

I: State Information

State Information

Plan Year

Start Year:

2014

End Year:

2015

State DUNS Number

Number

11040545

Expiration Date

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

Agency Name

New Hampshire Department of Health and Human Services

Organizational Unit

Division of Community Based Care Services, Bureau of Drug and Alcohol Services

Mailing Address

105 Pleasant St.

City

Concord

Zip Code

03301

II. Contact Person for the Grantee of the Block Grant

First Name

Shannon

Last Name

Quinn

Agency Name

Division of Community Based Care Services, Bureau of Drug and Alcohol Services

Mailing Address

105 Pleasant St.

City

Concord

Zip Code

03301

Telephone

603-271-5889

Fax

603-271-6105

Email Address

syquinn@dhhs.state.nh.us

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

9/27/2013 8:03:12 AM

Revision Date

12/5/2014 9:48:39 AM

V. Contact Person Responsible for Application Submission

First Name

Shannon

Last Name

Quinn

Telephone

603-271-5889

Fax

603-271-6105

Email Address

syquinn@dhhs.state.nh.us

Footnotes:

I: State Information

Assurance - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	<input type="text" value="Nancy L. Rollins"/>
Title	<input type="text" value="Associate Comissioner"/>
Organization	<input type="text" value="New Hampshire Dept. of Health and Human Services"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Assurance - Non-Construction Programs

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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Nancy L. Rollins
Title	Associate Commissioner
Organization	New Hampshire Dept. of Health and Human Services

Signature: *Nancy L. Rollins* Date: *9/24/13*

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug- Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

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

For purposes of paragraph, regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

Name	<input type="text" value="Nancy L. Rollins"/>
Title	<input type="text" value="Associate Comissioner"/>
Organization	<input type="text" value="New Hampshire Dept. of Health and Human Services"/>

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

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- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

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

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
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The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

Name	Nancy L. Rollins
Title	Associate Comissioner
Organization	New Hampshire Dept. of Health and Human Services

Signature:

Nancy L. Rollins

Date:

9/24/13

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements and Delegation Letter (Form 3)

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

Title XIX, Part B, Subpart II of the Public Health Service Act

Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32

Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

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

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

Name of Chief Executive Officer (CEO) or Designee

Title

Signature of CEO or Designee¹: _____ Date: _____

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

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements and Delegation Letter (Form 3) - Fiscal Year 2014

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
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Name of Chief Executive Officer (CEO) or Designee
 Title

Signature of CEO or Designee¹: Nancy L. Rollins Date: 9/24/13

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

Footnotes:



STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

MARGARET WOOD HASSAN
Governor

September 26, 2013

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, Maryland 20857

RE: FFY2014/15 Substance Abuse Prevention and Treatment Block Grant Application

Dear Ms. Simmons:

As the Governor of the State of New Hampshire, I hereby authorize Nancy Rollins, Associate Commissioner of the Department of Health and Human Services, to sign and make all assurances and certifications required by the Substance Abuse and Mental Health Services Administration (SAMHSA) for the FFY2014/15 Substance Abuse Prevention and Treatment (SAPT) Block Grant application.

With every good wish,

A handwritten signature in blue ink that reads "Meggie H".

Margaret Wood Hassan
Governor

I: State Information

Disclosure of Lobbying Activities

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

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

Name	<input type="text" value="Shannon Quinn"/>
Title	<input type="text" value="Training Coordinator"/>
Organization	<input type="text" value="NH Bureau of Drug and Alcohol Services"/>

Signature: _____ Date: _____

Footnotes:

The New Hampshire Bureau of Drug and Alcohol Services does not use any funds for lobbying.

II: Planning Steps

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

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:

New Hampshire - 2014/15 Behavioral Health Assessment and Plan

Planning for the 21 month period October 1, 2013 to June 30, 2015

Step I: Overview of NH's substance abuse prevention, early intervention, treatment and recovery support system:

OVERVIEW

The Bureau of Drug and Alcohol Services (BDAS) is part of the New Hampshire Department of Health and Human Services (DHHS), Division of Community Based Care Services (DCBCS). Also included in this Division are the Bureaus of Behavioral Health, Developmental Services, and Elderly and Adult Services, as well as the New Hampshire Hospital (acute psychiatric services). These bureaus and programs - report directly to the Associate Commissioner of DHHS.

The following units structure BDAS internally: Prevention Services; Clinical Services, including Impaired Driver Services; Access to Recovery; Resources and Development; and Business and Financial Services.

BDAS treatment, intervention and recovery support services include:

- 17 substance abuse treatment providers, offering a variety of programs at 30 locations throughout the State of New Hampshire to include; outpatient, intensive outpatient, short term residential, transitional living and one long term residential program for pregnant and parenting women.
- 2 outpatient programs for adolescents age 12-17 and one short-term residential and one transitional living program for adolescents age 12-17.
- 1607 hours monthly of Outpatient Services, including 39 hours specifically for pregnant and parenting women.
- 1764 hours monthly of Intensive Outpatient Services, including 349 hours specifically for pregnant and parenting women.
- Clinically Managed High Intensity Residential Treatment services for 32 women and their children annually.
- Clinically Managed Medium Intensity Residential Treatment services for 685 adults and 139 adolescents annually.
- Clinically Managed Low Intensity Residential Treatment services for 228 adults and 4 adolescents annually.
- Administrative oversight of 8 Opiate Treatment Programs (not funded by BDAS)
- Oversight of 7 Impaired Driver Care Management Programs at 22 sites and approximately 200 Impaired Driver Services Providers
- The Bureau employs a Master's level LADC eligible clinician for crisis and referral services and initial brief case management of priority populations such as pregnant and parenting women and injection drug users.
- BDAS has partnerships with the Department of Public Health Services/Maternal & Child Health and Disease Surveillance along with DOC, Division of Youth & Family and other agencies.
- Services to the LGBT population are offered at all BDAS contracted services.
- All BDAS contracted providers are sensitive to ethnic needs and interpreters are arranged for Spanish and French speaking clients if needed. A majority of the Spanish population is located in the southern part of the state where there is a program offering a continuum of care with Spanish speaking staff available.

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Prevention

BDAS funds 13 Regional Public Health Networks (RPHN) that are geographically designed to cover every community in the state to support communities in their efforts to prevent and reduce alcohol and other drug misuse, and related health promotion services. The 13 regions facilitate community-based alcohol and other drug prevention planning and implementation. RPHN utilize evidenced based approaches and best-practices and the continued operations of the Strategic Prevention Framework Model (assessment, capacity, planning, implementation and evaluation). The revised regional structure is an initiative of the Department of Public Health Services and BDAS in alignment of their respective regional initiatives to create efficiencies, eliminate duplication, and build upon the strengths of the two systems; increasing the range of Ten Essential Public Health Services and Substance Misuse Prevention and Related Health Promotion activities within defined geographic regions that include all communities in New Hampshire. One primary scope of work for each RPHN is the development of a broad Regional Public Health Advisory Committee(s) comprised of leaders from key community sectors to serve in an advisory role. Regional leadership will serve in an advisory capacity while also building additional capacity among regional partners to protect and promote the overall health of their communities.

Each region consists of a fiscal sponsor, full time paid Certified Prevention Specialist, Public Health Advisory Committee, and RPHN Subgroup with a shared focus on alcohol and other drug prevention. The RPHN Subgroup represents the region and community sectors (local government, business, healthcare, education, safety, and community support agencies) that align with the Governor's Commission Collective Action Collect Impact 5-year plan for the state (<http://www.dhhs.nh.gov/dcbcs/bdas/documents/collectiveaction.PDF>). In June 2012 the each region completed a 3-year regional plan; located on the following web site: <http://www.dhhs.nh.gov/dcbcs/bdas/prevention.htm>. The RPHN collaborates with the broader community that includes other human service agencies, federally funded Drug Free Communities grantees, and leveraging other resources in the implementation of this 3-year plan through other partnerships in creating prevention prepared communities.

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

NH was awarded two federal grants:

- 1) Partnership for Success II
- 2) Partnership for Success SEOW

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The Partnership for Success II is a three year grant that addresses underage drinking and non-medical prescription drug use among 12-25 year olds. Six contracts have been established that will impact 15 schools and 2 colleges to achieve the following outcomes:

- Reduce underage drinking among persons aged 12 to 20
- Reduce prescription drug misuse and abuse among persons aged 12 to 25

The Partnership for Success SEOW is a one-year grant to enhance and expand the New Hampshire State Epidemiological Outcomes Workgroup in its efforts to reduce the misuse of alcohol and other drugs. The goals of this project are to improve utilization across multiple state agencies and to enhance state level indicators in the development of the State Epidemiological Outcomes Workgroup manual of the functions, membership, processes and products.

Also, it is anticipated that the state prevention funds will become available in SFY 2014. The Governor's Commission on Alcohol & Drug Abuse Prevention, Intervention and Treatment are tasked with allocating these funds for targeted prevention strategies.

Impaired Driver Services

The Impaired Driver Services system changed significantly as of January 1, 2013. These changes include:

- Greater emphasis on clinical services for individuals convicted of impaired driving offenses
- An approval process for clinicians providing services to impaired drivers
- Increased monitoring of both clinicians and clients

BDAS has oversight of the Impaired Driver Care Management Programs as well as the Impaired Driver Education Programs and Impaired Driver Services Providers. This change will increase both the availability and quality of services for individuals convicted of impaired driving offenses. BDAS continues to work with the programs listed above, courts, and the Department of Safety to refine and improve this system.

Treatment Services

The Bureau has implemented several changes that are consistent with a good and modern addictions system, including:

- Implementation of the Web-based Information Technology System (WITS) electronic health record which all BDAS treatment contracted service providers are currently utilizing at various levels.
- Requiring all providers to utilize certain best practices, including assessment with either the Addiction Severity Index or Global Assessment of Needs and treatment planning using the MATRS model.

The Bureau provides on-going technical assistance and quality assurance monitoring relative to the implementation of these tools and practices.

The Bureau will continue to fund services for pregnant women and women with dependent children. These services currently include:

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- A partnership between a treatment program with a comprehensive service array (Southeastern NH Services in Dover NH) and a Federally Qualified Health Center (Goodwin Health Center in Rochester NH) to offer an Intensive Outpatient Program for pregnant women and women with dependent children.
- The Cynthia Day Family Center (CDFC), a residential treatment program for pregnant substance abusing women and women with dependent children. The program accommodates up to 16 women and 16 children.

The Bureau will continue to mandate priority admission for injection drug using individuals as required by the SAPT Block Grant. New Hampshire takes a broad perspective in defining IDUs as those individuals with current or a past history of injection drug use, preferring this term rather than only intravenous drug use.

Infectious Disease

The Bureau takes a broad approach to infectious disease. In NH, the tuberculosis rate is relatively low. NH is also not an HIV incidence state. However, various strains of hepatitis, particularly A, B and C, are a concern. BDAS has worked closely with the Viral Hepatitis Unit of the NH Division of Public Health Services and routinely promotes their trainings, approximately two per year. One of BDAS' Clinical Services Unit staff, the Women's Services Network (WSN) Coordinator, is a trained Viral Hepatitis Educator.

Infectious disease is addressed in Administrative Rule He-A 302.06 Clinical Manual. Providers are also referred to Treatment Improvement Protocol (TIP) #6, *Screening for Infectious Diseases Among Substance Abusers* and #11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases*, in developing their policies. These are submitted during applications in response to BDAS treatment services' biannual Request for Proposals and are then included in treatment contracts that are then monitored as part of provider site visits.

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Recovery Supports

New Hampshire Access to Recovery (NHATR) provides clinical and recovery support services to criminal justice clients, impaired driving clients, military, veterans, and clients coming from contracted Bureau services. NHATR has currently served over 4,000 clients and is contributing toward building the infrastructure for a state-wide Resiliency and Recovery Oriented System of Care.

Friends of Recovery NH (FOR-NH) has gone through re-structuring over the past year and is now actively developing peer Recovery Coaching using the Connecticut Communities for Addiction Recovery model in NH. BDAS remains committed to expanding recovery supports and is utilizing the Access to Recovery grant to expand capacity for recovery support services in NH. It has enabled us to support peer Recovery Coaching as well as a variety of other recovery support services, including transportation vouchers, employment services, and anger management programming. Potentially BDAS will be able to sustain some of these services through the Affordable Care Act. In addition, BDAS Request for Proposals for treatment services that will be released in December 2013 will once again include integration with recovery support services and development of a Resiliency and Recovery Oriented System of Care.

The Bureau is currently involved in the contract process to fund one recovery community organization which will provide peer support services for family members.

PERFORMANCE MONITORING

Substance Misuse Prevention and Related Health Promotion

Outcome and evaluation measure instruments will be administered in cooperation with the NH Center for Excellence and Monthly submission of process evaluation data via the web-based performance monitoring system (P-WITS) and other surveys and reports as required by BDAS (e.g. PARTNER survey, Regional Network Evaluation, Regional Network Annual Report).

- Percentage of increase of evidence-based programs, practices and policies adopted by sector as recorded in P-WITS data collection system.
- Increase in the amount of funds and resources leveraged in the implementation of prevention strategies as recorded in P-WITS data collection system.
- Number of and increase in the diversity of Center for Substance Abuse Prevention (CSAP) categories implemented across Institute of Medicine (IOM) classifications as outlined in the Block Grant Requirements as recorded in P-WITS data collection system.
- Number of persons served or reached by IOM classification as recorded in P-WITS data collection system.
- Number of Strategic Prevention Framework key products produced and milestones reached and reported annually in the Regional Network Annual Report and as recorded in P-WITS data collection system.
- Short-term, intermediate, and long-term outcomes measured and achieved as outlined in the NH Regional System Logic Model.

New Hampshire - 2014/15 Behavioral Health Assessment and Plan

Long term Population level change will be measured by the National Outcomes Measures: 30 day prevalence rate, perception of harm and risk, age of onset, perception of disapproval, AOD related expulsions and suspensions, DUI, traffic fatalities, number of evidence based interventions, and number of persons served by age, gender, race and ethnicity.

Substance Abuse Treatment and Recovery Support Services

BDAS Contract managers monitor performance through in-person site visits and record reviews conducted via the Web Information Technology System (WITS) electronic health record. Reviews include, but are not limited to comprehensiveness, readability and organization of client files; client demographic and collateral contact information; health and medical information; client treatment history; screenings and assessments (required to utilize Addiction Severity Index for assessments); treatment plan and updates (required to use the MATRS model); program activities and progress notes; Notice of Client Rights; discharge planning; and releases of information.

Workforce and Best Practices

BDAS contracts with three state level agencies that provide quality improvement toward best practices, evidence-based interventions, workforce and professional training for alcohol and other drug service professionals, and certification standards.

The New Hampshire Center for Excellence (CFEx) is a state level contract that provides technical assistance and fosters systems change and related professional development to support community level practitioners in implementing evidence-based interventions and improving their practices to address substance use issues through prevention, intervention, treatment and recovery support services. Technical assistance is provided through various formats, including webinars, learning collaboratives, on-site consultation, and group meetings, as well as by posting tools, relevant data and resources on a professional provider web site: www.nhcenterforexcellence.org. Additionally, CFEx provides data analysis and data products to support BDAS and the State Epidemiological Outcomes Workgroup.

The NH Training Institute on Addictive Disorders provides high quality training and workforce development activities to enhance the skills of the prevention, intervention, treatment and recovery supports services workforce through training opportunities that meet requirements for licensure and certification; increasing provider knowledge and skills in applying outcome-supported policies, programs and practices; and cross-training opportunities that increase effective integration of services. Their training events are affordable and accessible to people across the state and meet different adult learning styled and levels through the integration of face-to-face, distance and blended learning opportunities.

The NH Certification Board's primary purpose is to ensure high quality standards for NH's substance abuse prevention specialists by aligning with the International Certification & Reciprocity Consortium (IC&RC) standards. The NH Certification Board and IC&RC principles call for prevention practitioners to stay abreast of the latest research findings, employ best practices, apply innovations in prevention methods, and follow industry trends in order to ensure the competency of the services they provide. The NH Certification Board provides management and oversight at the state level to ensure NH prevention practitioners are

New Hampshire - 2014/15 Behavioral Health Assessment and Plan

prevention specialists certified. The state requires that all contracted prevention services have lead staff who are prevention specialist certified, and maintains this certification through the two year renewal process by obtaining the necessary certification hours.

The Resources and Development Unit of BDAS develops and provides introductory training and consultation to professionals in related service systems, e.g. health, education, corrections and social services, on addiction, recovery and practices to address substance use issues with clients in their systems.

