***State of New Hampshire, Department of Health and Human Services***
***Substance Abuse Block Grant COVID-19 Supplemental Funding Plan Proposal***
***Award Number: 1B08TI083509-01***

The state of New Hampshire, Department of Health and Human Services (DHHS) is grateful to SAMHSA for the approximately $6.53 Million in supplemental block grant funding to help combat the COVID-19 pandemic as well as to provide relief to individuals, families, and communities who have been impacted by the pandemic. Below, please find our funding plan proposal addressing gaps across the alcohol and other drug continuum of care, many of which have been exacerbated by the pandemic. It is important to note that the costs included are estimates and we do anticipate shifting funding between projects based on need.

*Integrate WITS Data in the Enterprise Business Intelligence Platform (Estimated Cost $1,000,000)*
Individuals with substance use disorders (SUDs) often have complex co-occurring physical health, mental health, and social needs. In the past year, the pandemic has made it increasingly difficult to provide the necessary services needed by this population. Simultaneously, the level of need is increasing for many individuals due to loss of income, housing, social support, and other services as well as social isolation.

New Hampshire (NH) utilizes the Web Information Technology System (WITS) for billing, reporting, and data collection for substance misuse services. In addition, we have implemented an Enterprise Business Intelligence Platform (EBI) that includes the following items: technology architecture to support internal and external reporting, data transformation and modeling; data governance to comply with federal and state legislation; metadata management for data integrity and search ability; and integration components. Over the last several years we have been able to integrate several data sources from within the state in an effort to build a 360 degree view of the services provided in New Hampshire to include: COVID-19 response data sources, vital records, commercial insurance claims, Medicaid claims, child support, eligibility, elderly adult services, child welfare, emergency department syndromic surveillance, emergency department discharge data, and components of the WITS system. This funding will be used to partner with DHHS's Bureau of Information Services to support a professional services team using an existing contract to extract, transform and load the data contained in the WITS system into the EBI and then model the data with other data sources to include, but not limited to Medicaid claims, child welfare, vital records, DHHS services eligibility (SNAP, TANF, etc.), child support, and elderly and adult services. This will expand our view of the services a client is receiving, or may not be receiving, allowing for improved care coordination. In addition, an integrated data system would show a clearer picture of services and outcomes to improve NH's data informed response to these complex issues.

*Substance Use Disorders and Mental Health Epidemiologist (Estimated Cost $150,000)*
The New Hampshire Drug Monitoring Initiative (DMI) is a holistic strategy to provide awareness and combat drug distribution and misuse. In line with this approach, the DMI obtains data from various sources and provides monthly and annual products for stakeholders as well as situational awareness releases as needed. Over the course of the pandemic, the DMI reflected a shift in substance use patterns from opioid use to stimulant use (NH Data | Bureau of Drug and Alcohol Services | NH Department of Health and Human Services). In addition, other data sources showed an increase in alcohol use (New Hampshire alcohol sales up 10% during pandemic, worrying advocates (concordmonitor.com)). Our lack of capacity to do an epidemiological analysis of these patterns hampered our ability to respond to these data trends in an effective manner. While this is a long existing gap, COVID-19 highlighted the needs in this area.

DHHS does not currently employ an epidemiologist specifically for behavioral health. This pilot project will allow DHHS to test the utility of such a position in responding to substance misuse and mental health impacts related to COVID-19 as well as more broadly with a goal of improving both prevention and response measures. Some expected outcomes from this pilot project are a better understanding of both the incidence and prevalence of behavioral health (substance use and mental health) disorders in NH; the cost and burden of these disorders at the community, state, and federal levels; and evidence informed strategies for both preventing and mitigating behavioral health disorders. We will collaborate with DHHS's Bureaus of Information Services, Population Health and Community Services, Mental Health Services, and Program Quality on this project.

*Workforce Development Efforts (Estimated Cost $350,000)*
The COVID-19 pandemic exacerbated the existing behavioral health workforce shortage in a number of ways. NH's existing provider network reported a number of the direct impacts during our regular COVID-19 Check-In calls. Many of our residential providers reduced bed capacity to meet social distancing and

other health and safety guidelines, resulting in staff layoffs. Clients not wanting to enter or remain in residential treatment services during the pandemic worsened this situation. In addition, many staff in direct care settings did not feel safe working directly with clients and chose to leave their positions. While some staff were able to find employment in other agencies, others transitioned out of the field, making it difficult for providers to fill what open positions were available, which will be an on-going issue as services transition back towards pre-pandemic delivery. Additionally, staff across many fields vacated the workforce due to personal or family medical concerns or to provide dependent care.

