered by another payer. Allowable uses include:

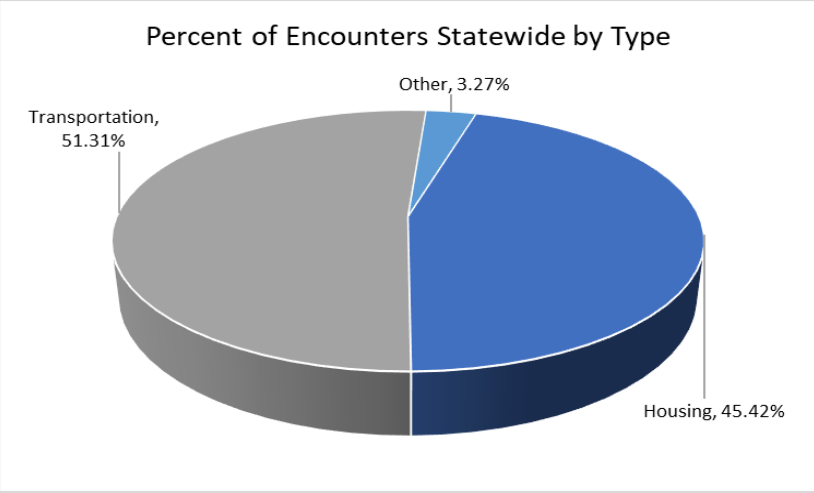
- Transportation to and from recovery-related treatment programs and services
- Childcare to permit a client to attend treatment and recovery-related medical appointments
- Short-term housing or coverage of other expenses needed to remove financial barriers to obtaining and/or retaining safe housing. Doorway staff may refer clients to local shelters, recovery housing providers, transitional living programs and/or pay for short-term hotel stays. Local respite services may be reimbursed by Doorways on a fee-for-service basis or through a capacity-based agreement.
- Light snacks
- Clothing appropriate for weather conditions or job interviews
- Other uses that are pre-approved by DHHS

DOORWAY PROGRAM OVERVIEW (CONTINUED)

Local Flex Fund Utilization, CY2022

- Over 50% of the encounters statewide were for transportation, followed by housing supports (45%)
- Slightly over 3% of funds were used for other activities such as food, clothing, gift cards and obtaining government issued IDs necessary for enrolling in health care coverage





DOORWAY PROGRAM OVERVIEW (CONTINUED)

Local Flex Fund Utilization

- A total of 1,898 Flex Fund clients (97%) received Flex Funds from only one Doorway; 53 clients received Flex Funds from two Doorways; fewer than 10 clients received Flex Funds from three or more Doorways
- Expenditures per client ranged from less than $100 for 409 clients to more than $2,500 for 38 clients, with nearly half of Flex Fund clients (907) receiving between $200 and $999 in Flex Funds support

Number of Clients Receiving Flex Funds from Multiple Doorways*	
Number of Doorways	Number of Clients
1	1,898
2	53
3 or more	<10
Total	1,953

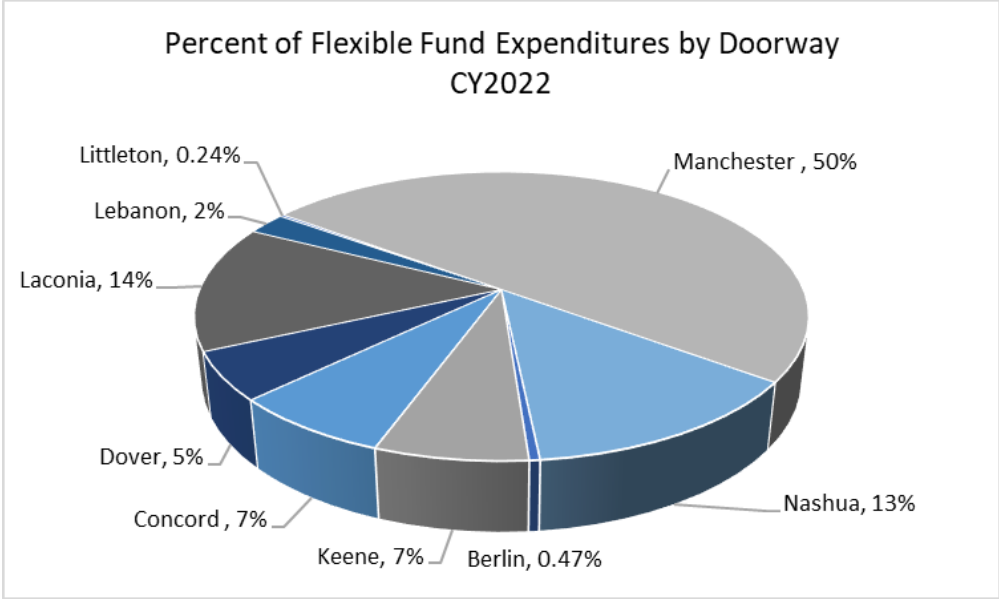
Summary of Expenditures by Client*	
Amount	Number of Clients
Less than $100	409
$100 - $199	176
$200 - $499	445
$500 - $999	462
$1,000 - $2,499	423
$2,500 and Above	38
Total	1,953

* Use of unique recipient IDs was inconsistent in the first part of CY2022; thus, an unduplicated count of recipients is available for only a subset of the total Flex Fund encounters reported.

DOORWAY PROGRAM OVERVIEW (CONTINUED)

Local Flex Fund Expenditures

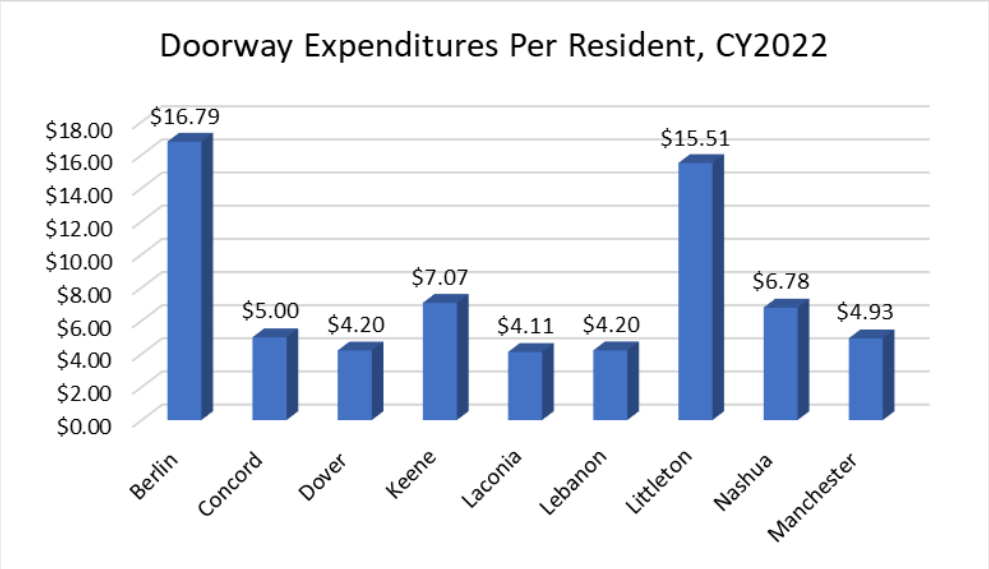
- Manchester reported approximately 50 % of the expenditures statewide
- Laconia and Nashua reported 14% and 13%, respectively
- Concord and Keene each reported 7% of the statewide expenditures, followed by Dover (5%) and Lebanon (2%)
- Littleton and Berlin reported less than 1% of statewide flex fund expenditures



DOORWAY PROGRAM OVERVIEW (CONTINUED)

Doorway Site Expenditures per Resident, CY2022

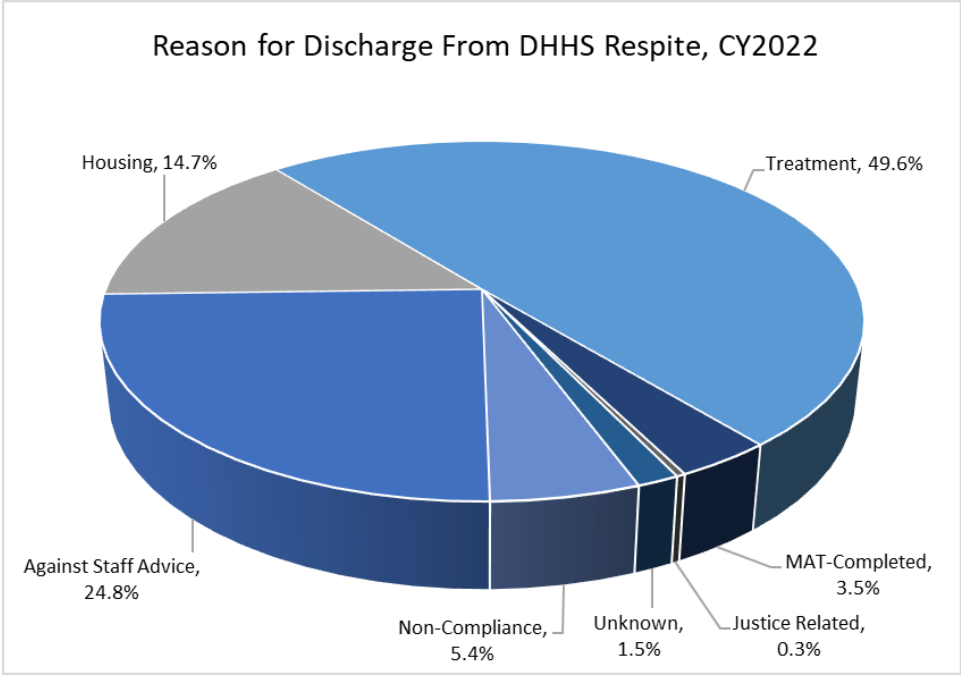
- Per resident costs (including Flexible/Respite funds and Naloxone) range from a high of $16.79 to a low of $4.11
- Berlin and Littleton represent rural regions with small populations (less than 40,000 residents in each catchment area)
- The statewide, annual average Doorway expenditure per New Hampshire resident is $5.93



DOORWAY PROGRAM OVERVIEW (CONTINUED)

DHHS Contracted Respite – Discharge Reasons, CY2022

- Nearly 50% of discharges were for treatment-related reasons
- Approximately 15% of discharges were to housing
- Approximately 25% of discharges were against staff advice
- 5% of discharges were for non-compliance
- Completion of MAT was identified in 3.5% of discharges
- Less than one percent of discharges were recorded as justice-related



DOORWAY EVALUATION OVERVIEW

METHODS, DATA EXTRACTS AND LIMITATIONS

DOORWAY EVALUATION OVERVIEW

Evaluation Goals

- Evaluate Doorway model (structure, policies and operations)
- Identify Doorway elements (e.g., local models, policies, activities) that are most successful in promoting access to care, engagement in treatment and recovery
- Evaluate role of the Doorway program within New Hampshire's system of care
- Develop recommendations to improve program performance and enhance access to, and retention in, OUD treatment (e.g., policies, operations, reimbursement and finance models)
- Identify alternative delivery system models

DOORWAY EVALUATION OVERVIEW (CONTINUED)

Evaluation Methods

Review of Historical Information & Data

- DHHS Reports and Presentations
- Doorway Meeting Minutes
- Policy Briefs
- Data Summaries

Stakeholder Interviews & Focus Groups

- Nine Doorway Sites (2-2.5-hour interviews, including post-interview validation meetings)
- Three Doorway focus group sessions
- University of New Hampshire TA Team
- DHHS Respite Providers
- DHHS-SOR Staff

Analyses of Available Data for CY2022

- Monthly Activity Reports
- Expenditures and third-party revenues (i.e., DHHS invoice tracking data)
- DHHS Respite Vendor Data Extract
- Flexible Needs Fund (i.e., DHHS Back-up reports)
- Medicaid Claims (State Fiscal Year 2021 – 2022)
- DHHS GPRA Data Extract
- DHHS Other SOR Vendor Data Extract

DOORWAY EVALUATION OVERVIEW (CONTINUED)

Use of Data and Limitations

General

- DHHS Doorway reporting formats and data requirements were revised several times in CY2022
- SOR vendors do not have uniform reporting requirements
- Time-limited nature of the evaluation activities did not allow for standardized data development
- Inconsistent use of recipient IDs within and across data sets presented challenges in calculating unduplicated counts and linking recipients across and within data sets (consistency improved the second half of 2022)
- Data limitations identified across data sets restricts ability to compare performance across sites
- Analyses should be considered exploratory

DHHS Respite Vendor Data

- DHHS-SOR staff compiled vendor data into one extract to share with PHPG; PHPG removed duplicate entries when the client ID, date of discharge and treatment setting, were identical
- Expenditure data for respite was compiled by PHPG using paid amounts and bed days reflected in monthly invoices paid by DHHS
- Data for 1,005 stays at NH Respite and 244 stays at Granite Recovery in CY2022 were examined
- Secondary data sets were not available to the evaluators for validation of data integrity and completeness of the compiled extracts. Overall, fewer visits were recorded (based on discharge date) in October and November of 2022

DOORWAY EVALUATION OVERVIEW (CONTINUED)

Use of Data and Limitations (continued)

Flexible Needs Fund Data

- Flex Fund reports included blank fields and inconsistent terminology related to:
  - Recipient ID
  - Housing-related supports (e.g., short-term housing, respite housing, recovery housing)
  - Transportation purpose, end location, round trip data and provider
  - Service dates were not standardized (e.g., date paid, date of service, to/from date)
  - Some reimbursements were recorded as a lump sum payment for multiple clients or a payment for capacity whether used or not
- PHPG compiled a data set using monthly flex fund reports from each of the nine Doorways
- Flex Fund data was examined for 6,359 encounters in CY2022; each encounter represents one record
- Flex Fund expenditures compiled from the back-up detail may be higher than final Doorway payments due to a DHHS disallowance, budget caps or transfer of costs to another fund source (e.g., unmet needs)

DOORWAY EVALUATION OVERVIEW (CONTINUED)

Use of Data and Limitations (continued)

Activity Report Data

- Since the start of the Doorway model, Doorway sites have submitted monthly Activity Reports that provide de-identified demographic and utilization data
- Two additional measures were added at the beginning of CY2022:
  - Established Client Clinical Re-assessments Completed by Primary Diagnosis Type
  - Established Clients Seen by Primary Reason Type
- The following measures were added in October 2022:
  - New Clients Seen by Age
  - New Clients Seen by Employment Status
  - New Clients Seen by Ethnicity
  - New Clients Seen by Health Insurance Status
  - New Clients Seen by Housing Status
  - New Clients Seen by Justice System Involvement Status

DOORWAY EVALUATION OVERVIEW (CONTINUED)

Use of Data and Limitations (continued)

Government Performance and Results Act (GPRA) Data

- SAMSHA requires federal grantees to perform initial GPRA assessments, six-month follow-up assessments and assessments upon discharge
- Doorways are required to complete GPRA assessments on behalf of individuals requiring treatment for opioid or stimulant use
- An extract of GPRA assessments was created from the GPRA database that includes unduplicated assessment data for interviews conducted in State Fiscal Year 2022

Medicaid Data

- Medicaid ID numbers are not routinely stored/collected; Medicaid IDs were obtained through the following approaches
  - Member rosters provided by Doorway sites
  - GPRA extracts were provided by DHHS that included a sample of Medicaid IDs
  - Claims data analysis to identify Medicaid participants who received a Medicaid-covered service from a Doorway Provider Number
- Due to limitations in matching Doorway members to Medicaid eligibility, the analysis is based on a sample and therefore does not represent Medicaid utilization and expenditures for the complete Doorway population
- Because Doorway Provider Numbers were used for both Doorway and non-Doorway members in some instances, the sample was further refined to include only members with a minimum SUD claim total of $100 in State Fiscal Year 2022; the Manchester site does not have a Provider Number
- Due to methodology for identifying Medicaid IDs for Doorway members, caution should be exercised when reviewing Doorway-specific data

DOORWAY EVALUATION OVERVIEW (CONTINUED)

Use of Data and Limitations (continued)

Sample Medicaid Data

- A sample of members who were served by Doorways and eligible for Medicaid coverage in State Fiscal Year 2022 (SFY2022) were identified
- Valid Medicaid IDs were identified for 2,972 Medicaid participants in SFY2022
- Medicaid claims with dates of service in SFY2022 and Medicaid eligibility data for SFY2022 were extracted for analysis
- Medicaid claims with dates of service in SFY2021 also were evaluated to distinguish between new Doorway members and Doorway members who participated prior to SFY2022

Doorway Site	Number of Members in Medicaid Sample
Berlin	144
Concord	608
Dover	298
Keene	384
Laconia	130
Lebanon	110
Littleton	397
Manchester	461
Nashua	440
Total	**2,972**

DOORWAY EVALUATION OVERVIEW (CONTINUED)

Findings and recommendations are presented within the following domains:

- System of Care: Defining and aligning roles and creating incentives for collaboration across the system of care
  - Standardize Doorway Model of Care
  - Define and Align State Priorities, and Initiatives and Incentivize Collaboration
- Quality Framework, Benchmarks and Monitoring: Defining data and quality standards
  - Develop Monitoring and Performance Improvement Framework
  - Standardize Data Collection and Establish Benchmarks
- Financing and Sustainability: Enhancing the current financing model and promoting sustainability
  - Enhance Third Party Revenue, Including Medicaid
  - Clarify Medicaid MCO Obligations
  - Centralize Management of Flexible Needs Fund
  - Enhance SOR and Medicaid Transportation
  - Enhance Access and Utilization of DHHS Respite Services
  - Enhance Medicaid Authorities and Multi-payer Approaches
  - Explore Alternative Delivery System Models

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE

System of Care Findings

- *Doorways serve as essential and immediate access points for SUD/OUD treatment*
- *Immediacy of assessment, transportation, housing and case management (24/7) are vital for engaging hard-to-reach clients struggling with OUD*
- *There are opportunities to better align DHHS policies and funding across the system of care for SUD/OUD*

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Findings - Doorway Operations

Doorways serve as essential and immediate access points for SUD/OUD treatment

Without the Doorway Program:

- There is no guaranteed place to get a clinical assessment 24/7 and immediate action on next steps
- Clients may not get to the right level of care and "loop" through the system multiple times without success
- Clients may knock on multiple doors before they get help; many will disengage because help isn't immediate

"Pre-Doorway it was referral only, no clinical assessment was completed to help guide placement decisions and treatment options"
– Doorway Interviewee

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Findings - Doorway Operations (continued)

Doorways serve as essential and immediate access points for SUD/OUD treatment (continued)

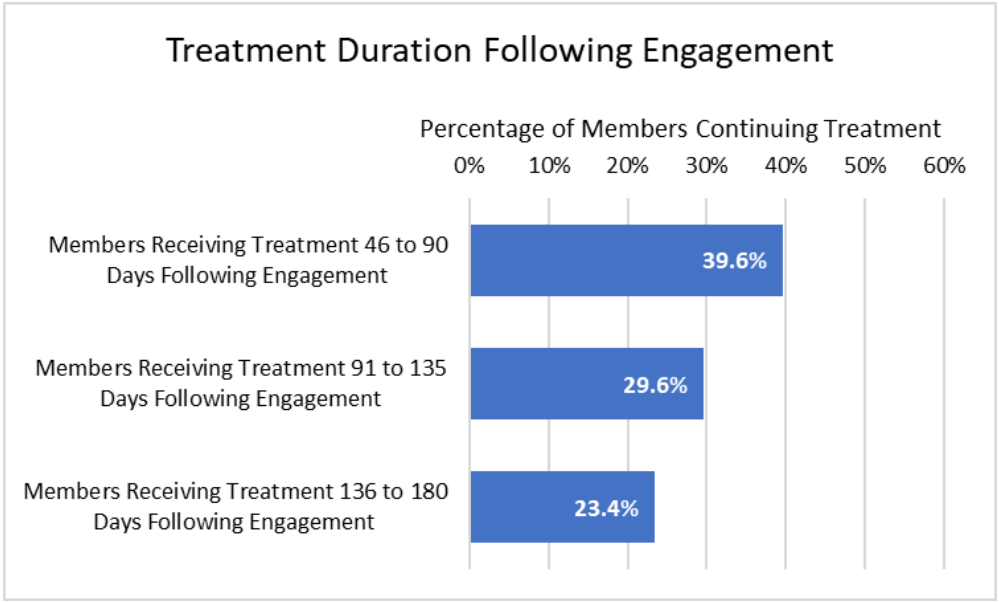
- More than half (54%) of new clients seen were walk-ins to the Doorway sites in CY2022 another 20% were referred by medical professionals, social service agencies, clergy or other
- The number of members waiting for treatment openings declined from 2,524 in CY2021 to 2,336 in CY2022
- The number of days waiting for treatment declined from more than 22,000 in CY2021 total days to less than 10,000 total days in CY2022
- In SFY2022, total ED visits in the 6 months prior to engagement with the Doorway equaled 4,038; ED visits in the 6 months following engagement total 3,008, representing a reduction of 26%

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Findings - Doorway Operations (continued)

Doorways serve as essential and immediate access points for SUD/OUD treatment (continued)

- A total of 717 Medicaid members were identified as initiating treatment (e.g., receiving one or more SUD treatment services within 45 days of a Doorway-billed service)
- Nearly 40% of Doorway Medicaid members continued to receive Medicaid SUD treatment services after the first 45 days following the first Doorway-billed service
- 30% of Doorway Medicaid members continued to receive Medicaid SUD treatment services after the first 90 days



FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Findings - Doorway Operations (continued)

Differences in Doorway operations can, in part, be attributed to differences in geography and access to community resources (e.g., treatment services, proximity to respite, recovery housing and transportation providers)

- **Single Entity Model** - Eight Doorways are operated by a single lead entity (Five by the grantee/hospital and three by a member of the grantees health system) delivering all core services
- **Contracted Service Model** - One Doorway grantee was asked to take over a Doorway site after another vendor suspended operations. The host agency delivers all core services apart from ASAM level of care evaluations, which are subcontracted to a variety of local partners
- **Local Community Contracts** - Seven Doorways have contracts to purchase respite, MOUD, and/or Doorway staffing (e.g., peer recovery, medical oversight) from local partners

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Findings - Doorway Operations (continued)

Fundamental Doorway processes are more similar than different and promote a face-to-face standard for care management that is essential for engaging hard-to-reach clients

All Doorways offer:

- **Immediate Engagement and Access**: Clients are met by licensed staff (e.g., CRSWs, LADCs) to discuss wants/needs. Staff focus on finding resources to address immediate needs, harm reduction, safety and other issues (e.g., food, health coverage, safe housing, naloxone kits)
- **Access to Specialized Resources**: Each Doorway identified local resources and/or referral agreements to assist with specialized populations (e.g., pregnant women, veterans, families, unhoused)
- **Engagement and Outreach**: Formal outreach is attempted with clients who are not ready to engage in treatment; individual bridge counseling and/or recovery planning groups are offered

Eight Doorways offer:

- **Immediate Assessment**: In all but one Doorway, ASAM level of care assessments are completed when staff first meet clients (exceptions are made when the client has immediate medical, or crisis needs)
- **Access to MOUD within 72-Hours:** Six Doorways report availability within 0-24 hours, two within 72-hours and one within two weeks. Seven Doorways have onsite availability; the remaining two represent larger urban centers with access to a wide array of SUD/OUD treatment options in the community

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Findings - Doorway Operations (continued)

Access to the following Doorway services promote client success and should be maintained absent federal funding:

- ***Immediate screening and evidenced based (ASAM) assessment*** (i.e., 24/7) is vital in engaging hard-to-reach clients who are struggling with addiction
- Mechanisms to ***immediately transport*** someone to ***safe housing*** while awaiting treatment has been a lifeline for many individuals
- ***Facilitated referrals*** (warm/live transfers) and ***case management supports*** to navigate the treatment system are essential for individuals struggling with OUD

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Findings - Doorway Operations (continued)

Access to Doorway services promotes client success and should be maintained absent federal funding (continued)

An examination of GPRA data at intake and at follow-up/discharge showed **improvements in**:

- **Acuity of SUD diagnoses**: the percentage of members reporting a moderate/severe SUD decreased from 66.9% to 49.7%; the percentage of members who reported an SUD in remission increased from 14.1% to 36.9%
- **Housing stability**: the percentage of members who rented or owned their residences increased from 30.3% to 45.5% at follow-up/discharge
- **Health Satisfaction**: the percentage of members who reported that they were Dissatisfied or Very Dissatisfied with their health decreased from 19.3% at intake to 14.5% at follow-up/discharge; the percentage of members who reported that they were Very Satisfied or Satisfied with their health increased from 54.1% at intake to 61.4% at follow-up/discharge
- **Self-Satisfaction**: 24.5% of members reported being Dissatisfied or Very Dissatisfied at the time of intake, compared to 14.5% at follow-up/discharge; the percentage of members whose self-satisfaction was reported at Very Satisfied or Satisfied increased from 47.6% at intake to 61.4% at follow-up/discharge

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Findings - State Policies, Priorities and Initiatives

There are opportunities to better align DHHS policies, funding and oversight across the publicly funded behavioral health delivery system

- A formal relationship between "Spokes"(treatment providers) and Doorways is not defined
  - No uniform requirements regarding closed-loop referrals, treatment provider engagement in coordination, treatment planning and transitions of care with the Doorways
  - Unclear alignment of State initiatives (e.g., SOR, Certified Community Behavioral Health Clinics, Medicaid MCO and Medicaid SUD/OUD Demonstration, integrated MH/SUD initiatives)
- Gaps in Doorway funding for clients with alcohol use disorder
- Client rights and protections (e.g., grievance and appeals processes) are unclear; acceptable sanctions for rule violations in respite, recovery housing programs are not articulated or aligned across the system of care

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Findings - State Policies, Priorities and Initiatives

Some aspects of Medicaid and commercial coverage create barriers to timely access to treatment for OUD

- Medicaid MCO Prior Authorization (PA) requirements divert staff time from direct care (approvals can take up to hour or more while clients wait at the Doorway) and hinder access to timely treatment (e.g., failure to approve withdrawal management for OUD)
- Marketplace policies are expensive; clients drop out of treatment due to high deductibles and co-pays

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Findings – State Policies, Priorities and Initiatives

Respite program rules, models of care and collaboration/communication could be enhanced

- Policies and operations vary across locations
- Clients who are banned do not have options to appeal or ask for modifications
- Treatment plans may be modified without Doorway collaboration (e.g., clients may be waiting for a 60- or 90-day program, however discharge is to a 28-day program)
- Client may be discharged without Doorway staff knowing disposition
- Nearly 50% of respite discharges were for treatment related reasons, 15% were for other housing, 5% were for non-compliance/rule violations
- In approximately 25% of respite stays, members left against staff advice

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

- Enhance Doorway policies to support a seamless statewide model of care
- Define and align roles and create incentives for collaboration across publicly funding system (BDAS, SOR, MH, Medicaid, Licensing)

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Recommendations – Doorway Operations

Enhance Doorway policies to support a seamless statewide model of care

- Develop uniform model of care standards
- Develop a Doorway ROI that allows communication and care planning across Doorways, respite and treatment providers
- Establish a clinical review forum/grand rounds for case reviews
- Develop member-driven shared care plans for coordination with Doorway, respite and treatment providers
- Enhance web-based technology to support coordination and care planning

A summary of options and considerations is presented on the next slides. Options could be combined or implemented individually to support operations

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Recommendation: Enhance Doorway policies to support a seamless statewide model of care

Options	Considerations
Develop uniform standards of care for Doorway sites (e.g., timelines for assessment and access to care, screening tools, telehealth capabilities, onsite services, communication)	• Creating a uniform approach may limit local innovation, responsiveness and access to unique community partnerships or services • Reductions in federal funding may not support adding new services or capabilities to the current core service requirements
Create a universal Release of Information (ROI) that allows communication and care planning across Doorways, respite and treatment providers	• Use of standard ROI could result in increased paperwork if host agency still requires site-specific forms • ROI would need to articulate the level of coordination expected across Doorways and with other partners
Establish a clinical/grand rounds forum with staff from each Doorway to discuss complex clients and those who receive care from multiple Doorways	• Grand rounds could be defined in Doorway contract • Respite providers could be invited as relevant