II: Planning Steps

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

Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

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

Unmet Service Needs; State Specific Priority Populations

Sources of data used are: NSDUH, YRBS, and BRFSS as summarized in the Draft NH Epi Profile. This data indicates that the populations listed below are identified as experiencing the highest rates of use and experiencing the greatest consequence (impact to these individuals, their families and communities, as well as the cost to the state) from substance abuse and are therefore identified among the groups with the greatest need for services:

Youth, address high prevalence rates for:

- Underage drinking (30 day use)
- Binge drinking
- Marijuana (30 day use)
- Prescription drug use (lifetime, perception of harm and 30 day use)

Young Adults:

- Binge drinking
- Marijuana (30 day use)
- Prescription drug use (lifetime, perception of harm and 30 day use)

Adults:

- Binge drinking
- Marijuana (30 day use)
- Prescription drug use (lifetime, perception of harm and 30 day use)

Data Sources that Informed the ATR Grant Proposal

- Justice Reinvestment in New Hampshire, 2010. A review by the Justice Center Council on State Government, 2010
- National Survey on Drug Use and Health, 2008
- Office of National Drug Control Policy, Substance Abuse Treatment Admissions by Substance of Abuse, 2005
- NH DWI Commission
- (NH) DWI Services Subcommittee Hearing, 2 Feb 2010 Minutes
- NH CEDS data
- Interviews with Susan Brown, National Guard Director of Psychological Health, Major Atwood, NHNG, US Dept of Veterans Affairs (Patricia Read email)

ATR Clients

- Total: 3,000
- DWI Clients: 1589 (53%)
- DOC Clients: 1155 (39%)
- Vets & C4: 256 (8%)

State Specific Priority Populations

- Substance abusing pregnant women and women with dependent children
- Injection Drug Users (IDUs) or individuals with a past history of any injection drug use, not just intravenous drug use
- Criminal Justice involved clients
- Impaired Driver Clients (NH individuals arrested in New Hampshire for driving while under the influence of alcohol or drugs or NH individuals arrested out of state for DUI who need to complete requirements to satisfy requirements for reinstatement of NH driver's license privileges). According to New Hampshire State Police records, in 2012:
 - 50 fatalities resulted from accidents involving an impaired driver.
 - 4920 were convicted of an impaired driving offense by New Hampshire courts.
- Criminal Justice involved and Impaired Driving clients are currently being served under the Access to Recovery grant; however, this funding ends September 2014 so it is necessary to plan for sustaining the current level of service for this population. NH Parents/guardians with a founded case of abuse or neglect that have been identified with a substance use disorder.
- NH Veterans and other members of the military in NH (NH National Guard) with a substance use disorder.
- Individuals in NH with co-occurring mental health and substance use disorders.
- Services currently supported by ATR may be available in the future from the implementation of the Mental Health Parity and Addictions Equity Act.

Critical Gaps in Services

Limited Selective and Indicated Prevention Services

A full range of comprehensive selective and indicated prevention services across the state's behavioral health system of care is limited. This includes a wide range of evidenced based strategies targeted to high risk youth and families, and other high risk populations such as, substance using women of child bearing age and Lesbian, Gay, Bi-Sexual, and Transgendered (LGBT). The primary challenges are lack of data and limited funding. NH does not collect data that is specific to LGBT populations therefore targeting this high risk population effectively is difficult. NH is in the process of forming a Governor's Commission Task Force on neo-natal exposure to alcohol and drugs to better prevent and treat these issues. In 2013 NH was awarded the three-year Partnership for Success Federal Grant which NH is implementing student assistance targeting several high risk schools and colleges. This grant provides universal services in partnership with BDAS Public Health Networks to the targeted area population, and array of selective and indicated services limited to these high risk schools and targeting youth and young adults.

Limited Universal Prevention Services

As of July 1, 2013 the Bureau's Prevention Services Unit, within the scope of work of substance misuse prevention health promotion services, integrated with Division of Public Health Services in the redesign of the 13 Public Health Networks that include every community in NH. In addition, BDAS is working more collaboratively within the larger umbrella of DHHS Behavioral Health Services to improve overall integration of mental, emotional and behavioral (MEB) services including suicide prevention across the state. Although progress has been made, we are lacking sufficient capacity for data collection and analysis across systems, identification of best practices and funding for a full array of services.

Gaps in the treatment system

There are a number of gaps in the current treatment system, including:

- There are limited services in New Hampshire for pregnant and parenting women, particularly those with Opiate Use Disorders. A particularly large gap is in integrated services where pregnant women could receive both medical and substance use disorders treatment at a single location.
- The currently available services in New Hampshire are not adequate to meet the needs of injection drug users.
- Lack of medical detoxification and medication assisted treatment services, which may or may not be funded by Medicaid funding in the future. The primary population in need of these services are people addicted to opiates, including prescription drugs and heroin.

- It is necessary to continue with the development and implementation of standards for treatment services which are based on the principles outlined in SAMHSA's National Behavioral Health Quality Framework and Description of a Good and Modern Addictions and Mental Health Service System as well as the Center for Substance Abuse Treatment's Treatment Improvement Protocols in the state as well as for technical assistance and quality assurance monitoring for providers as they implement these practices within their agencies.
- Care coordination services are currently available to Access to Recovery clients only and this funding stream will be ending September 2014. It is important that these services be expanded to all clients in order to increase access to and coordination among service providers. Services currently supported by ATR may be available in the future from the implementation of the Mental Health Parity and Addictions Equity Act.
- There is currently a lack of coordination between substance use treatment and primary care and providers of other medical services. Facilitating communication and coordination between these treatment systems would allow clients to engage in didactic therapies with medication and other support from the primary care provider.
- The Bureau has significantly increased funding for transitional housing programs; however, there is a need for further expansion of these services. The need for additional services is evidenced by monthly utilization figures for currently contracted transitional living providers, which are consistently, well above 100%.
- Currently, there are only limited peer and non-peer Recovery Support Services available in New Hampshire. A significant barrier to the development of these services is lack of provider buy-in which must be overcome in order to continue expanding the service array. Furthermore, the available services are currently funded by Access to Recovery funding which will end in September 2014.

Developing Service Delivery System for Individuals Convicted of Driving While Impaired (DW) offenses

Recent legislation has significantly improved the array and quality of services available to individuals convicted of Driving While Impaired (DWI) offenses. There are currently developmental issues impacting this system including concerns that service capacity in some regions of the state is not sufficient to meet the needs of individuals living in those regions; the need to refine the system and partnerships within the system based on lessons learned during the implementation of this new system of care and identification of additional resources to support these services.

Limited prevalence, consequence and outcome data collection and analysis capacity

Although there have been some resources available to the Bureau for the collection, analysis and utilization of state and regional data made available through the original

State Epidemiological Outcomes Workgroup (SEOW) established under the Strategic Prevention Framework Grant (SPF-SIG) that ended in 2010, this capacity was primarily focused on meeting the objectives of that grant. The Bureau recognizes the need to expand this capacity across the array of the service delivery system to meet the objectives of data driven decision making and performance contracting. For this reason the work of the newly established SEOW under the Partnership for Success II grant, in addition to meeting the objectives of that grant will be expanded to meet these broader objectives that will include certain mental health data (suicide prevention, Neonatal abstinence Syndrome). These efforts will be enhanced by the capacity of the contracted NH Center for Excellence (CFEx) to make this data more accessible and user friendly. BDAS working in Partnership with the Division of Public Health Services – DPHS (BDAS and DPHS have collaborated on integrating our Regional Prevention Networks and Regional Public Health Networks and on the New Hampshire Wisdom data system) will make this information available to the public and our community partners on a number of web sites, including the Department of Health and Human Services and Drugfreenh.org.

Limited Capacity for Program Management and Contract Performance Data Collection and Analysis

The Bureau has implemented the WITS (Web Information Technology System) electronic health record for all contracted treatment, prevention, Access to Recovery, opiate treatment program and Impaired Driver Services providers and this system includes tools that increase capacity for program management and contract performance data collection; however, many of these are still in development. This developmental process has interfered with the ability to tie performance to payment and for providers and the Bureau of Drug and Alcohol Services to use the system to monitor performance data.

The Bureau is moving forward with a number of initiatives to enhance our contract performance monitoring capacity, including:

- Addressing problems with the features currently available in WITS.
- Expanding features available in the WITS electronic health record system to contractors, potentially including the billing component of this system.
- Prevention Services Unit is now using WITS Prevention Module for performance monitoring of the RPHNs
- Collaborating with the Division of Public Health to collaborate and coordinate on epi work on the collection, analysis and sharing of data and the possible interoperability of IT systems.

BDAS is placing greater emphasis on the integration and collaboration with other systems on the provision services and health promotion in consideration of potential opportunities made available under the Affordable Care Act (ACA). This includes

partnering with the Division of Public Health Services in integrating our Regional Prevention Networks (RPHN) with the Regional, as well as BDAS supporting and utilizing New Hampshire Wisdom, the new public health IT system.

This work will include the substance prevention coordinators expanding their scope of work to include, behavior health promotion, with an emphasis on suicide prevention. This work will also include expanding clinical practices for substance use disorders broadly across health and social service systems, with an emphasis on the mental health and primary care systems in New Hampshire. The idea is to implement a modified SBIRT (Screening, Brief Intervention and Referral to Treatment) model in the state. This would include primary care setting screening for substance use disorders, applying early interventions, conducting full SUD (substance use disorders) evaluation when indicated, addressing lower levels of acuity address by substance abuse counselors on sight and referring high levels of acuity to specialty substance use disorders treatment.

New Hampshire State Epidemiological Outcome Workgroup (SEOW)

Context and Purpose:

The NH State Epidemiological Workgroup (SEOW) is multifaceted and multidimensional research, assessment, and evaluation workgroup designed to address the prevalence and risk of mental, emotional, and behavioral disorders in NH communities and to promote analytical thinking and methods in support of improved mental, emotional and behavioral health in NH. The work of the SEOW will have implications for funding priorities, policy recommendations, state strategies, and infrastructure design changes.

The larger purpose of the SEOW is to practice everyday epidemiology at a state and community level with a focus on substance abuse (SA) and mental health (MH). Since the practice of all epidemiology is by its very nature a team effort, New Hampshire has formed and reformed a SEOW Team with members that include both professionals and laypersons that are tasked with dealing with communities of people.

Like the medical practice of epidemiology in general, the practice of SA and MH health epidemiology involves the application of theory, methods, and the established epidemiological facts to circumstances of ordinary community life. Contrasted with medical practice dealing with individuals, SA and MH epidemiology is a bio-psychosocial and environmental process related to both individuals and community well being.

In addition to the investigatory and detective work using surveillance methods common to epidemiology, the SEOW is mostly concerned with how disorders and consequences of SA and MH can be prevented and minimized in the future. The SEOW leadership acknowledged that the SEOW must be conscious of the degree of scientific rigor applied to this enterprise, and to deal adequately with the nature of compromises, and

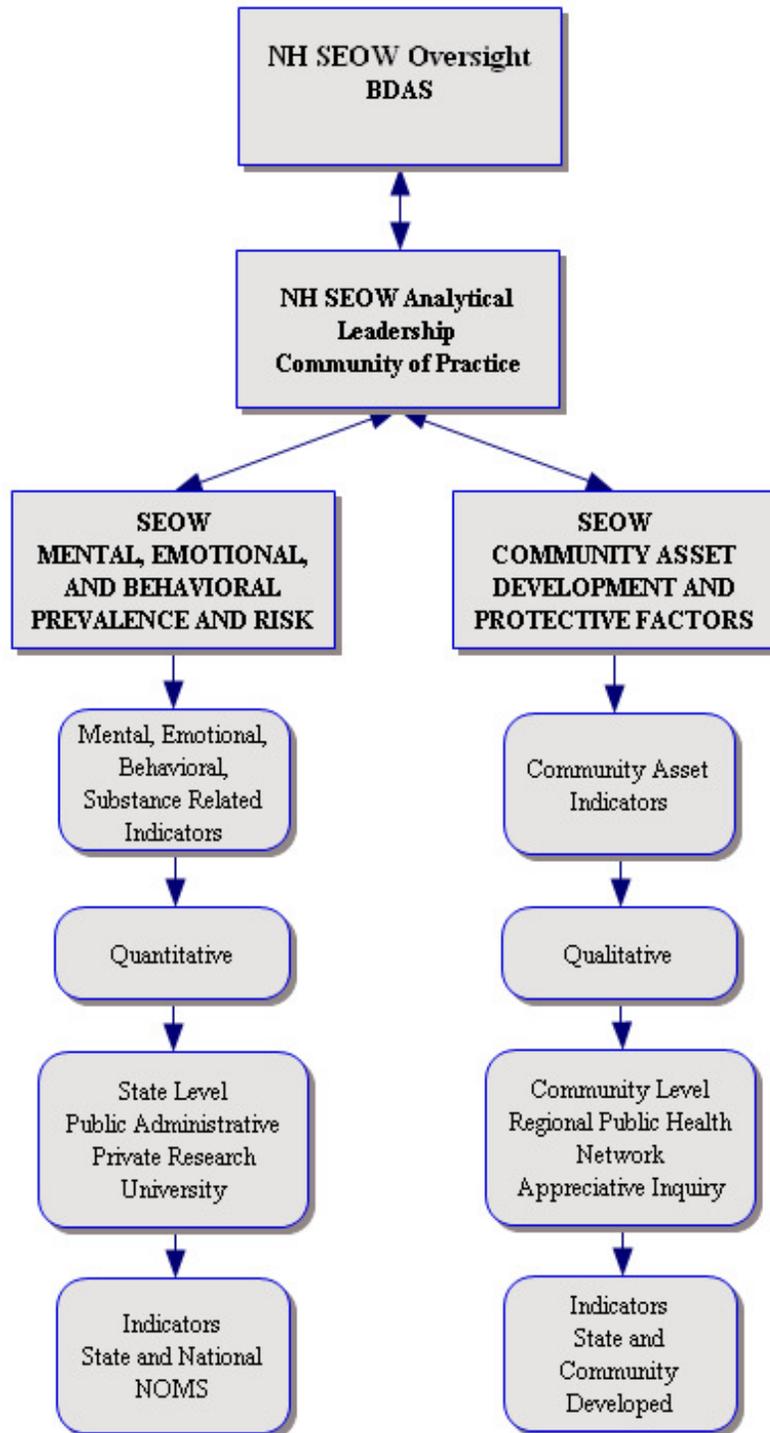
especially to the uncertainty of its conclusions, given the vagaries of the types of data gathered and analyzed.

Finally, since SA and MH epidemiology involves multilevel and multiagency work, it will be important to have close ties to community stakeholders, yet balance collaborative enterprises with state level bureaucracies. Given the variety of audiences who will be both providing and receiving information in interacting with the SEOW, the requirements of the SEOW to act as persuaders as well as information disseminators must be understood. Support from voluntary organizations, and commitments to public presentations, and to communities at large, is universally acknowledged. Thus, to facilitate the operation of the SEOW it is important to establish well-defined processes regarding leadership and coordination of SEOW activities

Mission Statement: “The NH SEOW promotes analytical thinking and methods in support of improved mental, emotional and behavioral health in NH.”

Structure – see chart on the next page

**SEOW / SAMHSA
Community of Practice
National Behavioral Health Quality Framework (NBHQF)**



Composition of New Hampshire's State Epidemiological Outcomes Workgroup (SEOW)

SEOW Leadership:

Leadership is participatory in nature, with primary guidance coming from Jeffrey Metzger, PhD – SEOW Chair, Epidemiologist for the Bureau of Drug and Alcohol Services (BDAS).

SEOW Chairperson and point of Contact:

Jeffrey L. Metzger, PhD, MBA, MEd
Senior Management Analyst
Chair - State Epidemiological Outcomes Workgroup
Bureau of Drug and Alcohol Services
Division of Community Based Care Services
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Membership, Organization, Workgroup, Role, Data Set, Responsibilities

The SEOW is divided into two subgroups, a State Epidemiological Outcomes Workgroup – Mental, Emotional, and Behavior (SEOW-MEB) and a State Epidemiological Outcomes Workgroup – Community Asset Development (SEOW-CAD).

The SEOW-MEB follows aspects of a more traditional epidemiological team that studies and influences the risk dimension of the risk and protective factor model, and infrastructure at the state level. The SEOW-MEB performs quantitative analysis and constructs a state level profile that will be reported to BDAS and SYNECTICS. The members of this group are state workers representing a broad array of state agencies including Departments of Safety, Health and Human Services, Education, Corrections, Justice, as well as analysts from nonprofits, private agencies, and universities. The purpose of the SEOW-MEB is risk assessment by examining consumption and consequence indicators.

The SEOW-CAD is an action research based epidemiological model that studies protective factors, or community assets, at community levels. As a community level epidemiological outcomes workgroup engaged in action research and concerned with community infrastructure, this group examines newly created qualitative data garnered using an interview methodology of community stakeholders. As such this group aligns with the state's community network. Participants serve in one of two subgroups. SEOW-MEB or SEOW-CAD: Leadership serves on both groups.

II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #: 1
Priority Area: IV Drug Users
Priority Type: SAT
Population(s): IVDUs

Goal of the priority area:

Increase the awareness of the prevalence of and risk for Hepatitis C, TB, and other infection diseases among 1) IVDUs and 2) providers serving IVDUs, by collaborating with the Division of Public Health (DPHS) to sponsor provider training on these topics.

Strategies to attain the goal:

Encourage contracted treatment providers utilization of Hepatitis and other DPHS sponsored trainings related to the public health risks associated with injection drug use.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: 75% of all BDAS Treatment Providers will participate in Hepatitis training sponsored by DPHS in SFY 2014/15.
Baseline Measurement: Number of BDAS funded treatment providers
First-year target/outcome measurement: 6 (37.5%) BDAS funded treatment providers will show proof that staff have participated in DPHS Hepatitis training.
Second-year target/outcome measurement: 13 (75%) BDAS funded treatment providers will show proof that staff have participated in DPHS Hepatitis training.

Data Source:

Documentation provided by treatment providers.

Description of Data:

Certificates of completion for staff who attended training.

Data issues/caveats that affect outcome measures::

Potential for limited availability of DPHS training.

Priority #: 2
Priority Area: Significant gaps in the current treatment system
Priority Type: SAT
Population(s): Other (NH Treatment System for Individuals w/ SUDs)

Goal of the priority area:

Continue with the development and implementation of standards for treatment services which are based on the principles outlined in SAMHSA's National Behavioral Health Quality Framework and Description of a Good and Modern Addictions and Mental Health Service System as well as the Center for Substance Abuse Treatment's Treatment Improvement Protocols in the state as well as for technical assistance and quality assurance monitoring for providers as they implement these practices within their agencies.