Across the alcohol and other drug continuum of care, an anemic workforce (Reports | NHPCBH Workforce) continues to hamper our prevention, intervention, treatment, and recovery efforts. While we recognize that this is an issue nationwide, we are aware that other states have developed innovative programs that may be replicable in New Hampshire. We would utilize this funding to replicate one or more of these programs in New Hampshire and/or build on existing initiatives, which may include but not be limited to providing funding for education, professional development, and/or internships; contributions to the Student Loan Repayment Plan; and/or direct funding to providers for staff to achieve licensure. Funding will help to increase community-based behavioral health workforce capacity through the education, recruitment, and training of a professional and peer workforce with the knowledge, skills, and abilities to provide and coordinate the full continuum of substance misuse and mental health services. Our partners in these efforts will be determined based on the specific projects pursued.

*Expansion of SBIRT for Youth and Young Adults in Community and School Based Organizations (Estimated Cost $800,000)*

In a study conducted by the Centers for Disease Control (CDC) (Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020 | MMWR (cdc.gov)) depression, anxiety and substance misuse as a coping mechanism rose during the pandemic. This is especially true for adolescents and young adults. According to CDC findings, 26.8% of individuals between the ages of 18 to 24 responded that they have experienced an increase in depression and anxiety since the beginning of the pandemic with 13.3% of these same individuals reporting the misuse of substances to cope with depression and anxiety. The impact of COVID-19 is brutally illustrated by the number of children and young adults who are currently "boarding" in New Hampshire's emergency departments while awaiting a bed at a psychiatric facility. In a March 31, 2020 bulletin (Microsoft Word - Long Form ED Boarding at Zero v 2 03.31.2020.docx (naminh.org)), NAMI-NH announced the promising news that, for the first time in eight years, no one was boarding in an emergency department while awaiting a bed. One year later, the same organization reported "53 adults and 33 children being boarded in hospital emergency rooms waiting for a psychiatric bed to open" (Supreme Court Takes Up 'Boarding' Psych Patients in Hospital Emergency Rooms - InDepthNH.orgInDepthNH.org). This was in spite of additional children's beds being opened at New Hampshire State Hospital.

Adolescents and young adults are in a critical window of vulnerability to substance misuse and substance use disorders and NH consistently ranks among the top in the nation for young adult substance misuse. Regular (past month) illicit drug use rates are significantly higher in NH than the nation (11.5% US, 15.5% NH) and, in the 18-25 year old age group, rates of illicit use follow the same pattern (24% in US, 31.8% in NH). NH also experiences higher than national rates of cocaine use in the past year for the 18-25 year old age group (6.0% in the US, 10.7% in NH). Early access to screening and counseling is a cost effective way to prevent and reduce the impact of untreated mental health and substance misuse among young people. In the guidance to states on the use of this funding, SAMHSA specifically recommended the expansion of Screening Brief Intervention and Referral to Treatment (SBIRT) targeted to youth and young adults. This project would enhance access to SBIRT for adolescents and young adults by providing technical assistance to an estimated 50 school districts, institutions of higher learning and/or other organizations serving the target populations who express a desire to implement an evidenced based SBIRT practice. Technical assistance provided would build capacity by ensuring providers have the knowledge and skills to implement SBIRT in their respective settings in a successful manner. This would include outreach and recruitment of organizations using existing networks and partnerships. Potential partners for this project are NH's Regional Public Health Networks (New Hampshire Regional Public Health Networks (nhphn.org)), DHHS's Division of Public Health Services, the NH Department of Education, and/or the NH Department of Military Services and Veteran Affairs.

*Support Harm Reduction Programming (Estimated Cost $750,000)*

As a result of COVID-19 safety precautions and service delivery interruptions, as well as the increased risk of isolation and disconnection from SUD support services, NH has witnessed a significant increase in the need for harm reduction services across the state. (WEEKLY EARLY EVENT DETECTION REPORT (nh.gov)) Existing harm reduction service providers have continued to engage individuals who inject

drugs as well as social service providers and public health experts from across the state about changes and adjustments made to SUD services. This engagement has made clear that there is a significant need for harm reduction services to expand into additional communities for the prevention of disease transmission and fatality associated with substance misuse. It will take a significant amount of time for SUD service providers and all social service agencies that serve fragile populations to return to pre-COVID operations.