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Recommendation: Enhance Doorway policies to support a seamless statewide model of care (continued)

Options	Considerations
Develop and exchange member-driven shared care plans across Doorways, respite and treatment providers • Shared care plans refer to a brief 1–2-page member-driven summary of goals, recommended level of care, recovery supports and crisis plan • Shared care plans could be part of the WITS record or established and transmitted as part of a closed loop referral system • DHHS could require a care conference with the member, Doorway and respite staff prior to changes being made and/or for members who may have more complex or challenging behaviors	• Creation of shared care plans may represent new paperwork requirements for some agencies • Shared care plans could be limited to those clients who are ready to engage in recovery or who have a treatment plan

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Recommendation: Enhance Doorway policies to support a seamless statewide model of care (continued)

Options	Considerations
Enhance web-based technology to support coordination and care planning such as: • Providing read-only access to local teams to view information in WITS across Doorways • Designating and training local staff to initiate client transfers and update WITS as needed • Developing or procuring a care management software platform for Doorway use that supports the desired care standards (e.g., notifications for follow-up and/or missing information)	• In the absence of a health information exchange network, procuring care management software may result in duplicative data entry (local systems and state systems) • Ongoing/on-demand training tools may be required to address staff turnover • Standard care management software could also support standardized data definitions (e.g., drop downs), reporting and quality standards • Implementation of a standard care management software package may be time consuming

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Recommendations – State Policies, Priorities and Funding

Define and align roles and create incentives for collaboration across publicly funding system (BDAS, SOR, MH, Medicaid, Licensing)

- Develop or enhance interagency mechanisms for adoption of best practices and policies across DHHS funding sources, including SAMHSA and other SUD/OUD grant programs
- Support system of care development with Policy and Learning Collaboratives
- Support timely access to care and create incentives for collaboration
- Address Gaps in Medicare and Commercial coverage
- Include Doorways in ADT event notification or similar alert or closed-loop referral system
- Create standardized requirements for DHHS respite and recovery housing providers
- Define client rights, grievance and appeals policies for respite, recovery housing and other providers

A summary of options and considerations is presented on the next slides. Options could be combined or implemented individually to support operations

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Recommendation: Define and align roles and create incentives for collaboration across publicly funding system (BDAS, SOR, MH, Medicaid, Licensing)

Options	Considerations
Develop or enhance interagency mechanisms to align roles, policies and funding across DHHS funding sources, including SAMHSA and other SUD/OUD grant programs to: • Define roles and create incentives for treatment providers to work with Doorways (e.g., Hub and Spoke roles) • Minimize funding gaps (e.g., funding for alcohol use disorder) • Limit duplication (e.g., multiple client assessments across Doorway and/or treatment providers) • Align care planning and communication requirements across providers	• Alignment would require an inventory of current efforts, fund sources and DHHS agreement on priorities • DHHS may have an existing interagency planning structure that could be augmented to include SAMHSA and other grant SUD/OUD funded efforts • Funding for alcohol use disorder could be aligned to support Doorway operations (e.g., Medicaid and other grants funds) • For entities with multiple awards (SAMHSA or other funds). contracts could be streamlined • May require DHHS staffing or other resources to support planning efforts • Communications across providers could be supported with a closed-loop referral platform
Support system of care development with Learning and Policy Collaboratives that include Doorway, respite program staff and treatment providers to share best practices, discuss policy barriers with DHHS and integrate quality monitoring frameworks	• Facilitating formal collaborative structure may require more DHHS staff and/or reallocation of resources • Participation in policy and learning collaboratives may reduce staff availability for direct services • Learning collaboratives would allow best practices to emerge across sites and inform the quality framework • Policy collaboratives could help shape policy and refine current practices

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Recommendation: Define and align roles and create incentives for collaboration across publicly funding system (BDAS, SOR, MH, Medicaid, Licensing) (continued)

Options	Considerations
Support timely access to care and create incentives for collaboration by amending the Medicaid MCO contract to: • Eliminate PAs for OUD treatment when the referral is from a Doorway • Recognize withdrawal management as a medically necessary service for OUD	• Recognizes Doorways as system of care entry points • Creates incentives for treatment providers to coordinate care with Doorways • Diverts staff time back to provision of direct services • Currently, the Medicaid MCO (Contract Section 4.2.15) requires that members served in Doorways with integrated on-site pharmacies have immediate access to pharmaceuticals • Could be extended to other comprehensive providers who use ASAM screening tools (CMHCs, CCBHCs,)
Address Gaps in Medicare and Commercial Coverage by using SOR as a risk pool for uncompensated care and coverage holes (co-pays, high deductibles)	• Could create a disincentive to pursuing third party coverage • Creates incentives for treatment providers to coordinate care with Doorways
Include Doorways in admission, discharge, transfer (ADT) event notification system or other similar alert or closed loop referral system	• Receiving ADT notices could allow Doorways to better track and support transitions of care, conduct GPRA and other follow-ups • To be most effective, most treatment providers would need to participate • Implementation of SUD/OUD electronic notices could be phased-in between Doorways and inpatient/residential providers

FINDINGS AND RECOMMENDATIONS: SYSTEM OF CARE (CONTINUED)

Recommendation: Define and align roles and create incentives for collaboration across publicly funding system (BDAS, SOR, MH, Medicaid, Licensing) (continued)

Options	Considerations
Create standardized state level requirements for respite and recovery residences who receive state and/or federal funding • Enhanced per diems could be explored for providers who support preferred medication protocols, including dosage levels and types (e.g., methadone, mental and physical health-related) or who support more complex clients • Require standard and routine trainings on crisis de-escalation and mediation • Rules and subsequent changes approved by DHHS and distributed to Doorways and other providers prior to taking effect	• Creates one set of expectations for providers who are funded through multiple state and federal grants • Could create more administrative burden for providers who receive limited state and federal grant funds • Recognizes importance of supporting clients who require methadone, psychotropic or other medications in respite and recovery housing
Define client rights, grievance and appeals (G&A) processes for respite and recovery housing providers including; • Clear criteria and time limits for client sanctions/restrictions • Reporting of provider-initiated discharges and a state level team for the review of client discharges and sanctions • Expedited appeal process that can be initiated by the Doorway or the client and resolved while client is waiting for placement • Requirements for collaboration with Doorway teams prior to expelling a client from a housing or respite	• G&A processes may already exist for providers who work with BDAS, Medicaid and MH • Could create more administrative burden for providers who are not currently required to have a G&A process • Use of sanctions and G&A trends could provide valuable feedback for quality improvement and policy initiatives • Supports communication and planning for more complex clients • Supports accountability for state and federal funds

FINDINGS AND RECOMMENDATIONS: QUALITY FRAMEWORK AND MONITORING

Quality Framework & Monitoring Findings

- *Administrative and reporting requirements do not fully support quality monitoring and outcome tracking*

FINDINGS AND RECOMMENDATIONS: QUALITY FRAMEWORK AND MONITORING (CONTINUED)

Findings - Quality Framework, Monitoring and Benchmarks

Administrative and reporting requirements do not fully support quality monitoring and outcome tracking

- Administrative burden is extensive and diverts staff time from client care (many Doorways report 2.5 days per month for invoicing and data reporting)
- Differences in documentation and format types hinders uniform and timely analyses across Doorways
- Reporting templates do not include data definitions or standard cell formats across data sets, vendors or reporting years
- Lack of a common recipient ID within and across data sets prohibits outcome tracking
- Inability to track Medicaid enrollees limits the information available to support policy and program innovations
- Quality measures (process and outcomes) are not defined, feedback on client experience of care is limited

FINDINGS AND RECOMMENDATIONS: QUALITY FRAMEWORK AND MONITORING (CONTINUED)

- Create a quality monitoring and improvement framework
- Standardize data collection and establish benchmarks

FINDINGS AND RECOMMENDATIONS: QUALITY FRAMEWORK AND MONITORING (CONTINUED)

Recommendations – Quality Framework, Monitoring and Benchmarks

Create a quality monitoring and improvement framework

- Create quality benchmarks (e.g., performance standards, client satisfaction, complaints and grievance, and outcome measures) and monitor trends
- Distribute Doorway focused client satisfaction surveys in other sites (e.g., respite and treatment programs)

A summary of options and considerations is presented on the next slides. Options could be combined or implemented individually to support operations

FINDINGS AND RECOMMENDATIONS: QUALITY FRAMEWORK AND MONITORING (CONTINUED)

Recommendation: Create a quality monitoring and improvement framework

Options	Considerations
Create quality benchmarks and monitor quarterly trends • Define performance standards e.g., timeliness of completing ASAM LOC assessments • Define measures and data needs • Track client satisfaction and outcomes • Focus on 1-2 performance improvement projects annually (could be supported by Learning and Policy Collaboratives)	• Quality monitoring could be supported with unified care management platform • Framework could be supported in part by data in monthly activity reports • May increase administrative burden due to reporting requirements • Contract remedies for poor performance could include corrective action planning, termination and replacement of host or other sanctions
Distribute Doorway focused client satisfaction surveys in other sites Ask Doorway partners (e.g., respite, recovery houses) to distribute client satisfaction surveys as they relate to client's recent experience with the Doorway	• Clients may be more willing to fill out surveys outside of the Doorway setting • Clients may be more prepared (e.g., clinically stable) to complete surveys • Including client experience of care is essential for quality improving planning

FINDINGS AND RECOMMENDATIONS: QUALITY FRAMEWORK AND MONITORING (CONTINUED)

Recommendations – Quality Framework, Monitoring and Benchmarks

Standardize data collection and establish benchmarks

- Create standardized formats and templates for reporting across Doorway awards and SAMHSA grants (for vendors with multiple SAMHSA awards)
- Define and require common IDs across data sets
- Develop process to collect and maintain Medicaid enrollment data for Doorway clients

A summary of options and considerations is presented on the next slides. Options could be combined or implemented individually to support operations

FINDINGS AND RECOMMENDATIONS: QUALITY FRAMEWORK AND MONITORING (CONTINUED)

Recommendation: Standardize Data Collection and Establish Benchmarks

Options	Considerations
Create standardized reporting formats across Doorway/SOR sites and SAMHSA grant awards (for vendors with multiple SAMHSA awards) including for: • Invoicing and required back-up detail • Flex funds and monthly activity reports • Third party collections Include defined input fields with drop down menus, standardized cell formats (e.g., mm/dd/yyyy) and data definitions on tracking templates • Standard definitions of encounters across all data sets and included on reporting templates	• Standardization would allow for outcome and performance tracking • Creation of standard requirements for providers with multiple grant awards may require collaboration with SAMHSA • Flex funds fields for transportation reporting could be simplified to date paid, date of service, round trip/one way, purpose of trip (treatment, respite, pharmacy, Doorway services) • Determine if provider attestation is allowable for back-up documentation. Time savings may be limited if documentation detail is required at current level
Define and require a common ID across all data sets and vendors (e.g., WITS ID)	• WITS data entry requirements could be modified to include all Doorway clients and diagnoses
Develop process to collect and maintain Medicaid enrollment information for Doorway clients (e.g., Medicaid ID, DOB,, etc.)	• Include all clients regardless of whether Medicaid was billed • Monthly enrollment formats should be standardized and include definition for active members

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY

Doorway Financing & Sustainability Findings

- *There are opportunities to enhance current coverage policies to support the Doorway model of care*
- *Medicaid Managed Care Organizations (MCOs) are obligated to provide care management; engagement of members served by Doorways appears to be limited*
- *New Medicaid State Plan, 1115 Demonstration and/or multi-payer reforms could be developed to support Doorway services*
- *Operating nine independent Doorway entities offers strengths and challenges*

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Findings - Financing and Sustainability

There are opportunities to enhance third-party claiming to better support the Doorway model of care (e.g., immediate face-to-face engagement and care management for hard-to-reach clients)

- Private insurers do not recognize the same provider credentials (e.g., LADC, CRSW, MLADC) or covered services as Medicaid
- Current Medicaid rates and SUD reimbursable services are not supporting Doorway operations
- The methodology for offsetting Doorway expenses with third party revenue and indirect rates are inconsistent across the State (e.g., total collections, allocation of hours, allocation of staff time)

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Findings - Financing and Sustainability

Medicaid Managed Care Organizations are obligated to provide care management; engagement of members served by Doorways appears to be limited

- Five Doorways report little or no interaction with Medicaid MCOs; four Doorways report meeting regularly with the Medicaid MCOs to discuss billing and coverage policies
- Common MCO practices (e.g., telephonic) do not effectively engage hard-to-reach members who present at Doorways struggling with SUD/OUD
  - The current Medicaid MCO contract (in accordance with state and federal regulations) requires MCOs to provide care management for members with SUD/OUD and clients at higher risk (Sections 4.10 and 4.10.5.1 respectively)
  - Medicaid MCO contract Section 4.10.1.6 defines Care Management as direct contact with a member focused on the provision of various aspects of the member's physical and mental health, SUD status and needed social supports that shall enable the Member in achieving the best health outcomes

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Findings - Financing and Sustainability

Flexible Funds support timely access to treatment and safe housing. However, management of flexible funds creates administration challenges

- Flex funds address health related social needs and fill gaps in the delivery system
- Immediacy of decision-making and fund availability 24/7 is important to engage hard-to-reach clients
- Allocations by region result in some regions being under budget and others over budget
- Aspects of the flex fund policies vary across Doorways (e.g., income eligibility, length of benefit, process for local authorizations)

Getting people to safe place and assisting them with flex funds builds trust and increases the likelihood they will get the help they need.

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Findings - Financing and Sustainability

Medicaid transportation rules and availability of services (SOR and Medicaid) are challenging for clients with OUD

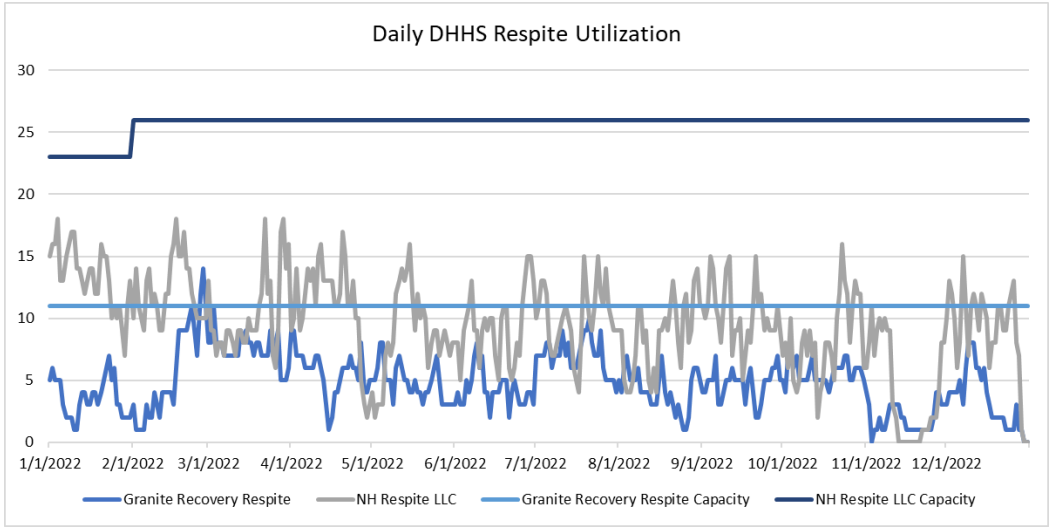
- Immediacy of transportation supports 24/7 is vital to establishing safe housing and engaging clients in recovery planning and treatment
- Transportation encounters reimbursed with flex funds are provided to Medicaid members; absent barriers, many of these services potentially could be covered under the Medicaid transportation benefit
- Medicaid notice requirements (e.g., 48-hours) do not work for members with OUD who may be in crisis and/or need immediate access to treatment service to support engagement
- Transportation vendors cancel without notice or do not offer services in the rural areas; rural service providers are closing due to driver shortages; Uber not available in northern and rural regions
- Doorway clients have reported negative experiences with drivers (sexually inappropriate, not trained, pressure for clients to leave appointments early)

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Findings - Financing and Sustainability

Statewide respite programs are vital, however were under utilized and are difficult to reach for residents in rural areas.

- Immediate availability is essential for client success and safety, especially after- hours
- One DHHS-funded location is rural and hard to reach, the second is urban and may not be appropriate when clients are trying to minimize proximity to drug activity
- One respite program was at or above capacity for 3 days during CY2002; the majority of the time, capacity was between 40% and 59%



FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Findings - Financing and Sustainability

New Medicaid State Plan or 1115 Demonstration initiatives could be developed to support Doorway services

- Doorway services are funded with discretionary federal funds. Federal funds are being reduced and could be eliminated in the future
- Medicaid enhancements offer an opportunity to support future sustainability

"Don't use the funding for things that can be billed or that are already here – use it to fill holes in the system" – Doorway Interviewee

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Findings - Financing and Sustainability

Operating nine independent Doorway entities offers strengths and challenges

- Doorways can be responsive to community needs and collaborate with local providers
- Doorways have access to other treatment programs and staff within the host agency system
- Expertise developed across multiple settings and professionals creates opportunities for sharing innovations, emerging best practices and policy successes
- Each Doorway has its own client record system and WITS log-in creating barriers for information sharing and timely access to treatment for some clients
- Smaller and more rural regions see fewer clients and have higher per capita costs
- Clients perceive the Doorway as one program and may be confused by nine separate policies and/or paperwork requirements
- Level and types of staffing (e.g., APRN, MD, LCSW) varies across Doorways

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

- Enhance third-party revenues to support Doorway model of care (e.g., immediate face-to-face engagement and care management for hard-to-reach clients)
- Clarify and recognize Doorway model of care as part of Medicaid MCO care management obligations
- Improve availability of Flexible Need Fund
- Enhance Medicaid revenues and SOR funded transportation services
- Improve access and enhance management of DHHS respite utilization
- In the absence of federal funds, explore expansion of Medicaid authorities and alternative reimbursement models for Doorway services

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Recommendations – Doorway Financing and Sustainability

Enhance third-party revenues to support Doorway model of care (e.g., immediate face-to-face engagement and care management for hard-to-reach clients)

- Advance legislation to include a full array of SUD provider types (e.g., LADC, MLADC, CRSW) and services in commercial plans
- Create a Doorway-specific coverage rules and rate structure for current Medicaid services
- Standardize how indirect rates and third-party offsets are applied to SOR invoices across Doorways

A summary of options and considerations is presented on the next slides. Options could be combined or implemented individually to support operations

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Recommendation: Enhance third-party revenues for Doorway services

Options	Considerations
Advance legislative changes to require commercial coverage for SUD services that mirrors Medicaid including coverage of CRSWs, LADCs or MLADCs	• Could create workforce incentives and fill gaps in staffing if additional provider types were recognized • Would enhance third party revenue from commercial plans • Promotes a statewide standard of care for SUD/OUD
Enhance guidance and coverage policies for currently allowable Medicaid services provided by the Doorway (e.g., Screening Brief Intervention Referral to Treatment, SUD Screening, Crisis Intervention, Peer Recovery Support Services, Recovery Support Services, Evaluation, Continuous Recovery Monitoring)	• Doorways could be recognized as a provider under current SUD coverage policies and in alignment with their role (e.g., care management) • DHHS could choose to set a rate based on current Doorway service requirements and costs • Rates could be tiered based on staff performing the services (CRSW, LADC, PHD, MD, etc.) • Accessing Medicaid for allowable services will preserve SOR funds for flexible needs and other system of care gaps (e.g., naloxone training and distribution, transportation, housing, support for families)
Standardize how indirect rates and third-party revenue offsets are applied across Doorways	• Options to standardize indirect rates such as establishing a single statewide rate, rate ceiling or tiered rates aligned with host site contributions • Offset approaches based on clinician time create an incentive to bill third parties and preserves local funding • Offset approaches based on total collections preserves SOR funding

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Recommendations – Doorway Financing and Sustainability

Clarify and recognize Doorway model of care as part of Medicaid MCO care management obligations

- Clearly define Medicaid MCO obligations for members with SUD/OUD
- Create MCO Healthy Behavior Program incentives for members to engage with Doorways and recovery planning

A summary of options and considerations is presented on the next slides. Options could be combined or implemented individually to support operations

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY(CONTINUED)

Recommendation: Clarify and recognize Doorway model of care as part of Medicaid MCO care management obligations

Options	Considerations

Clearly define MCOs obligations related to supporting members with SUD/OUD to address best practices, including core services provided by the Doorways	• The State could require that MCOs offer care management for members with OUD through local face-to-face programs
	• The State could require MCOs to recognize Doorways as a specialized care management provider under the contract
	  • Transition to an all-inclusive Medicaid rate or capacity-based agreement to fund Doorway services
	  • Could also include care management for alcohol use disorder
	• Accessing Medicaid for allowable services will preserve the Flexible Needs Fund for other uses and allow SOR funds to be diverted to other system of care gaps

Enhance MCO Healthy Behavior Incentive Program requirements (Section 4.9.4.6) to include member incentives for SUD/OUD treatment and recovery	• Could offer motivation for members to engage in treatment and recovery planning • Could support Doorway follow-ups and completion of GPRA assessments

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Recommendations – Doorway Financing and Sustainability

Improve availability of Flexible Needs Fund

- Centralize management of the fund through DHHS (or another entity) while maintaining immediacy and local decision-making

A summary of options and considerations is presented on the next slides. Options could be combined or implemented individually to support operations

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Recommendation: Improve availability of Flexible Needs Fund

Options	Considerations
Centralize management of flex funds at DHHS (or another entity) while maintaining local decision-making. Define one set of policies related to SAMHSA limitations, income eligibility and record keeping, while retaining immediacy of Doorway decision making over: • Eligibility (financial and clinical) • Type of social supports needed to close gaps (e.g., housing, emergency utility or rent payments, childcare, transportation, care gaps, length of benefit) • Funding amounts per service	• Immediacy is a key element of success for Doorway clients. New processes should support immediate decisions and not delay access to transportation or housing • Would allow for timely distribution of funds across regions as needed • Would require on-going immediate communication to Doorways regarding availability • Soft targets could be established for regions and reconciled monthly or quarterly • If income guidelines are established, DHHS could adopt a sliding scale or spend down option clients who may be slightly over income eligibility

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Recommendations – Doorway Financing and Sustainability

Enhance Medicaid revenues and SOR-funded transportation services

- Revise Medicaid transportation rules for members with OUD to maximize utilization
- Explore options to contract for specialized transportation services in Medicaid and/or SOR program
- Require Medicaid MCOs to reimburse Doorway transportation under the "Family and Friends Mileage Reimbursement Program" when a covered service is arranged for members and authorized by a Doorway

A summary of options and considerations is presented on the next slides. Options could be combined or implemented individually to support operations

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Recommendation: Enhance Medicaid revenues and SOR-funded transportation services

Options	Considerations
Revise Medicaid transportation rules to create SUD/OUD-related exclusions to Medicaid notice requirements	• Medicaid providers may not have on-call drivers in every region of the state
Contract for specialized SUD/OUD transportation services as statewide Medicaid or SOR providers. Medicaid and SOR could jointly fund transportation services such as: • The creation of a statewide registry of Doorway authorized drivers or providers • Contracting with a new or existing service unique to SUD/OUD (e.g., the Recover Cab model)	• Use of CRSWs as drivers may encourage members to follow through with recovery plans • Maintaining a central registry of individual drivers or providers may require staff and/or IT resources • Discrimination of Medicaid versus SOR allowable rides (e.g., member eligibility and covered benefits) would be required • Would require Doorways to document Medicaid ID/MCO ID for each trip
Require Medicaid MCOs to reimburse out-of-network transportation when arranged and authorized by a Doorway. Doorway continues to arrange for immediate transportation, and is recognized by MCOs as authorizing entity for reimbursement	• Medicaid has an existing "Family and Friends Mileage Reimbursement Program" for ride payments • MCOs could sub-contract with Doorway or otherwise authorize Doorways to arrange the transportation service and reimburse the Doorway for allowable rides • Accessing Medicaid for allowable services will preserve SOR funds for other needs

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Recommendations – Doorway Financing and Sustainability

Improve access and enhance utilization management of DHHS respite

- Add DHHS contracted services across more regions
- Establish a reimbursement approach that adjust payment rates for utilization (e.g., risk corridor, tiered payment rates based on occupancy)
- Ensure daily utilization information is available to Doorways

A summary of options and considerations is presented on the next slides. Options could be combined or implemented individually to support operations

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Recommendation: Improve access and enhance management of DHHS respite utilization

Options	Considerations
Fund additional respite sites that are accessible to northern regions through the DHHS statewide contract	• This could include centralizing current, capacity-based agreements between Doorway sites and respite providers at DHHS • DHHS could prioritize the use of statewide providers (based on driving time and clinical appropriateness)
Establish a reimbursement approach for capacity-based contracts that adjusts payment rates for utilization (e.g., risk corridor, tiered payment rates based on occupancy)	• Providers may require a guaranteed base amount to maintain operations and access to needed capacity • Requires utilization data to be submitted and monitored monthly or quarterly by DHHS
Ensure daily utilization information is available to Doorways	• Require respite programs to distribute information on real-time bed availability to Doorways. This could be accomplished using a formal bed tracking system or via a daily census report

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Recommendations – Doorway Financing and Sustainability

In the absence of federal funds, explore expansion of Medicaid authorities and alternative reimbursement models for Doorway services

- Explore a bundled rate that establishes a population based and/or multi-payer approach to funding as part of a Medicaid reform model
- Expand Medicaid eligibility for low-income individuals in need of SUD treatment (e.g., 200% of the federal poverty level)

A summary of options and considerations is presented on the next slides. Options could be combined or implemented individually to support operations

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Recommendation: In the absence of federal funds, explore expansion of Medicaid authorities and alternative reimbursement models for Doorway services

Options	Considerations
Explore a bundled rate that establishes a population based/multi-payer approach to funding based on Medicaid reform model	• Bundled rates could be based on the full array of services offered by Doorways • Would reduce administrative burden related to claiming • Creates flexibility to support individualized needs • May require designation of Doorways as targeted case management entities or crisis stabilization programs under the Medicaid State Plan; programs that provide comprehensive/integrated treatment could be designated as specialized health homes • Commercial participation in funding could be based on members served or overall health plan enrollment by region or statewide
Expand Medicaid eligibility for low-income individuals in need of SUD treatment (e.g., 200% of the federal poverty level)	• Would enable Medicaid to support individuals who are currently uninsured • Would require a Section 1115 Medicaid Demonstration • Benefit could be limited to SUD/OUD treatment and care coordination services

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Recommendation: Consider alternative delivery system structure for Doorway services

Statewide Doorway

- Single lead entity with nine or more regional satellite locations and management of flex funds
  - Executive and data analytics staff
  - Centralized policy and decision making
- Regional sites could be operated through sub-contractual agreements or through single lead entity
- Sub-contracts establish responsibilities for operational process and data reporting
  - Use of single care management platform
  - Realtime data sharing and quality monitoring
  - Case conferences/grand rounds
  - Standardized staffing patterns
- Centralized distribution of Flex Funds and Naloxone

Statewide Facilitating Organization

- Non-profit entity with coordination of current and future Doorway locations and management of flex funds
  - Executive and data analytics staff
  - Reps from each local Doorway comprise Board and provide oversight
  - Standardized policy, retain decision making at local level
- MOUs established with each local Doorway for
  - Standardized ROI and other operational processes
  - Local data collection and reporting to centralized data hub (could be supported with single software platform)
  - Realtime data sharing and quality monitoring
  - Case conferences/grand rounds
- Could expand Doorway services to other providers with fidelity to DHHS model of care requirements

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Alternative Delivery Model Considerations

Alternative delivery models such as a statewide Doorway or statewide facilitating organization have the potential to enhance service delivery and reduce administration burden by:

- Identifying and facilitating statewide adoption of best practices
- Creating accountability for statewide access and clinical collaboration
- Streamlining and facilitating collaboration between Doorways and partners (e.g., respite, DHHS, MCOs)
- Enhanced flexibility for timely allocation and distribution of funds based on local needs
- Streamlining management of funds (e.g., allocation of funds to one entity may improve flexibility for federal grant claiming)
- Standardizing staffing patterns and policies across regions
- Actively supporting the DHHS quality monitoring framework (e.g., review and validation of data reports, creation of common member ID, real-time data dashboards)
- Realigning DHHS management responsibilities (e.g., contract, funding, accountability, quality oversight, data validation)

FINDINGS AND RECOMMENDATIONS: FINANCING AND SUSTAINABILITY (CONTINUED)

Alternative Delivery Model Considerations (continued)

- Procuring a single lead could disrupt services, current referral agreements and local partnerships
- Loss of shared staff across host agency programs may limit client access to treatment and destabilize other SUD program services
- Local understanding of gaps and resources may be reduced if leadership/control is not embedded in each community

APPENDIX 1. REGIONAL DOORWAY OPERATIONS

OPERATIONS, SERVICES, COMMUNITY PARTNERSHIPS AND STAFFING

APPENDIX 1. REGIONAL DOORWAY OPERATIONS

Doorway Operating Structure and Local Contracts

Operational Model	Doorway (Operated By)	Population	# of sites	Local Contracts
Five operated directly by SOR awardee	Dover (Wentworth Douglas Hospital)	231,319	2*	▪ N/A
	Keene (Cheshire Medical Center)	98,377	1	▪ 4 local respite beds**
	Lebanon (Dartmouth Hitchcock Medical Center)	85,501	1	▪ 3 local respite beds**
	Littleton (Littleton Regional Hospital)	38,102	1	▪ MAT/Medical Director
	Laconia (Concord Hospital)	128,764	1	▪ 1 FTE peer recovery
Three subcontracted to a single entity in SOR awardee's health system	Berlin (Weeks Medical Center)	34,538	4*	▪ N/A
	Concord (Riverbend CMHC)	134,447	1	▪ 2 local respite beds**
	Nashua (Foundation Medical Partners)	249,393	1	▪ .5 FTE peer recovery ▪ Afterhours screening and respite (flat rate/month)
One subcontracted to multiple entities	Manchester (Catholic Medical Center and contracted community partners)	359,271	1	▪ Assessments, as needed ▪ 10 local respite beds**† ▪ Afterhours staffing on respite unit for 24/7 coverage

* Dover recently opened a second site for MAT related to all SUD diagnostic groups; Berlin, offers clients teleconferences with Doorway staff from three outreach locations

** All local respite arrangements are capacity-based agreements whereby payment is made to hold a bed open until 5-7pm each day, regardless of whether it is used by a Doorway client

† Originally planned as a DHHS contract with Farnham Center, CMC agreed to implement the contract as local agreement; Manchester assessments are currently contracted w/two providers; a partnership with a third vendor is in process

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

Doorway Integration with Host (SOR Awardee)

Doorway	Setting	Co-located w/Other Svs	Supports provided by SOR Awardee		
			Invoicing DHHS	Fully Integrated*	Notes
Berlin	Community	SUD/MOUD	✓		Hospital ED and inpatient units refer to Doorway
Concord	Community	SUD/MOUD & Drug Court			Concord Hospital's only function is receiving DHHS payments; VP for BH at Hospital is Riverbend's CEO;
Dover	Community	Across from hospital	✓	✓	Doorway staff complete assessments and provide case management in the hospital (inpatient and ED)
Keene	Community	N/A	✓	✓	Hospital ED and inpatient units refer to Doorway
Laconia	Hospital	N/A	✓	✓	Doorway recovery coaches are available to hospital 24/7 (ED and inpatient units)
Lebanon	Community	Addiction treatment program	✓	✓	Addiction treatment staff, ED, Pharmacy and nursing staff are available to Doorway, as needed,
Littleton	Community	N/A	✓	✓	Doorway is a department of the hospital
Manchester	Community	N/A	✓	✓	CMC offers business supports, apart from EMR and provides access to specialized services for pregnant women, veterans, and integrated PCP/BH services for homeless clients
Nashua	Community	Daily outreach/street work	✓	✓	Doorway staff run groups onsite and meet with individuals who are in hospital as needed

* Includes use of EMRs, business office, payroll/HR, legal, policy, and clinical supports

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

SOR Funded Doorway Positions (40-hour FTE)

Doorway	Program Oversight	Director, Managers	Case Managers (CRSWs)	SUD Professionals (LADC, MLADC)	Nurses or APRNs	MDs	Medical Assistants	Clinical Supervisors	Admin/Reception	Total
Berlin	.5	.5	1	1.5	.5		1.5		1	6.5
Concord	.5	1	2	2		0.02		.05		5.57
Dover	.1	1.5	3	1.2	.8		1	1	2	10.6
Keene		1	†	4.5					2	7.5
Laconia		.5	2†	1					1†	4.5
Lebanon		.5	.5	.5		.10			.5	2.10
Littleton	.4	1	1	1	.4	1.2	†		1	6
Manchester	1		4*						1	6
Nashua	.5	.5	2.5	1.5					1.25	6.25
Total	3	6.5	16	13.2	1.7	1.32	2.5	1.05	9.75	55.02

*Two staff are working toward CRSW in Manchester; †Littleton Practice Manager and case managers are also medical assistants, Keene clinicians perform case management, Laconia admin and care managers are also peer specialists

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

Doorway Client Access to Medications for OUD

Doorway	Access to Medications for OUD			Estimated Wait for MOUD†	Number of Other MOUD Providers in Region/Accessible to Doorway Clients		
	Onsite*	Partner Agency	Induction in the ED		1-2	3-4	4 or More
Berlin	✓	✓		90% - 1-2 weeks	✓		
Concord	✓	✓	✓	100% - 0-72 hours			✓
Dover	✓	✓	✓	100% - 0-24 hours			✓††
Keene	✓	✓	✓	100% - 0-48 hours			✓
Laconia	✓**	✓	✓	100% - 0-24 hours		✓	
Lebanon	✓	✓	✓	90% - 0-24 hours		✓	
Littleton	✓	✓	✓	100% - 0-24 hours		✓	
Manchester		✓	✓	95% - 0-24 hours			✓
Nashua		✓	✓	100% - 0-24 hours			✓

* Onsite access refers to MOUD by Doorway staff or through co-location with an existing program
** Laconia MOUD program is one mile away
† Wait times are staff estimates
† † access to some providers is challenging

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

Services and Supports Currently Offered at the Doorway Location ("✓" provided by Doorway Staff; "P" provided by Partner Agency)

Doorway	Core Doorway Services					Other Services							
	Screening and Crisis Stabilization	Evaluation and Planning	Facilitated Referrals	Continuous Recovery Monitoring	Naloxone Distribution	Support for Loved Ones	Peer Support	Individual Therapy	Groups	Assess for co-occurring MH	Psychiatric Consults/Meds	Application Assistance*	Other
Berlin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Concord	✓	✓	✓	✓	✓	✓	✓	✓		✓	P	✓	
Dover	✓	✓	✓	✓	✓	✓	P	✓	✓	✓	✓	✓	SOS recovery center contract
Keene	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	Advocacy w/DOC; ambulatory withdrawal services; mindfulness; yoga; assistance w/ DMV IDs
Laconia	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	
Lebanon†	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	PCP services, food pantry, clothing, medical-legal project help with civil complaints (e.g., evictions, benefits) are available onsite
Littleton	✓	✓	✓	✓	✓	✓	P	✓	✓	✓	P	✓	Telehealth visits w/other providers
Manchester	✓		✓	✓	✓	✓	✓					✓	Groups are planned
Nashua	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	Syringe Service Program

*Applications for health coverage, food benefits, etc.; † Other services are funded through a combination of other SOR awards and hospital resources

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

Identification of Doorway Clients

- Individuals are considered a "Doorway client" when they:
  - Ask for help
  - Do not know what treatment options are available or needed to support their recovery
  - Are receiving treatment and need additional services (not available at the treatment program) to support or maintain their recovery such as case management, safe housing, transportation, flex funds for a unique need
    - Treatment programs may also refer the client back to the Doorway because they need a different level of care.

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

Intake and Assessment – Walk Ins

- All Doorway clients meet with a Doorway staff person (CRSW, LADC or SUD Clinician) on the same day they walk into the Doorway office
- Assessments are completed during the first visit based on the clinical profile/presentation of client. Doorway staff focus on meeting the immediate needs of the client before engaging them in ASAM Level of Care Assessment. This may mean first securing:
  - Medical care or assessments
  - Nutritious meal/hydration
  - Withdrawal management services
  - Safe housing/respite
  - Transportation to safe housing or the Doorway
  - MOUD induction in the ED or bridge prescription
  - Other crisis stabilization services and supports
- All Doorways strive to have ASAM and other assessments completed within 72 hours of meeting the client.

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

Intake and Assessment – Walk ins

Doorway	Greeted by Dedicated Doorway Staff	Immediate Meeting with	ASAM LOC Assessment*	Notes
Berlin	✓	CRSW, LADC	100% same day	If client comes into the ED, Doorway staff will meet them there to do intake and ASAM assessment; whoever is available meets client, making an immediate connection is essential to process
Concord	✓	CRSW	100% same day	Typically meet with CRSW first for screening and identifying needs
Dover	✓	CRSW, MLADC	100% same day	
Keene	✓	LADC, MLADC	100% same day	Staff rotate coverage for walk-ins; others are scheduled for appointments
Laconia		CRSW	90% same day	Client is met by Doorway staff in hospital reception area or ED by CRSW for screening; then meets with clinician
Lebanon	✓	LADC, LICSW, MLADC	100% same day	If client has a recent assessment and referral from another provider, they may go straight to MAT/addiction treatment program
Littleton	✓	LADC, CRSW	100% same day	Meet with LADC for assessment and goal setting then meets with CRSW to work on getting needs met and referrals in process
Manchester	✓	CRSW	75% 24-72 hours	Client meets with Resource Specialist (CRSW) to determine need and complete intake. If partner agency has an opening, an ASAM will be completed on same day
Nashua	✓	CRSW	90% same day	CRSW completes screens (e.g., PHQ-9, GAD-7); Not typical for clients to call or set-up appointments most are walk-in or engaged through streetworker outreach

* Exceptions for clients whose medical needs may be an immediate priority; or leave respite against staff advice

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

Intake and Assessment - GPRA

- All Doorways report that the GPRA is completed the same day as the intake with the exceptions of clients who walk-in at closing or who's medical issues or crisis needs may take priority
  - In some cases, a client may be sent for medical clearance and not return to complete the intake
- Staff estimate GPRA completion on the same day as intake as being between 60% – 100%, with five Doorways reporting 90-100% success
- Seven Doorways complete additional screening tools during the intake (e.g., PHQ-8, GAD-7, Columbia Suicidality Scale, etc.)
- One Doorway embeds GPRA questions into the level of care assessment

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

Intake and Assessment – Telephonic

- All Doorways will work with the caller to address immediate needs and connect them to resources over the phone
- Doorways may arrange transportation to Doorway or respite placement the same day, if client is in unsafe housing or needs further assessment
- Doorways prefer in-person assessment however telephonic, or telehealth intakes are offered at most

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

Intake and Assessment - Special Populations (e.g., Pregnant Women, Veterans, Unhoused)

- No difference in intake process, however the next steps and response vary based on the population (e.g., referral to specialized program, PCP or prenatal care, respite, food, etc.)
- All Doorways reported relationships with local resources for specialized populations (Veterans, Pregnant Women, Unhoused)
- One Doorway proactively calls the VA to get approval to proceed with treatment. The VA has denied care in the past because there is a VA-operated facility nearby

Intake and Assessment - Clients Served by Another Doorway

All Doorways secure a release of information (ROI) and assist the client in calling the other Doorway or with permission reach out on the client's behalf to:

- Team with the other Doorway, based on clients wants and needs (e.g., if they still have a connection to the other area, but are accessing treatment in new region)
- Transfer care to the new Doorway
- Reconnect the client to the original Doorway

To facilitate communication, at least one Doorway proactively includes all other Doorways on their ROI form

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

Clients who are not ready for treatment

All Doorways attempt to:

- Keep the client engaged and work on immediate needs, harm reduction and other issues related to social determinants of health and safety (e.g., food, health coverage, safe housing, naloxone kits)
- Perform outreach and/or assign the individual to a caseload for follow-up calls

Doorway	Examples of Activities/Services Offered
Berlin	Create a recovery plan; offer a 6-week support group
Concord	Individual bridge counseling; peer skills group 2x/week run by partner program
Dover	Self-care kits, food, bus tickets, sunscreen, access to contraception; attempt outreach first 3-5 days after a visit; bridge therapy for motivational enhancement; connect to peer support
Keene	Schedule a follow-up visit in a few days for bridge counseling, try to engage on any issue; outpatient and groups are offered; local provider referrals and outreach
Laconia	Refer to recovery coach to stay engaged; community syringe service program
Lebanon	Recovery coach/peer support; offer skills group (focus on harm reduction)
Littleton	Meet with CRSW for engagement/support; offer peer support services
Manchester	CRSW offers peer support; provide recommendations for support from other groups for harm reduction: as a Catholic institution, cannot distribute condoms or participate in syringe service programs
Nashua	syringe service program; recovery group (run 2 days/week) or individual recovery coaching

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

Operations and Service Agreements

- Eight Doorways are operated by a single lead entity. (Five by the grantee and three by a member of the grantees health system). One subcontracts for ASAM level of care evaluations
- Seven Doorways offer MOUD onsite (by Doorway staff or through co-location with an addiction treatment program). The remaining two represent larger urban centers with access to a wide array of SUD/OUD treatment options in the community
- Seven Doorways have contract with local partners for respite, MOUD, and/or staffing

Differences in Doorway operations can, in part, be attributed to differences in geography and access to community resources (e.g., treatment services, proximity to respite, recovery housing and transportation providers)

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

Collaboration with Medicaid Managed Care Organizations:

- Five Doorways report little to no interface with Medicaid MCOs
- Four Doorways report meeting regularly with the Medicaid MCOs to discuss billing and coverage policies
- There is little to no interaction with the MCO care management or population health programs. MCO care planning for Doorway clients appears to be limited (e.g., as a special needs population)
  - One Doorway reported working with an MCO that offers a week's worth of food/meals for some clients transitioning from inpatient into a recovery residence (as a value-added benefit)
- Doorway clinicians may call the MCO Utilization Management Unit regarding specific clients related to treatment authorizations (e.g., when a treatment facility refuses a client due to coverage issues)
- Telephonic care management offered by MCOs is not well suited for hard-to-reach members struggling with OUD

APPENDIX 1. REGIONAL DOORWAY OPERATIONS (CONTINUED)

Impact of Doorways on SUD/OUD System of Care

Doorways enhance the delivery system by:

- **Destigmatizing OUD**: Providing education and awareness to break down barriers/stigma in working with clients with OUD in ED, inpatient, PCP and FQHC settings
- **Enhancing Access to MOUD**: Doorways have filled gaps by:
  - Working with EDs to support induction and provide bridge prescriptions
  - Having MOUD prescribers available onsite or co-locating with existing programs
  - Partnering with other community-based providers (e.g., center and office-based addiction treatment programs)
- **Collaboration**: Working with community partners and other Doorways to wrap services around individuals to support engagement and recovery

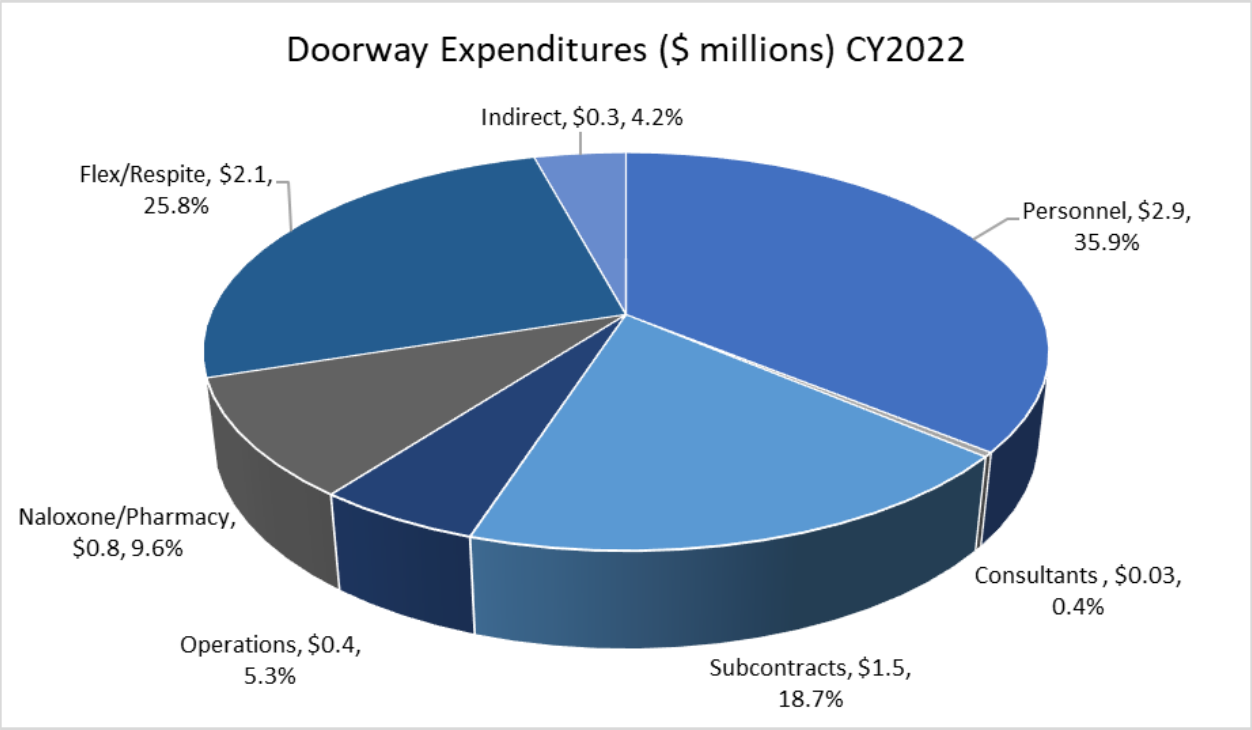
APPENDIX 2. DOORWAY FINANCING

CY2022 SNAPSHOT

APPENDIX 2. DOORWAY FINANCING

Doorway Program Expenditures

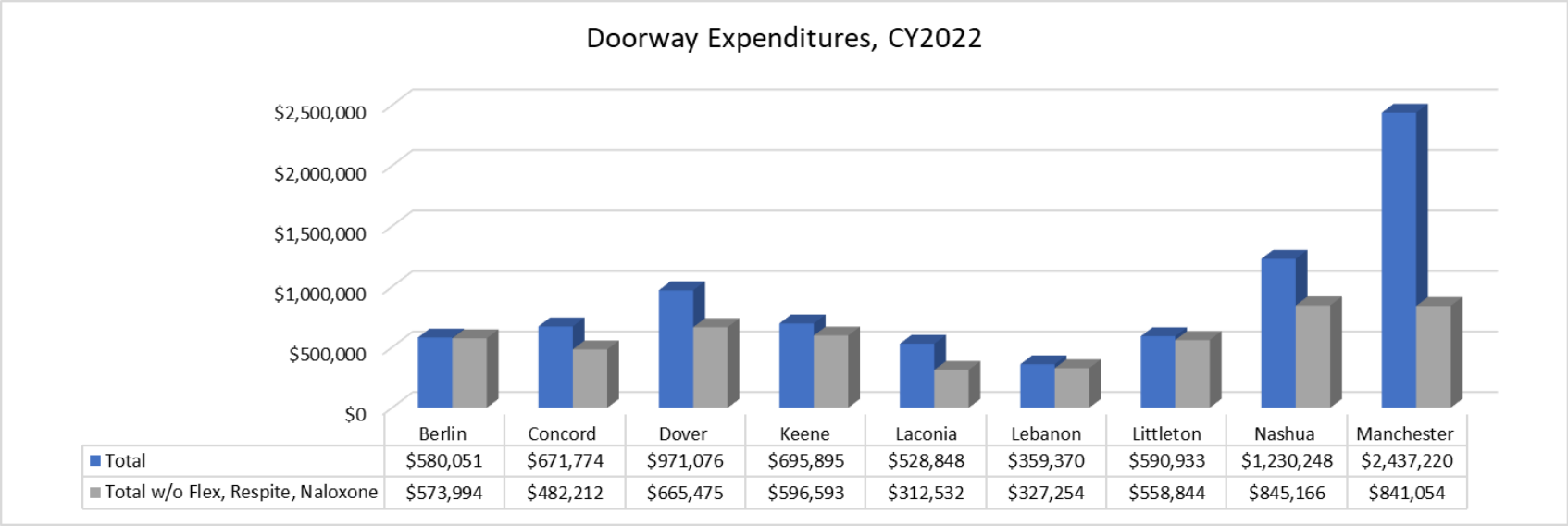
- DHHS-SOR invoices for CY2022 totaled **$8,065,415** for Doorway programs



APPENDIX 2. DOORWAY FINANCING (CONTINUED)

Doorway Program Expenditures

- Absent Flexible Needs, Respite and Naloxone, annual expenditures per site range from $312k to $845k
- The two Doorways with the most populated service areas (Manchester and Nashua) represent the largest expenditures

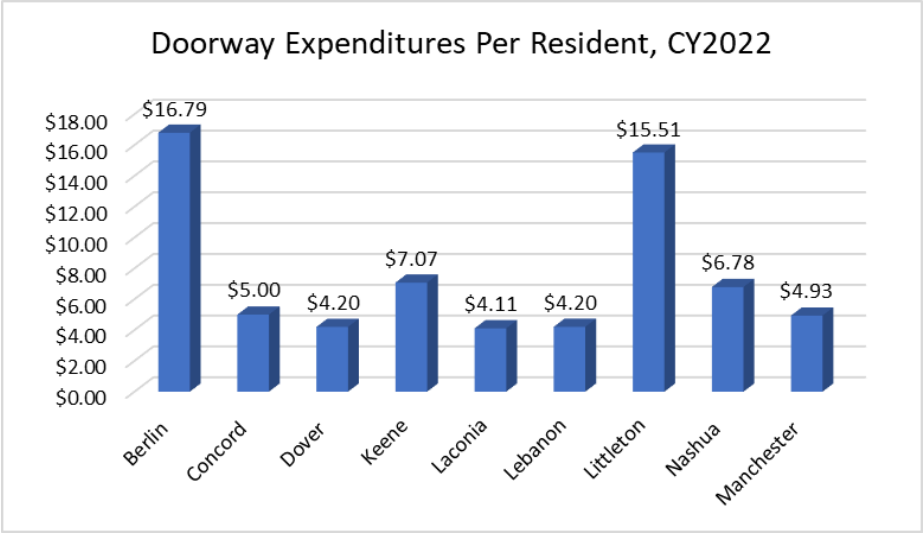


	Berlin	Concord	Dover	Keene	Laconia	Lebanon	Littleton	Nashua	Manchester
Total	$580,051	$671,774	$971,076	$695,895	$528,848	$359,370	$590,933	$1,230,248	$2,437,220
Total w/o Flex, Respite, Naloxone	$573,994	$482,212	$665,475	$596,593	$312,532	$327,254	$558,844	$845,166	$841,054

APPENDIX 2. DOORWAY FINANCING (CONTINUED)

Doorway Program Expenditures

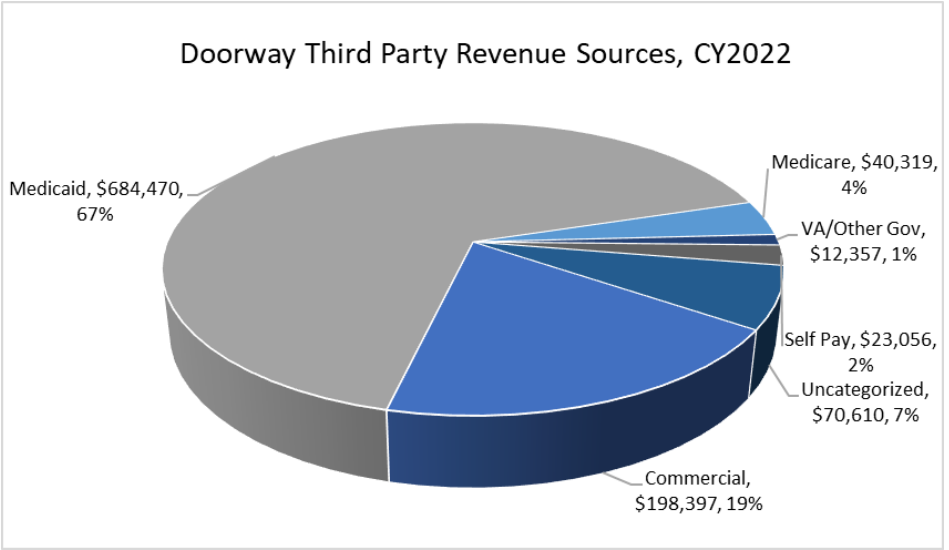
- Per resident costs (including Flexible/Respite funds and Naloxone) range from a high of $16.79 to a low of $4.11
- Berlin and Littleton represent rural regions with small populations (less than 40,000 residents in each catchment area)
- The statewide average is $5.93 per resident



APPENDIX 2. DOORWAY FINANCING (CONTINUED)

Doorway Revenue

- Medicaid represents 67% of third-party revenue, followed by commercial plans with 19%
- One site (Manchester) does not have third party revenue offsets, evaluation and treatment are provided at partner agencies; case management provided by the Doorway staff is not billed
- Methodology for revenue offsets vary:
  - 100% of collections
  - Allocation of clinician salary expenses based on the amount of time clinicians spent providing services covered by third parties



APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS

A. DHHS FUNDED RESPITE SERVICES

APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS

DHHS Respite Services: Respite services are short-term and available for individuals who are waiting for treatment services and who are unhoused or have unstable or unsafe living situations. In CY2022, DHHS contracted with two Respite Vendors to maintain the availability of respite beds for Doorway clients 24 hours a day, seven days a week.

- New Hampshire Respite, LLC, located in Nashua, New Hampshire, maintained 26 beds daily in January of 2022 and 23 beds daily for the remainder of the year
- Granite Recovery Respite, located in Effingham, New Hampshire, maintained 11 beds daily each month

DHHS Respite Vendor Data

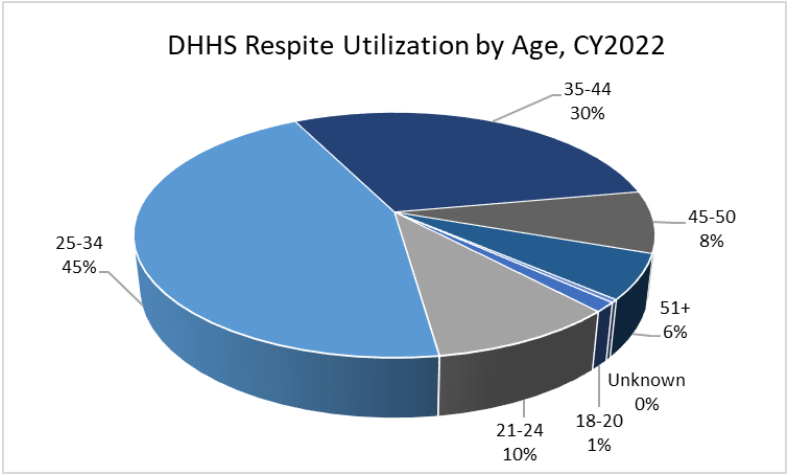
- DHHS-SOR staff compiled vendor data into one extract to share with PHPG
- PHPG removed duplicate entries when the client ID, date of discharge and treatment setting, were identical.
- Expenditure data for respite was compiled by PHPG using paid amounts and bed-days reflected in monthly invoices paid by DHHS.
- Information for 1,005 stays at NH Respite and 244 stays at Granite Recovery in CY2022 was examined.