Strategies to attain the goal:

Revisit the task of determining the ideal array of services for the State based on SAMHSA's National Behavioral Health Quality Framework and

Description of a Good and Modern Addictions and Mental Health Service System, utilization of treatment services, calls to BDAS regarding needed services, provider surveys, and other resources. Once this array has been identified, develop standards for all services within the array.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Clearly documented ideal service array for New Hampshire with accompanying standards.
Baseline Measurement: Current service array for New Hampshire.
First-year target/outcome measurement: Clearly documented ideal service array for New Hampshire.
Second-year target/outcome measurement: Clearly defined standards for all services included in the ideal service array for New Hampshire.

Data Source:

BDAS documentation of service array and standards.

Description of Data:

Listing of the ideal service array for New Hampshire with clear standards for each service.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 3
Priority Area: Criminal justice clients, including impaired drivers.
Priority Type: SAT
Population(s): Other (Criminal/Juvenile Justice, Including Impaired Drivers)

Goal of the priority area:

Reduce recidivism of criminal justice clients, including impaired drivers.

Strategies to attain the goal:

1. Continue to serve individuals convicted of impaired driving offenses through the impaired driver care management system.
2. Continue to serve criminal justice involved clients through ATR, SAPT Block Grant, and other state funded treatment services.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Percent of clients without arrests in the past 30 days at admission
Baseline Measurement: In SFY13 480 clients (89.34%) of clients reported no arrests in the past 30 days at admission
First-year target/outcome measurement: 2% increase (10 clients) from SFY13 Percent of clients without arrests in the past 30 days at admission
Second-year target/outcome measurement: 5% increase (24 clients) from SFY13 Percent of clients without arrests in the past 30 days at admission

Data Source:

WITS/SSRS reports

Description of Data:

Information on arrests in the past 30 days is collected from clients at admission to and discharge from a program.

Data issues/caveats that affect outcome measures::

Arrest information is self-reported.

Indicator #: 2

Indicator: Percent of clients without arrests in the past 30 days at discharge

Baseline Measurement: In SFY13 150 clients (96.38%) reported no arrests in the past 30 days at discharge

First-year target/outcome measurement: 2% increase (3 clients) from SFY13 percent of clients without arrests in the past 30 days at discharge

Second-year target/outcome measurement: 5% increase (7 clients) from SFY13 percent of clients without arrests in the past 30 days at discharge

Data Source:

WITS/SSRS reports

Description of Data:

Information on arrests in the past 30 days is collected from clients at admission to and discharge from a program.

Data issues/caveats that affect outcome measures::

Arrest information is self-reported

Priority #: 4

Priority Area: Improve Data Collection and Analysis capacity

Priority Type: SAT

Population(s): Other (Systemwide SAP/SAT)

Goal of the priority area:

To Develop an integrated data plan to inform policy, programming for services and performance based contracting.

Strategies to attain the goal:

1. Identify data needs by program areas.
2. Identify population level data available in New Hampshire.
3. Determine how to best utilize population level data and program data collected by BDAS to inform policy and programming for services and performance based contracting.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Develop a scope of service and secure a contract for consultant to develop an integrated data plan that outlines the type of data needed by domain; the availability of needed data, plans to address gaps in the availability of needed data; cost benefit of collecting data that is needed but not available; and how data will be used to inform policy and services

Baseline Measurement: No plan is currently in place

First-year target/outcome measurement: Develop a high level scope of service for this contract for each of the domains (i.e. Prevention, treatment, impaired driver, OTPs) and secure a consultant contract

Second-year target/outcome measurement: Develop an integrated data plan, that includes the overall data related objectives of the plan and a plan for each program area.

Data Source:

Contract

Description of Data:

Scope of work

Data issues/caveats that affect outcome measures::

Unknown

Indicator #: 2
Indicator: Initiate implementation of the integrated data plan and conduct a qualitative evaluation of how the plan is being utilized
Baseline Measurement: No data plan is currently being implemented
First-year target/outcome measurement: Implement utilization of the integrated data plan by the (SSA) director and administrators of each fo the BDAS program areas.
Second-year target/outcome measurement: Conduct a qualitative evaluation of how the plan is being utilized, including; What policy and service changes are being implemented as a result of the plan and how implementation of the plan is improving sevice delivery.

Data Source:

Data Plan

Description of Data:

Demonstrate how data is being utilized.

Data issues/caveats that affect outcome measures::

Unknown

Priority #: 5
Priority Area: Alcohol, Marijuana, Nonmedical Use of Pain Relievers
Priority Type: SAP
Population(s): Other (Young Adults)

Goal of the priority area:

Reduce percent of population using all three substances across the age group.

Strategies to attain the goal:

13 regional designed Public Health Networks utilize the Strategic Prevention Model in the implementation of effective strategies. These strategies were identified through convening community level stakeholders in data assessment, capacity development, planning, and implementation. Strategies are aligned with the six CSAP categories targeting universal, selective populations and a limited number of indicated. Outcomes are evaluated for effectiveness in desired prevention outcomes that are cultural appropriate and sustainable. Strategies include: policy changes impacting behavior; sector best practice implementation, e.g. business, medical and education; media campaigns targeting social norms and raising awareness; and student assistance.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Percent of age group using alcohol in the past month
Baseline Measurement: 73.2%
First-year target/outcome measurement: 69%
Second-year target/outcome measurement: 67%

Data Source:

National Survey for Drug Use and Health (NSDUH) Data

Description of Data:

The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 300 individuals for each of three population groups (individuals aged 12 and older) randomly selected each year. Reports are provided

annually.

Data issues/caveats that affect outcome measures::

State data, samples are combined over two survey years to provide an adequate sample size in each report. Hence, annual data is actually two years worth of data, so samples overlap from one year to another when reported annually.

Indicator #: 2

Indicator: Percent of age group using marijuana in the past month

Baseline Measurement: 27%

First-year target/outcome measurement: 23%

Second-year target/outcome measurement: 21%

Data Source:

National Survey for Drug Use and Health (NSDUH) Data

Description of Data:

The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 300 individuals for each of three population groups (individuals aged 12 and older) randomly selected each year. Reports are provided annually.

Data issues/caveats that affect outcome measures::

State data, samples are combined over two survey years to provide an adequate sample size in each report. Hence, annual data is actually two years worth of data, so samples overlap from one year to another when reported annually.

Indicator #: 3

Indicator: Percent of age group using pain relievers nonmedically in the past year

Baseline Measurement: 12.3%

First-year target/outcome measurement: 10%

Second-year target/outcome measurement: 8%

Data Source:

National Survey for Drug Use and Health (NSDUH) Data

Description of Data:

The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 300 individuals for each of three population groups (individuals aged 12 and older) randomly selected each year. Reports are provided annually.

Data issues/caveats that affect outcome measures::

State data, samples are combined over two survey years to provide an adequate sample size in each report. Hence, annual data is actually two years worth of data, so samples overlap from one year to another when reported annually.

Priority #: 6

Priority Area: Alcohol, Marijuana, Nonmedical Use of Pain Relievers

Priority Type: SAP

Population(s): Other (Youth Aged 12-17)

Goal of the priority area:

Reduce percent of population using all three substances in this age group.

Strategies to attain the goal:

13 regional designed Public Health Networks utilize the Strategic Prevention Model in the implementation of effective strategies. These strategies were identified through convening community level stakeholders in data assessment, capacity development, planning, and implementation. Strategies are aligned with the six CSAP categories targeting universal, selective populations and a limited number of indicated. Outcomes are evaluated for effectiveness in desired prevention outcomes that are cultural appropriate and sustainable. Strategies include: policy changes impacting behavior; sector best practice implementation, e.g. business, medical and education; media campaigns targeting social norms and raising awareness; and student assistance.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Percent of age group using alcohol in the past month
Baseline Measurement: 17.0%
First-year target/outcome measurement: 14%
Second-year target/outcome measurement: 13.0%

Data Source:

National Survey for Drug Use and Health (NSDUH) Data

Description of Data:

The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 300 individuals for each of three population groups (individuals aged 12 and older) randomly selected each year. Reports are provided annually.

Data issues/caveats that affect outcome measures::

State data, samples are combined over two survey years to provide an adequate sample size in each report. Hence, annual data is actually two years worth of data, so samples overlap from one year to another when reported annually.

Indicator #: 2
Indicator: Percent of age group using marijuana in the past month
Baseline Measurement: 11.4%
First-year target/outcome measurement: 9%
Second-year target/outcome measurement: 8%

Data Source:

National Survey for Drug Use and Health (NSDUH) Data

Description of Data:

The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 300 individuals for each of three population groups (individuals aged 12 and older) randomly selected each year. Reports are provided annually.

Data issues/caveats that affect outcome measures::

State data, samples are combined over two survey years to provide an adequate sample size in each report. Hence, annual data is actually two years worth of data, so samples overlap from one year to another when reported annually.

Indicator #: 3
Indicator: Percent of age group using pain relievers nonmedically in the past year
Baseline Measurement: 6.1%
First-year target/outcome measurement: 4%
Second-year target/outcome measurement: 3%

Data Source:

National Survey for Drug Use and Health (NSDUH) Data

Description of Data:

The National Survey on Drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 300 individuals for each of three population groups (individuals aged 12 and older) randomly selected each year. Reports are provided annually.

Data issues/caveats that affect outcome measures::

State data, samples are combined over two survey years to provide an adequate sample size in each report. Hence, annual data is actually two years worth of data, so samples overlap from one year to another when reported annually.

Priority #: 7
Priority Area: Pregnant women and women with dependent children
Priority Type: SAT
Population(s): PWWDC

Goal of the priority area:

Increase the number of pregnant and parenting women and children served by 5%.

Strategies to attain the goal:

1. Continue funding intensive outpatient and residential treatment programs that are specifically designed for pregnant and parenting women.
2. Continue to prioritize admission for pregnant women into contracted treatment services. Currently, programs are required to admit pregnant women within 24 hours of initial contact with the program.
3. Broadly disseminate Pregnant and Parenting Women Services brochure to medical providers.

Annual Performance Indicators to measure goal success

Indicator #: 1
 Indicator: Number of pregnant and parenting women served.
 Baseline Measurement: 103 PPW admitted to contracted services in SFY2013
 First-year target/outcome measurement: 5% increase (108 women total) over SFY2013 PPW admissions
 Second-year target/outcome measurement: 10% Increase (113 women total) over SFY2013 PPW admissions

Data Source:

Web Information Technology System (WITS).

Description of Data:

WITS admissions of PPW to both specialty and other contracted treatment services.

Data issues/caveats that affect outcome measures::

Ensuring referral source is required in WITS and that OB and Primary Care are options in the code tables.

Indicator #: 2
 Indicator: Number of referrals of pregnant and parenting women to contracted treatment providers from OB and other primary care settings.
 Baseline Measurement: SFY2013 referrals of PPW to contracted tx providers from OB and other primary care settings is 0 as this data was not previously collected.

First-year target/outcome measurement: 2 % of all PPW women referrals will come from OB and other primary care settings.

Second-year target/outcome measurement: 4% of a PPW referrals will come from OB and other primary care settings.

Data Source:

Web Information Technology System (WITS)

Description of Data:

WITS referrals of PPW from OB and primary care providers.

Data issues/caveats that affect outcome measures::

Ensuring referral source is required in WITS and that OB and Primary Care are options in the code tables.

Indicator #:

3

Indicator:

Admission of pregnant and parenting women who were referred from OB and primary care settings.

Baseline Measurement:

SFY2013 admission of PPW to contracted tx providers from OB and other primary care settings is 0 as this data was not previously collected.

First-year target/outcome measurement:

1% of all PPW admissions will be women who were referred from OB and other primary care settings.

Second-year target/outcome measurement:

2% of all PPW admissions will be women who were referred from OB and other primary care settings.

Data Source:

Web Information Technology System (WITS)

Description of Data:

WITS admissions of PPW referred from OB and primary care providers.

Data issues/caveats that affect outcome measures::

Ensuring referral source is required in WITS and that OB and Primary Care are options in the code tables.

Priority #:

8

Priority Area:

Facilitate coordination between substance use treatment and primary care services.

Priority Type:

SAT

Population(s):

Other (NH Treatment System for Individuals with SUDs)

Goal of the priority area:

Facilitate coordination between substance use treatment and primary care services.

Strategies to attain the goal:

Require all contracted treatment providers to coordinate with client's existing PCP throughout the course of treatment. If a client does not have a PCP, require contracted treatment providers to refer clients to a Community Health Center (CHC) in their area and facilitate engagement with the CHC.

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Number of clinical record reviews that evidence active coordination between contracted treatment providers and the client's PCP and/or referral to and facilitation of engagement with a CHC when the client does not have an existing PCP.

Baseline Measurement:

Survey of providers who report regular coordination with client's PCPs and/or referral to and facilitation of engagement with a CHC.

First-year target/outcome measurement:

50% of client record reviews will evidence active coordination with the client's PCP and/or

referral to and facilitation of engagement with a CHC when the client does not have a PCP.

Second-year target/outcome measurement: 75% of client record reviews will evidence active coordination with the client's PCP and/or referral to and facilitation of engagement with a CHC when the client does not have a PCP.

Data Source:

Client record reviews conducted as part of the site visits.

Description of Data:

Notes in the clinical file detailing efforts to coordinate with PCPs, referrals made to CHCs, and efforts to help the client engage with the CHC after referral.

Data issues/caveats that affect outcome measures::

None anticipated

footnote:

NH is amending its 2014-2015 Behavioral Assessment and Plan. The amendment can be found in the Section II Planning Steps attachments.

Amendment to 2014-2015 SABG Behavioral Health Assessment and Plan

The following narrative comprises the request from the New Hampshire Bureau of Drug and Alcohol Services (BDAS) to the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Services (CSAT), for approval on the use of Substance Abuse Block Grant funds (SABG) in fiscal years 2015, 2016 and 2017.

I. BACKGROUND

In addition to the devastating impact on individuals, families and communities, a conservative figure estimates that the misuse of alcohol and drugs cost the state \$1.3 billion¹ per year. The legislature passed the New Hampshire Health Protection Program (NHHP), the state's version of Medicaid Expansion, which Governor Maggie Hassan signed into Law on March 27, 2014. This program will provide health care coverage to individuals and families in New Hampshire 138% or below the Federal Poverty level and includes a robust array of services including early intervention, treatment and recovery support services that will help to address the devastating impact that the misuse of alcohol and drugs have on individuals, families and communities and will also reduce the financial impact on the state.

The Office of Medicaid Business and Policy (OMBP) at the New Hampshire Department of Health and Humans Services (NHDHHS) was assigned as the lead agency in developing and implementing this program. OMBP assigned the development of the substance use disorder (SUD) benefit under this program to their Medicaid Chief Medical director and requested that the Director of the BDAS, which serves as the single state agency – SSA (federal designation) to address the misuse of alcohol and drugs in New Hampshire, co-lead this effort. OMBP and BDAS convened an internal workgroup with representatives from multiple program areas from across the department and has worked very closely with an external stakeholders workgroup, with broad representation, in the development of the SUD service array. It should be noted that the development of SUD benefits under this program have been viewed as a particularly important accomplishment for New Hampshire, which has not included substance use disorder benefits in its Medicaid program, but will be proposing the same SUD benefit array for the currently eligible Medicaid recipients during the upcoming state budget process.

Having only limited resources to support SUD services in the past has resulted in the state having only a limited capacity for these important services at this time. For this reason the NHDHHS BDAS, with additional support from the New Hampshire Charitable Foundation, engaged its contracted Center for Excellence (the Center) to implement the "Treatment Capacity Assessment Project" to assess the capacity for substance use disorder treatment services across the state. A copy of this report is available on the NHDHHS website at: <http://www.dhhs.nh.gov/dcbcs/bdas/treatment.htm>. This assessment of substance use disorder (SUD) services was conducted between May and July of 2014 and included the surveying of licensed substance use and mental health professionals and representatives from organizations within major service delivery systems, including medically-based services such as SBIRT (screening, brief intervention, referral to treatment) and medication-assisted treatment (MAT) services, as well as the more traditional substance use disorder and recovery support services in behavioral

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health settings. This assessment report provides important context for the state and stakeholders to use in developing and directing leadership, resources, and activities such as technical assistance and training to expand the service capacity of licensed professionals and service delivery systems. The Center is in the process of developing a treatment locator with geo mapping that will be available in November of this year.

The Department of Health and Human Services, working closely with the Medicaid Managed Care Organizations and a broad array of external stakeholders, determined it would need to phase in many of the substance use disorders services under the NH Health Protection Program (NHHPP) due to this lack of capacity. In an effort to develop needed capacity the NHDHHS has identified a number of potential resources to support these efforts including 1115 demonstration waiver it has submitted to CMS (not yet approved) - <http://www.dhhs.nh.gov/section-1115-waiver/index.htm>, the Federal Block Grant and Governor's Commission General Funds (proposed to the Governor's Commission at a special retreat on May 5, 2014). The combination of available benefits and added SUD service capacity will give New Hampshire unprecedented resources going forward to address the misuse of alcohol and drugs in our state.

The primary purpose of this proposal is two-fold:

1. To obtain approval for the use of block grant funds to develop needed service capacity to address substance use disorders, including:
 - a. Withdrawal management
 - b. Medication-assisted treatment
 - c. Screening brief intervention, referral to treatment
 - d. Specialty substance use disorders treatment services
 - i. Intensive outpatient and partial hospitalizations services
 - ii. Low, medium and high residential treatment services
 - e. Recovery Support Services.
2. To utilize block grant resources in a manner that is complementary to resources being made available through the NHHPP and benefits available in private health plans on the New Hampshire Insurance Exchange, i.e. to support programs, practices and policies not covered by these programs, in support of New Hampshire's broad-based fiscal strategy to address the misuse of alcohol and drugs.