This project will utilize funding to support mobile harm reduction services both in the form of leased and customized vans to act as mobile service programs as well as funding transportation costs to meet with individuals within their communities. This addition to fixed site programming allows flexible expansion into underserved communities based on the needs of those communities. In addition to these direct services, this funding may support indirect costs, including, but not limited to: syringe disposal costs, personnel, fixed costs, client outreach materials, personnel training and education, marketing, non-syringe harm reduction supplies, professional services, and subcontracting costs.

*Support Mobile Crisis Response and 988 Rollouts (Estimated Cost $500,000)*
New Hampshire had begun to reimagine our behavioral health mobile crisis response prior to the onset of the pandemic and COVID-19 has only exacerbated this need. The increase in mental health distress and substance misuse during the pandemic as described above is highly likely to lead to additional individuals accessing mobile crisis response services and crisis hotlines. The national changes from the suicide prevention lifeline 10-digit number over to 988 also have estimated growth projections as the serviceable population changes to those experiencing mental health and substance use crises.

NH is planning for a crisis system redesign, through the model of Crisis Now (Crisis Now | Transforming Crisis Services) and with the pending implementation of 988 the state is procuring for a centralized crisis access point that will accept calls for both mental health and substance use crises across the lifespan and dispatch mobile support based on the assessed need of the caller. New Hampshire currently has three existing mobile crisis response teams in the more urban areas of Nashua, Concord and Manchester. The redesigned crisis system will include mobile response teams statewide. These teams will be dispatched to wherever the need is in the community (not hospital emergency departments) and work with crisis receiving and stabilization locations that serve everyone who comes through their doors from all referral sources. These services are for anyone, anywhere and anytime in line with the National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. The National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit specifically states "A preferred strategy for the person in distress that offers services focused on resolving mental health and substance use crisis" (p. 10). This funding will support evidence-based substance use disorder, suicide safer and trauma informed care training of the mental health providers across the state as well as the mobile crisis team staff, inclusive of peers and may include collaborative partners such as law enforcement and emergency medical services, This project is intended to ensure that those engaged in delivering crisis services have the knowledge, skills, and abilities to respond to individuals in a crisis where substance use is a factor. At a minimum, we will partner with DHHS's Bureau of Mental Health Services on this project.

*Tobacco Treatment ECHO for SUD Treatment Providers (Estimated Cost: $150,000)*
While tobacco use has always had deleterious impacts on individuals, this harm is increased by COVID-19 (WHO statement: Tobacco use and COVID-19). The Department sees this as a potential, although tragic, window of opportunity to break through some of the historical resistance to integrating tobacco treatment into treatment for other substance use disorders.

"'Smoking cessation in substance use disorder treatment can increase a person's chances for long-term recovery and reduces risks of smoking related illnesses.' said Dr. Elinore McCance-Katz, Assistant Secretary for Mental Health and Substance Use . . . The rate of tobacco-related deaths is substantially higher for people with substance use disorder (SUD) as compared with the general population. Despite this, in 2016 nearly 53 percent of substance misuse treatment facilities in the United States did not offer tobacco cessation services. Aside from the many known health benefits of quitting, tobacco cessation increases the odds of long-term abstinence from illicit drug use." (SAMHSA publishes a Tobacco Cessation Toolkit for Substance Use Disorder Treatment Programs | SAMHSA). DHHS's Bureaus of Drug and Alcohol Services and Tobacco Prevention and Cessation Program have already begun work to integrate tobacco treatment into SUD treatment programming; however, there has been a historical resistance to such efforts among SUD treatment providers for a number of reasons.

The ECHO model is effective in both reducing resistance among providers who are unsure of implementing a given practice as well as to improve practices and outcomes across provider cohorts

(Project ECHO and Opioid Education: a Systematic Review | SpringerLink). Based on the initial response to the ECHO model proposed above, funding may also be used to pilot technology based interventions in partnership with the Tobacco Prevention and Cessation Program utilizing this funding as well as funding that program has available for such interventions.

*Develop MAT and other substance misuse capacity within hospital systems (Estimated Cost: $400,000)*
As described above, depression, anxiety and substance misuse as a coping mechanism have risen during the pandemic. This increase has put greater pressure on hospital systems to respond to medical conditions and crises related to substance misuse during a time when they are already struggling to respond to the pandemic.