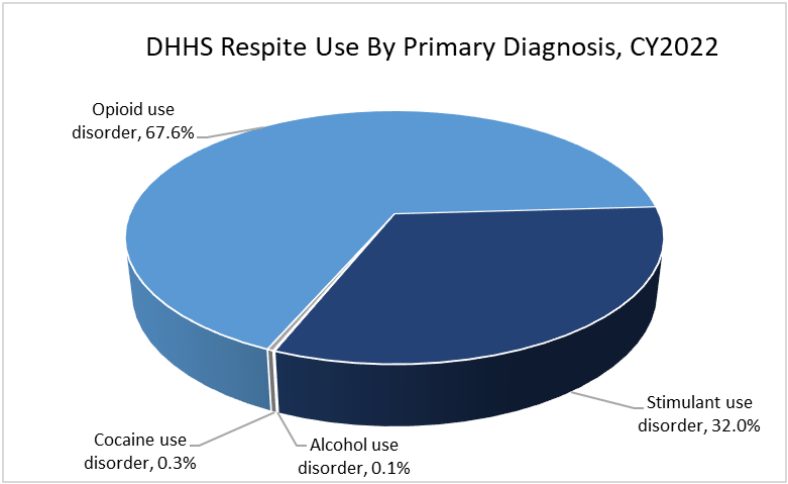
Secondary data sets were not available to the evaluators for validation of data-integrity and completeness of the compiled extracts. Overall, fewer visits were recorded (based on discharge date) in October and November of 2022. Analyses are considered exploratory.

APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

DHHS Contracted Respite Stays

- Over 68% of the stays were for men, 30% women and 1% were individuals who identified as non-binary
- 45% were for clients ages 25-34, 30% ages 35-40, 10% ages 21–24, 8% ages 45–50, 1% ages 18-20 years old and less than 1% of the stays the age was not reported
- 84% of stays clients identified as White, 5.4% Black, 5. 3% Latino/Hispanic, fewer than 2% multiracial, Asian, American Indian, Native Hawaiian, other Pacific Islander, or unknown
- Over 71% were unhoused/homeless, 10% unstably housed, 16% stably housed, 1.9% with unknown housing status at time of admission
- 67% of the admissions had a diagnosis of OUD, 32% stimulant use disorder and less than 1% cocaine use disorder or alcohol use disorder.

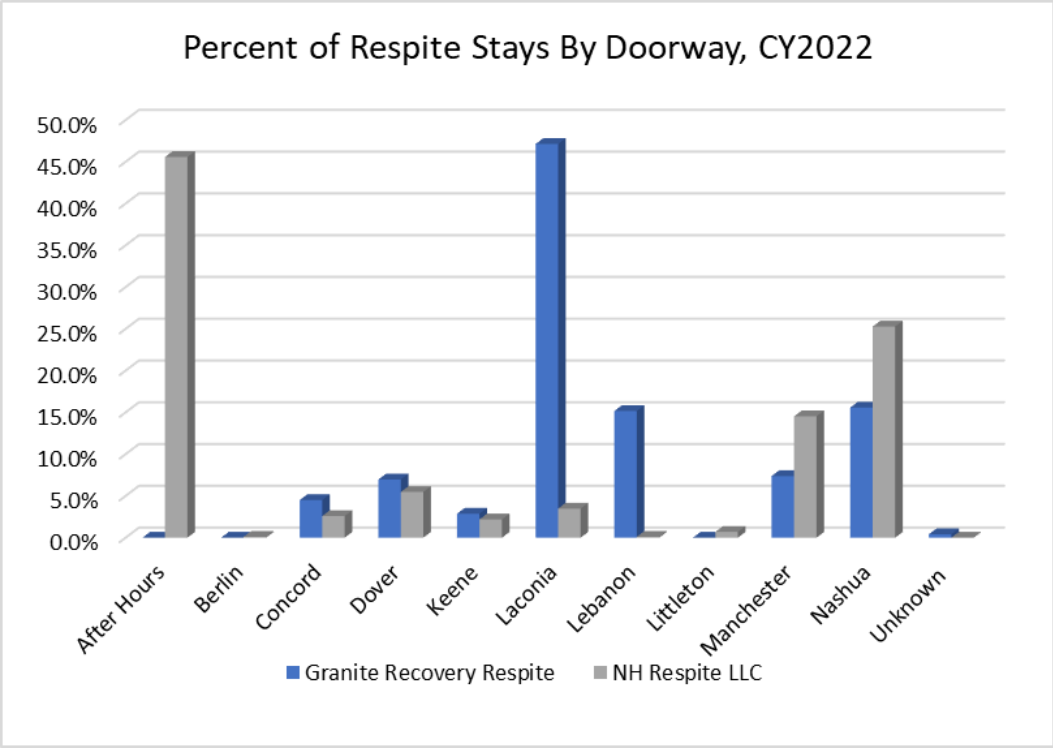




APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

DHHS Contracted Respite – Stays by Doorway

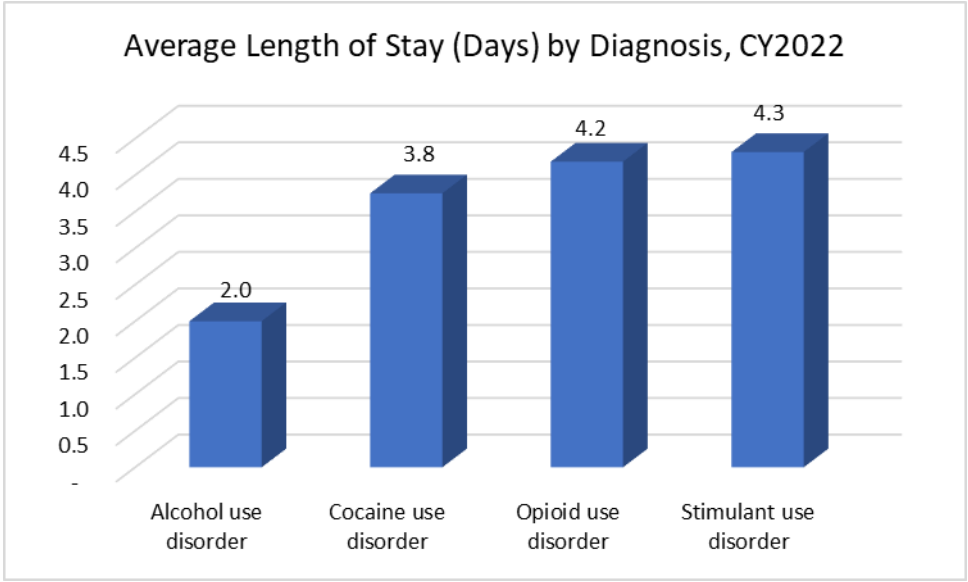
- 45.6% of stays in NH Respite are from the after-hours program, followed by the Nashua Doorway (25.3%).
- 47.1% of stays in Granite Recovery Respite are from the Laconia Doorway, followed by Nashua (15.6%) and Lebanon (15.2%)
- Clients of Doorways located in or adjacent to the respite provider sites are the most frequent clients



APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

DHHS Contracted Respite – Average Length of Stay

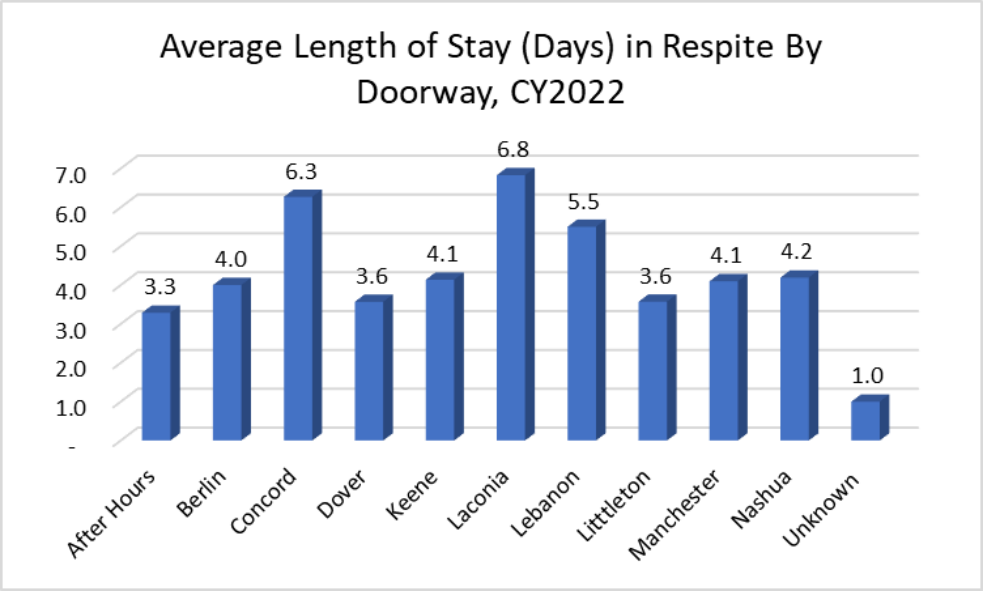
- The average length of stay for all admissions was 4.2 days.
- There were over 1200 stays for clients who had stimulant use (400 stays) and opioid use disorders (844 stays) and averaged 4.3 and 4.2 days respectively.
- There were four stays associated with clients who had cocaine use disorder with an average length of stays of 3.8 days.
- Alcohol use disorder was recorded as the diagnosis for a single two-day stay.



APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

DHHS Contracted Respite – Average Length of Stay (continued)

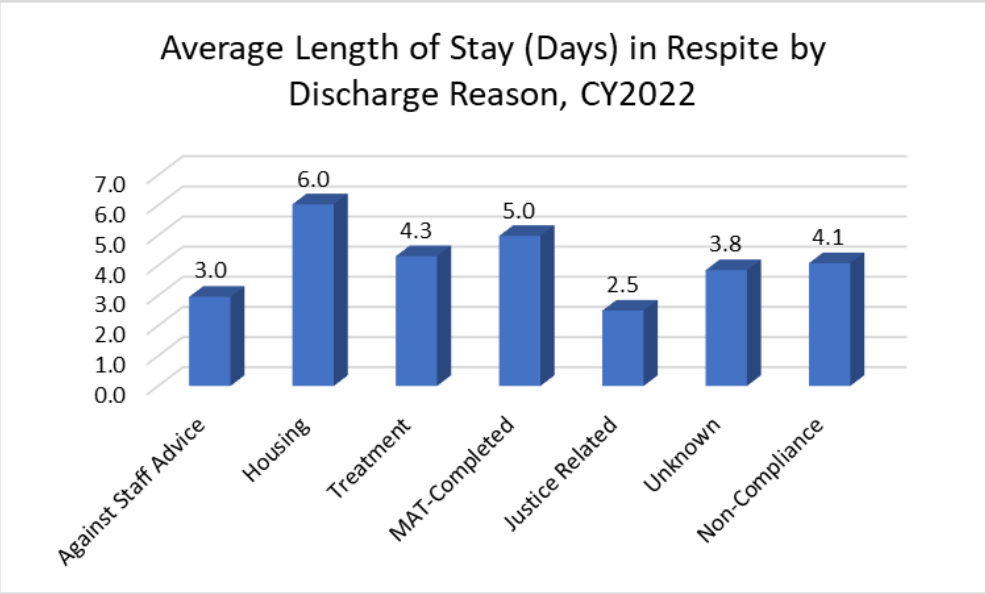
- Average length of stay was 3.5 days for NH Respite and 7.3 days at Granite Recovery
- Length of stay by Doorway was the highest for Laconia and Concord referrals at 6.8 and 6.3 days respectively, followed by Lebanon (5.5 days).
- Stays for the remaining Doorways ranged from 3.3 days to 4.2 days. The Doorway was not recorded for one respite stay.



APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

DHHS Contracted Respite - Average Length of Stay (continued)

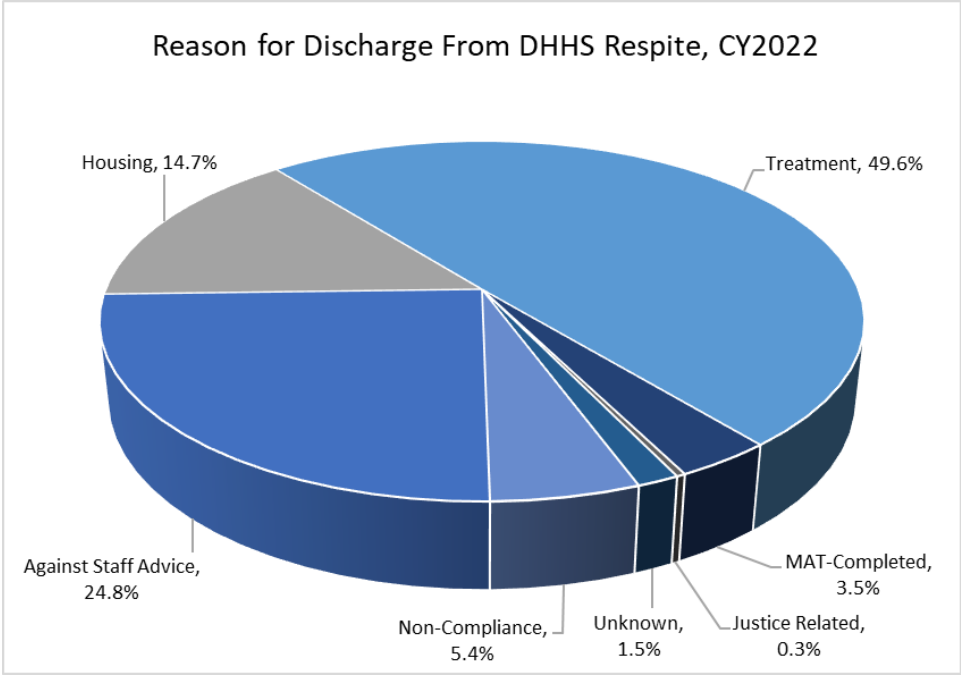
- The average length of stay was the longest for housing related discharges (6 days), followed by MAT completion (5 days) and treatment related discharges (4.3 days)
- Clients who left against staff advice averaged 3 days in respite



APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

DHHS Contracted Respite – Discharge Reasons

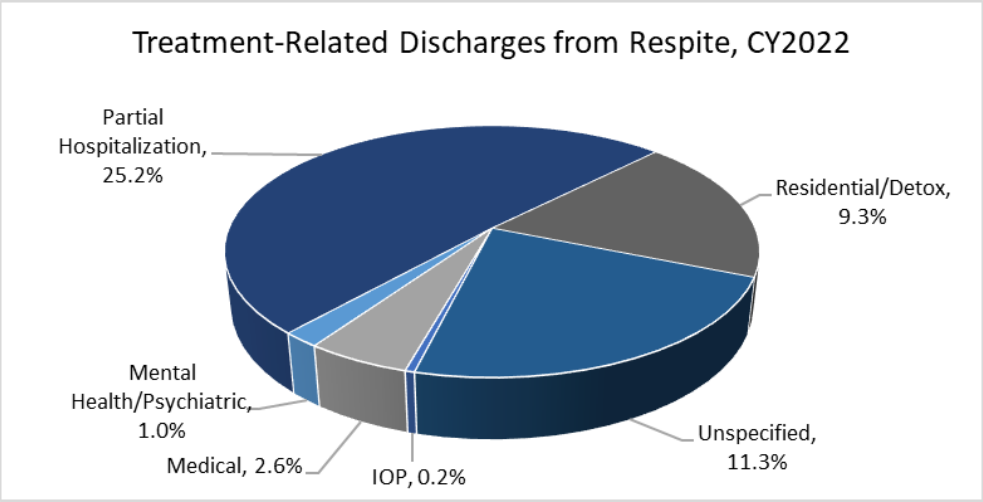
- Nearly 50% of discharges were for treatment-related reasons
- Approximately 15% of discharges were to housing
- Approximately 25% of discharges were against staff advice
- 5% of discharges were for non-compliance
- Completion of MAT was identified in 3.5% of discharges
- Less than one percent of discharges were recorded as justice-related



APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

DHHS Contracted Respite – Discharge Location

- 25% of treatment related discharges were to Partial Hospitalization programs
- 9.3% were to residential SUD treatment and withdrawal management services
- 2.6% were to medical treatment
- 1% were to mental health related treatment
- The type of treatment was not specified in 11.3% of the discharges



APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

DHHS Contracted Respite - Occupancy and Expenditures

- DHHS purchased 4,015 bed-days from Granite Recovery Respite and 9,397 bed days from New Hampshire Respite, LLC. Per diems were $250 per bed through September and $212.50 October – December.
- Granite Recovery Respite: Daily utilization reached 100% capacity for three days, 80% capacity for 22 days, 60% capacity for 89 days and at or above 40% capacity for 258 days during the year.
- NH Respite, LLC: Daily utilization never reached 80% capacity. The program reached 60% capacity for 18 days and 40% capacity for 245 days.

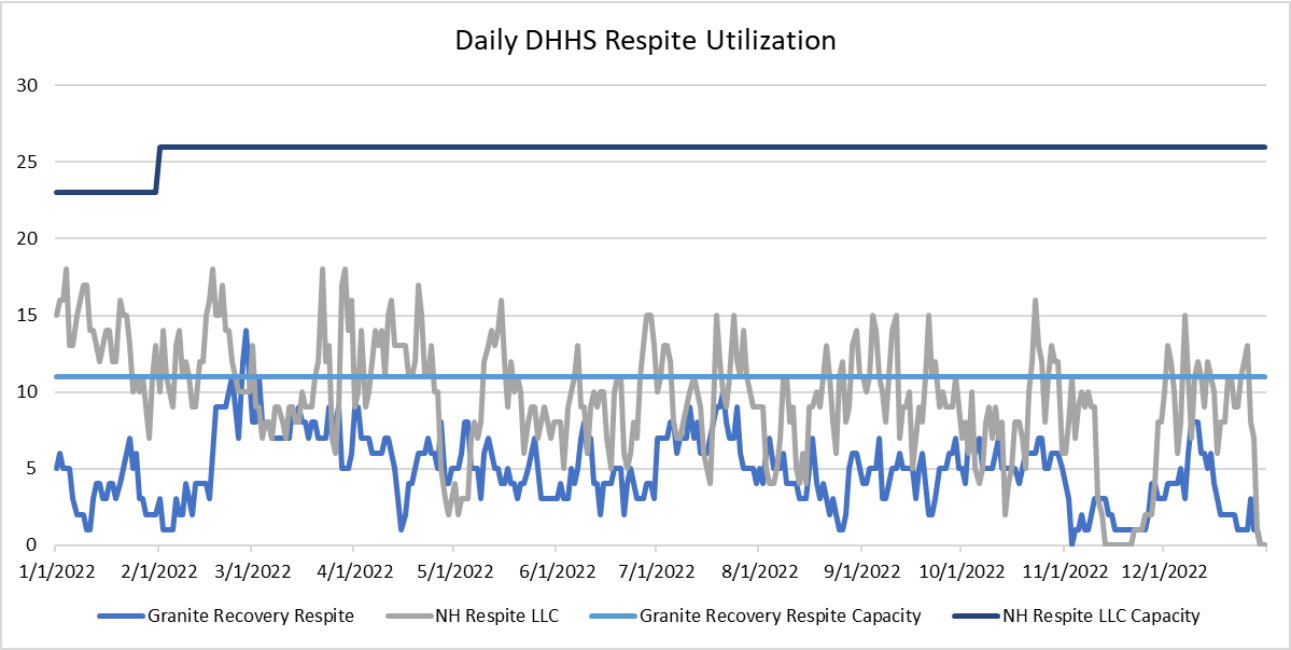
CY2022	Granite Recovery Respite (Capacity=11)		NH Respite, LLC (Capacity=26)*	
Days at or Above Capacity	3	1%	0	0%
Days at or Above Eighty Percent Capacity	22	6%	0	0%
Days at or Above Sixty Percent Capacity	89	24%	18	5%
Days at or Above Forty Percent Capacity	258	71%	245	67%

*In January 2022 capacity was 23 beds

APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

DHHS Contracted Respite - Occupancy

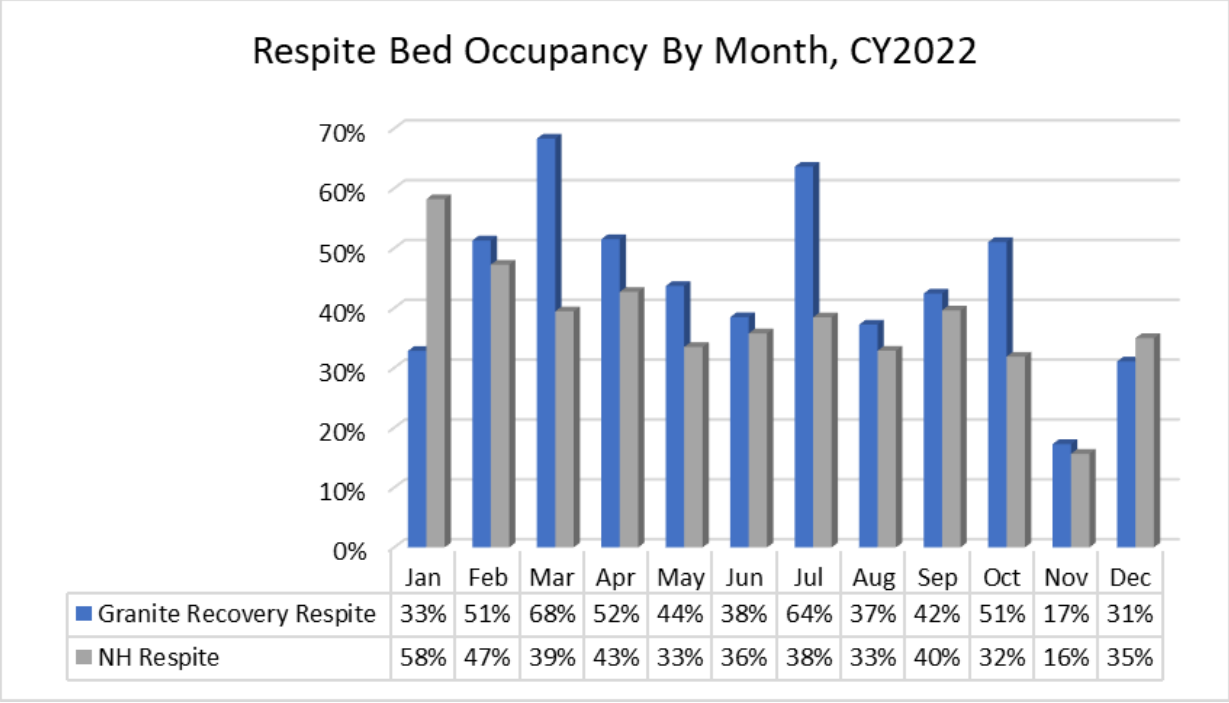
Daily utilization was higher for Granite Recovery Respite overall and in the winter months. With three days in February exceeding capacity



APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

DHHS Contracted Respite - Occupancy

- Overall annual occupancy for Granite Recovery Respite was 44%
- Overall annual occupancy for NH Respite Inc. was 37%



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Granite Recovery Respite	33%	51%	68%	52%	44%	38%	64%	37%	42%	51%	17%	31%
NH Respite	58%	47%	39%	43%	33%	36%	38%	33%	40%	32%	16%	35%

APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

B. LOCAL FLEXIBLE NEEDS FUND

APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

Local Flexible Needs Fund (Flex Funds): Flex Funds may be used for supports that promote access to care not otherwise covered by another payer. The DHHS designated the following as allowable uses:

- Transportation to and from recovery related treatment programs and services
- Childcare to permit a client to attend treatment and recovery-related medical appointments
- Short-term housing or other costs needed to remove financial barriers to obtaining and/or retaining safe housing. Doorway staff may refer clients to local shelters, recovery housing providers, transitional living programs and/or pay for short-term hotel stays. Local respite services may be reimbursed by Doorway on a fee-for-service basis or through a capacity-based agreement.
- Light snacks, clothing appropriate for weather conditions or job interviews, other uses that are pre-approved by DHHS

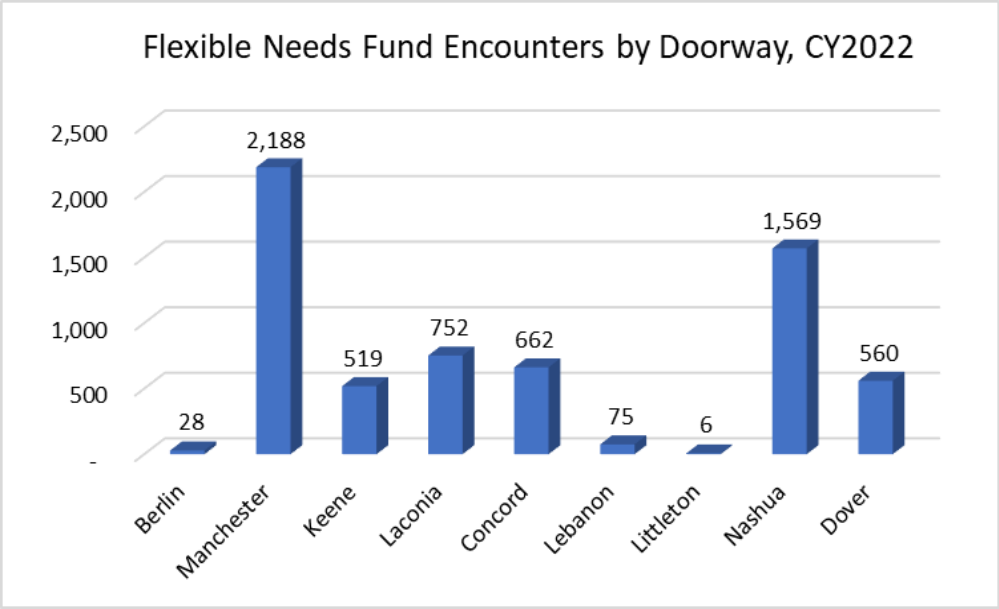
Local Flexible Needs Fund Data

- PHPG compiled a data set using monthly flex fund reports from each of the nine Doorways
- Flex Fund data was examined for 6,359 encounters in CY2022. Each encounter represents one record
- Flex Fund expenditures compiled from the back-up detail may be higher than final Doorway payments due to a DHHS disallowance, budget caps or transfer of costs to another fund source (e.g., unmet needs)

APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

Local Flex Fund Utilization – Encounters by Doorway

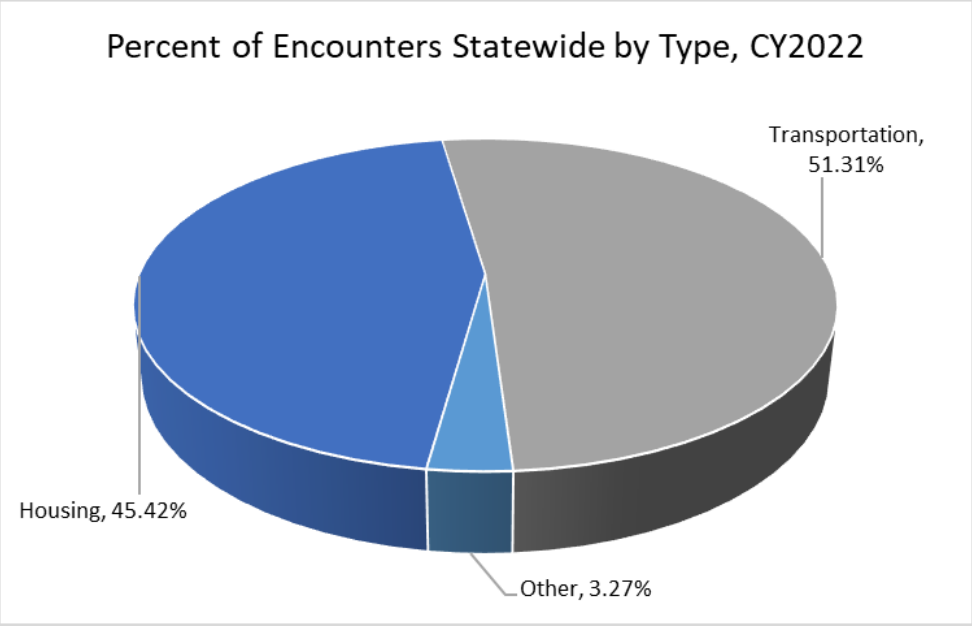
- In CY2022, the Doorways of Greater Manchester and Greater Nashua reported the most Flex Fund encounters (2,188 and 1,569, respectively). Keene, Dover, Concord, and Laconia Doorways reported between 500-760 encounters, Littleton, Berlin, and Lebanon Doorways reported fewer that 100 encounters.



APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

Local Flex Fund Utilization – Encounters by Type

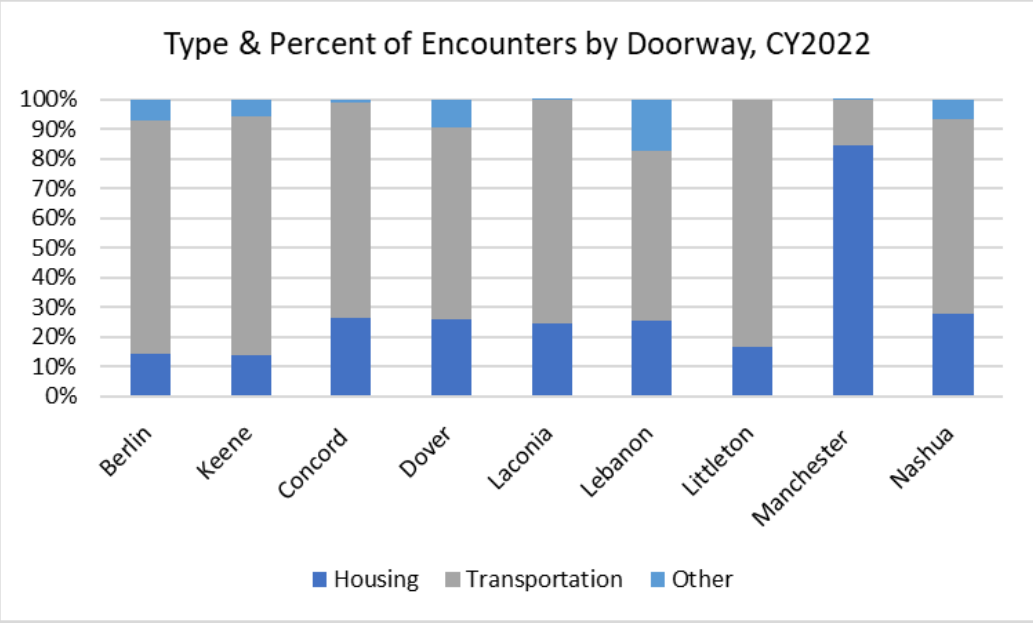
- Over 50% of the encounters statewide were for transportation, followed by housing supports (45%), slightly over 3% were for other activities such as food, clothing, gift cards and obtaining government issued IDs necessary for enrolling in health care coverage.



APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

Local Flex Fund Utilization – By Type and Doorway

- Doorway, transportation was the most common use, apart from the Doorway of Greater Manchester whose encounters were largely for housing.
- Other uses such as clothing, assistance obtaining health care coverage, light snacks and gift cards were limited. Three Doorways (Laconia, Littleton, and Concord) reported very few or no encounters for other supports.



APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

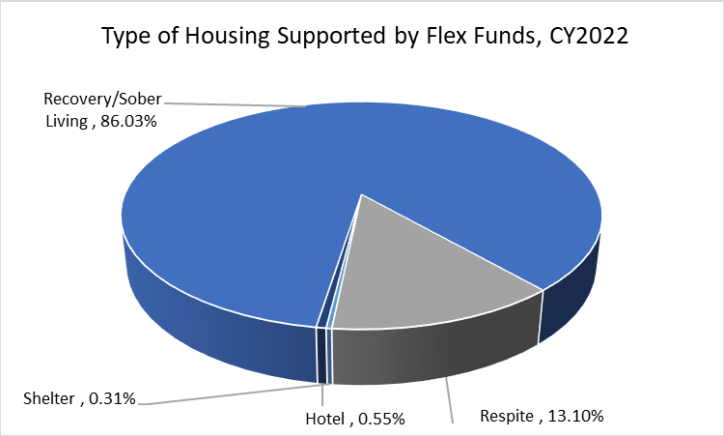
Local Flex Fund Utilization – Encounters by Provider Type

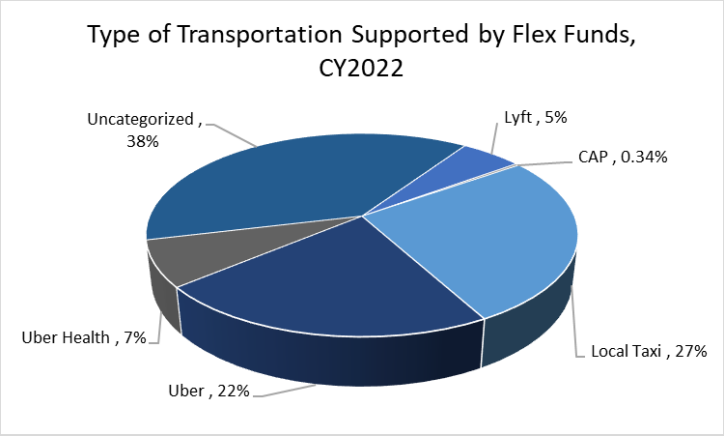
Housing Encounters

- 86% recovery and sober living programs
- 13% respite housing
- Less than 1% shelters and hotels

Transportation Encounters

- 34% Uber or Lyft
- 27% local taxi services
- 38% uncategorized
- Less than 0.5% Community Action Programs





APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

Local Flex Fund Utilization – Encounters by Client

- A total of 1,898 Flex Fund clients (97%) received Flex Funds from only one Doorway; 53 clients received Flex Funds from two Doorways; fewer than 10 clients received Flex Funds from three or more Doorways

Number of Clients Receiving Flex Funds from Multiple Doorways*	
Number of Doorways	**Number of Clients**
1	1,898
2	53
3 or more	<10
Total	1,953

* Use of unique recipient IDs was inconsistent in the first part of CY2022; thus, an unduplicated count of recipients is available for only a subset of the total Flex Fund encounters reported.

APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

Local Flex Fund – Expenditures by Client

- Expenditures per client ranged from less than $100 for 409 clients to more than $2,500 for 38 clients, with nearly half of Flex Fund clients (907) receiving between $200 and $999 in Flex Funds support

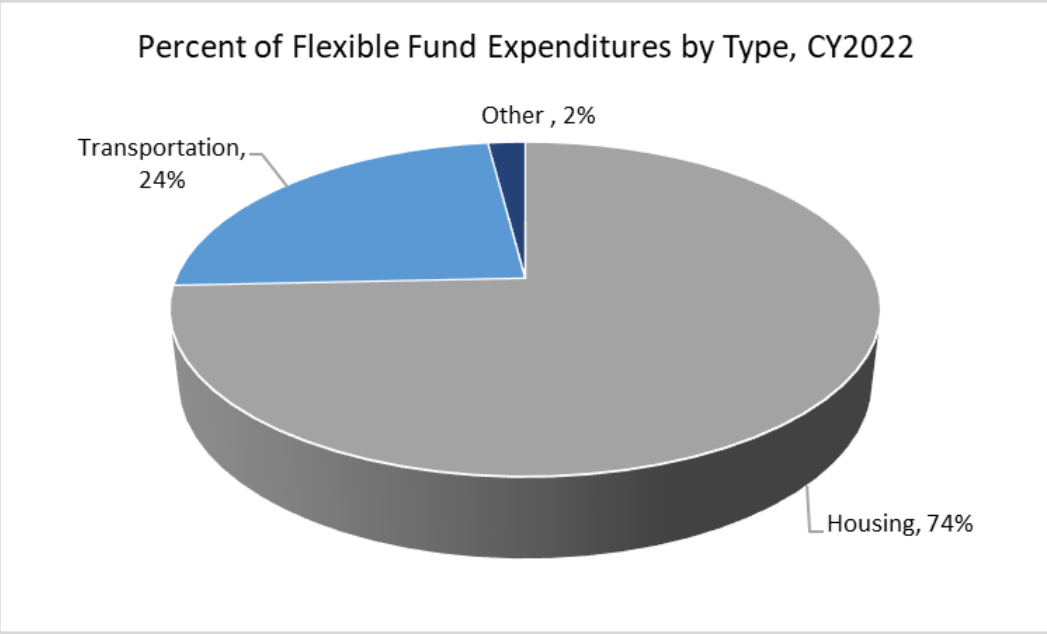
Summary of Expenditures by Client*	
Amount	**Number of Clients**
Less than $100	409
$100 - $199	176
$200 - $499	445
$500 - $999	462
$1,000 - $2,499	423
$2,500 and Above	38
Total	1,953

* Use of unique recipient IDs was inconsistent in the first part of CY2022; thus, an unduplicated count of recipients is available for only a subset of the total Flex Fund encounters reported.

APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

Local Flex Fund - Expenditures By Type

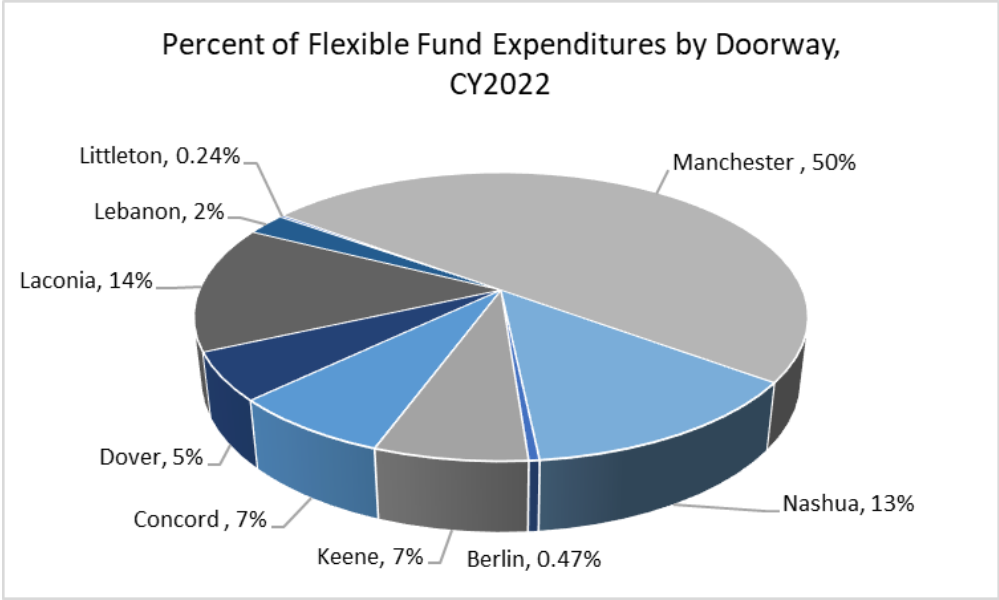
- 74% were for housing
- 24% were transportation
- 2% were for other services (e.g., clothing, light snacks, gift cards, government issued IDs)



APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

Local Flex Fund – Expenditures by Doorway

- Manchester reported approximately 50 % of the expenditures statewide
- Laconia and Nashua reported 14% and 13%, respectively
- Concord and Keene each reported 7% of the statewide expenditures, followed by Dover (5%) and Lebanon (2%)
- Littleton and Berlin reported less than 1% of statewide expenditures

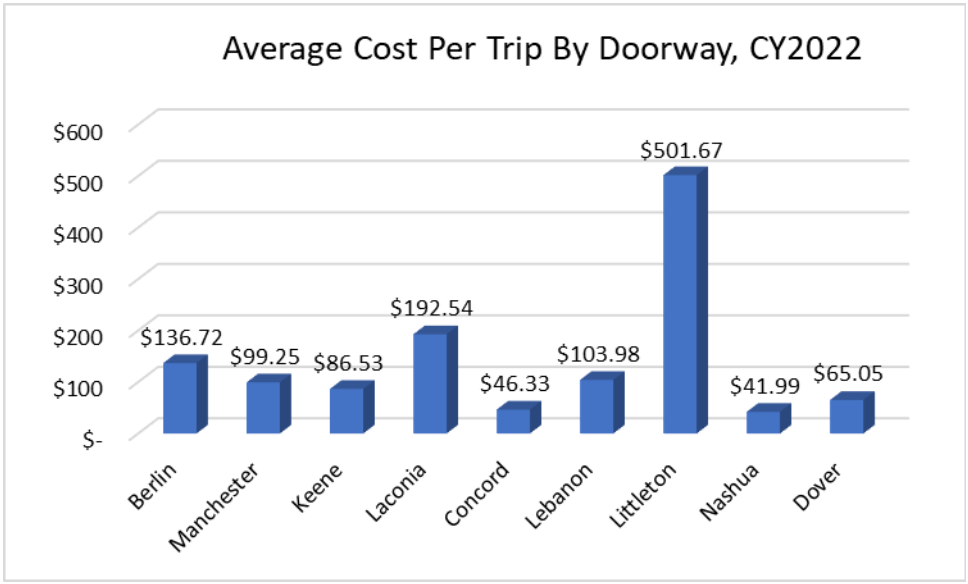


APPENDIX 3. RESPITE AND FLEXIBLE NEEDS FUNDS (CONTINUED)

Local Flex Funds – Transportation Expenditures

- Average cost per trip were highest for Littleton ($502 for 6 trips recorded)
- Nashua had the lowest average cost per trip ($42 for 1,028 trips recorded)

Region	# of Trips Recorded*
Berlin	29
Manchester	337
Keene	494
Laconia	657
Concord	483
Lebanon	60
Littleton	6
Nashua	1,028
Dover	364



* Encounters, with notes indicating the payment was for a round-trip payments were counted as 2 trips

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

A. MONTHLY ACTIVITY DATA

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Overview – Activity Report Data

- Since the start of the Doorway model, Doorway sites have submitted monthly Activity Reports that provide de-identified demographic and utilization data
- Two additional measures were added at the beginning of CY2022:
  - Established Client Clinical Re-assessments Completed by Primary Diagnosis Type
  - Established Clients Seen by Primary Reason Type
- The following measures were added in October 2022:
  - New Clients Seen by Age
  - New Clients Seen by Employment Status
  - New Clients Seen by Ethnicity
  - New Clients Seen by Health Insurance Status
  - New Clients Seen by Housing Status
  - New Clients Seen by Justice System Involvement Status

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Overview – Activity Report Data (Continued)

- Evaluation of Doorway program performance related to core services included an assessment of the following Activity Report measures:

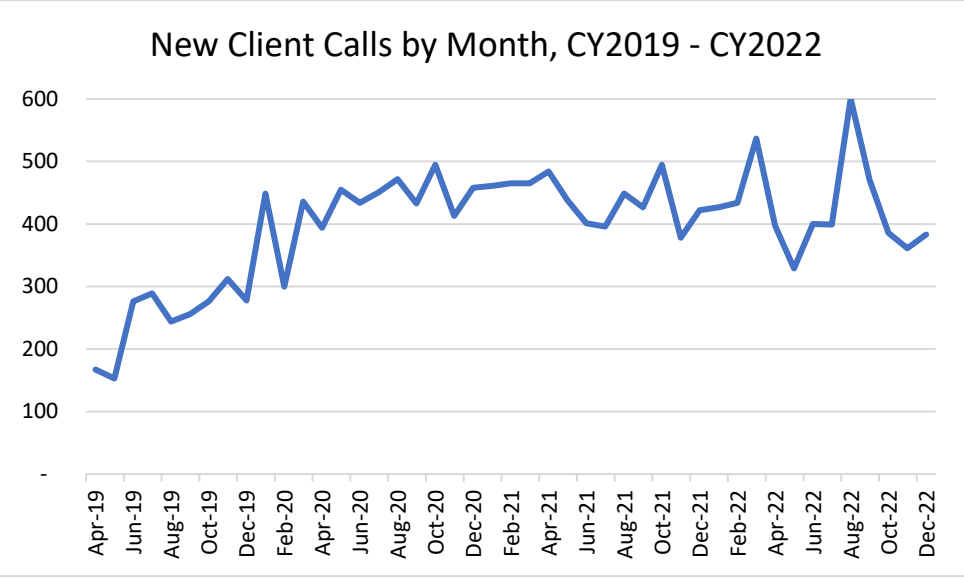
Core Service Area	Activity Report Measure(s)
Screening and Crisis Stabilization	• New Client Calls
Evaluation and Care Planning	• New Clients Seen • New Client Assessments
Facilitated Referrals	• Facilitated Referrals • MAT Provided by Doorway Site
Continuous Recovery Monitoring	• Established Clients Seen • Days Waiting for Treatment • Client Re-Assessments • Recovery Monitoring Contact Attempts
Naloxone Distribution	• Naloxone Kits

- Preliminary data for newly-established Activity Report measures also is presented

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Screening and Crisis Stabilization – New Client Calls

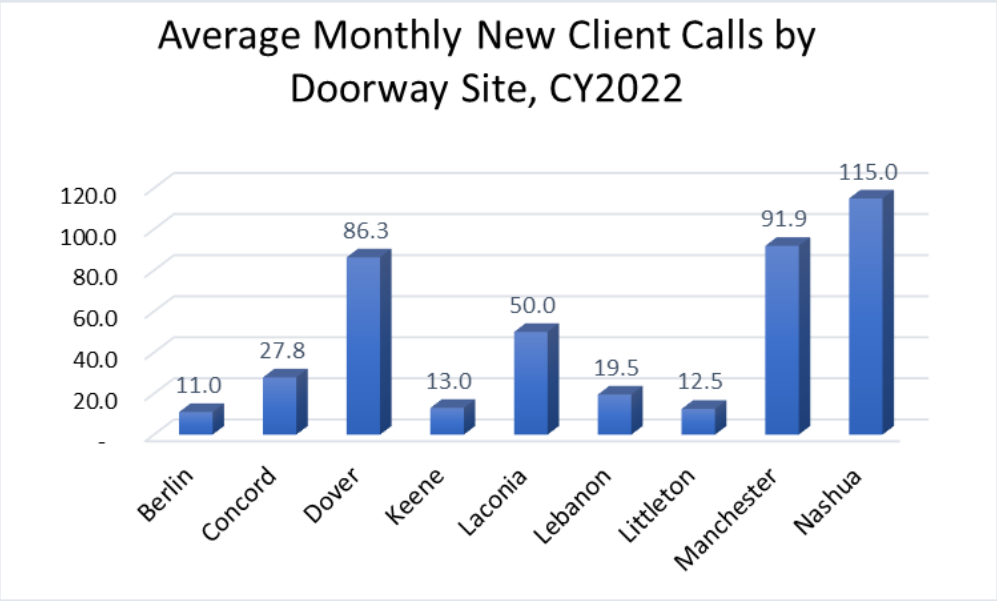
- Between April 2019 and December 2022, Doorway sites received nearly18,000 new client calls
- The average number of monthly calls increased from 250 in CY2019 to 427 in CY2022, an increase of approximately 71%
- The average number of monthly calls consistently averaged approximately 425 calls in CYs 2020, 2021 and 2022



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Screening and Crisis Stabilization – New Client Calls *(continued)*

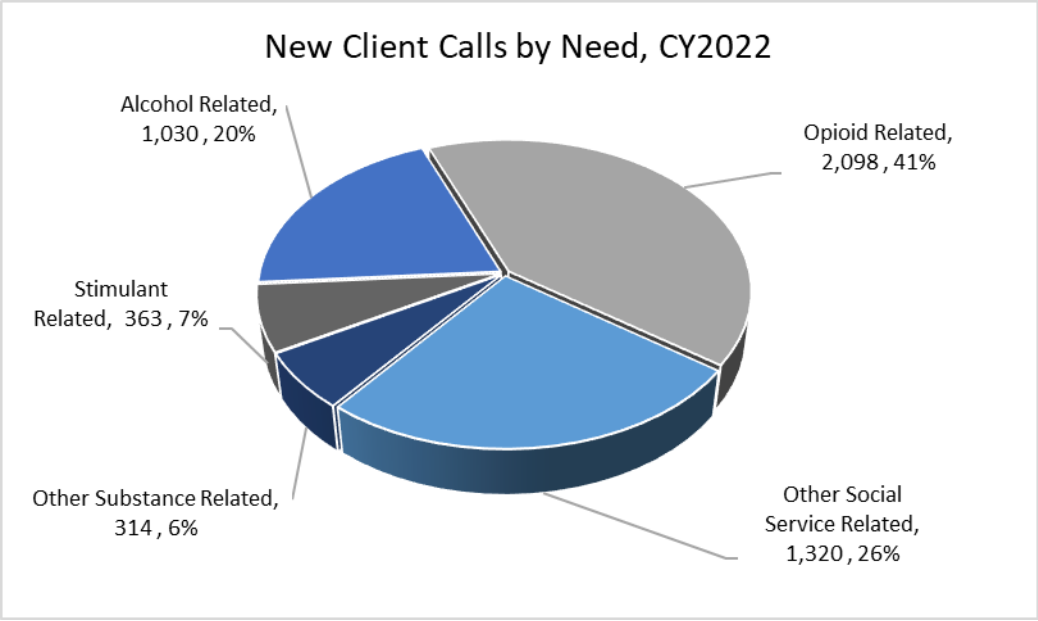
- Doorway sites received approximately 425 new client calls each month in CY2022, with an average of 47.5 calls per Doorway site
- The volume of calls received by Doorway site varies widely; three sites received an average of less than 15 calls per month, while the three highest-volume sites received more than 85 calls per month



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Screening and Crisis Stabilization – New Client Calls *(continued)*

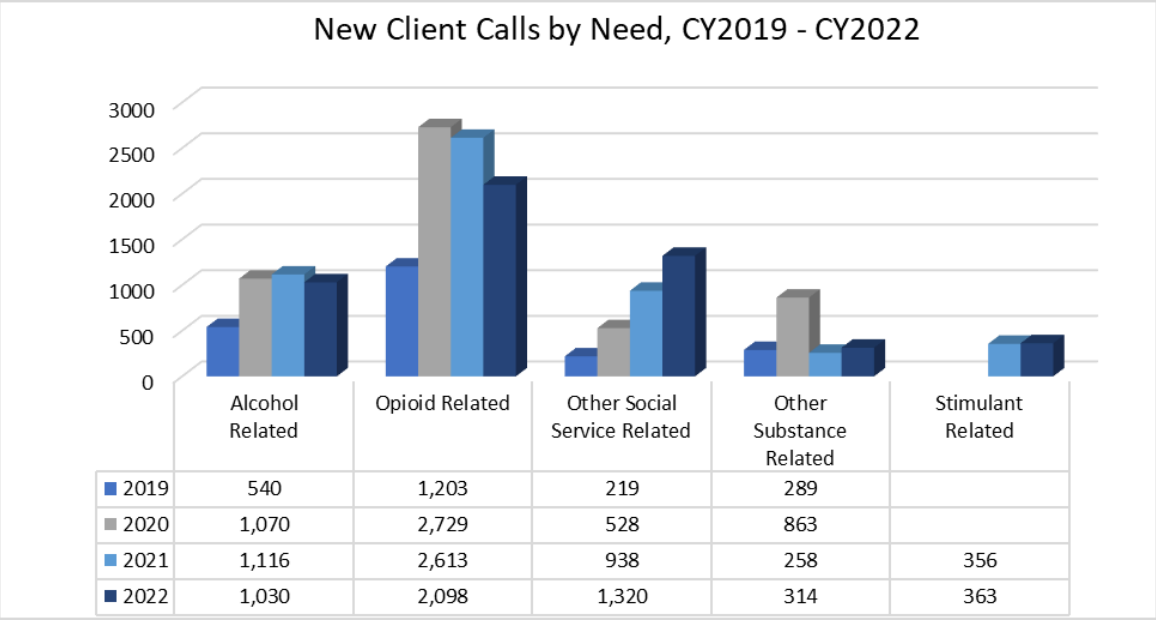
- Nearly half (48%) of new client calls in CY2022 were related to opioid and stimulant use
- Approximately one-fourth (26%) of new client calls were related to social service needs
- Approximately 20% of new client calls were related to alcohol use



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Screening and Crisis Stabilization – New Client Calls *(continued)*

- New client calls related to opioid use have declined from a high of 2,729 in CY2020 to 2,098 in CY2022
- Calls related to social service needs more than doubled between CY2020 and CY2022

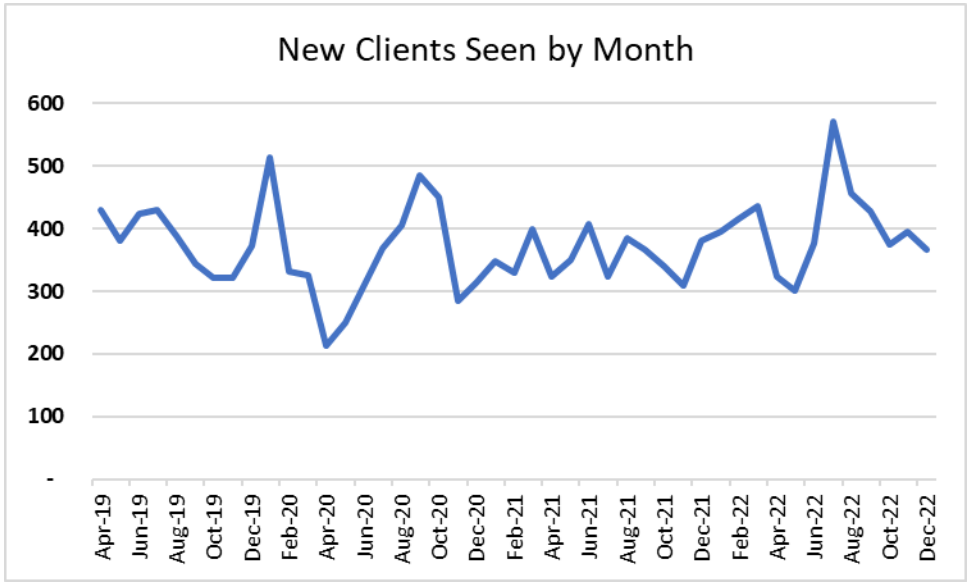


	Alcohol Related	Opioid Related	Other Social Service Related	Other Substance Related	Stimulant Related
2019	540	1,203	219	289	
2020	1,070	2,729	528	863	
2021	1,116	2,613	938	258	356
2022	1,030	2,098	1,320	314	363

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Evaluation and Care Planning – New Clients Seen

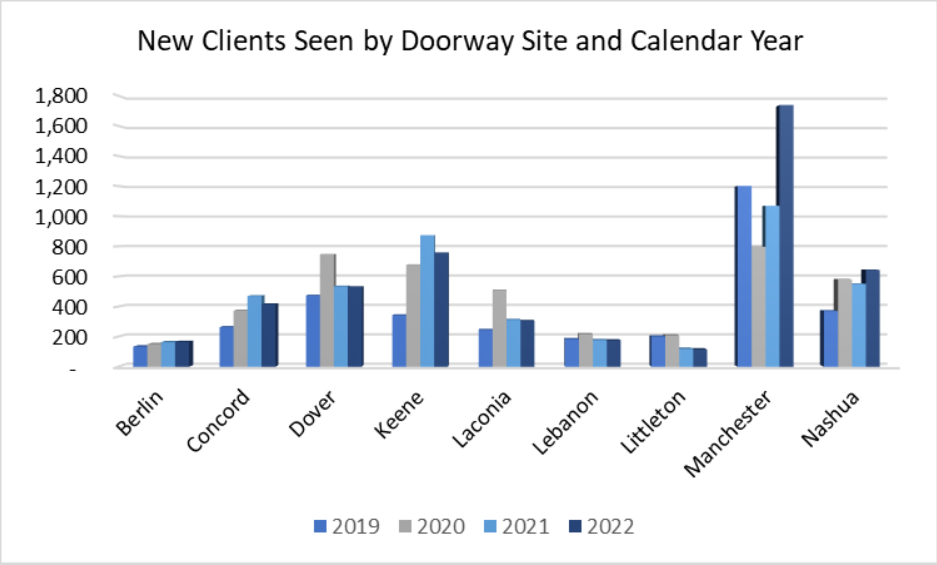
- Doorway sites saw an average of approximately 400 new clients each month in CY2022
- Doorway sites reported a total of 4,839 new clients seen in CY2022, representing a 13% increase compared to CY2021