It should be noted that state fiscal year 2015 has been identified as a transition year for the New Hampshire Health Protection Program that may initially result in a drop in the number of people served by the block grant and possible reduction in the use of block grant funds for this period as the Department of Health and Human Services works to re-allocate and optimize resources available to implement a broad-based comprehensive approach to address the misuse of alcohol and drugs, including a growing opioid epidemic in our state.

Finally, New Hampshire has traditionally spent down each block grant award in the second year of the award, often bumping up against the deadline for the use of these funds. SAMHSA approving this

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proposal will allow New Hampshire to use a portion of our FFY-2014 in the first year of this award period for the purposes outlined in this proposal.

II. ONE-TIME SERVICE CAPACITY DEVELOPMENT

- 1. Promoting awareness of the NH's Medicaid Expansion (NH Health Protection) Program**
Block Grant Priority Area 2: Significant gaps in the current treatment system; and Block Grant Priority Area 8: Facilitate Coordination between Substance Abuse Treatment services and Primary Care services

SFY 2015/2016

- Adults who will be eligible for Medicaid enrollment under NHHPP and, thus newly eligible for a substance use disorder benefit
- Other community-based organizations who may work with eligible populations who in turn may need and benefit from these services
- Behavioral health care professionals (agencies and those in private practice)

Public awareness and social marketing efforts within this initiative will include making individuals eligible for the NHHPP, that are at risk for or already misusing alcohol and drugs, aware of the resources within this program to address these issues. Efforts will primarily focus on at risk and priority populations including pregnant and parenting women, intravenous drug users, individuals involved with the criminal justice system and individuals misusing opioids. These efforts will include working with providers already serving these populations.

Substance misuse early intervention, treatment and recovery support services being made available under the New Hampshire Health Protection Program and on the Exchange will allow the state to address these issues more readily across the health care system, particularly for lower levels of acuity. For this reason it will be important to engage a broad range of providers within these systems to provide them with training and technical assistance needed to make these services available within these allied systems.

- 2. Increasing the number of prescribers who are certified to provide Medication-Assisted Treatment (MAT) – including ambulatory withdrawal management**
Block Grant Priority Area 2: Significant gaps in the current treatment system; and Block Grant Priority Area 8: Facilitate Coordination between Substance Abuse Treatment services and Primary Care services

SFY 2015/2016

- Medical professionals able to prescribe buprenorphine, naltrexone or other medications to assist in long-term recovery
- Specialty SUD treatment providers able to provide counseling and wrap-around supports to complement MAT

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The Bureau of Drug and Alcohol Services and the Division of Public Health Services, both within the NHDHHS, as well as resources from the contracted Center for Excellence, will be engaging community health centers and other primary care health care providers to develop capacity for medication-assisted treatment services. These services will include medication administration services that are either integrated with or coordinated with behavioral health services that will include active referral mechanisms to specialty substance use disorder treatment services as indicated.

3. *Increasing Capacity for Screening, Brief Intervention and Referral to Treatment (SBIRT) in NH's Community Health Center System*

Block Grant Priority Area 8: Facilitate Coordination between Substance Abuse Treatment services and Primary Care services

SFY 2015/2016

Supporting SBIRT implementation in multiple health and community settings to meet state plan recommendations promotes prevention, increases early identification and treatment of SUDs, with a special emphasis on at-risk populations. Funding will be utilized to develop needed infrastructure for these services, including personnel and indirect costs, interagency agreements, mechanisms for bi-directional referrals between primary care and specialty addiction treatment providers and to train staff in community health centers (CHCs) and other primary care settings in the SBIRT model, etc.

4. *Planning for the Development of a Full Continuum of Services on a Regional Basis*

Block Grant Priority Areas 5 & 6: Alcohol, marijuana, non-medical use of pain relievers for youth & young adults; and Block Grant Priority Area 2: Significant gaps in the current treatment system

SFY 2015

As part of a multi-year investment, NH BDAS proposes to initially allocate \$15,000 to support a planning process for each of the state's thirteen regional public health networks in state fiscal year 2015. Each of these thirteen public health networks has a Public Health Advisory Council (PHAC), which includes multidisciplinary representation across the six targeted sectors (Government, Education, Safety, Health Care, Business and Family/Community Supports). During this stage, resources are being made available to support planning and development of organizational structures needed within each of the regional public health networks to develop population strategies and a seamless continuum of prevention, early intervention, treatment and recovery support services to address the misuse of alcohol and drugs.

Pre-planning activities will include training and orientation of members of the PHAC about the nature and progression of the misuse of alcohol and drugs, their impact on their region, the principles of a recovery-oriented system of care, and the components of an accessible robust continuum of services, including population-level environmental strategies, prevention (selected), early intervention, treatment and recovery support services that will be cultivated in each of the thirteen public health regions in the state. These activities will include and overview of how a comprehensive approach can be utilized to address these issues, what service along the continuum are currently available in each region, gaps in services and how current services and new services can be better coordinated to more effectively

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address these issues, such as how screening, brief intervention and referral to treatment (SBIRT) and medication-assisted treatment (MAT) provided in primary care settings can be paired with substance use disorders treatment services. Nominal resources will be made available on an annual basis for each of the regional public health networks to facilitate the continuing education of the PHACs about the impact that substance misuse in their areas and to facilitate bi-directional communication between the PHACs and the NH Department of Health and Human Services (Bureau of Drug and Alcohol Services and the Division of Public Health Services) on the integration of behavioral health and primary care services in each of the public health regions.

5. Ensuring/establishing and maintaining a continuum of care within each region of the state's regional public health network system

Block Grant Priority Areas 5 & 6: Alcohol, marijuana, non-medical use of pain relievers for youth & young adults; and Block Grant Priority Area 2: Significant gaps in the current treatment system

SFY 2016/2017

Expanding upon the planning process outlined in the previous section, resources will be made available utilizing a strategic planning framework planning model, to develop capacity for a full continuum of services to address the misuse of alcohol and drugs in each of the thirteen public health regions in New Hampshire. The full continuum of strategies and services will include population-level strategies, selected prevention services, early intervention, and treatment and recovery support services, which will be coordinated with and complement services available in the larger health care system, such as screening brief intervention, referral to treatment (SBIRT) and medication-assisted treatment (MAT) being developed in primary care settings in these regions.

Activities will include:

- Assessment/gap analysis of service availability within the continuum of prevention, treatment and recovery support services, with a special emphasis to eliminate gaps for each of the SUD services (SBIRT, medication assisted treatment, specialty substance use disorders treatment and recovery support services) covered under the New Hampshire Health Protection Program - NHHPP (Medicaid Expansion).
- Utilizing the public health advisory councils (PHACs) and the regional public health networks to develop regional plans for developing needed capacity along the continuum of services and how these services will be coordinated on a regional basis.

Future activities will include developing the capacity for care coordination and bi-directional referrals among community-based organizations.

6. Workforce Development

Block Grant Priority Area 2: Significant gaps in the current treatment system

SFY 2015/2016

- a. Workforce Development: Providing training and technical assistance directed at behavioral health practitioners across the health care system to improve substance use disorders core competencies*

Promoting integrated, collaborative person-centered care is a priority of NHDHHS and a fundamental principle of health care reform. This initiative will promote the treatment of co-occurring substance use and mental health disorders across the larger health, behavioral health and social service systems in New Hampshire with benefits made available under the New Hampshire Health Protection Program (NHPPP). Technical assistance and training will primarily focus on health care practitioners in behavioral health and primary care settings, to develop the capacity or improve their abilities to conduct screening, assessment, brief interventions and counseling services for individuals with lower levels of substance use disorder acuity and mechanisms to refer clients to more intensive specialty services when indicated. This funding will allow primary care, behavioral health and other agencies to access training resources for their existing or new staff and to access technical assistance needed for organizational changes necessary for the provision of these services.

b. Resources to Assess, Expand and Enhance the Prevention Workforce Development

Prevention services are an important component of a comprehensive approach to address the misuse of alcohol and drugs. The prevention workforce will need to continue to evolve as advancements are made in the science of substance misuse prevention as well as efforts being made to link these services with the larger health care system. To its benefit, the prevention workforce in New Hampshire has a cadre of seasoned prevention professionals that possess a wealth of institutional knowledge that can be tapped to further develop the state's capacity for evidence-based prevention services. Agencies administering substance misuse prevention services will need technical assistance to integrate substance misuse prevention services with substance use disorder treatment and recovery support services as well as other wrap-around services (case management, etc.) being made available in the health care system. To accomplish this objective New Hampshire will conduct an assessment of the current workforce to identify a baseline of current competencies (knowledge, skills and abilities - KSA) that will be utilized to further develop and enhance prevention practitioner competencies.

Using the KSA assessment as a basis, current prevention training and technical assistance plans will be refined to address identified workforce needs. Seasoned members of the current workforce will be utilized to develop a professional mentoring program that will be aligned with the International Certification Reciprocity Consortium (IC&RC) standards and with requirements outlined in SAMHSA's "Prevention Core Competencies" guidelines.

The scope of work for this initiative will include three primary objectives:

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- To conduct an assessment of NH prevention professionals' core competencies (KSA) and capacity, create and implement a plan to address needs and to evaluate the outcomes of this plan;
- To develop and implement professional mentoring program and to evaluate the outcomes of this component of the program;
- To continue to expand prevention certification in New Hampshire through increased marketing and outreach.

7. *Infrastructure development for specialty SUD (substance use disorder) treatment services*

Block Grant Priority Area 2: Significant gaps in the current treatment system

To expand capacity for services being phased in under the New Hampshire Health Protection Program (NHHPP – Medicaid Expansion Program).

SFY 2015/2016

The NH Department of Health and Human Services will be making resources available to expand capacity for specialty substance use disorders treatment services (intensive outpatient, partial hospitalization and residential services) to meet service capacity needs for the Federal Block Grant and for the New Hampshire Health Protection Program (Medicaid Expansion). Expanding capacity for these services will also help to meet a number of objectives outlined in New Hampshire's state plan (Collective Action / Collective Impact), including improving health outcomes and improving access to these services. The proposed use of block grant funds will support entities in New Hampshire in developing new or additional capacity for specialty substance use disorders services. Resources will be utilized to secure facilities and equipment, improve business functions, to hire and train staff and to develop evidence-based substance use disorder programs. Applicants will be required to meet standards outlined in SAMHSA Technical Assistance Publications (TAPs) and Treatment Improvement Protocols (TIPs).

In summary, the primary objectives of the specialty treatment services infrastructure initiative is to expand the capacity for these needed services to improve access to these services at different levels of care in different regions of the state and ultimately to improve health outcomes by increasing the number of individuals receiving quality substance use disorders treatment services in New Hampshire.

8. *Building the infrastructure for peer and other recovery support services available in New Hampshire communities across the state*

Block Grant Priority Area 2: Significant gaps in the current treatment system

The NHDHHS' Bureau of Drug and Alcohol Services is working with a number of partners, including the Governor's Commission, the New Hampshire Charitable Foundation, New Futures, treatment providers, a number of peer-led recovery community organizations and others to develop critical low-cost, recovery support services. These services are designed to support individuals addicted to alcohol and

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drugs accessing and fully engaging in treatment services and to support them at a time when they are particularly vulnerable to relapse into active addiction during their early stages of recovery. These services will help connect these individuals to self-help groups and a variety of community-based services to help them to reach their full potential as contributing members of society.

SFY 2015/2016

a. Peer Recovery Support Services

The NHDHHS included peer recovery support services in the substance use disorder (SUD) benefit array under the New Hampshire Health Protection Program – NHPPP (Medicaid Expansion) and plans to allocate state and federal funding for these services. However, like many other states, there is currently only very limited capacity for these services.

In an effort to further develop capacity for these services and to promote the role of recovery, and communities locally in supporting individuals in the early stages of recovery, the NH Department of Health and Humans Services is planning to make federal and state funding resources available, for both direct and indirect costs associated with the operations of peer recovery community organizations (RCO). This investment will include resources to support the operating costs of regionally-based recovery centers on a gradually reduced basis while they are able to increase revenues to sustain operations of these centers over the long term. Resources will also support training capacity in the state for peer recovery coaches and to build a referral network, communications and marketing approaches to help health care systems, community-based organizations and general public awareness of these services, their purpose and how individuals can access services. Training resources will be made available for individuals providing peer recovery support service through a recovery community organization and to connect these services with outpatient or comprehensive substance use disorder treatment programs and other health care services on a regional basis.

b. Certified Recovery Support Workers

Training resources will be made available to agencies that provide specialty substance use disorder services and other health care providers to hire, train and support program start-up costs for certified recovery support workers (CRSWs) under the New Hampshire Board of Alcohol and Drug Abuse Professional Practice. The role of the CRSW will be similar in some ways and an alternative service to that of the peer recovery specialist. The CRSW position, in addition to playing a critical role to support individuals addicted to alcohol and drugs better engaging in services and supporting their early recovery, is also designed as a workforce development tool to support a track for individuals interested in a career as a substance use disorder professional.

c. Ancillary Recovery Support Services

In addition to the recovery supports described in this section above, the NHDHHS will be supporting the development of other “enhanced services” to better engage individuals in treatment and support them in their early stages of recovery, such as transportation, child care and continuous recovery monitoring case management services.

III. REALLOCATION OF BLOCK GRANT FUNDS FOR ON-GOING SERVICES

9. Enhanced Services for Pregnant and Post-Partum Women

Block Grant Priority Area 7: Pregnant women and women with dependent children

SFY 2015/2016

Enhanced services are specialized services that remove barriers to a client's participation in treatment. Examples include services for women needing substance use disorders treatment that offers access to resources such as child care, transportation, providing or arranging for primary medical care, referral for prenatal care, and pediatric care for their children. These services might also include specialized gender-specific trauma, informed programming for women with a history of physical and sexual abuse, as well as child care and parenting skills training for women in treatment to ensure that women and women with custodial children are able to access needed services.

10. Funding for SBIRT Service for clients without health insurance

Block Grant Priority Area 8: Facilitate Coordination between Substance Abuse Treatment services and Primary Care services

SFY 2015/2016

Funding will be utilized to support SBIRT service at community health centers and other primary care settings for at risk populations that lack access to health insurance. Community health centers have expressed concern that resources are needed to support SBIRT services for indigent clients that do not have access to health insurance. They have indicated that their charter requires that all Federally Qualified Health Centers' patients have access to the same array of services regardless of their ability to pay for those services.

11. Supporting evidence-based Student Assistance Program (SAP) prevention programming in schools

Block Grant Priority Areas 5 & 6: Alcohol, marijuana, non-medical use of pain relievers for youth & young adults

SFY 2015/2016

Student Assistance Programs (SAPs) are comprehensive, evidence-based approaches to prevention education, parent education, policy improvement, and early identification and referral to services for youth that are at risk or already misusing alcohol or other drugs and to address interrelated mental or emotional health issues. BDAS has been supporting SAPs in fifteen middle and high schools through the SAMHSA Partnership for Success II grant and is committed to continuing to support and expand these services in additional schools, utilizing joint state / local funding models. This funding will be utilized to support an additional +/- 20 middle and high school SAP programs across the state.

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12. Ensuring adequate, centralized, cost-effective training, technical assistance and evaluation services are available to support initiatives one through eleven
Block Grant Priority Areas 2 & 8: Significant gaps in the current treatment system; Facilitate Coordination between Substance Abuse Treatment services and Primary Care services

SFY 2015/2016

The NHDHHS proposes to proportionally expand capacity for training and technical assistance resources needed to support the initiatives identified to be approximately 10% of the cost of those initiatives. Training and technical assistance will include support for needed systems development, use of evidence-based practices and evaluation.

Substance Abuse Block Grant - PROPOSED FUNDING SUMMARY SFY 2015 - 2016		ANNUAL AMOUNT
1	Promoting awareness of the NH's Medicaid Expansion, known as the NH Health Protection Program (HPP) and its Substance Use Disorder (SUD) benefit	\$50,000
2	Increasing the number of prescribers who are certified to provide Medication-Assisted Treatment (MAT)	\$200,000
3	Increasing capacity for Screening, Brief Intervention and Referral to Treatment (SBIRT) in NH's community health center system – amount per year for both SFY 15 & 16	\$650,000
4	Planning for the development of a full continuum of services on a regional basis	\$195,000 (SFY 15) \$130,000 (SFY 16/17)
5	Ensuring/establishing and maintaining a continuum of care within each region of the state's regional public health network system – state fiscal year 2016	\$1,300,000
6	a. Providing training and technical assistance directed at workforce development to address SUD and co-occurring disorders across the larger health care system	\$200,000
	b. Prevention services workforce development	\$32,000
7	Infrastructure development for specialty SUD treatment services	\$500,000
8	Building the infrastructure for peer recovery support services in the community	\$200,000
9	Enhanced services for pregnant & post-partum women, including, child care, active facilitation of OB & primary care, transportation, parenting skills development, etc.	\$150,000
10	SBIRT service for indigent clients at FQHCs	\$130,000
11	Supporting evidence-based Student Assistance Program (SAP) prevention programming in schools	\$1,350,000
	SUBTOTAL	\$4,925,000
12	Ensuring adequate, centralized, cost-effective training, technical assistance and evaluation services are available to support these initiatives noted above	\$492,500
	TOTAL	\$5,449,500

ⁱ Shoveling Up; The Cost of Substance Abuse on State Systems, 2009 and the PolEcon Report released by New Futures, 2012.