Since SFY 2017, BDAS has contracted with the Foundation for Healthy Communities (Home - Foundation for Healthy Communities (healthynh.org)) to develop medication-assisted treatment (MAT) within hospital systems, including emergency departments and associated physician practices. As MAT became more established, it also became clear that additional bandwidth is needed within hospital systems around substance use disorder treatment as a whole. Hospitals report problems with initiating MAT in the Emergency Department if patients' primary care practices are not providing MAT. Protocols, practices and workflows are not in place so that hospital staff providing acute care to treat injuries or diseases caused by SUDs can also treat the SUDs. Hospital systems in NH who have initiated services through previous contracts are requesting assistance to broaden their ability to fully integrate SUD services throughout the system so that they can institutionalize best practices for treating SUDs as chronic illnesses. Funding would be used to develop interdisciplinary hospital systems that identify, engage, treat, and coordinate services for people with an SUD to improve patient and hospital outcomes. This approach uses any "reachable moment" to enhance patient-centered care and hospital outcomes by providing MAT and other interventions and linking patients to SUD care and harm reduction support after discharge. As a part of the contracting process, the Department will require that interventions be consistent with activities described within the SAMHSA Evidence-based Practices Resource Center. Partners for this project will include the Foundation for Healthy Communities.

*Contingency Management (Estimated Cost: $250,000)*
As described above, during the pandemic, NH has seen a shift in substance use patterns towards increased use of stimulants. Unlike Opioid and Alcohol Use Disorders, there is no FDA approved medication assisted treatment for stimulant use disorders at this time. According to the journal article "Contingency management for the treatment of methamphetamine use disorder: A systematic review Drug and Alcohol Dependence" (Contingency management for the treatment of methamphetamine use disorder: A systematic review - PubMed (nih.gov), contingency management is effective in reducing methamphetamine use and increases attendance of recovery-related appointments in people with methamphetamine use disorders. Furthermore, According to Principles of Drug Addiction Treatment: A Research-Based Guide (View PDF (drugabuse.gov)), contingency management is highly effective in increasing treatment retention and promoting abstinence. Just as MAT was initially viewed with a level of skepticism and distrust, so is contingency management. In order to combat this, funding will be used to provide technical assistance and education to providers around contingency management as well as support for implementing contingency management programming. Partners in this effort will include substance use disorder treatment providers.

*Support Clients' Unmet Needs (Estimated Cost: $250,000)*
According to the National Institute for Health, stressful events can profoundly influence the misuse of alcohol or other drugs. Stress is a major contributor to the initiation and continuation of substance misuse, as well as to substance misuse relapse after periods of recovery. (Community Drug Alert Bulletin - Stress & Substance Abuse | NIDA Archives (drugabuse.gov); ALCOHOL RESEARCH: Current Reviews (nih.gov)) In addition to the stress of fear for our health and that of loved ones and social isolation, the pandemic has led to many other stressors, including but not limited to individuals losing employment, children learning remotely, and childcare centers closing, forcing parents to leave employment and lose the associated income.

Individuals with substance use disorders who are seeking recovery often face barriers well beyond their substance use including access to transportation and child care, food insecurity, housing insecurity, educational and employment challenges and many others. These barriers can trigger stress and relapse, particularly for individuals in early recovery and are often more acute for individuals living in rural and other underserved communities. This funding would be used to help individuals to alleviate these barriers through connection with community resources and financial assistance. Partners on this project will include substance use disorder treatment providers and other community based organizations.

*Expansion of Technology (Estimated Cost: $250,000)*

In response to the pandemic, New Hampshire's providers stood up telehealth at an astounding rate to ensure that clients could remain connected to treatment services; however, this did not provide any additional level of connection outside of treatment appointments. In normal times, much of this additional connection would have been found through community based support groups, recovery community organizations, and other prosocial activities; however, the health and safety requirements of the pandemic meant that these natural supports were no longer available to individuals in treatment and recovery.