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Evaluation and Care Planning – New Clients Seen *(continued)*

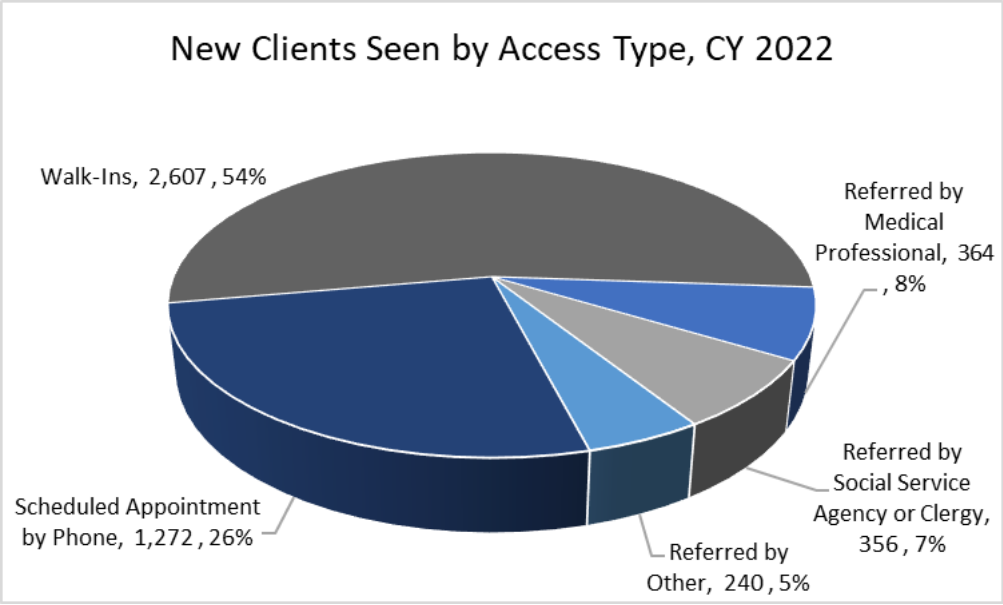
- The average number of new clients seen by Doorway site ranged from 114 to 1,738 in CY2022
- Five of the nine Doorway sites reported a similar number of new client visits in CY2021 and 2022 (i.e., less than five percent change)
- Two sites reported seeing fewer new clients in CY2022 compared to CY2021 and two sites reported seeing more new clients



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Evaluation and Care Planning – New Clients Seen *(continued)*

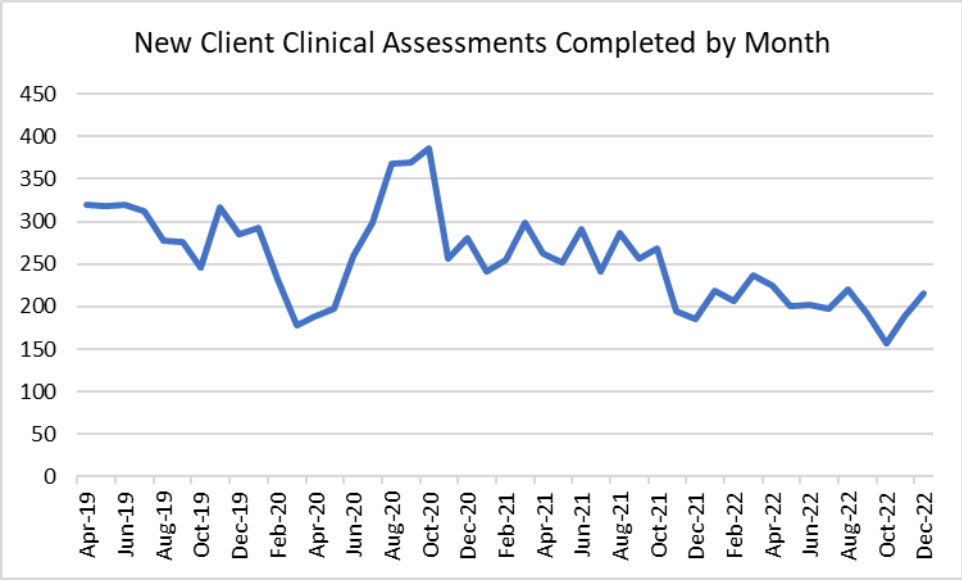
- More than half (54%) of new clients seen were walk-ins to the Doorway sites in CY2022
- Approximately 20% of new clients seen were referred by medical professionals, social service agencies, clergy or other



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Evaluation and Care Planning – New Client Assessments

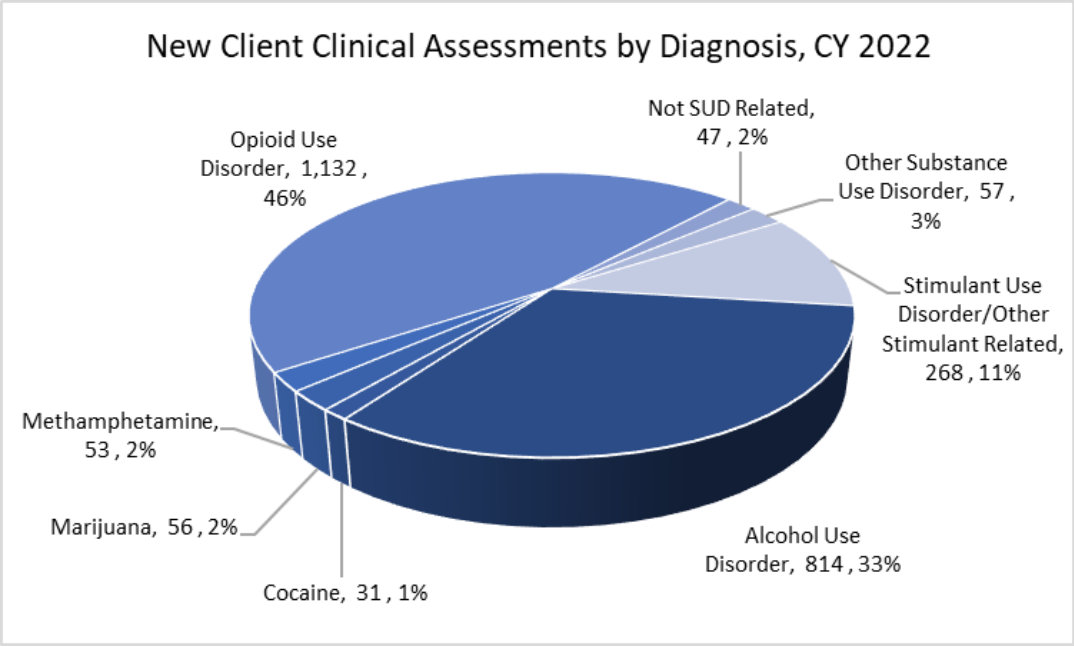
- Doorway sites reported completion of 2,458 new client clinical assessments in CY2022, with an average of 205 assessments completed monthly
- The number of reported new client clinical assessments between CY2021 and CY2022 declined by approximately 19%, from 3,032 to 2,458



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Evaluation and Care Planning – New Client Assessments *(continued)*

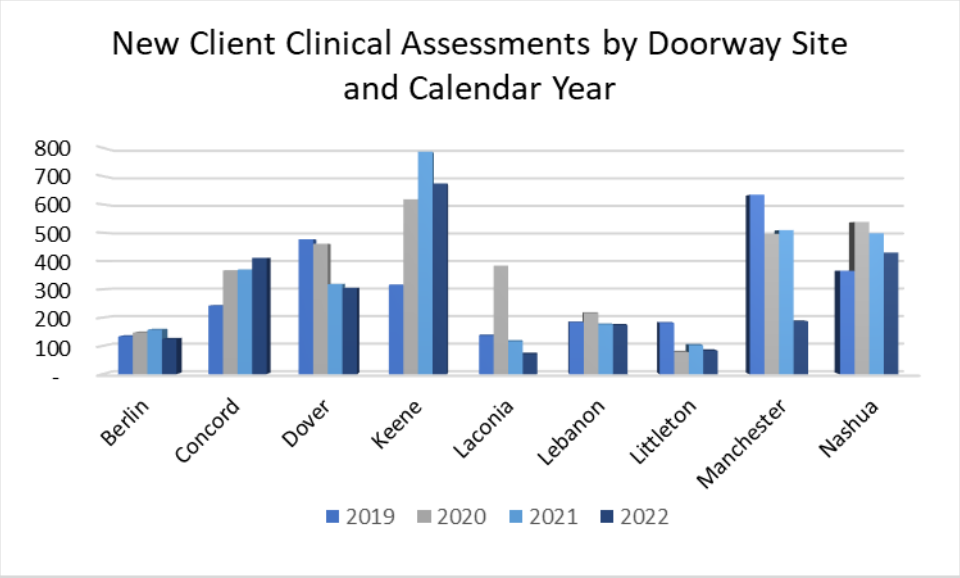
- Approximately 46% of new client clinical assessments were related to opioid use disorder
- Approximately one-third of assessments were related to alcohol use disorder



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Evaluation and Care Planning – New Client Assessments *(continued)*

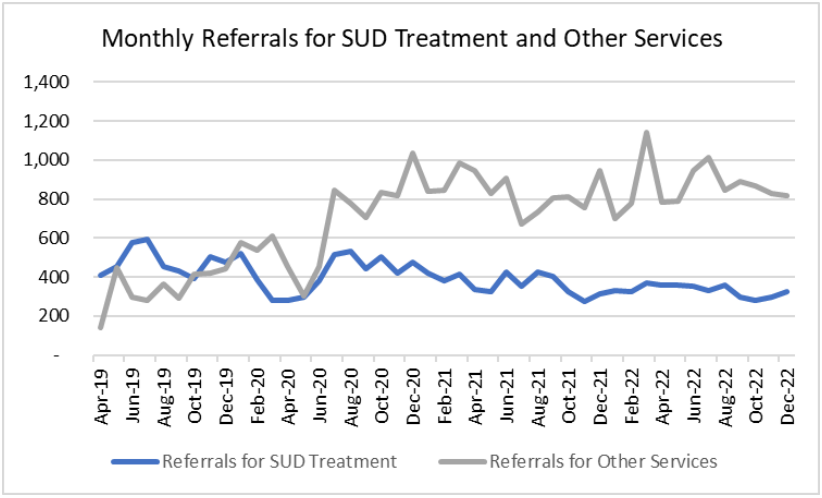
- Eight of the nine Doorway sites reported a decline in new client clinical assessments between CY2021 and 2022
- The average number of new client clinical assessments completed monthly by Doorway site ranged from 5.9 assessments to 56.2 assessments



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Facilitated Referrals - Doorway Site Referrals for SUD Treatment

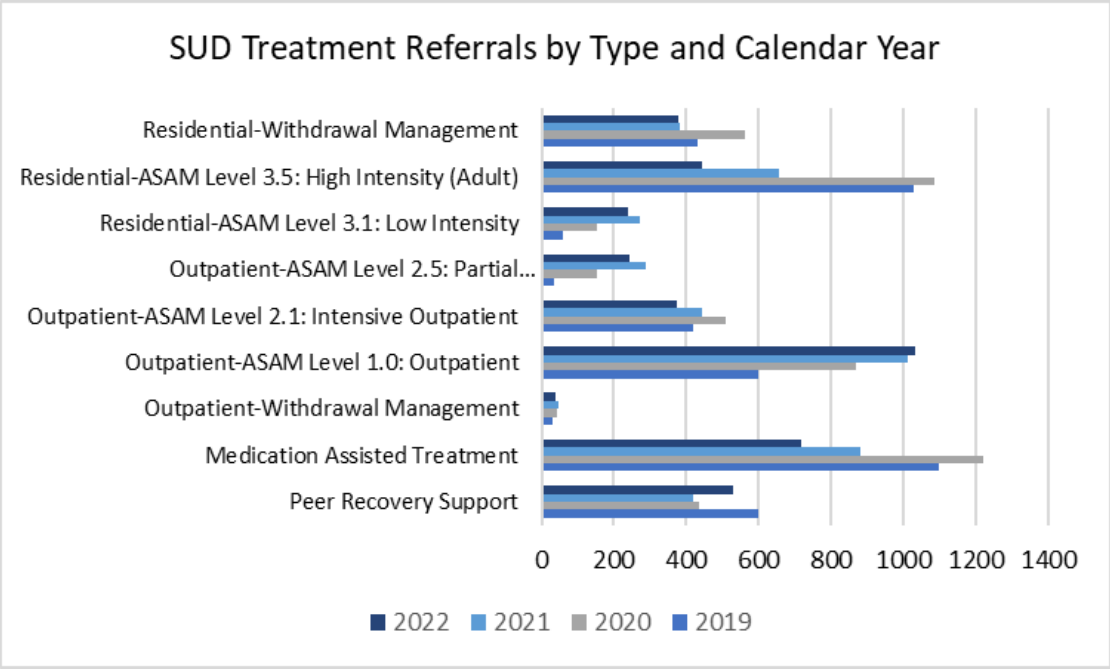
- Doorway sites initiated nearly 4,000 referrals for SUD treatment in CY2022 and more than 10,400 referrals for other services
- The average number of monthly referrals for SUD treatment declined between CY2021 and CY2022, from 367 to 333
- Referrals for other services have increased from approximately 8,000 referrals in CY2020 to approximately 10,000 in CY2022



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Facilitated Referrals - Doorway Site Referrals for SUD Treatment *(continued)*

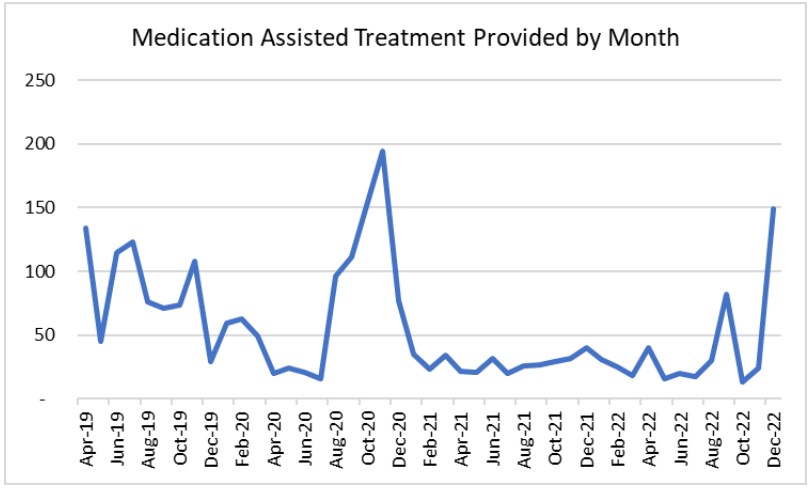
- Referrals for Level I Outpatient services represent approximately 25% of total referrals for SUD treatment in CY2022
- Referrals for Medication Assisted Treatment and Level 3.5 High Intensity Residential treatment have declined between CY2020 and CY2022

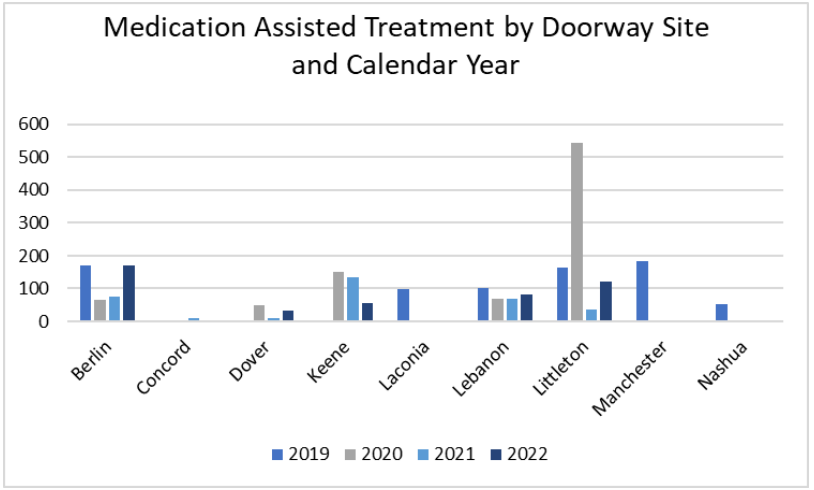


APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Medication Assisted Treatment (MAT)

- Several Doorways also offer MAT treatment; other Doorways may provide bridge prescriptions or MAT induction in the ED
- Eight Doorway sites reported that they provided MAT in 2020 but the number of sites providing MAT decreased to five in CY2022

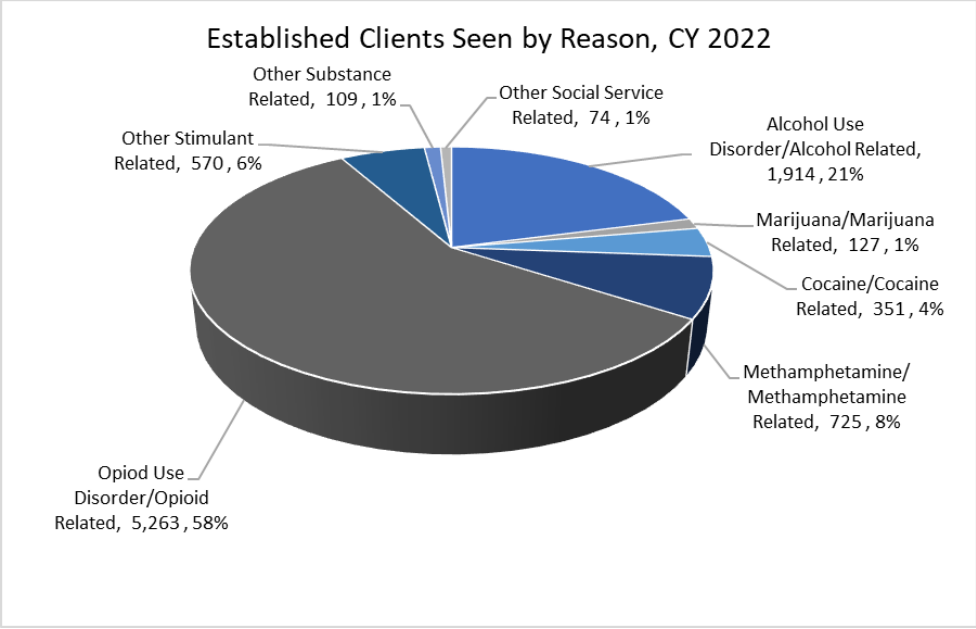




APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Continuous Recovery Monitoring - Established Clients Seen

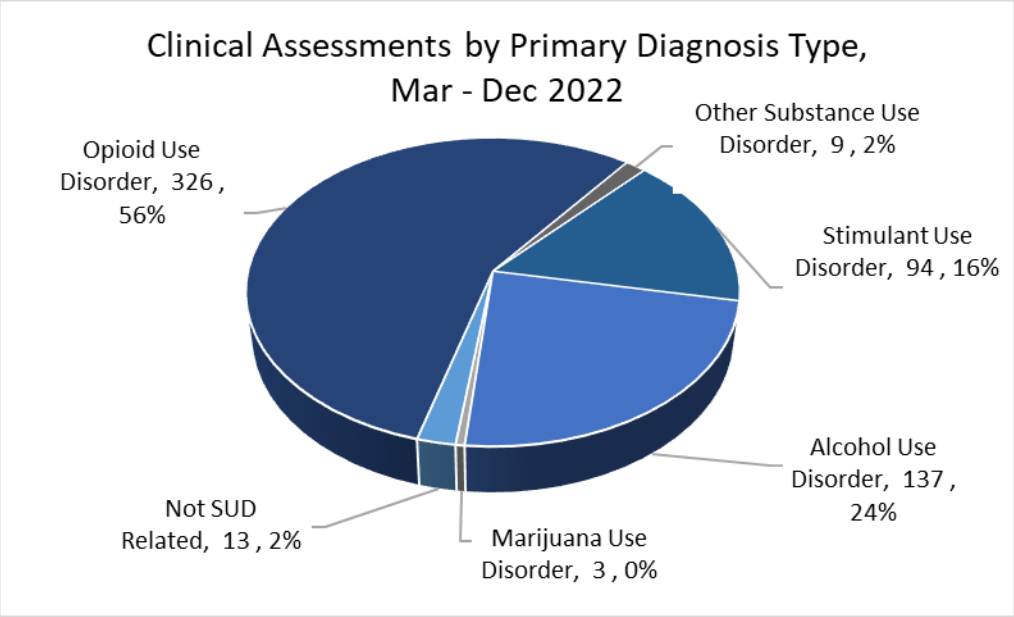
- Doorway Sites reported a total of 9,133 interactions with established clients in CY2022
- More than 5,200, or 58%, of client interactions were related to opioid use
- Approximately 21% of client interactions were related to alcohol use



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Continuous Recovery Monitoring - Re-Assessments for Established Clients

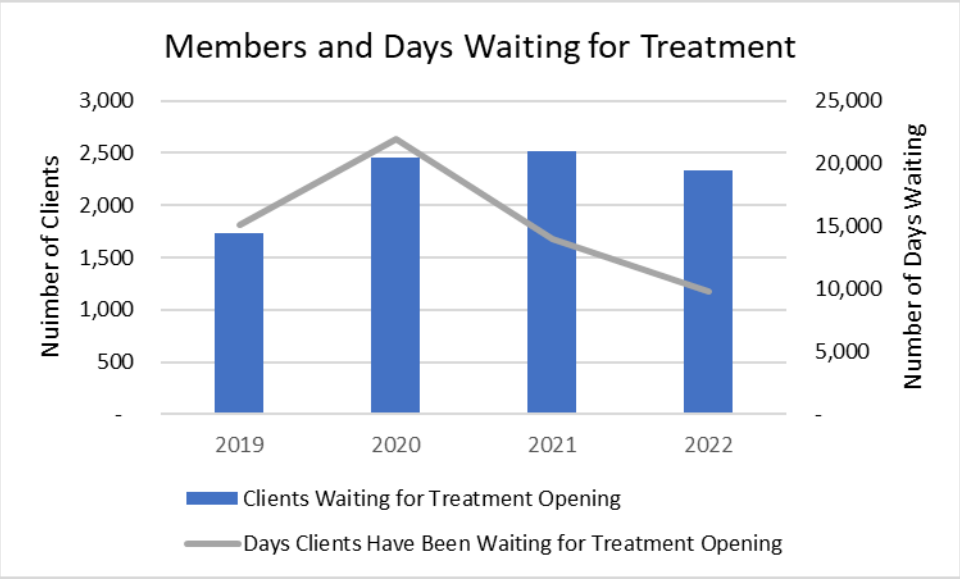
- Reporting of clinical assessments for established clients began in March 2022
- The majority of clinical re-assessments were performed on behalf of clients with opioid-related treatment needs



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Continuous Recovery Monitoring - Members and Days Waiting for Treatment

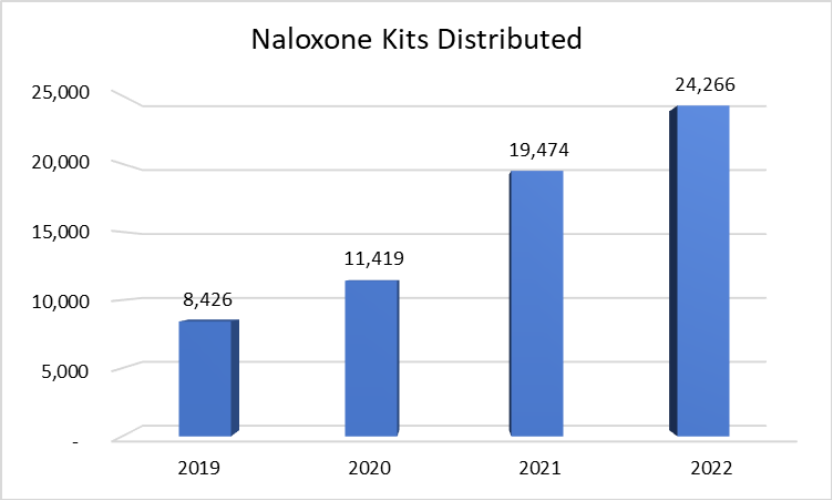
- The number of members waiting for a treatment opening declined from 2,524 in CY2021 to 2,336 in CY2022
- The number of days waiting for treatment declined from more than 22,000 total days to less than 10,000 days in CY2022

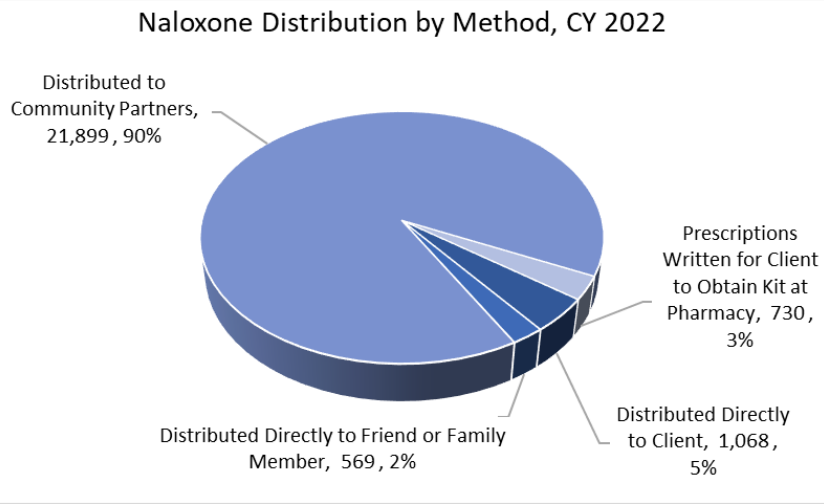


APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Naloxone Distribution

- Doorway sites distributed Naloxone kits or wrote prescriptions to obtain kits from pharmacies
- The total number of naloxone kits distributed/prescribed increased by approximately 25% between CY2021 and CY2022

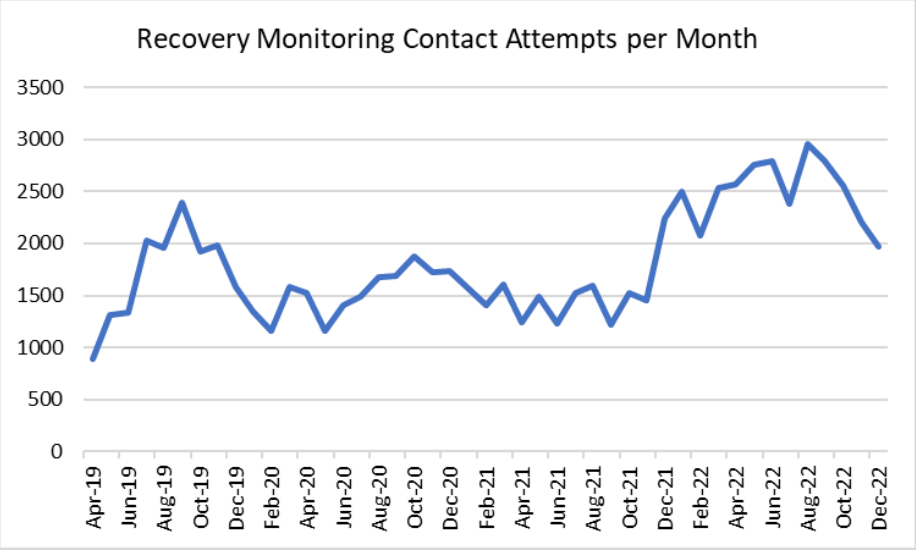




APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Continuous Recovery Monitoring - Recovery Monitoring Contact Attempts