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures

Expenditure Period Start Date: 7/1/2013 Expenditure Period End Date: 6/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention [*] and Treatment	\$5,027,447		\$0	\$3,028,830	\$3,706,625	\$0	\$233,000
a. Pregnant Women and Women with Dependent Children [*]	\$786,000		\$0	\$0	\$0	\$0	\$0
b. All Other	\$4,241,447		\$0	\$3,028,830	\$3,706,625	\$0	\$233,000
2. Substance Abuse Primary Prevention	\$1,340,652		\$0	\$991,619	\$626,522	\$0	\$100,395
3. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	\$335,163		\$0	\$575,620	\$812,094	\$0	\$0
11. Total	\$6,703,262	\$0	\$0	\$4,596,069	\$5,145,241	\$0	\$333,395

* Prevention other than primary prevention

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Expenditure Period Start Date: 7/1/2013 Expenditure Period End Date: 6/30/2015

Service	Unduplicated Individuals	Units	Expenditures
Healthcare Home/Physical Health			\$0
Specialized Outpatient Medical Services			\$0
Acute Primary Care			\$0
General Health Screens, Tests and Immunizations			\$0
Comprehensive Care Management			\$0
Care coordination and Health Promotion			\$0
Comprehensive Transitional Care			\$0
Individual and Family Support			\$0
Referral to Community Services Dissemination			\$0
Prevention (Including Promotion)			\$0
Screening, Brief Intervention and Referral to Treatment			\$0

Brief Motivational Interviews			\$0
Screening and Brief Intervention for Tobacco Cessation			\$0
Parent Training			\$0
Facilitated Referrals			\$0
Relapse Prevention/Wellness Recovery Support			\$0
Warm Line			\$0
Substance Abuse (Primary Prevention)			\$0
Classroom and/or small group sessions (Education)			\$0
Media campaigns (Information Dissemination)			\$0
Systematic Planning/Coalition and Community Team Building(Community Based Process)			\$0
Parenting and family management (Education)			\$0
Education programs for youth groups (Education)			\$0
Community Service Activities (Alternatives)			\$0
Student Assistance Programs (Problem Identification and Referral)			\$0
Employee Assistance programs (Problem Identification and Referral)			\$0

Community Team Building (Community Based Process)			\$0
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			\$0
Engagement Services			\$0
Assessment			\$0
Specialized Evaluations (Psychological and Neurological)			\$0
Service Planning (including crisis planning)			\$0
Consumer/Family Education			\$0
Outreach			\$0
Outpatient Services			\$0
Evidenced-based Therapies			\$0
Group Therapy			\$0
Family Therapy			\$0
Multi-family Therapy			\$0
Consultation to Caregivers			\$0
Medication Services			\$0

Medication Management			\$0
Pharmacotherapy (including MAT)			\$0
Laboratory services			\$0
Community Support (Rehabilitative)			\$0
Parent/Caregiver Support			\$0
Skill Building (social, daily living, cognitive)			\$0
Case Management			\$0
Behavior Management			\$0
Supported Employment			\$0
Permanent Supported Housing			\$0
Recovery Housing			\$0
Therapeutic Mentoring			\$0
Traditional Healing Services			\$0
Recovery Supports			\$0
Peer Support			\$0
Recovery Support Coaching			\$0

Recovery Support Center Services			\$0
Supports for Self-directed Care			\$0
Other Supports (Habilitative)			\$0
Personal Care			\$0
Homemaker			\$0
Respite			\$0
Supported Education			\$0
Transportation			\$0
Assisted Living Services			\$0
Recreational Services			\$0
Trained Behavioral Health Interpreters			\$0
Interactive Communication Technology Devices			\$0
Intensive Support Services			\$0
Substance Abuse Intensive Outpatient (IOP)			\$0
Partial Hospital			\$0

Assertive Community Treatment			\$0
Intensive Home-based Services			\$0
Multi-systemic Therapy			\$0
Intensive Case Management			\$0
Out-of-Home Residential Services			\$0
Children's Mental Health Residential Services			\$0
Crisis Residential/Stabilization			\$0
Clinically Managed 24 Hour Care (SA)			\$0
Clinically Managed Medium Intensity Care (SA)			\$0
Adult Mental Health Residential			\$0
Youth Substance Abuse Residential Services			\$0
Therapeutic Foster Care			\$0
Acute Intensive Services			\$0
Mobile Crisis			\$0
Peer-based Crisis Services			\$0

Urgent Care			\$0
23-hour Observation Bed			\$0
Medically Monitored Intensive Inpatient (SA)			\$0
24/7 Crisis Hotline Services			\$0
Other (please list)			\$0

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$5,105,934	
2 . Substance Abuse Primary Prevention	\$1,361,582	
3 . Tuberculosis Services		
4 . HIV Early Intervention Services**		
5 . Administration (SSA Level Only)	\$340,395	
6. Total	\$6,807,911	

* Prevention other than primary prevention

** HIV Early Intervention Services

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	\$170,000	
	Selective		
	Indicated		
	Unspecified		
	Total	\$170,000	
Education	Universal	\$170,000	
	Selective	\$2,500	
	Indicated		
	Unspecified		
	Total	\$172,500	
Alternatives	Universal	\$170,000	
	Selective	\$2,632	
	Indicated		
	Unspecified		
	Total	\$172,632	
Problem Identification and Referral	Universal	\$5,000	
	Selective	\$50,000	
	Indicated	\$13,000	
	Unspecified		
	Total		

	Total	\$68,000	
Community-Based Process	Universal	\$170,000	
	Selective		
	Indicated		
	Unspecified		
	Total	\$170,000	
Environmental	Universal	\$170,000	
	Selective		
	Indicated		
	Unspecified		
	Total	\$170,000	
Section 1926 Tobacco	Universal	\$50,000	
	Selective		
	Indicated		
	Unspecified		
	Total	\$50,000	
Other	Universal		
	Selective		
	Indicated		
	Unspecified	\$388,450	
	Total	\$388,450	
Total Prevention Expenditures		\$1,361,582	
Total SABG Award*		\$6,807,911	
Planned Primary Prevention Percentage		20.00 %	

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

footnote:

Education - Selective - High-risk - RPHN - Vet Corp Support
Alternative - Selective - RPHN - Higher-need/risk population
Problem ID and Referral - Universal - RPHN SBIR Px

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	\$905,000	
Universal Indirect	\$388,450	
Selective	\$55,132	
Indicated	\$13,000	
Column Total	\$1,361,582	
Total SABG Award*	\$6,807,911	
Planned Primary Prevention Percentage	20.00 %	

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

footnote:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

Expenditure Period Start Date: Expenditure Period End Date:

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

footnote:

Due to the high cost of high risk population services and the lack of sufficient funding, NH Prevention system is unable to provide selective and indicated services for high risk youth and families, and other high risk populations such as, substance using women of child bearing age and Lesbian, Gay, Bi-Sexual, and Transgendered (LGBT), and military. There are efforts across regions universal direct prevention services that raise awareness about high risk populations.

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Expenditure Period Start Date: 10/1/2013 Expenditure Period End Date: 9/30/2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$0	\$0	\$0					
2. Quality Assurance	\$285,250	\$332,500	\$0	\$617,750				
3. Training (Post-Employment)	\$72,000	\$0	\$0	\$72,000				
4. Education (Pre-Employment)	\$0	\$0	\$0					
5. Program Development	\$5,200	\$0	\$0	\$5,200				
6. Research and Evaluation	\$0	\$0	\$0					
7. Information Systems	\$26,000	\$100,000	\$0	\$126,000				
8. Enrollment and Provider Business Practices (3 percent of BG award)	\$0	\$0	\$0					
9. Total	\$388,450	\$432,500		\$820,950				

footnote:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

NH has not yet determined what the essential benefit package for NH is.

C: Coverage M/SUD Services

Narrative Section - BG 2014/15

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. *Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?*

New Hampshire Medicaid does not at this time include benefits for substance use disorders. The New Hampshire Legislature has established a Commission to Study the Expansion of Medicaid. Information about the work of the Commission and status of this study can be found at:

<http://www.dhhs.nh.gov/sme/index.htm>

2. *Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?*

New Hampshire Medicaid does not at this time include benefits for substance use disorders and does not have a plan for monitoring whether individuals and families have access to Mental Health and Substance Use Disorders through a Qualified Health Plan.

3. *Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.*

The New Hampshire Insurance Department would have responsibility for monitoring access to services by Qualified Health Plans. It is not known what this monitoring process would include.

4. *Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?*

It is not known at this time whether or not the SSA will be involved in reviewing and complaints or possible violations of MHPAEA.

5. *5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?*

Unknown at this time.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

D. Health Insurance Marketplaces

Narrative Section - BG 2014/15

NH does not have the capacity to report on Health Insurance Marketplaces at this time.

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Encounter/utilization/performance analysis; and
 - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

E. Program Integrity

Narrative Section - BG 2014/15

The New Hampshire Bureau of Drug and Alcohol Services – BDAS (SSA) does not have the capacity to report on this narrative at this time.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
 - a) What information did you use?
 - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
 - a) Educating State Medicaid agencies and other purchasers regarding this information?
 - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

F. Use of Evidence in Purchasing

Narrative Section - BG 2014/15

NH does not have the capacity to report on Use of Evidence in Purchasing at this time.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

G. Quality

Narrative Section - BG 2014/15

NH does not have the capacity to report on Quality at this time.

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

H. Trauma

Narrative Section - BG 2014/15

NH does not have the capacity to report on Trauma at this time.

IV: Narrative Plan

I. Justice

Narrative Question:

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

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{42,43} Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

I. Justice

Narrative Section - BG 2014/15

Criminal justice involved individuals , including those on probation or parole and those convicted of a driving while impaired offense are currently served under that Access to Recovery grant. This grant has also served to build an infrastructure of providers who will be able to provide services to criminal justice involved and other individuals under the Affordable Care Act.

A committee chaired by the Chief Justice of the New Hampshire Supreme Court is actively developing specialty courts in New Hampshire and the NH SSA is supportive of their efforts.

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

J. Parity Education

Narrative Section - BG 2014/15

NH does not have the capacity to report on Parity Education at this time.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Footnotes:

K. Primary and BH Integration

Narrative Section - BG 2014/15

The New Hampshire Bureau of Drug and Alcohol Services – BDAS (SSA) is actively involved in the state's State Innovation Model (SIM) and Balance Incentive Program (BIP) initiatives. In addition the SSA is involved in the following efforts to integrate / coordinate substance use disorders treatment services and primary care services:

- Has a strong working relationship with the Division of Public Health Services (BDAS and DPHS are both under the New Hampshire Department of Health and Human Services), including the SSA:
 - Participating with DPHS to submit a proposal to SAMHSA in 2013 for an SBIRT grant (not awarded) that sought to coordinate primary care services provided in New Hampshire FHQs with specialty substance use disorders treatment services administered by the Bureau of Drug and Alcohol Services (when indicated).
 - BDAS and DPHS have integrated our regional alcohol and drug prevention coalitions (supported by Block Grant funds) and regional public health networks starting in state fiscal year 2013.
- The Bureau of Drug and Alcohol Services is working in collaboration with the Health & Medical Work Group of the Governor's Commission Prescription Drug Task Force to provide enhanced services for individuals in New Hampshire that are dependent on opioid drugs, including heroin and non-medical use of opioid based prescription pain medication. This initiative will coordinate services under two primary models, Screening, Brief Intervention, Referral to Treatment (SBIRT) and Medication Assisted Treatment (MAT).

The New Hampshire SSA does not have the capacity to report on this narrative section beyond the information provided above.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

L. Health Disparities

Narrative Section - BG 2014/15

The New Hampshire Bureau of Drug and Alcohol Services – BDAS (SSA) does not have the capacity to report on this narrative at this time.

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

M: Recovery

Narrative Section - BG 2014/15

Indicators/Measures

1. Yes
2. No. While the NH SSA does employ several people in recovery in significant leadership roles, we do not document their recovery status due to privacy concerns.
3. Yes
4. Yes
5. Yes
6. Yes
7. Yes
8. BDAS is attempting to educate our partner systems and stakeholders to the principles and values of a Resiliency and Recovery-oriented system of care (RROSC) so that we will all be consistent in our approach to persons attempting to gain, enhance and/or maintain their recovery.

We have initiated a pilot program for Recovery Coaching for persons with co-occurring disorders with Recovery Coach training and ATR-funded services expanding to MH peer support centers and consultation between the Recovery Community Organizations (RCO) and the MH Peer Support Center staff.

Involvement of Individuals and Families

The Governor's Commission Treatment Taskforce is an advisory group for treatment and recovery services in the state. Several individuals in recovery are standing members of this taskforce. They provide a strong voice in the discussion of plans, delivery and evaluation of services. Our state-wide RCO provides training and consultation on Recovery Coaching and Parent Peer Support as well as providing these services.

The Behavioral Health Advisory Council, which was created by the Bureau of Behavioral Health to inform Mental Health Services, has expanded to include people representing Substance Abuse Services and addresses both of these issues as well as co-occurring concerns.

Through the Access to Recovery grant, individuals have the opportunity to access care coordination and recovery coaching. Both of these services are focused on helping the client to identify strengths and needs and design a plan for meeting their needs and capitalizing on their strengths. In addition both Access to Recovery and contracted services standards include engaging the client in treatment planning and other decision making relative to their treatment and recovery.

NH is committed to the expansion of recovery-oriented services. We are adopting standards consistent with a RROSC. We are empowering our state-wide RCO to provide leadership in this development by contracting for their services, providing consultation and connections to increase access to multiple sources of funding and promoting recovery-oriented services. Our contracts require providers to incorporate values and standards of RROSC into their services. BDAS-sponsored training has stresses a recovery orientation and education about the array of recovery support services.

M: Recovery

Narrative Section - BG 2014/15

Housing

New Hampshire has recently increased funding for transitional housing programs, which allow the individual to live in a supportive environment while still being active members of the community; however, technical assistance through BRSS TACS in developing other options for individuals to access housing would be very beneficial.

IV: Narrative Plan

N. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
5. How is the state's budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

N: Prevention

Narrative Section - BG 2014/15

- 1) The NH State Epidemiological Outcomes Workgroup (SEOW) produces a state epidemiological profile that is reflective of state and local level data on substance use consumption patterns, consequences of use, and the associated risk and protective factors. At the local level, state contracted Regional Public Health Networks convene their data work groups to review the data, conduct local level focus groups in determining contributing factors to define the best possible approaches that would impact the risk and protective factors in reducing prevalence use. For example, one regional network determined that high school youth have social access to alcohol and to reduce this access the network conducted a campaign targeting parents (information dissemination); increase in parental observance of social hosting laws and monitoring youth alcohol use; increase collaborative activity around substance use prevention activities in region and across the six sectors (community-based process). Regions primarily target universal and selective populations.
- 2) Each regional network conducted the five steps of the strategic prevention model that produced a three-year strategic plan for each of the ten regions. Within each plan strategies were identified and aligned with the data and risk and protective factors. NH Center for Excellence, the state's technical assistance quality improvement contractor, provided technical assistance for each region to ensure strategies chosen addressed contributing factor(s) that demonstrated strength of evidence and overall fit and feasible of the intervention. NH follows SAMHSA evidence-based determination chart. Primary prevention programs, practices, and strategies or interventions are approved once they meet the above rigor of evidence determined by the NH Center for Excellence. Regions are encouraged to secure additional sources of funding or in-kind resources in the implementation of their strategies, and report out on how block grant and other resources were used in support these efforts and the implementation of the planned strategies.
- 3) Overall prevention capacity is supported and advanced by the following:
 - a. The State of New Hampshire has established 13 Regional Public Health Networks (RPHN) (as of July 1, 2013) that are combined contracts with NH Division of Public Health Services' in regional public health emergency preparedness and substance misuse prevention. These RPHN coordinate the development and implementation of a range of community and public health improvement activities, including substance misuse prevention scope of work. Each Regional Public Health Network has one full-time equivalent coordinator to carry out the regions substance misuse prevention activities. The Regional Public Health Networks contract share some primary functions: engage and convene community sectors, and develop Public Health Advisory Council (PHAC). The role of PHAC is to advise the Regional Public Health Network in the identification of regional public health priorities that based on community health assessments; assure the implementation of programs, practices and policies that are evidence-based to meet improved health outcomes; and advance the coordination of services among partners.

N: Prevention

Narrative Section - BG 2014/15

- b. NH substance misuse prevention efforts are supported by a public-private partnership with the New Hampshire Charitable Foundation (NHCF) and BDAS. NHCF has made a ten-year commitment and investment approximately \$1.2 million dollars per year in prevention. NHCF and BDAS have a memorandum of agreement that supports this overall investment.
- c. The system is built upon the six-sector model; six sectors are: business, health/medical, safety/enforcement, government, education, family & community supports. Each sector has stake in the health and wellness of the community in which they work, live, play and learn. Each regional network engages with the six-sectors and provides technical assistance (community-based process) with each sector in adoption of a set of best practices to reduce the prevalence of alcohol and other drug misuse. Regions are required to have representation of the six-sectors on their leadership teams.
- d. The NH Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment published their five-year plan in March 2013. This plan utilizes the six sector model, thereby encouraging community sectors to engage and adopt prevention strategies at the community and individual organizational level to complement state-level efforts to achieve the goals of reducing alcohol and other drug misuse.
- e. A professional prevention work force is a priority in NH. By mid-year NH will conduct an assessment of the prevention workforce and the alignment IC&RC core competencies. This assessment will determine strengths and gaps within the NH workforce. Based on these findings a plan will be developed and implemented to improve NH workforce. NH prevention service providers contracted with the state are required to be Certified Prevention Specialist in alignment with the IR&RC. NH NPN works very closely with NH Certification Board in support of the advancement and expansion of the NH prevention work force. It has been proposed to institute prevention professional mentoring program through the NH Certification Board. Mentors would be compensated by receiving a limited number of CEUs toward recertification and the mentees (new or seasoned prevention professionals) would receive much needed support and guidance.
- f. NH has adopted the new national Substance Abuse Prevention Skills Training (SAPST) curriculum and training, 5 NH professionals are being trained as SAPST trainers September 2013. NH first SAPST will be conducted early November 2013 and is expected to be conducted annually.
- g. Additionally, each RPHN is required to conduct at minimum 10 Appreciative Inquiries per year. Appreciative Inquiries are a positive approach in building capacity within the region and sector involvement.

N: Prevention

Narrative Section - BG 2014/15

- 4) Outcome data will be collected through our contract with FEI, P-WITS. All prevention plans: goals, objectives and strategies are recorded and approved prior to implementation. Once plans are approved within P-WITS providers can begin reporting their prevention activities and outcomes. Aggregated monthly and annually reports will generate from P-WITS. Process data will be compared to recorded short, intermediate and long term outcomes; as follows:
 - a. **Short-term:** increase of collaboration across the engagement – integration continuum, improve trust among stakeholders, increase prevention activities support by other leveraged resources, increase implementation of evidenced based programs & practices (EBPP), increase number of people reached by EBPP.
 - b. **Intermediate:** increase perception of risk of harm, increase perception of wrongness, decrease accessibility/availability of substances, increase parental monitoring, decrease community norm favorable toward substance use, increase age of onset of first use, increase exposure to prevention messaging.
 - c. **Long term:**
 - i. **Decreased past 30-day use of alcohol**
 1. high school aged youth from 38.4% in 2011 to 34.56% in 2017
 - ii. **Decreased past 30-day binge drinking**
 1. high school aged youth from 23.8% in 2011 to 21.42% in 2017
 2. 18-25 year olds from 51% in 2008-2009 to 45.9% in 2017
 - iii. **Decreased past 30-day use of marijuana –**
 1. high school aged youth from 28.4% in 2011 to 25.6% in 2017
 2. 18-25 year olds from 28% in 2008-2009 to 25.2% in 2017
 - iv. **Decreased past 30-day misuse of Prescription drugs**
 1. high school aged youth from 10.4% in 2011 to 9.36% in 2017

All levels of outcome, process and outcome data will help to inform NH if our prevention strategies are working. The short and intermediate measures are early indicators, which will allow NH to assess and determine if we are meeting improved outcomes. If these earlier outcomes are not favorable then we will revise our prevention plan.

- 5) Currently there is a small amount of state funds allocated for primary prevention (SFY 2104 & 2015). These funds will support prevention services across the state which includes implementation of the Strategic Prevention Framework.
- 6) NH SABG prevention set-aside total is \$1,340,652 of which \$1,184,490 are in contract with community level preventions services, this represents 88% of the funds supporting community level prevention.

N: Prevention

Narrative Section - BG 2014/15

- 7) NH contracts with the NH Center for Excellence (CFEx) that facilitates NH Service to Science process. This allows locally developed programs and practices to be reviewed by an expert panel for endorsement as evidence-based or best practice based upon current research. CFEx provides technical assistance in program design and evaluation to meet specific outcomes. Most prevention approaches are based upon evidence of effectiveness.
- 8) 13 Regional Public Health Networks mainly conduct universal and selective prevention approaches that support and impact environmental change and adoption of best practices. Here is a list of programs, policies and practices:

Olweus Bullying Prevention Program (OBPP)	Buyers Beware Campaign
Mass Media/Social Marketing Campaign	Screening, Brief Intervention, and Referral
Project Alert	Life of an Athlete
Good Behavior Game	All Stars (Junior Community)
Communities Mobilizing for Change on Alcohol	Rx Drug Task Force
Alcohol EDU for High School	Coordinated School Health and Wellness Program (CSHP)
Challenging College Alcohol Abuse (CCAA)	Community Mobilization through Appreciative Inquiry
Communities That Care	Support Prescription Monitoring Program
Enhance Enforcement	Ensure Safe Storage and Disposal of Prescription Drugs
Media Power Youth: Elementary & Middle School Curricula Training	Screening and Intervention for College Students (BASICS)
Teen Institute Summer Leadership Program (high school)	Teen Institute Training for Youth: Leaders in Prevention (middle school)
Change Prescriber Practices - Trainings for Providers	Strengthening Families Program, Celebrating Families
Making Change	Operation: Military Kids (OMK)
Community Diversion Program	Saturday Teen Night Program
Communities Mobilizing for Change on Alcohol (CMCA)	Youth to Youth (Y2Y), Dover Youth Empowerment Model
Alternative Activities for High-Risk Youth	Suicide Prevention Initiative
Data Collection: Youth Risk Behavior Survey (YRBS)	Screening and Intervention for College Students (BASICS)
Drug Free Workplace Initiative: Healthy Workplace and Wellness Outreach	Student Assistance Program/Project SUCCESS
Communities Mobilizing for Change on Alcohol (CMCA)	Youth Leadership Institute (YLI) Model
Life Skills Training	Parental Monitoring - Guiding Good Choices & Staying Connected to Your Teen
Permanent Prescription Drug Disposal Locations	NH Teen Institute Training

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

O. Children and Adolescent BH

Narrative Section - BG 2014/15

NH is in the early stages of implementing a Children's Behavioral Health System of Care (SOC) that crosses all child-serving systems. BDAS and other recovery advocates have been at the table as this SOC was being developed to ensure that concerns about substance use prevention, treatment and recovery are included in the SOC.

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

NH does not have any federally recognized tribes.

P. Tribes

Narrative Section - BG 2014/15

NH does not have any federally recognized tribes.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

Q: Data and IT

Narrative Section - BG 2014/15

NH BDAS (Bureau of Drug and Alcohol Services) currently employs the Web Information Technology Services (WITS) data system for all SAPT funded treatment services, Impaired Driver Care Management Program's (IDCMP), Prevention Services, and Access to Recovery Services (ATR). This system also provides a complete electronic health record, and collects all required TEDS data and also has a full contract administration and billing modules.

For BDAS treatment services the WITS system employs a unique client identifier based on the client's initials, DOB, gender, and last 4 digits of the SSN. This allows BDAS to collect and report unduplicated encounters, demographics, client characteristics data, dates of service, types of service, amounts of service, levels of service and units of services by level of care, by client, by facility or by agency. This data combined with financial data from the contract module also provides cost data for units of service by client, level of care facility.

WITS data collected from the State of NH BDAS contracted providers in the form of Substance Abuse and Mental Health Services Administration's (SAMHSA) National Outcome Measures (NOMS) data and Treatment Episode Data Set (TEDS). The BDAS is required to provide this data to receive funding via the Federal Block Grant.

WITS is also compliant with various coding conventions including ICD-10 and CPT/HCPCS. Beyond this WITS is internally capable of integrating Medicaid and non-Medicaid provider data. However, at this time the state of NH does not maintain a discrete Medicaid benefit for alcohol and drug treatment, although serious efforts are currently directed toward this purpose by 2014 for inclusion in the Affordable Care Act initiative.

BDAS staff regularly meet with DHHS staff involved in developing the Health Information Exchange (HIE), Health Information Technology (HIT), Medicaid initiatives and other similar matters arising from ACA and related activities. Electronic record system inter-operability remains an important topic of discussion among many others. Much of this occurs under the auspices of the state's federally funded HIE development project. As this effort progresses at the national level and as standards are developed, it is expected that BDAS/DHHS will work to incorporate various coding and program conventions as appropriate

The NH Center for Excellence (CFEx) maintains a website for prevention and treatment services and has created a data repository in collaboration with the SEOW. The BDAS has developed a capacity for population level data and direct service data through prevention services in the WITS system. CFEx has been involved in compiling SEOW data into a draft State Epi Profile Report that is currently in the process of being finalized. See <http://www.nhcenterforexcellence.org/>

BDAS and the Public Awareness and Education Task Force of the Governor's Commission on Prevention, Intervention and Treatment have created a website for NH "individuals, families and communities, to get informed, get involved and get help." See <http://drugfreenh.org/>

Q: Data and IT

Narrative Section - BG 2014/15

The NH SEOW is a multidisciplinary working group chaired by the BDAS Epidemiologist with a mission to promote analytical thinking and methods in support of improved behavioral health in NH. To do this, the SEOW is tasked with increasing access to data and data products that address substance use and behavioral health issues to inform prevention and treatment efforts and broader policy in the state.

The NH CFEx maintains a website for prevention and treatment services and has created a data repository in collaboration with the SEOW. CFEx compiles SEOW data into a State Epidemiological Profile. See <http://www.nhcenterforexcellence.org/> Additionally, CFEx is designing 12 individual Issue Briefs that BDAS will disseminate throughout the state over the course of SFY 14. Each Brief will accompany a press release and will be further distributed through a variety of partners' communication channels, such as industry or association newsletters, email lists, web sites, social media, or other means. They will also be posted on www.drugfreenh.org and the NH DHHS website. Below are the anticipated topics and timing of the Issue Briefs:

SEPTEMBER 2013	Young Adults Heroin
OCTOBER 2013	Rx Drugs
NOVEMBER 2013	Business/ Workplace
DECEMBER 2013	Marijuana
JANUARY 2014	Women/ Prenatal
FEBRUARY 2014	College Students
MARCH 2014	Primary Care
APRIL 2014	Alcohol
MAY 2014	Youth
JUNE 2014	Military
JULY 2014	Justice involved
TOTAL	12

The BDAS has developed a capacity for population level data and direct service data through prevention services in the WITS system.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

R. Quality Improvement Plan

Narrative Section - BG 2014/15

The New Hampshire SSA is working to develop a comprehensive quality improvement and assurance plan for both the SSA and service providers.

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

Footnotes:

The 2013 State Suicide Plan was developed to focus and coordinate suicide prevention efforts in NH. The NH Suicide Prevention Council (SPC) and its partners guide and implement these activities by engaging public and private stakeholders. The Plan is based on an understanding of evolving best practices, as well as strengths and constraints of the current political economic climate.

The Plan is updated every three years to ensure that it continues to move state suicide prevention efforts forward and to address the evolving needs of NH's residents and communities. The SPC provides an annual report to the Governor pursuant to statute RSA 126-R: 2, which establishes the SPC.

Joe Harding, Director of BDAS, serves on the SPC as well as the Council's Leadership Committee. Lindy Keller, BDAS Resources and Development Administrator, serves on the Suicide Fatality Review Committee. Ann Crawford, BDAS Prevention Services Regional Coordinator, serves on the NH Youth Suicide Prevention Assembly (YSPA).

New Hampshire

Suicide Prevention Plan

January 2013



Suicide Prevention Council

The mission of the State Suicide Prevention Council is to reduce the incidence of suicide in New Hampshire by accomplishing the goals of the State Suicide Prevention Plan:

- * Raise public and professional awareness of suicide prevention;*
- * Address the mental health and substance abuse needs of all residents;*
- * Address the needs of those affected by suicide; and*
- * Promote policy change*

For more information on the State Suicide Prevention Plan, contact Jo Moncher at jamoncher@dhhs.state.nh.us



STATE OF NEW HAMPSHIRE
OFFICE OF THE GOVERNOR

MARGARET WOOD HASSAN
Governor

July 2, 2013

I want to thank the New Hampshire Suicide Prevention Council for its work on the 2013 State Suicide Prevention Plan. Since the Plan's last revision in 2010, New Hampshire has accomplished a great deal, and the Suicide Prevention Council has been instrumental in helping to guide these efforts.

Legislatively established in 2008, this Council is responsible for the oversight of the implementation of the State Suicide Prevention Plan, and has developed a strong public and private partnership throughout the State to accomplish this goal. As citizens of New Hampshire, we can all be proud that our Connect Program is a National Best Practice Program that has trained hundreds of professionals and community members to prevent and respond effectively to suicide across the lifespan. Additionally, New Hampshire is a national model for our work recognizing the training and prevention efforts needed to support our veterans and military families. Due to the efforts of the Council, New Hampshire is now recognized as a Leadership State and was awarded one of the first Garrett Lee Smith grants through the Substance Abuse and Mental Health Services Administration.

Suicide, however, remains the second-leading cause of death for New Hampshire young people, and is a major concern for all ages. We must continue our efforts to reduce the number of suicides and suicide attempts statewide. Prevention must be a collaborative effort. The entire community must share the responsibility of identifying at-risk individuals and ensuring that these individuals receive essential, life-saving services. Broad awareness of the warning signs of suicide can only increase appropriate referrals and interventions.

This 2013 State Suicide Prevention Plan has been a true collaboration among many stakeholders, and I look forward to working together to address this issue that affects all of our citizens.

With every good wish,

A handwritten signature in blue ink that reads "Maggie H" followed by a long horizontal line.

Margaret Wood Hassan
Governor



From the State Suicide Prevention Council

Child and Family Services
of NH

Disabilities Rights Center

Elliot Hospital

Faith Based Community

Genesis Behavioral Health

Injury Prevention Center

Lakes Region Partnership
for Public Health

NAMI NH

New Futures

NH Association of Counties

NH Community Behavioral
Health Association

NH Dept. of Corrections

NH Dept. of Education

NH Dept. of Health and
Human Services

NH Dept. of Safety

NH General Court

NH Hospital Association

NH Medical Society

NH Mental Health Council

NH National Guard

NH State Senate

Office of the Chief Medical
Examiner

Survivors of Suicide Loss

VA Medical Center

Youth Suicide Prevention
Assembly

As the member organizations of the State Suicide Prevention Council (SPC), we are pleased to present the 2013 State Suicide Prevention Plan. Our hope is that this Plan will help to guide and focus our efforts in addressing the tragedy and burden of suicide across New Hampshire.

The Plan was developed through the wisdom, expertise and collaboration of the SPC, as well as many groups, committees and organizations who have dedicated time and resources to study the issue of suicide and to look at prevention and postvention across the lifespan.

Community collaboration is at the heart of SPC and is included throughout the Plan. The partnerships that have developed at all levels - public and private, local, state and federal, and military and civilian - continue to guide our efforts.

The planning process also included input from the 2012 National Strategy for Suicide Prevention, recognizing our nation's new approach in enlisting all individuals in the fight to prevent suicide.

The State Suicide Prevention Plan was last revised in 2010 and since that time, the SPC has accomplished much to address suicide prevention across the State. The Leadership Team spearheaded several strategic planning sessions, including a 50-person retreat at New Hampshire Hospital and a 100-person summit at the Concord Holiday Inn. Both events addressed state plan development, community collaboration and sustainability.

In 2012, the SPC partnered with the National Alliance on Mental Illness NH and the Youth Suicide Prevention Assembly on the Annual Suicide Prevention Conference. With close to 300 individuals attending, this conference continues to grow every year, reaching the largest and most diverse gathering of individuals in the nine-year history of this Conference.

The SPC will continue to build on the momentum and collective knowledge that has been gained in suicide prevention to strengthen capacity and sustainability to reduce the risk of suicide for all New Hampshire citizens and promote healing for all those affected by suicide. Despite significant challenges with a struggling economic environment including budget cuts and reduced access to mental health and substance abuse treatment, our State will continue to make progress in suicide prevention work in many diverse and systemic ways.

Knowing that it takes all of us working together with common passion and goals, we would like to thank everyone who has been involved in suicide prevention efforts in our State.



2013 Revised

New Hampshire Suicide Prevention Plan

*Presented by the
New Hampshire Suicide Prevention Council
(SPC)*

INTRODUCTION

Suicide – a Major Issue in New Hampshire

Suicide is a significant public health problem in NH:

- Between 2004 and 2008 suicides outnumbered homicides by more than 8 to 1.
- Suicide is the second leading cause of death for those from age 15 to 34.
- Between 2002 and 2011, firearms were the leading method used, representing 42% of all suicide deaths.
- Three times more males than females ages 10-24 died by suicide between 2005 and 2009.
- Suicidal behaviors, which include attempts as well as completed deaths, are a significant cause of inpatient hospitalization, emergency and outpatient treatment.
- In an average year, between 2004 and 2008, 156 people died; nearly 185 were hospitalized and close to 945 were treated in emergency departments for self-inflicted injuries.
- These attempts and suicides represented an estimated \$16.8 million in acute health care costs alone in 2008.
- For each suicide death, family and close friends are at higher risk for suicide themselves.
- Many others are affected in a variety of ways, including those providing emergency care to the victims and those who may feel they failed to prevent the death.