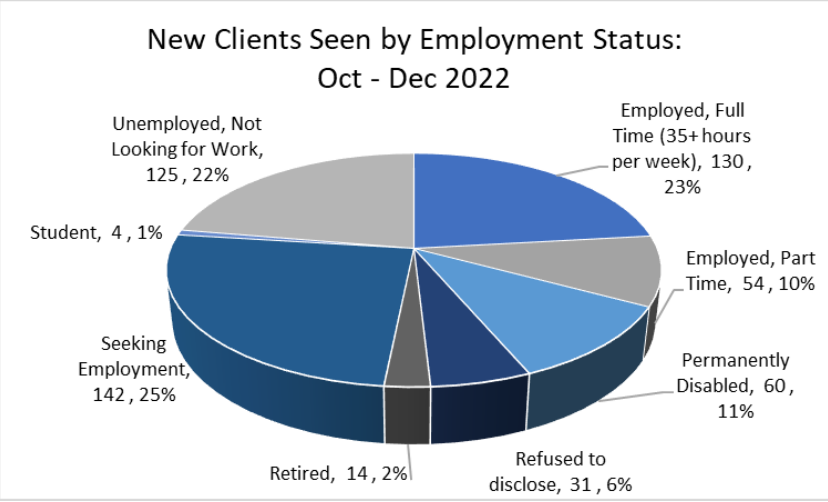
- Doorway sites reported an average of approximately 2,500 contact attempts each month in CY2022
- Recovery monitoring contact attempts increased significantly from approximately 18,000 total calls in CY2021 to more than 30,000 in CY2022

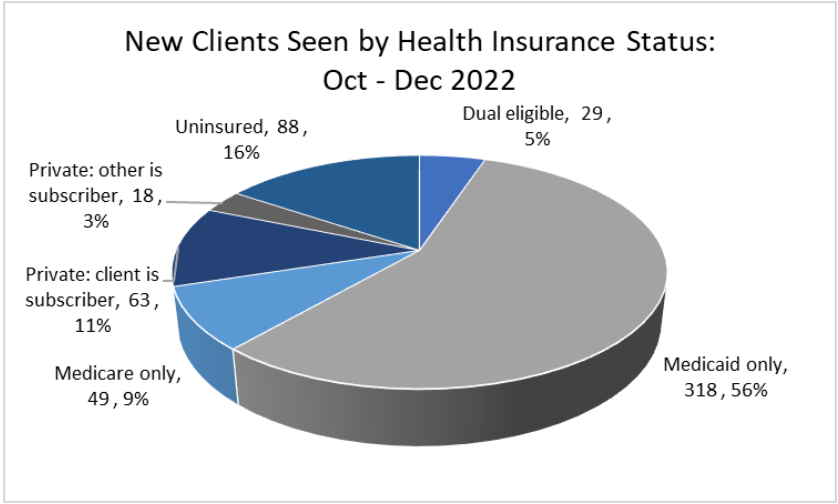


APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

New Activity Report Measures

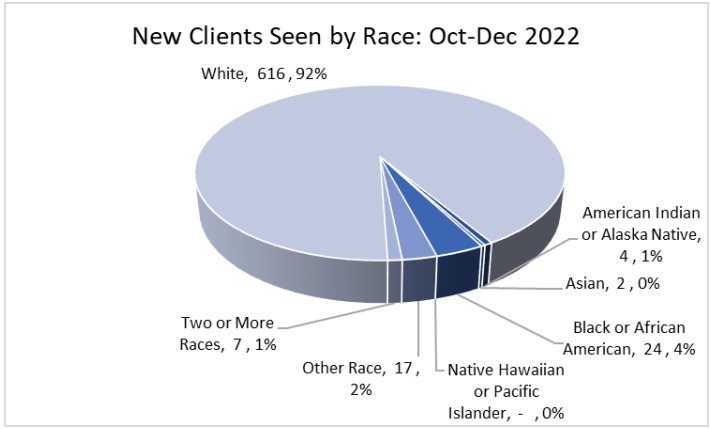
- The following measures were added to Doorway site reporting requirements, effective October 2022:
  - New Clients Seen by Employment Status
  - New Clients Seen by Health Insurance Status
  - New Clients Seen by Race
  - New Clients Seen by Ethnicity
  - New Clients Seen by Housing Status
  - New Clients Seen by Justice Involvement Status

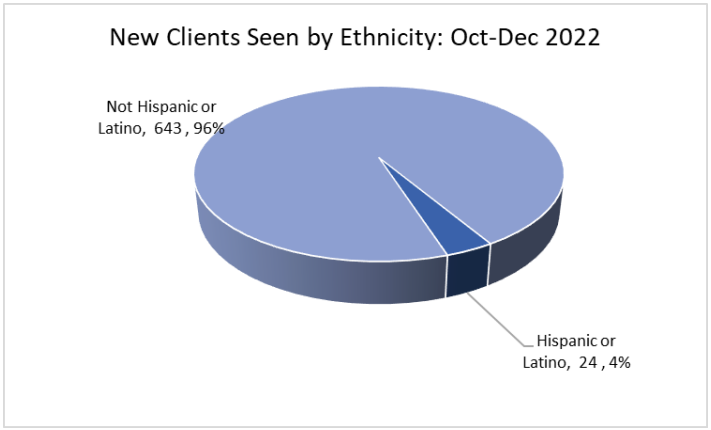


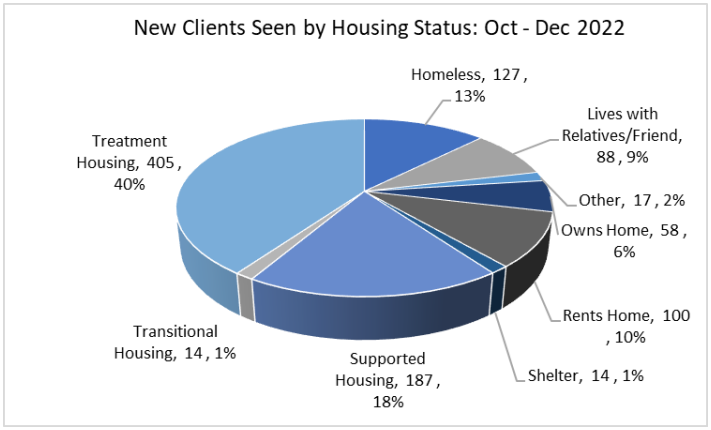


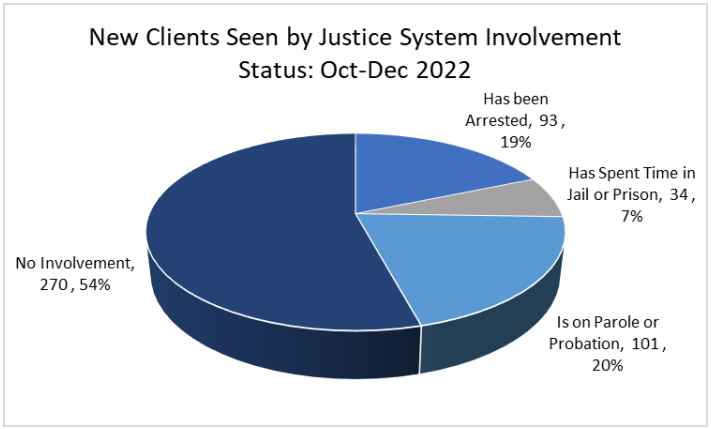
APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

New Activity Report Measures *(continued)*









APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS (CONTINUED)

B. GPRA DATA

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Overview - GPRA

- The Government Performance and Results Act (GPRA) requires federal agencies to establish near-term performance goals as well as long-term goals and objectives
- SAMHSA requires federal grantees to perform initial assessments, six-month follow-up assessments and assessments upon discharge
- Doorways are required to complete GPRA assessments on behalf of individuals requiring treatment for opioid or stimulant use
- An extract of GPRA assessments was created from the GPRA database that includes unduplicated assessment data for interviews conducted in State Fiscal Year 2022

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Overview – GPRA (continued)

- Doorway sites completed approximately 6,900 assessments between SFY2020 and SFY2022
- Initial assessments accounted for 65.2% of the total assessments performed between SFY2020 and SFY2022

Doorway Site	SFY 2020				SFY21				SFY22			
	Intake	6-Month Follow Up	Discharge	Total	Intake	6-Month Follow Up	Discharge	Total	Intake	6-Month Follow Up	Discharge	Total
Berlin	86	32	5	123	135	23	4	162	84	55	1	140
Concord	136	6		142	80	16	6	102	133	16	2	151
Dover	357	43	1	401	213	34	1	248	139	53	4	196
Keene	178	33	4	215	312	56	22	390	253	170	2	425
Laconia	220	7		227	212	19	4	235	164	31		195
Lebanon	80	26		106	117	28		145	95	53		148
Littleton	53	2	4	59	28	5	1	34	30	3		33
Manchester	58	1		59	719	9	37	765	770	66	23	859
Nashua	40	1		41	563	47	13	623	310	263	115	688
Total	**1,208**	**151**	**14**	**1,373**	**2,379**	**237**	**88**	**2,704**	**1,978**	**710**	**147**	**2,835**

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

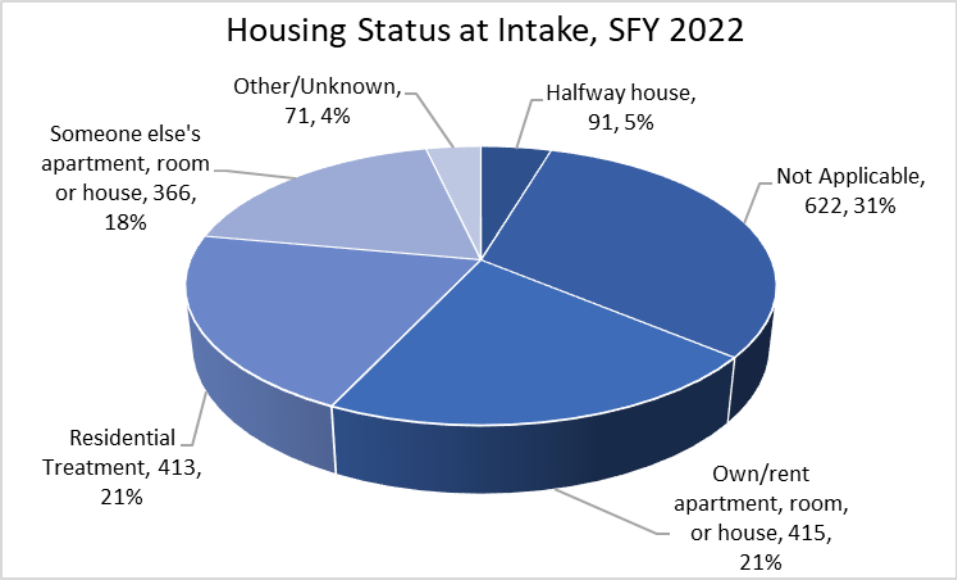
GPRA Intake Assessments – Reported Daily Usage, SFY2022

- Current alcohol and drug usage information is collected as part of the intake screening
- In SFY22, the percentage of Doorway members who reported daily usage of drugs or alcohol are as follows:
  - Alcohol use - 5.0%
  - Illegal drugs - 29.6%
  - Cocaine - 5.9%
  - Heroin – 18.1%

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

GPRA Intake Assessments – Housing Status, SFY2022

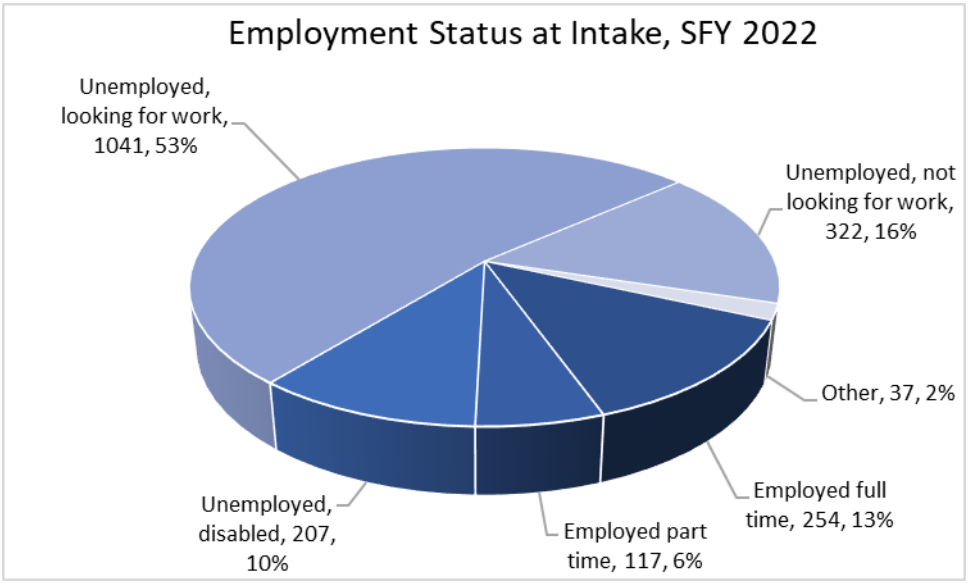
- Approximately 20% of Doorway members reported owning or renting their residences
- More than one-fourth of Doorway members indicated that they were staying in residential treatment or a halfway house



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

GPRA Intake Assessments – Employment Status, SFY2022

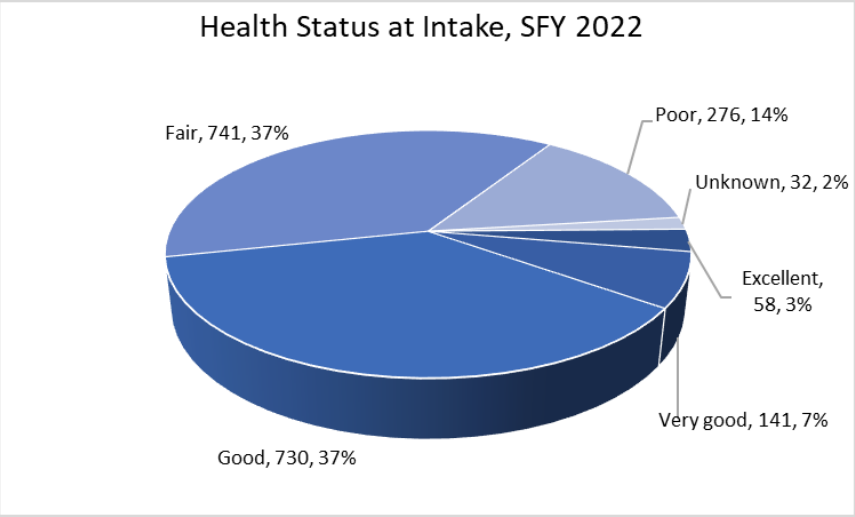
- Nearly 20% of Doorway members reported full-time or part-time employment
- Nearly 80% of members reported their status as unemployed and two-thirds of these members indicated that they were looking for work

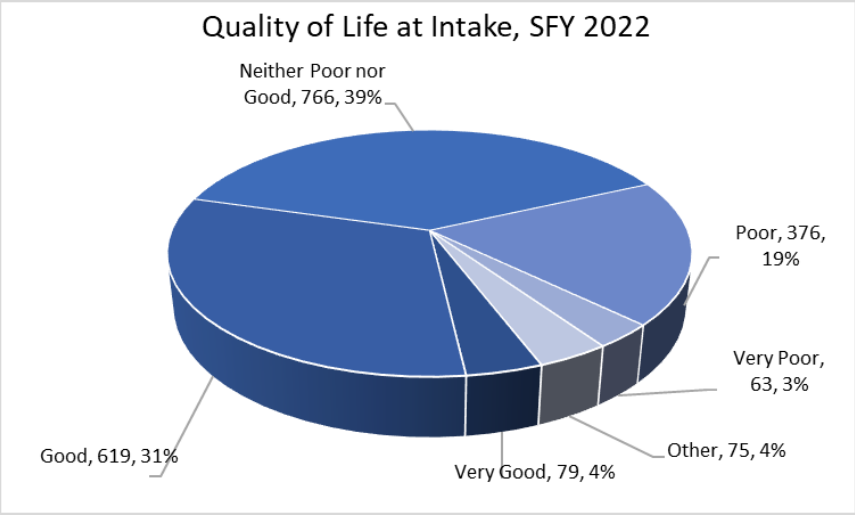


APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

GPRA Intake Assessments – Health Status and Quality of Life, SFY2022

- Approximately one-half of Doorway members reported their health status as Fair or Poor
- Approximately 22% of Doorway members reported their quality of life as Poor or Very Poor

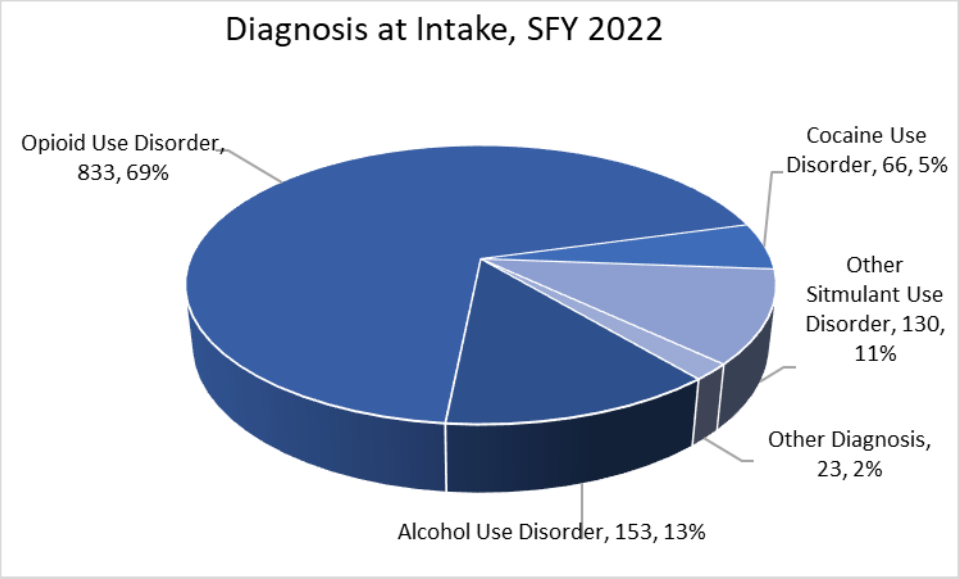




APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

GPRA Intake Assessments – Primary Diagnosis, SFY2022

- Approximately 1,200 members reported a primary diagnosis at the time of the GPRA assessment
- Nearly 70% of members reported a primary diagnosis of opioid use disorder
- Approximately 16% of members reported a diagnosis of cocaine use disorder or other stimulant use disorder



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

GPRA Intake, Six-Month Follow-Up, and Discharge Assessment – SFY2022

- In order to evaluate changes over time, an extract was created that includes members who had an intake assessment as well as a follow-up or discharge assessment in SFY2022
- A total of 290 members had an intake and follow-up/discharge assessment
- Summaries on the following pages present assessment responses at intake compared to responses for the same questions at the six-month follow up or upon discharge

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

GPRA Intake, Six-Month Follow-Up, and Discharge Assessment – Housing, SFY2022

- The percentage of members who rented or owned their residences increased from 30.3% to 45.5% at follow-up/discharge
- The percentage of members receiving residential treatment declined from 19.7% at the time of intake to 6.2% at follow-up/discharge

Housing Type	Intake		6-Month Follow-up/Discharge		Increase/ Decrease	Percentage Change
	Members	Percentage of Total	Members	Percentage of Total		
Halfway house	7	2.4%	26	9.0%	19	271%
Other housed/unknown	8	2.8%	12	4.1%	4	50%
Own/rent apartment, room, or house	88	30.3%	132	45.5%	44	50%
Residential treatment	57	19.7%	18	6.2%	-39	-68%
Someone else's apartment, room or house	69	23.8%	58	20.0%	-11	-16%
Institution	20	6.9%	8	2.8%	-12	-60%
Shelter	8	2.8%	5	1.7%	-3	-38%
Street/Outdoors	33	11.4%	31	10.7%	-2	-6%
Total	**290**	**100.0%**	**290**	**100.0%**	**0**	**0%**

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

GPRA Intake, Six-Month Follow-Up, and Discharge Assessment – Health Satisfaction, SFY2022

- The percentage of members who reported that they were Dissatisfied or Very Dissatisfied with their health decreases from 19.3% at intake to 14.5% at follow-up/discharge
- The percentage of members who reported that they were Very Satisfied or Satisfied with their health increased from 54.1% at intake to 61.4% at follow-up/discharge

Health Satisfaction	Intake		6-Month Follow-up/Discharge		Increase/ Decrease	Percentage Change
	Members	Percentage of Total	Members	Percentage of Total		
Very Satisfied	14	4.8%	26	9.0%	12	86%
Satisfied	143	49.3%	152	52.4%	9	6%
Neither Satisfied or Dissatisfied	72	24.8%	66	22.8%	-6	-8%
Dissatisfied	42	14.5%	34	11.7%	-8	-19%
Very Dissatisfied	14	4.8%	8	2.8%	-6	-43%
Other/Unknown	5	1.7%	5	1.4%	0	0%
Total	**290**	**100.0%**	**290**	**100.0%**	**0**	**0%**

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

GPRA Intake, Six-Month Follow-Up, and Discharge Assessment – Self Satisfaction, SFY2022

- Regarding self satisfaction, 24.5% of members reported being Dissatisfied or Very Dissatisfied at the time of intake, compared to 14.5% at follow-up/discharge
- The percentage of members whose self satisfaction was reported at Very Satisfied or Satisfied increased from 47.6% at intake to 61.4% at follow-up/discharge

Self Satisfaction	Intake		6-Month Follow-		Increase/ Decrease	Percentage Change
	Members	Percentage of Total	Members	Percentage of Total		
Very Satisfied	13	4.5%	36	9.0%	23	177%
Satisfied	125	43.1%	136	52.4%	11	9%
Neither Satisfied or Dissatisfied	76	26.2%	55	22.8%	-21	-28%
Dissatisfied	53	18.3%	46	11.7%	-7	-13%
Very Dissatisfied	18	6.2%	13	2.8%	-5	-28%
Other/Unknown	5	1.7%	4	1.4%	-1	-20%
Total	**290**	**100.0%**	**290**	**100.0%**	**0**	**0%**

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

GPRA Intake, Six-Month Follow-Up, and Discharge Assessment – Acuity of SUD Diagnosis, SFY2022

- Reported SUD diagnoses were combined based on acuity level
- The percentage of members reporting a moderate/severe SUD decreased from 66.9% to 49.7%
- The percentage of members who reported a SUD in remission increased from 14.1% to 36.9%

SUD Diagnosis Level (includes alcohol, opioid, cocaine, other stimulants and inhalants)	Intake		6-Month Follow-up/Discharge		Increase/ Decrease	Percentage Change
	Members	Percentage of Total	Members	Percentage of Total		
Mild	16	5.5%	6	2.1%	-10	-63%
Moderate/severe	194	66.9%	144	49.7%	-50	-26%
Mild, in remission	14	4.8%	14	4.8%	0	0%
Moderate/severe, in remission	27	9.3%	93	32.1%	66	244%
Total	**251**	**100.0%**	**257**	**100.0%**	6	2%

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

GPRA Intake, Six-Month Follow-Up, and Discharge Assessment – Quality of Life, SFY2022

- The percentage of members who reported their quality of life as Very Good or Good increased from 45.5% to 59.6% at follow-up/discharge
- The percentage of members who reported their quality of life as Poor or Very Poor decreased from 17.6% at intake to 13.9% at follow-up/discharge

Life Quality	Intake		6-Month Follow-up/Discharge		Increase/ Decrease	Percentage Change
	Members	Percentage of Total	Members	Percentage of Total		
Very Good	16	5.5%	32	11.0%	16	100%
Good	116	40.0%	141	48.6%	25	22%
Neither Poor Nor Good	103	35.5%	72	24.8%	-31	-30%
Poor	42	14.5%	34	11.7%	-8	-19%
Very Poor	9	3.1%	6	2.1%	-3	-33%
Other/Unknown	4	1.4%	5	1.7%	1	25%
Total	**290**	**100.0%**	**290**	**100.0%**	**0**	**0%**

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS (CONTINUED)

C. MEDICAID DATA

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Overview- Medicaid Data

- Medicaid claims and eligibility data were evaluated to gain an understanding of Medicaid services provided to Doorway members
- Medicaid ID numbers are not routinely stored/collected; Medicaid IDs were obtained through the following approaches
  - Member rosters provided by Doorway sites
  - GPRA extracts were provided by DHHS that included a sample of Medicaid IDs
  - Claims data analysis to identify Medicaid participants who received a Medicaid-covered service from a Doorway Provider Number*
- A sample of members who were served by Doorways and eligible for Medicaid coverage in State Fiscal Year 2022 were identified
- Valid Medicaid IDs were identified for 2,972 Medicaid participants in State Fiscal Year 2022
- Due to limitations in matching Doorway members to Medicaid eligibility, the analysis is based a sample and therefore does not represent Medicaid utilization and expenditures for the complete Doorway population
- Due to methodology for identifying Medicaid IDs for Doorway members, caution should be exercised when reviewing Doorway-specific data

*Because Doorway Provider Numbers were used for both Doorway and non-Doorway members in some instances, the sample was further refined to include only members with a minimum SUD claim total of $100 in State Fiscal Year 2022; the Manchester site does not have a Provider Number

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Medicaid Sample of Doorway Members

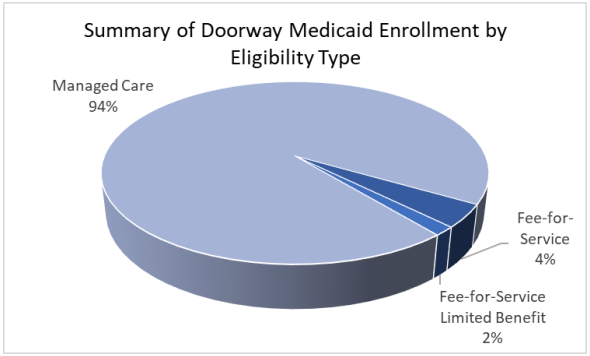
- A total of 2,972 Medicaid participants were identified as Doorway members in SFY22
- Medicaid claims with dates of service in SFY22 and Medicaid eligibility data for SFY22 were extracted for analysis
- Medicaid claims with dates of service in SFY21 also were evaluated to distinguish between new Doorway members and Doorway members who participated prior to SFY22
- Total members identified by Doorway site are presented below

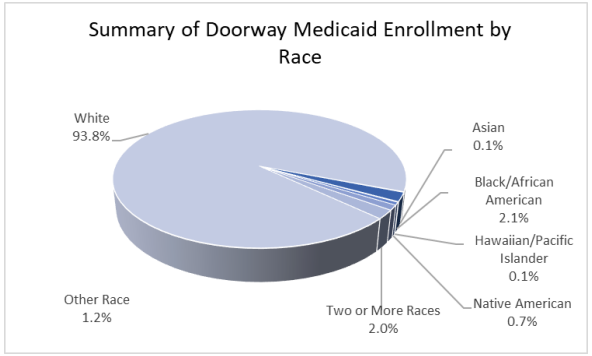
Doorway Site	Number of Members in Medicaid Sample
Berlin	144
Concord	608
Dover	298
Keene	384
Laconia	130
Lebanon	110
Littleton	397
Manchester	461
Nashua	440
Total	**2,972**