The data above is from *New Hampshire's 2011 Suicide Prevention Annual Report: Suicide Across the Lifespan*. Annual NH Suicide Data reports can be found here: <http://www.theconnectprogram.org/annual-reports-suicide-prevention-data-nh>

Underlying Principles for the State Suicide Prevention Plan

- **Suicide is generally preventable.** The vast majority of people who die by suicide have mental illness and/or substance use disorders which research demonstrates can be successfully treated. Early identification and access to care are essential.
- **Prevention must be a collaborative effort.** The entire community must share the responsibility of identifying and getting those at risk into needed services. Most people who die by suicide give some indication they are contemplating suicide before they die. Broad awareness of warning signs of suicide will increase appropriate referrals and interventions.
- **Risk factors** occur at the community as well as the individual level. Identifying and addressing community risk factors as well as individual risk factors is an important suicide prevention strategy. Likewise, communities that build and support protective factors will benefit not just in preventing suicide but also in improving public health and public safety.
- **Promoting healing and reducing risk following a suicide** (postvention) for both individuals and communities is an important component of suicide prevention efforts.
- **Significant investments** of time and other resources are required to prevent suicide. Focusing on recognized Best Practices will ensure that these efforts lead to positive outcomes across the lifespan, across the state and across cultures.
- **Suicide prevention must become a part of all of our ongoing work** and become embedded throughout our communities including our schools, health care systems, corrections at all levels. **The NH Suicide Prevention State Plan will be most effective when it is implemented from an ecological perspective that encourages working across individuals, families, communities, workplaces, the military, organizations and systems.**

State Suicide Prevention Plan Process

This Plan has been developed to focus and coordinate suicide prevention efforts in New Hampshire. The SPC and its partners will guide and implement these activities by engaging public and private stakeholders. The Plan is based on an understanding of evolving best practices, as well as the strengths and constraints of the current political and economic climate.

The Plan is updated every three years to ensure that it continues to move state suicide prevention efforts forward and to address the evolving needs of NH's residents and communities. The SPC will provide an annual report to the Governor pursuant to statute RSA 126-R: 2, which establishes the SPC.

COMMUNICATIONS & PUBLIC EDUCATION SUBCOMMITTEE

Goal 1: Promote Awareness that Suicide in NH is a Public Health Problem that is Generally Preventable

Objective 1.1: Promote recognition of suicide as a generally preventable public health problem and promote active involvement in prevention activities.

1. Partner with key stakeholders, including public health regions, throughout the State on planning and convening an annual conference in order to build awareness of suicide prevention, increase knowledge of best practices for prevention, intervention and response to suicide, and increase collaboration, networking and support.

Objective 1.2: Promote education that includes hopeful messaging to NH residents on risk factors, suicide-warning signs, help seeking behaviors, and resources.

1. Create audience specific messaging that encourages individuals to take steps towards preventing suicide, and coordinate with other national, state and local media efforts.
2. Maintain a central repository website updated regularly for press releases, presentations, and fact sheets that include data, risk and protective factors, warning signs, and resources.
3. Periodically repeat surveys to measure attitudes towards suicide prevention and media reporting.
4. Design and sponsor wide dissemination of public health messages and education on suicide prevention, using traditional and new/social media.
5. Encourage communities to effectively implement protocols listed in the Suicide Prevention Resource Center's Best Practice Registry.
6. Continue to educate the general public as well as health care providers and other key stakeholders (e.g. law enforcement/first responders) on risk factors and the efficacy of reducing access to lethal means for those at risk of suicide, particularly regarding firearms and medications.
7. Disseminate and promote information regarding the National Suicide Prevention Lifeline (1-800-273-8255).

Objective 1.3: Encourage new and diverse stakeholders, including policy makers, who work on preventing suicide in all communication subcommittee activities.

1. Review progress and update the State Suicide Prevention Plan.
2. Increase venues where the work of the SPC can be highlighted, e.g. newsletters, etc.

Goal 2: Reduce the Stigma Associated With Obtaining Mental Health, Substance Misuse and Suicide Prevention Services

Objective 2.1: Increase the proportion of the public that views mental disorders as real illnesses, equal and inseparable components of overall health, that respond to specific treatments and consumers of these services as persons taking responsibility for their overall health.

1. Disseminate information to legislators, policy makers, providers and the public demonstrating that there are effective treatments for mental illness and substance use disorders.
2. Educate the public and key gatekeepers that their acceptance of persons with mental illness and substance use disorders and their addressing suicide openly can reduce suicide risk and prevent suicidal behaviors.

3. Provide opportunities for the public to hear from those in recovery from mental illness, survivors of suicide loss, and survivors of suicide attempts, making use of existing speakers bureaus in NH such as *In Our Own Voice*, *Life Interrupted* and *Survivor Voices*.
4. Support initiatives which increase insurance coverage and reimbursement and access to treatment for mental illness and substance use disorders.

Goal 3: Promote Safe Messaging, Media Reporting and Portrayal of Suicidal Behavior

Objective 3.1: Increase the proportion of media professionals who have received training in appropriate reporting of suicidal events, identifying allies who will educate the media and journalism teachers on the national Reporting on Suicide: Recommendations for the Media.

1. Continue and expand efforts to participate in the education of journalism students in New Hampshire on the importance of sensitive reporting of suicide and suicide behavior.

Objective 3.2: Increase the number of sources (public health officials, school personnel, medical examiners, etc.) who have received contact from suicide prevention representatives around media recommendations and training/consultation in appropriate responses to inquiries from media professionals concerning suicide and suicidal events.

1. Incorporate orientation to the *Reporting on Suicide: Recommendations for the Media* and safe messaging in general into all suicide prevention training.

Objective 3.3: Promote news reports and portrayals in NH that observe appropriate reporting of suicidal events, present prevention messages and offer positive adaptations and non-stigmatizing views of mental illness.

1. Continue to respond to positive and negative media stories on an ongoing basis.
2. Cultivate relationships with media personnel for proactive dialogue around media reporting on suicides and encourage media contact with identified SPC spokespersons when suicide incidents occur.
3. Encourage all media reports to encourage hope and help seeking and include information on local supports and treatment resources as well as the National Suicide Prevention Lifeline (1-800-273-8255).

Goal 4: Support survivors of suicide attempts and survivors of suicide loss through the implementation of support and education programs for family, friends, and associates of people who completed or attempted suicide.

Objective 4.1: Support survivors of suicide loss (SOSL) services.

1. Continue distribution of Medical Examiner's Suicide Survivors Bereavement packet and maintain the list of resources for support.
2. Promote American Foundation for Suicide Prevention's (AFSP) annual teleconference for SOSL.
3. Support the continued development of a NH SOSL Network.
4. Encourage use of funds raised by SOSL in NH to promote SOSL resources, information and events.
5. Explore the establishment of a statewide SOSL Committee as part of the SPC to provide oversight and coordination of resources and a voice to planning at the state level.
6. Explore opportunities and strategies for engaging and offering supports and education to suicide attempt survivors and their families/loved ones.

DATA COLLECTION AND ANALYSIS SUBCOMMITTEE

Goal 1: Improve and Expand Suicide Surveillance Systems

Objective 1.1: Produce and disseminate periodic reports on suicide and suicide attempts to policy makers and stakeholders.

1. Produce annual report on suicide to include suicide deaths, attempts, hospitalizations and Emergency Department (ED) visits and ideation utilizing available data sources.
 - a. On a yearly basis, review available data sources to identify other relevant information to include in the annual report.
 - b. Expand and improve methods and templates for reporting on suicide data.
 - c. Coordinate with the Suicide Fatality Review Committee to include recommendations resulting from their case reviews in the annual report.
 - d. Include in annual document progress reports from statewide and local efforts such as suicide prevention grantees (campus and state), coalitions, and other coordinated suicide prevention efforts.
2. Provide interim reports on data related to attempts, deaths, and other related factors to the SPC as requested.
3. On an annual basis, review the guidelines for appropriate release of data (including suppression of smaller numbers) to ensure that current best practices are being followed.
4. On an annual basis, review the summary of pertinent epidemiology terms included within the annual report and update as needed.

Objective 1.2: Increase the proportion of organizations and institutions that routinely collect and analyze reports on suicide attempts, deaths, and related factors.

1. Improve data collection on suicidal behavior.
 - a. On a yearly basis, review the data extraction tools used with compiling data from the Medical Examiner's Office. Refine the extraction tool as needed.
 - b. Track current trends in NH and national data related to suicide deaths and make recommendations to the Medical Examiner's Office on additional and/or alternative data to collect following a suicide death.
2. Investigate data sources related to help-seeking behavior.
 - a. Inventory current data sources and questions used.
 - b. Recommend integration of questions on help-seeking behavior in other surveys when appropriate.
3. Increase and maintain representation by organizations and institutions that would benefit from collecting, analyzing, reporting and utilizing data related to suicide attempts and deaths.
4. Continue assessing needs around the collection and analysis of data.
5. Revisit and update the 2010 review of professional literature on best practices around suicide data collection and analysis every two years.
6. Support New Hampshire's proposal submission for the National Violent Death Reporting System.

Objective 1.3: Increase the proportion of organizations and institutions that utilize data to develop and/or evaluate interventions.

1. Collaborate with other sub-committees of the NH Suicide Prevention Council to increase the number of suicide prevention initiatives in the state that utilize relevant data in an appropriate manner.
2. Include evaluations of current initiatives.

3. Encourage the dissemination of evaluation results.

Objective 1.4: Conduct ongoing epidemiological analyses of current and historical suicide-related and substance misuse data.

1. Increase analysis capacity for all suicide-related data.
 - a. Identify key data sources, tools and personnel.
 - i. Explore nontraditional data sources.
 - ii. Explore emerging technologies and analysis (e.g., small area analysis, GIS).
 - b. Collaborate with key personnel on coordinated analysis.
 - c. Explore how integrating different data sets may identify high-risk populations, regions or other trends, which would inform suicide prevention efforts.

MILITARY AND VETERANS SUBCOMMITTEE

Goal 1: Educate the Public to Improve Recognition of At Risk Behaviors and the Use of Effective Interventions.

Objective 1.1: Promote effective educational programs to the general public to increase awareness, comfort, and knowledge of resources on potentially suicidal veterans, service members and/or their families.

Goal 2: Promote training to personnel that are directly involved with veterans, service members and/or their families who exhibit high risk, concerning behaviors.

Objective 2.1: Promote effective educational programs for community providers who serve veterans, service members, and/or their families to promote collaboration with the Veterans Administration and the involved military unit (NH National Guard, Reserves).

Goal 3: Coordinate delivery of informational material to the community and treatment sites on resources on potentially suicidal veterans, service members and/or their families.

Objective 3.1: Regular delivery of informational outreach materials to local hospitals, Veteran Service Organizations (VSO), military units, law enforcement, family programs, and community resource locations.

Goal 4: Ensure that the Military and Veterans Subcommittee collaborates with all other SPC Subcommittees.

Objective 4.1: Request and share minutes/agenda of all State Suicide Prevention Council subcommittee meetings.

Objective 4.2: Subcommittee members of the SPC band together as needed to form a Task Force to work on Suicide Prevention Council projects (i.e.; revise the State Plan or create the Strategic Plan for the SPC), which will build and improve our collaboration and cohesiveness as a council.

CROSS TRAINING & PROFESSIONAL EDUCATION SUBCOMMITTEE

Goal 1: Promote Effective Clinical and Professional Practices

Objective 1.1: Promote guidelines for clinical practice and continuity of care for all health care providers who treat persons with suicide risk.

1. Promote routine screening for suicide risk and the documentation of results in the provision of health care.
2. Promote the use of concrete, specific and individualized mental health follow-up plans for patients treated for suicidal ideation or behavior.
3. Encourage post-assessment contact to reinforce plans where appropriate (e.g. Project RED).
4. Promote use of effective protocols for ensuring collaboration and effective communication among professionals.
5. Promote education on laws/RSAs, ethical obligations, and best practices regarding the sharing of information related to the treatment of individuals at risk for suicide.
6. Promote and cultivate relationships with other agencies and individuals so that collaboration and response can occur seamlessly and in a timely manner.
7. Foster sustainability and infrastructure by encouraging exchange of information/learning among providers and systems who are implementing best practices in suicide prevention.
8. Stay abreast of current trends, research and resources in suicide prevention and disseminate as appropriate.
9. Promote the use and availability of research based, age and culturally appropriate screening and assessment tools.

Goal 2: Support sustainability and infrastructure of best practices in NH by promoting training and protocols to community members, schools, organizations and providers on the prevention of suicide and related behaviors.

Objective 2.1: Encourage recertification and continued delivery of training programs through existing NH trainers in Connect, Counseling on Access to Lethal Means (CALM) Applied Suicide Intervention Skills Training (ASIST), Assessing and Managing Suicide Risk (AMSR) and other best practices that are available in NH.

Objective 2.2: Promote culturally informed training to mental health and substance use disorder treatment and prevention providers on the recognition, assessment and management of at-risk behavior.

Objective 2.3: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors for all health professions including graduate and continuing education.

Objective 2.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.

Objective 2.5: Promote the implementation of protocols and programs for clinicians and clinical supervisors, first responders, crisis staff and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

Goal 3: Promote the integration and coordination of suicide prevention activities across multiple sectors and settings.

Objective 3.1: Promote awareness of local and regional resources for suicide assessment and intervention to Accountable Care Organizations (ACOs).

Objective 3.2: Promote training for primary care Providers, care managers and ambulatory care staff around risk assessment and referral and their relationship to untreated medical conditions (e.g. asthma).

Objective 3.3: Promote integration of suicide prevention and interventions into all relevant health care reform efforts.

Objective 3.4: Strengthen linkages between systems and build on existing infrastructure of suicide prevention efforts such as communities, organizations, systems and trainers that have implemented best practices around suicide prevention.

Objective 3.5: Consider options and resources for a central clearing house (i.e. statewide website) that can provide readily available information to NH citizens about suicide prevention and postvention resources and supports as well as upcoming events, trainings, etc.

Goal 4. Support efforts to reduce risk and promote healing after a suicide by identifying and linking existing programs and resources with needs.

Objective 4.1: Inform key stakeholders who may be in need of or involved in postvention response (i.e. faith leaders, school superintendents) about existing resources, such as Disaster Behavioral Health Response Teams (DBHRTs), National Alliance on Mental Illness NH Chapter (NAMI NH), Community Mental Health Centers (CMHCs), Survivor Network & Resources, Postvention Trainers and Coalitions.

Objective 4.2: Support coalitions in having readily available information about postvention practices and resources in their region such as Victims Inc, Samaritans, survivor of suicide loss support groups, medical examiner and related information packets.

Objective 4.3: Encourage utilization of postvention training and protocols (i.e. After a Suicide Toolkit, Media Recommendations) for first responders, law enforcement, emergency departments, schools and others who may be involved or affected by a suicide to reduce risk of contagion and promote healing.

PUBLIC POLICY SUBCOMMITTEE

Goal 1: Develop and implement public policy initiatives to ensure the sustainability of suicide prevention efforts.

Objective 1.1: Require training in suicide prevention for education, healthcare, mental health and substance misuse professional licensure and certification in New Hampshire.

1. Research licensure and certification requirements for above-mentioned professions.
2. Outreach to Professional Practice Subcommittee for input and partnership on achieving goal.
3. Develop strategic approach for working with above-mentioned licensure and certification boards to encourage training in suicide prevention as part of credentialing requirements.

Objective 1.2: Require schools to include mental wellness/suicide prevention education as part of the health curriculum.

1. Outreach to the State Board of Education and the NH Department of Education for support in achieving goal.
2. Create workgroup to develop strategic approach for achieving goal.

Objective 1.3: Recruit additional subcommittee members and formalize expectations of membership.

1. Review subcommittee charter annually with members of subcommittee.
2. Develop and implement member recruitment plan.

Objective 1.4: Support other subcommittees with policy needs.

1. Outreach to other subcommittees to offer support with policy issues.

Objective 1.5: Track legislation related to suicide prevention and advocate where appropriate.

1. Utilize legislative tracking document to track legislation of interest to the Suicide Prevention Council.
2. Report on legislation of interest at Suicide Prevention Council meetings.
3. With support of SPC leadership, testify on legislation of importance to Suicide Prevention Council.

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

IV. Narrative Plan

T. Use of Technology

Interactive Communication Technologies (ICTs) include but are not limited to: text messaging, e-therapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, videos, case manager support and guidance, and telemedicine.

NH does not currently use Interactive Communication Technologies as described above and does not have the capacity to report on strategies; applications; incentives; support; or barriers regarding the use of this technology at this time.

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

U: Technical Assistance Needs

Narrative Section - BG 2014/15

BDAS has created a Center for Excellence for both prevention and treatment services that is supported by the Governor's Commission Alcohol Fund. The Centers for Excellence (CFEX) maintains at a high level through the BDAS a public/private partnership with the State of NH Charitable Foundation. The relationship between the BDAS and CFEX provides two teams of TA for our providers/allied professionals, one for prevention services and one for treatment providers.

Future technical assistance (TA) needs relate to development of a Resilient and Recovery Oriented System of Care (RROSC), specifically for the development of Recovery Community Organizations (RCOs) that will oversee Peer and other Recovery Coaches in communities statewide. BDAS may require technical assistance in addressing the specific needs of families in a recovery-oriented system of care.

BDAS continues to have a need for RROSC and is involved with SAMHSA, the State Innovation Model (SIM), and Balance Incentive Program (BIP). It would be helpful to the BDAS to receive some TA that would ensure that the State of NH BDAS RROSC objectives are consistent with the larger objectives of the states BIP and SIM initiatives.

The Center for Excellence has grant writing requirements included in their scope of services and has successfully assisted the Bureau in securing a SPE grant through SAMHSA.

The changing landscape due to the Affordable Care Act (ACA) the BDAS will likely require technical assistance in coordinating care primary health care for substance use disorders (SUD). The BDAS may need technical assistance for establishing consistent and fair market driven rates for the various services in various treatment levels of care and recovery support services.

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.⁴⁵ This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

⁴⁵ SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

Letters of support indicating agreement with the description of their role and collaboration with the SSA have been requested and will be added once received.

V. Support of State Partners

Narrative Section - BG 2014/15

Pregnant Women and Women with Dependent Children

BDAS Primary Partners (Pregnant Women and Women with Dependent Children):

The Bureau of Drug and Alcohol Services (BDAS), which serves as the SSA for NH) identified the goal of increasing the number of pregnant and parenting women receiving alcohol and other drug intervention and/or treatment services in the state supported system by 5%, which is identified in the priority section of this application. BDAS requires state supported programs to admit pregnant women within 24 hours of initial contact. BDAS will continue to promote quick access and prenatal support with its contracted treatment providers for this population.