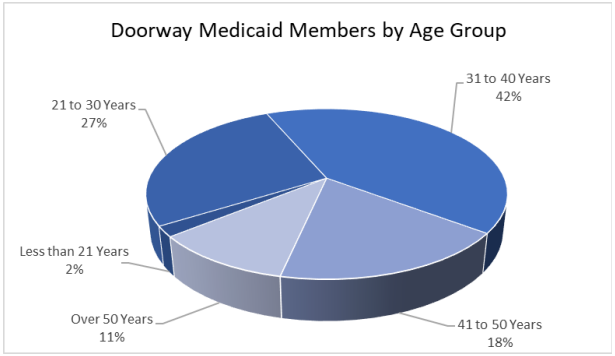
APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Doorway Medicaid Sample - Demographics, SFY22

- Approximately two-thirds (63.3%) of participants in the sample are male and 36.7% are female
- The majority of Doorway members were enrolled in Medicaid managed care
- Approximately 98% of Doorway members reported their race as White
- Approximately 70% of Doorway members are under 50 years of age







APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Doorway Medicaid Sample – Primary County of Residence, SFY2022

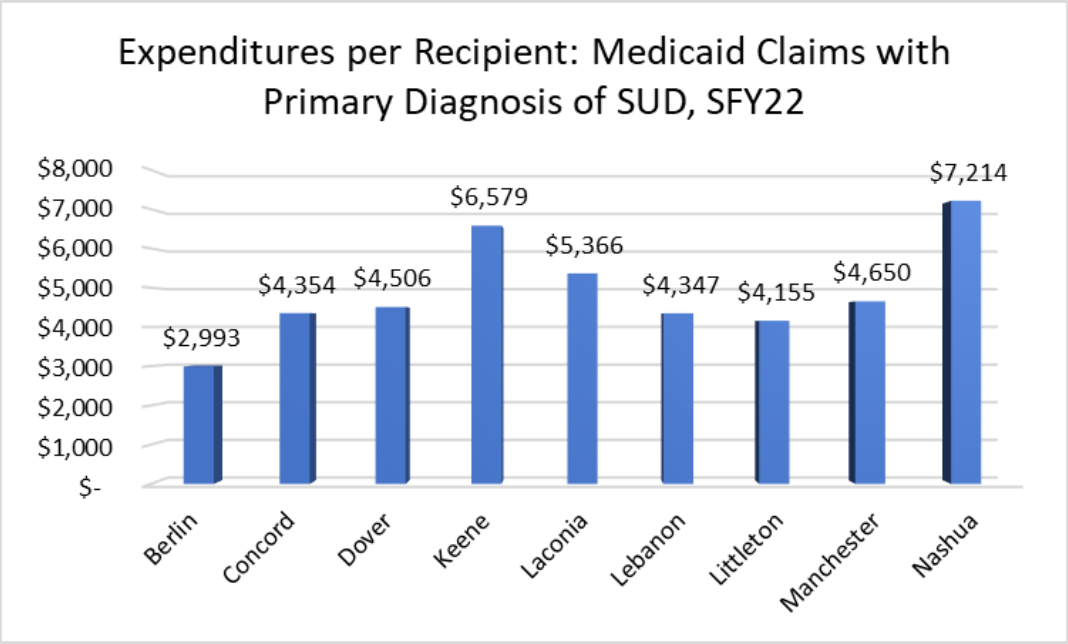
- All Doorway sites serve members residing in multiple counties

Doorway Site	Members	Primary County of Residence	Percentage of Members in Primary County	Number of Other Counties with Five or More Members
Berlin	144	Coos	79%	3
Concord	608	Merrimack	63%	8
Dover	298	Strafford	63%	5
Keene	384	Cheshire	69%	8
Laconia	130	Belknap	54%	6
Lebanon	110	Sullivan	46%	4
Littleton	397	Grafton	49%	10
Manchester	461	Hillsborough	62%	10
Nashua	440	Hillsborough	77%	6
Total	**2,972**			

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Doorway Medicaid Sample - Medicaid Expenditures for SUD, SFY2022

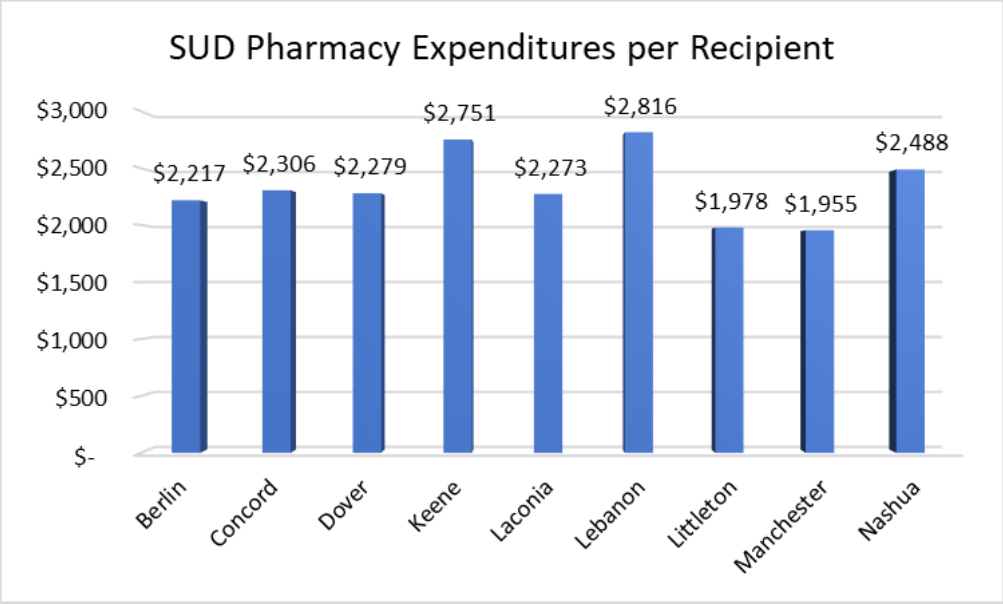
- Medicaid claims (not including pharmacy) with a primary diagnosis of SUD equaled $15.1 million in SFY22
- Average Medicaid expenditures per Doorway member in the Medicaid sample were $5,077 in SFY22
- Medicaid expenditures per recipient by Doorway site ranged from $2,993 to $7,214



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Doorway Medicaid Sample - Doorway SUD Pharmacy Medicaid Expenditures, SFY22

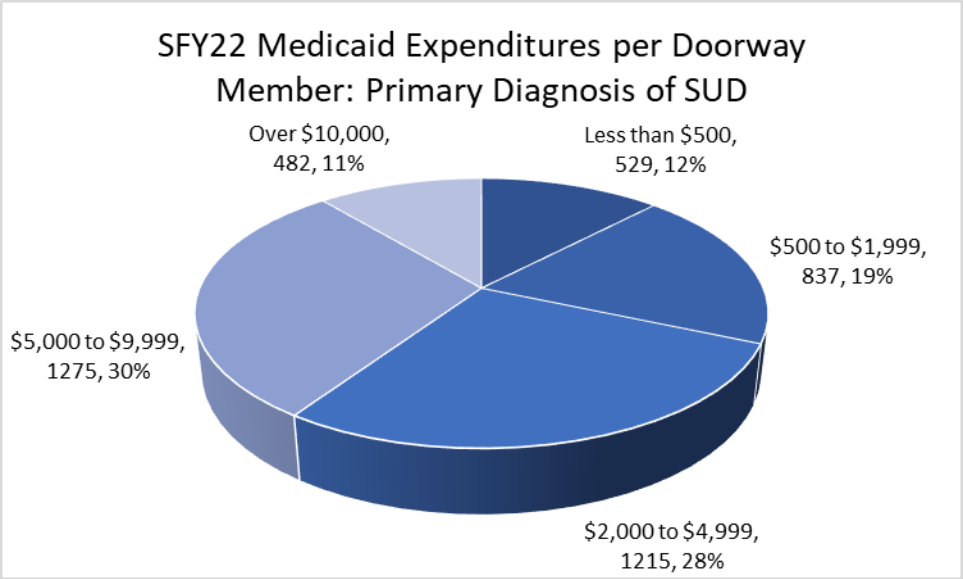
- A total of 1,716 of 2,972 Medicaid members received SUD pharmacy in SFY2022, representing 57.8% of the Medicaid sample population
- Average Medicaid expenditures per recipient in SFY22 equaled $2,308
- Expenditures per recipient were relatively similar across Doorway sites, ranging from $1,955 to $2,816



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Doorway Medicaid Sample - Expenditures per Doorway Member, SFY22

- Medicaid SUD treatment expenditures were less than $2,000 for approximately one-half of Doorway members
- Eleven percent of Doorway members received SUD treatment services that exceeded $10,000 in SFY22



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

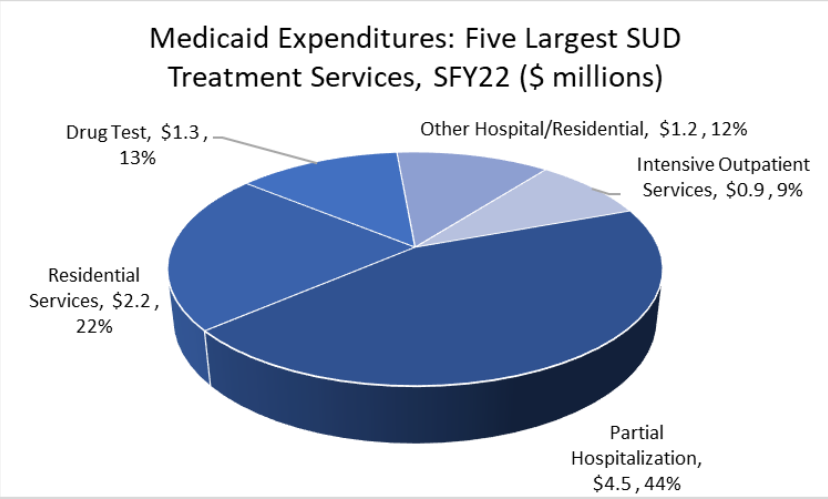
Medicaid Doorway Sample - Service Utilization, Recipients and Expenditures, SFY2022

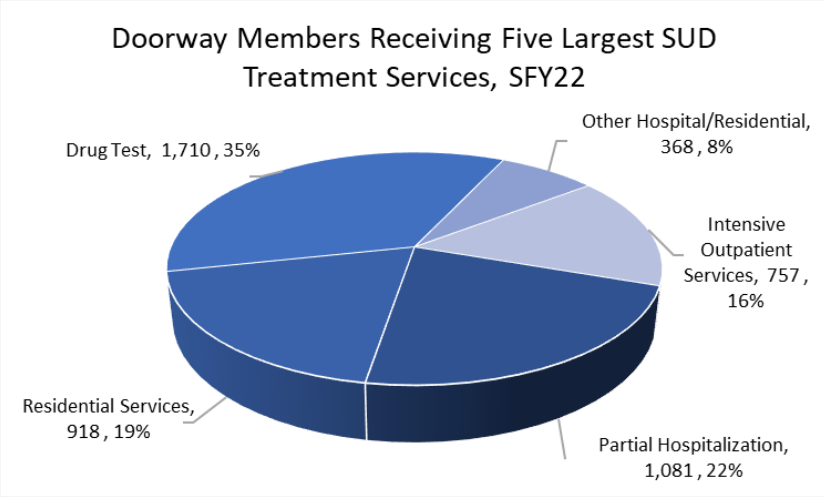
SUD Service	Procedures	Recipients	Paid	Average Procedures per Recipient	Average Paid per Procedure	Average Paid per Recipient
Alcohol and/or Drug Assessment	2,053	1,480	$ 343,114	1.4	$ 167	$ 232
Alcohol and/or Drug Counseling - Group	1,754	255	$ 53,499	6.9	$ 31	$ 210
Alcohol/Drug Screening	401	358	$ 24,575	1.1	$ 61	$ 69
Behavioral Health Counseling and Therapy	5,645	934	$ 598,066	6.0	$ 106	$ 640
Care Planning and Facilitated Referral	1,371	494	$ 70,882	2.8	$ 52	$ 143
Case Management	113	23	$ 45,837	4.9	$ 406	$ 1,993
Continuous Recovery Monitoring	996	343	$ 13,240	2.9	$ 13	$ 39
Crisis Intervention	144	89	$ 27,788	1.6	$ 193	$ 312
Crisis Stabilization	43	32	$ 5,660	1.3	$ 132	$ 177
Diagnostic Test	2,053	576	$ 106,998	3.6	$ 52	$ 186
Drug Test	26,938	1,710	$ 1,281,880	15.8	$ 48	$ 750
ED Visit	1,870	668	$ 277,496	2.8	$ 148	$ 415
Family/Couple Counseling	536	47	$ 131,181	11.4	$ 245	$ 2,791
Group Psychotherapy	1,078	162	$ 55,316	6.7	$ 51	$ 341
Hospital Visit	644	179	$ 29,053	3.6	$ 45	$ 162
Intensive Outpatient Services	7,616	757	$ 897,474	10.1	$ 118	$ 1,186
MAT Administration	10,262	425	$ 169,579	24.1	$ 17	$ 399
Medically Monitored Withdrawal Management	579	294	$ 196,909	2.0	$ 340	$ 670
Office Visit	9,133	1,624	$ 710,862	5.6	$ 78	$ 438
Other Diagnostic	24	23	$ 1,801	1.0	$ 75	$ 78
Other Hospital/Residential	1,405	368	$ 1,207,007	3.8	$ 859	$ 3,280
Other Services	6,091	962	$ 217,579	6.3	$ 36	$ 226
Partial Hospitalization	17,641	1,081	$ 4,467,337	16.3	$ 253	$ 4,133
Peer Recovery Supports	558	184	$ 33,264	3.0	$ 60	$ 181
Psychiatric Services	2,103	615	$ 138,030	3.4	$ 66	$ 224
Residential Services	12,173	918	$ 2,236,205	13.3	$ 184	$ 2,436
Total	**113,224**	**2,972**	**$ 13,340,643**	**38.1**	**$ 118**	**$ 4,489**

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Doorway Medicaid Sample - Service Utilization, SFY2022

- Medicaid expenditures for the five largest treatment services equaled $10.1 million, representing approximately 75% of total Medicaid expenditures for claims with a primary diagnosis of SUD
- Approximately 1,700 members received a Medicaid-paid drug test and 1,081 members received partial hospitalization services

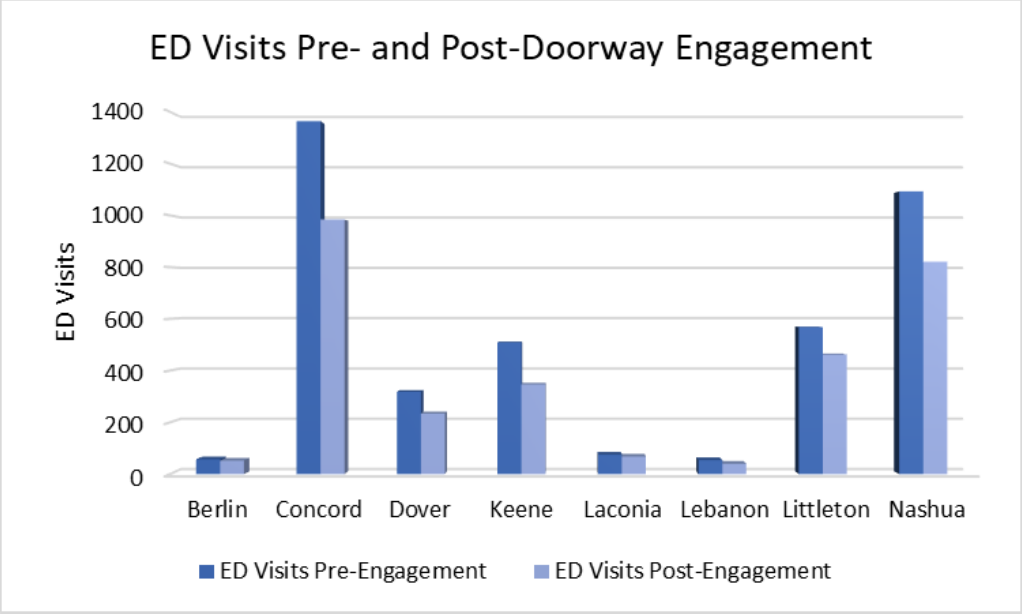




APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Doorway Medicaid Sample - Emergency Department Utilization, SFY2022

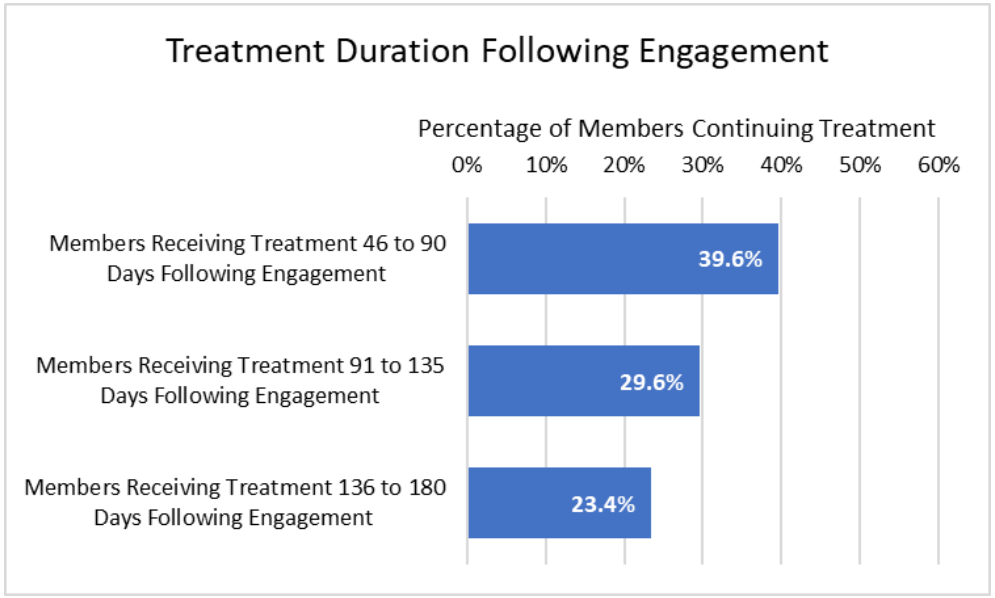
- ED utilization was evaluated by isolating the Medicaid sample to members with intake/start dates in SFY22 and no Doorway Medicaid claims history in SFY21 (results do not include Manchester Doorway members)
- Total ED visits for the 6 months prior to engagement equaled 4,038; ED visits in six months following engagement totaled 3,008, representing a reduction of 26%



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Doorway Medicaid Sample - Duration of Treatment, SFY2022

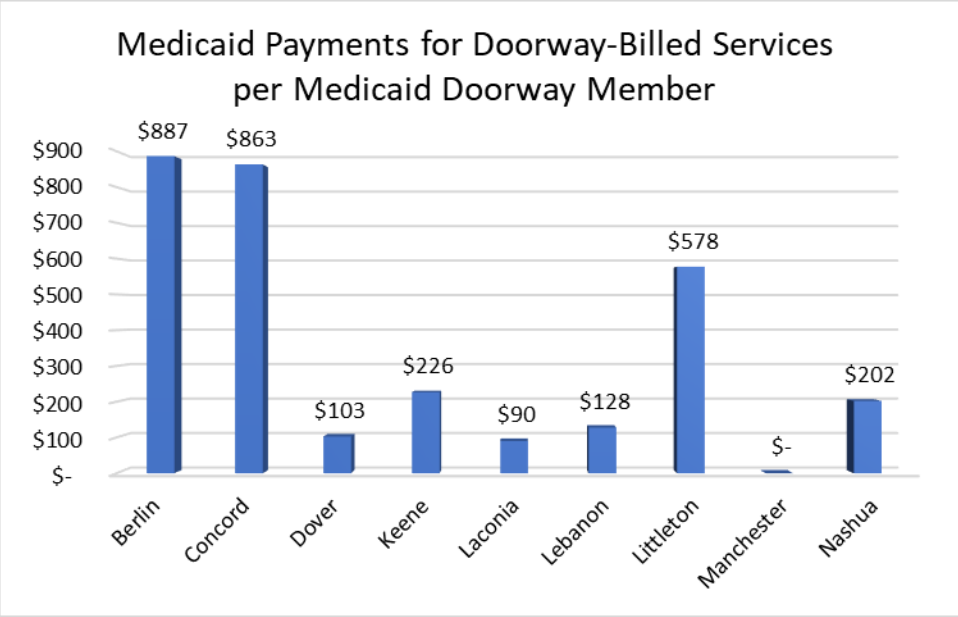
- A total of 717 members in the Medicaid sample received one or more SUD treatment services within 45 days of a Doorway-billed service
- Nearly 40% of Doorway Medicaid members continued to receive Medicaid SUD treatment services after the first 45 days following the first Doorway-billed service and 30% of Doorway Medicaid members continued to receive Medicaid SUD treatment services after the first 90 days



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Doorway Medicaid Sample - Doorway Provider Numbers, SFY2022

- Doorway sites received approximately $1.1 million in Medicaid funding
- Average Medicaid expenditures per member ranged from $0 to $887



APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Doorway Medicaid Sample - Medicaid Providers, SFY2022

- The ten providers with the highest annual Medicaid payments accounted for approximately 58.4% of total SUD treatment services

Provider Name	Medicaid Expenditures	Percent of Total Expenditures
LIVE FREE RECOVERY SERVICES, LLC	$2,087,425.05	15.6%
KING HEALTHCARE GROUP, LLC	$1,196,611.47	9.0%
BONFIRE BEHAVIORAL HEALTH, LLC	$904,306.82	6.8%
THE GRANITE HOUSE SOBER LIVING, LLC	$777,786.63	5.8%
NEW FREEDOM ACADEMY, LLC	$666,730.02	5.0%
DOMINION DIAGNOSTICS, LLC	$520,838.12	3.9%
MANCHESTER ALCOHOLISM REHABILITATION CENTER	$492,152.62	3.7%
RIVERBEND COMMUNITY MENTAL HEALTH, INC.	$463,573.25	3.5%
SOUTHEASTERN NEW HAMPSHIRE ALCOHOL AND DRUG ABUSE SERVICES	$364,033.42	2.7%
WEEKS MEDICAL CENTER	$354,937.67	2.7%
Total: Ten Largest Providers	**$7,828,395.07**	**58.7%**

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Doorway Medicaid Sample - Ten Largest Medicaid Providers by Doorway Site, SFY2022

Berlin	Concord	Dover
WEEKS MEDICAL CENTER	RIVERBEND COMMUNITY MENTAL HEALTH, INC.	SOUTHEASTERN NEW HAMPSHIRE ALCOHOL AND DRUG ABUSE SERVICES
BONFIRE BEHAVIORAL HEALTH, LLC	LIVE FREE RECOVERY SERVICES, LLC	BONFIRE BEHAVIORAL HEALTH, LLC
MANCHESTER ALCOHOLISM REHABILITATION CENTER	PRECISION TOXICOLOGY, LLC	THE GRANITE HOUSE SOBER LIVING, LLC
THE GRANITE HOUSE SOBER LIVING, LLC	THE GRANITE HOUSE SOBER LIVING, LLC	KING HEALTHCARE GROUP, LLC
LIVE FREE RECOVERY SERVICES, LLC	CONCORD HOSPITAL, INC.	HCA HEALTH SERVICES OF NEW HAMPSHIRE INC
BLUE HERON NEUROFEEDBACK AND COUNSELING	NEW FREEDOM ACADEMY, LLC	NEW FREEDOM ACADEMY, LLC
NEW FREEDOM ACADEMY, LLC	KING HEALTHCARE GROUP, LLC	MANCHESTER ALCOHOLISM REHABILITATION CENTER
AEGIS SCIENCES CORPORATION	MANCHESTER ALCOHOLISM REHABILITATION CENTER	LIVE FREE RECOVERY SERVICES, LLC
SOBRIETY CENTERS OF NEW HAMPSHIRE	SOUTHEASTERN NEW HAMPSHIRE ALCOHOL AND DRUG ABUSE SERVICES	HOPE ON HAVEN HILL, INC
SOUTHEASTERN NEW HAMPSHIRE ALCOHOL AND DRUG ABUSE SERVICES	BLUEPRINT RECOVERY CENTER, LLC	DOMINION DIAGNOSTICS, LLC

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Doorway Medicaid Sample - Ten Largest Medicaid Providers by Doorway Site, SFY2022 (continued)

Keene	Laconia	Lebanon
LIVE FREE RECOVERY SERVICES, LLC	LIVE FREE RECOVERY SERVICES, LLC	HEADREST
BRIDGE STREET RECOVERY, LLC	SOBRIETY CENTERS OF NEW HAMPSHIRE	DARTMOUTH-HITCHCOCK CLINIC
DOMINION DIAGNOSTICS, LLC	BONFIRE BEHAVIORAL HEALTH, LLC	LIVE FREE RECOVERY SERVICES, LLC
BONFIRE BEHAVIORAL HEALTH, LLC	DOMINION DIAGNOSTICS, LLC	BLUE HERON NEUROFEEDBACK AND COUNSELING
KING HEALTHCARE GROUP LLC	HORIZONS COUNSELING CENTER, INC.	DOMINION DIAGNOSTICS, LLC
DARTMOUTH-HITCHCOCK CLINIC	KING HEALTHCARE GROUP, LLC	MARY HITCHCOCK MEMORIAL HOSPITAL
PHOENIX HOUSES OF NEW ENGLAND, INC.	CONCORD HOSPITAL-LACONIA	BONFIRE BEHAVIORAL HEALTH, LLC
CHESHIRE MEDICAL CENTER	BRIDGE STREET RECOVERY, LLC	THE GRANITE HOUSE SOBER LIVING, LLC
NEW FREEDOM ACADEMY, LLC	CONCORD HOSPITAL-FRANKLIN	MANCHESTER ALCOHOLISM REHABILITATION CENTER
THE GRANITE HOUSE SOBER LIVING, LLC	NEW FREEDOM ACADEMY, LLC	HCA HEALTH SERVICES OF NEW HAMPSHIRE INC

APPENDIX 4. MONTHLY ACTIVITY, GPRA AND MEDICAID DATA ANALYSIS

Doorway Medicaid Sample - Ten Largest Medicaid Providers by Doorway Site, SFY2022 (continued)

Littleton	Manchester	Nashua
BONFIRE BEHAVIORAL HEALTH, LLC	THE GRANITE HOUSE SOBER LIVING, LLC	KING HEALTHCARE GROUP, LLC
LITTLETON HOSPITAL ASSOCIATION	NEW FREEDOM ACADEMY, LLC	LIVE FREE RECOVERY SERVICES, LLC
WEEKS MEDICAL CENTER	LIVE FREE RECOVERY SERVICES, LLC	LIFE SERVICES FOR RECOVERY, LLC
DOMINION DIAGNOSTICS, LLC	MANCHESTER ALCOHOLISM REHABILITATION CENTER	BONFIRE BEHAVIORAL HEALTH, LLC
BLUE HERON NEUROFEEDBACK AND COUNSELING	KING HEALTHCARE GROUP, LLC	THE GRANITE HOUSE SOBER LIVING, LLC
LIVE FREE RECOVERY SERVICES, LLC	BONFIRE BEHAVIORAL HEALTH, LLC	DOMINION DIAGNOSTICS, LLC
AEGIS SCIENCES CORPORATION	BLUEPRINT RECOVERY CENTER, LLC	HARBOR HOMES, INC.
THE GRANITE HOUSE SOBER LIVING, LLC	PRECISION TOXICOLOGY, LLC	FOUNDATION MEDICAL PARTNERS INC
MANCHESTER ALCOHOLISM REHABILITATION CENTER	SOBRIETY CENTERS OF NEW HAMPSHIRE	NEW FREEDOM ACADEMY, LLC
BLUEPRINT RECOVERY CENTER, LLC	LIFE SERVICES FOR RECOVERY, LLC	PRECISION TOXICOLOGY, LLC