In an effort to better serve this population, BDAS directed resources from its contracted Center for Excellence this past year to facilitate an operational plan for BDAS and the Maternal and Child Health (MCH) Unit at the Division of Public Health Services (DPHS) to submit a joint proposal to SAMHSA for a Screening, Brief Intervention and Referral to Treatment (SBIRT) grant. Unfortunately New Hampshire was not selected for this grant at this time. BDAS will continue to work closely with the MCH unit at Public Health to improve alcohol and other drug prevention, early intervention and treatments services in community health centers and to refine its application for any future SBIRT grant offerings.

BDAS developed a brochure promoting treatment for pregnant women, highlighting their priority status for admission to our services and listing all state-funded treatment services with contact information. The brochures have been printed in English and in Spanish and are being disseminated through a variety of venues in the state, including health care, criminal justice and other social service sites. BDAS will continue to urge the active promotion of our educational material about the risk of alcohol and drug use during pregnancy to women of child bearing age as well as our giving priority admissions to pregnant women to medical providers, including community health centers, Obstetrics and Gynecology medical providers across the state. The BDAS Director (SSA), who serves as the Executive Director of the Governor's Commission on Alcohol and Drug Abuse Prevention, Intervention and Treatment (herein after referred to as "the Governor's Commission" or "Commission"), will continue to work with the Chair of the Commission and the Chair of its "Alcohol and Other Drug Prenatal Exposure" task force, to develop and implement prevention, early intervention and treatment outreach activities, with emphasis on SBIRT model, targeting women of child bearing age that are at particular risk for engaging in alcohol and or drug use during pregnancy.

Pregnant women are identified as population of focus in New Hampshire's Alcohol and Drug Plan for the State, titled, Collective Action - Collective Impact (2013 -2017), with an objective of educating women of child bearing age on the risks associated with alcohol and drug use during pregnancy and providing culturally competent care for this population. A copy of this plan can be viewed and or downloaded at: <http://www.dhhs.nh.gov/dcbcs/bdas/plan.htm>

V. Support of State Partners

Narrative Section - BG 2014/15

Youth and Young Adults (DPHS)

Bureau of Drug and Alcohol Services (BDAS) has worked very closely with the Community Public Health Development (CPHD) at the Division of Public Health Services over the past three years to integrate the 14 regional public health Networks with the 10 regional alcohol and other drug prevention networks. The objective of this integration has been to build upon the strengths of each of the regional networks and to increase operational efficiencies of these networks at the regional and community level. BDAS and CPHD unit have issued joint contracts for these newly reconfigured 13 Regional Public Health Networks, starting July 1st of this year, which includes one FTE alcohol and other drug prevention coordinator in each of the networks.

These networks utilize the Strategic Prevention Framework model to implement strategies, as identified in their 3 year plans (approved by BDAS), to reduce the misuse of alcohol (including binge drinking), marijuana and non-medical use of prescription pain medication among youth and young adults (reference the priorities area of this application). These networks are engaging key stakeholders from each of the targeted sectors (government, education, safety, health and medical, business, family and community supports) to implement programs and strategies at the regional level to meet the objectives of their respective regional plans.

The Bureau of Drug and Alcohol Services (BDAS) has maintained a close working relationship over the past five years with the New Hampshire Charitable Foundation (NHCF), establishing an effective public/private partnership. The NHCF contributes funding for the AOD prevention elements of these regional networks coalitions administered by the Bureau of Drug and Alcohol Services, co-funds our contracted Center for Excellence and is providing funding for programs that will complement our Partnership for Success II initiative.

In addition, the NHCF has taken the lead in supporting the "Life of an Athlete" initiative that is being implemented in 81 high schools throughout the state. The Bureau will be administering additional resources for this program that were recently made available by the Governor's Commission. The Bureau of Drug and Alcohol Services, working through the Northeast Applied Prevention Technology Center (NE-CAPT), have started the process for review and consideration of this program as a SAMHSA identified evidenced-based program.

The Bureau of Drug and Alcohol Services and its contracted Center for Excellence (with support for this effort coming from the New Hampshire Charitable Foundation), has played a key role in the development and implementation and the state's strategy to reduce the misuse of alcohol and other drugs and related consequences. This plan includes as primary objectives, reducing the misuse of alcohol (including binge drinking), marijuana and the non-medical use of pain medication among youth and young adults, which is consistent with the Bureau's objectives identified in this block grant application. A copy of this plan can be accessed from the Bureau's web site at: <http://www.dhhs.nh.gov/dcbcs/bdas/plan.htm>

The Governor's Commission Prevention Task Force, with participation from the Bureau of Drug and Alcohol Services and numerous other stakeholder, has developed a "Model School Policy". BDAS contracted regional prevention networks, with the support of community level

V. Support of State Partners

Narrative Section - BG 2014/15

stakeholders from a number of different sectors, are promoting the adoption of the model school policies outlined in this document by school administrative units (SAUs) across the state, that will support our objectives of reducing the misuse of alcohol, marijuana and prescription drugs among youth in New Hampshire.

The Model School Policy can be accessed from the Bureau of Drug and Alcohol Services web page at: <http://www.dhhs.nh.gov/dcbcs/bdas/index.htm>

The Division of Youth, Children and Families at the New Hampshire Department of Health and Human Services has committed to the following objectives:

- Utilizing more comprehensive alcohol and other drug screening instruments for the families that it serves
- Making alcohol and other drug training available to child protection workers and other staff
- Working with the Bureau of Drug and Alcohol Services to make appropriate referrals to specialty alcohol and other drug services as indicated.

The New Hampshire Charitable Foundation has established a close working relationship with the Hilton Foundation, which is interested in promoting and making resources available for adolescent SBIRT programs in targeted areas of the country. The Hilton Foundation recently provided an overview of this initiative at the National Association of State Alcohol and Drug Abuse Director's Board meeting in August, which the BDAS director was able to attend as the Region One (New England) representative on the Board. The NHCF has in turn discussed funding a pilot network of adolescent SBIRT programming in New Hampshire in the near future, which will further support our efforts of reducing the misuse of alcohol, marijuana and non-medical use of pain medication among youth and young adults in the state.

Criminal Justice Involved

The Bureau of Drug and Alcohol Services (BDAS) has worked closely with the Office of the Administrative Judge for the District and Family Courts and the Department of Safety to implement the transformation of the impaired driver service delivery system in New Hampshire that resulted from the enactment of House Bill 283 in January of this year. In an effort to increase public safety, individuals convicted of an impaired driving offense will now be required to participate in screening and assessment for a substance use disorder within a shorter time span than previously required and to participate in a service model that includes on-going care coordination, treatment and/or recovery support services (when indicated). A certain portion (depending on the level of offense) of House of Correction time is suspended to encourage individuals to participate in the program, which can be imposed by the prosecutor/courts if individuals do not follow the requirements of their service plan.

Utilizing resources made available through the ATR, the Bureau of Drug and Alcohol Services has worked closely with the New Hampshire Department of Corrections (DOC) to make care coordination services available to individuals on probation and parole that are monitored by

V. Support of State Partners

Narrative Section - BG 2014/15

personnel in DOC district offices that did not have these services, as well as an array of clinical and recovery support services made available for this population throughout the state.

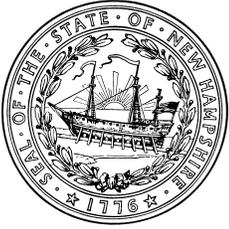
The SAMHSA Access to Recovery (ATR) grant has played a key role in developing additional capacity for substance use disorder care coordination, treatment and recovery support services beyond the specialty service system historically administered by the Bureau of Drug and Alcohol Services (supported by the block grant and state funds), for individuals involved with the criminal justice system. This includes a statewide care coordination system and an additional 143 independent ATR providers, of which 61 are also approved to provide impaired driver services. Although ATR is available to all members of the military in New Hampshire, about 90% of ATR clients are involved with the criminal justice system, with about 56% of the total number of clients served by the Access to Recovery program being convicted of an impaired driving offense in New Hampshire and an additional approximately 34% of the total served that are on probation or parole with the New Hampshire Department of Corrections. The ATR grant has allowed the state to develop, in part, the infrastructure necessary to better meet the future need and demand for services resulting from healthcare reform.

The Bureau of Drug and Alcohol Services and its contracted Center for Excellence, has assumed a lead role in supporting the Governor's Commission Prescription Drug Task Force and its sector workgroups in implementing the objectives of the Commission's Prescription Drug Strategy, titled "Call to Action; Responding to New Hampshire's Prescription Drug Epidemic". A copy of this strategy can be downloaded from the BDAS web site at:

<http://www.dhhs.nh.gov/dcbcs/bdas/commission.htm>

In addition, the Director of the Bureau of Drug and Alcohol Services (BDAS) actively participates on the New Hampshire Prescription Drug Monitoring Program Advisory Council, established in 2012. The New Hampshire PDMP Advisory Council has worked over this past year to develop its administrative rules and to establish a scope of work for the program, that will include an array of state and regional population level reports that will be utilized to inform future alcohol and drug policy and services. The New Hampshire PDMP was awarded a Federal Harold Rogers Grant to support the development and implementation of the program in September of 2013. Additional information can be obtained at the New Hampshire Board of Pharmacy web site at:

<http://www.nh.gov/pharmacy/prescription-monitoring/index.htm>



**GOVERNOR'S COMMISSION ON ALCOHOL & DRUG ABUSE
PREVENTION, INTERVENTION, AND TREATMENT**

BUREAU OF DRUG AND ALCOHOL SERVICES
105 Pleasant Street, Concord NH 03301
603-271-6100 TDD ACCESS: 1-800-735-2964

Governor Maggie Hassan

September 20, 2013

Timothy R. Rourke
Chairman

To Whom It May Concern;

Joseph P. Harding
Executive Director

The Governor's Commission on Alcohol and Other Drug Abuse Prevention, Intervention and Treatment wishes to express its strong support for the NH Department of Health and Human Services (DHHS), Bureau of Drug and Alcohol Services (BDAS), in pursuit of continued support through the Federal Substance Abuse Block Grant Program.

Betsy Abrahams

Commissioner Virginia Barry

The Commission was established in 2000 to develop and administer a state plan to address alcohol and other drug issues, to administer state funds to support substance use services, and to advise the Governor and Legislature on policy and budgetary matters related to substance use and its impact on New Hampshire communities.

Commissioner John J. Barthelmes

Senator Jeanie Forrester

Our most recent strategic plan, *Collect Action, Collective Impact*, calls for a coordinated response among state agency and community leaders to reduce substance use rates over all while increasing the number of those in need of substance use treatment who actually receive it. The leadership displayed by the Bureau of Drug and Alcohol Services, and their broad partnerships in accomplishing their efforts, is a significant driver of the state's overall strategy.

Attorney General
Joseph Foster

Amélie Gooding

Representative June Frazer

Senator Molly Kelly

Honorable Edwin W. Kelly

Chairman Joseph Mollica

Bureau staff is intimately involved in all aspects of the Commission's work. Additionally, the Commission has a significant history of using state funds under their purview to match and leverage the federal block grant for maximum impact. This include significant co-investment in treatment and prevention services, as well as infrastructure around technical assistance and training to drive quality improvement and outcome delivery of the substance use disorders field.

Chris Placey

Major General William N. Reddel, III

Stephanie A. Savard

The federal block grant is a critical tool in addressing New Hampshire's drug and alcohol abuse epidemic. The Commission strongly supports the efforts and the vision of BDAS in its proposal, and looks forward to continued partnership and access to federal block grant funds to reduce the harm caused by substance misuse and abuse in New Hampshire.

Representative Jim MacKay

Rebecca Ewing

Commissioner Nicholas A. Toumpas

Commissioner William L. Wrenn

Regards,

Timothy R Rourke
Chairman



NEW HAMPSHIRE
CHARITABLE FOUNDATION

CAPITAL LAKES MANCHESTER MONADNOCK NASHUA NORTH COUNTRY PISCATAQUA UPPER VALLEY

Memorandum

To: US DHHS, Substance Abuse and Mental Health Services Administration
CC: Joseph Harding, Director, NH Bureau of Drug and Alcohol Services
From: Tym Rourke, Director of Program and Substance Use Disorders Grantmaking
Date: September 23, 2013
Re: Support Letter – Request for Substance Use Prevention and Treatment Block Grant

The New Hampshire Charitable Foundation is one of the country’s largest Community Foundations. With assets over \$500 million, we seek to strengthen New Hampshire communities and inspire greater giving by investing charitable assets for today and tomorrow; connecting donors with effective organizations, ideas and people; and leading and collaborating on important public issues.

The Foundation’s second largest fund portfolio is designed to “reduce the burden caused to the citizens of New Hampshire by alcohol, tobacco and other drugs”. One of the only funds like it in the country, we focus our grant resources and staff expertise in this area on public policy related to substance use disorders, increasing knowledge and capacity of providers to provide evidence-based practice, and to facilitate increased community leadership and programming to prevent and treat substance use in communities.

Our strategic civic engagement and grantmaking in this area is executed in a unique and deep public/private partnership with state agencies and leaders, including the NH Bureau of Drug and Alcohol Services.

The Foundation offers its strong support to the state’s request for continued support from the Prevention and Treatment Block Grant. Foundation resources on this issue are not enough to address the complex issues related to substance use. However, leveraging our philanthropic capital against public funds and leadership on this issue is critical to our vision of reducing substance abuse in New Hampshire. We look forward to our continued partnership with the Bureau, and welcome the continued support of these critical resources to New Hampshire.

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

W. State BH Council

Narrative Section - BG 2014/15

New Hampshire (NH) Mental Health Planning Council was renamed the NH Behavioral Health Advisory Council (BHAC) in July 2011, embracing the encouragement from SAMHSA to "...expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well." The Bureau of Drug and Alcohol Services has assigned one staff person to attend the BHAC monthly meetings in an effort to incorporate and align some portion of our goals and objectives. The BHAC reviews SABG goals and objectives, however at this juncture does not provide any official guidance or suggestions. The council capacity is not sufficient at this stage of development. Therefore, it has been proposed by council members, a subcommittee forms under the State Planning Committee to identify how BHBG and SABG could better complement each other's plans and build a comprehensive approach to behavioral health issues to reduce and prevent substance abuse and mental health rates in NH.

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
No Data Available				

Footnotes:

Per our FPO, NH does not need to report on the Behavioral Health Advisory Council Members, as we are not submitting a combined application this year.

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)		
Family Members of Individuals in Recovery* (to include family members of adults with SMI)		
Parents of children with SED*		
Vacancies (Individuals and Family Members)	<input type="text"/>	
Others (Not State employees or providers)		
State Employees		
Providers		
Federally Recognized Tribe Representatives		
Vacancies	<input type="text"/>	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text"/>	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Per our FPO, NH does not need to report on the Behavioral Health Council Composition by Member Type, as we are not submitting a combined application this year.

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

X. Enrollment and Provider Business Practices

Narrative Section - BG 2014/15

NH does not have the capacity to report on Enrollment and Provider Business Practices, Including Billing Systems, and will not be setting aside 3 percent of our BG allocations to support this effort at this time.

However, NH is fortunate to have the NH Providers Association, which represents Alcohol and Other Drug Service Providers throughout NH. Their mission is to advocate, facilitate and enhance communication with funders, policy makers and the public to support the members' efforts to offer high quality substance abuse prevention, treatment, intervention, and recovery support services for the citizens of NH.

The Providers Association offers Third Party Billing Services to organizations and private practice individuals. These services include: 1) Billing readiness assessment, preparation and support; 2) Claims submission; 3) Claim denial follow-up and resolution; and 4) Claim analysis for data tracking. This billing service covers all billable services provided by an agency or individual.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

Y. Comment on the State Plan

Narrative Section - BG 2014/15

BDAS will post our SAPT Block Grant application, along with the 2 guidance documents for the application on the following web pages

- NH DHHS web page - <http://www.dhhs.nh.gov/dcbcs/bdas/SAPTGrant.htm>
- NH Center for Excellence - <http://nhcenterforexcellence.org/>
 - BDAS will also include information on our Block Grant and how to view and/or comment on it, in the NH Center for Excellence's quarterly newsletter.

The following state and federal partners will be alerted by email when our Block Grant Application is ready to be viewed both in draft and final forms:

- BDAS contracted agencies for treatment and recovery support services
- Early intervention (DWI service providers)
- Prevention services
- BDAS contracted services for training and evidence based practices
- Members of the Governor's Commission on Prevention, Intervention, and Treatment (*The Governor's Commission includes Department Commissioners from Health and Human Services, Corrections, Education, the Attorney General, and legislative (NH House and Senate) and public members*)
 - Each of the Governor's Commission Task Force members (*Treatment and Recovery Task Force, Prevention Task Force, Public Awareness Task Force*)
- Division of Community Based Care partner Bureaus
 - Behavioral Health, Developmental Services, Homeless and Housing Services, Elderly and Adult Services
 - NH Behavioral Health Advisory Council (BHAC) will be specifically solicited for comment
- Division of Public Health Services
- Office of Medicaid
- Division for Children, Youth and Families, which now includes Juvenile Justice Services
- Temporary Assistance to Needy Families
- New Futures (*a community partner organization*)

Subsequent emails will provide notices of specific changes or revisions and highlighted specific sections of the plan to prompt comment from citizens.

BDAS has both telephone and e-mail capacity to receive comments.