In recent years, a variety of technologies have been developed for clients in treatment and recovery; however, these have not been widely adopted in New Hampshire to date in spite of evidence of improved outcomes. For example, reSET and reSET-O are FDA-authorized Prescription Digital Therapeutics (PDTs) for patients with SUD which act as an adjunct to outpatient behavioral health and medical services. ReSET, is a 90-day PDT for SUD which provides cognitive behavioral therapy, as an adjunct to a contingency management system. ReSET-O, is an 84-day PDT for Opioid Use Disorder intended to act as an adjunct to outpatient treatment that includes transmucosal buprenorphine and contingency management. Both products include an associated dashboard for clinicians and other health care providers that displays information about patients' use of reSET, including lessons completed, patient-reported substance use, patient-reported cravings and triggers, compliance rewards, and in-clinic data inputs such as urine drug screen results. Funding would be used to assist existing providers in standing up the use of such technologies. Partners on this project will include substance use disorder treatment provider and recovery community organizations.

*Support for Recovery Community Organizations (Estimated Cost: $1,300,000)*
At the onset of the pandemic, Recovery Community Organizations (RCOs) showed incredible flexibility and creativity in transitioning to remote services. As RCOs reopen, they are incurring additional expenses due to necessary COVID safety precautions in-person and the need to continue to provide remote services. The pandemic also negatively impacted the RCOs ability to implement the sustainability plans they have in place, making continued funding a necessity. An additional factor impacting sustainability is that the current fee for service model in place for Medicaid reimbursement may not be the best model for funding RCOs. (https://new-futures.org/report/cost-covid-19-substance-use-treatment-and-recovery-providers)

In SFY17 when DHHS first began supporting RCOs, there was only one major provider in the state along with a number of very small, grass roots organizations which were attempting to get up and running. In response to this, DHHS procured a facilitating organization charged with providing support to these small RCOs to help them achieve national standards for the activities and operations of RCOs as well as to work towards sustainable operations. This model has been highly effective as evidenced by the rapid growth in healthy RCOs over the past 4 years. While the network of RCOs in NH has reached a point of near ideal robustness, sustainability of many of these programs relies heavily on continued funding through DHHS. All of these programs have plans to increase their sustainability through multiple efforts, including Medicaid and private insurance billing. In addition, we recognize that our current Medicaid funding model may not lend itself to sustainable billing for RCOs and will engage with Medicaid to analyze Medicaid funding models utilized by other states and evaluate the utility of those models for NH. Should an alternative model be identified, we will begin the process of implementing the model in NH. Potential partners for this project include DHHS's Division of Medicaid as well as the National Association of State Alcohol and Drug Abuse Directors.

*Support for Recovery Housing (Estimated Cost: $350,000)*
DHHS contracts with the New Hampshire Coalition of Recovery Residences (NHCORR) to certify recovery residences in accordance with the National Association of Recovery Residences (NARR) standards, which are the benchmark for quality in these types of facilities. In addition, NHCORR is also contracted to provide financial assistance for individuals to help pay for the cost of the recovery residence. Funding would be utilized to both support the operations of NHCORR to ensure safe recovery housing is available to individuals as well as to support requests for housing assistance, which are currently more than four times the amount that NHCORR has in their budget. According to NH's SUD access system, the Doorways, housing continues to be a critical gap, with the majority of Doorway participants reporting unstable housing or homelessness. NH will maintain support for, and expansion of, recovery housing including the supportive services offered at these facilities. Costs for both NHCORR as an organization and for recovery houses have increased due to the need to move much of the work to remote procedures and for necessary safety precautions due to COVID. At the same time, many houses needed to decrease the number of residents to allow for safe distancing at a time when the demand for recovery housing is high.

The estimated costs includes $150,000 for recovery housing assistance, paid directly to recovery residences on behalf of residents. The amount awarded essentially sits in a designated account that the recovery residence is able to charge against should the resident be unable to pay all or part of the cost of the recovery residence. These awards are currently $375 and residents may receive multiple awards; however, preference is given to first time applicants. The award amount may change based on additional funding. To be eligible for assistance, an individual must be in recovery, be accepted into or live in a NHCORR-Certified Recovery Residence, and complete a standard application (https://www.nhcorr.org/housingassistance). The application includes the following fields:

- Name;
- Date;
- Applicant's email;
- Age;
- Gender;
- Case manager and/or Organization Requesting Funds;
- Case Manager telephone number;
- Case Manager email;
- Weekly income (from all sources); and
- Any towns in NH where the applicant has a connection.

Again, we thank SAMHSA for this funding opportunity and look forward to your response. Please contact Jaime Powers, Director, Bureau of Drug and Alcohol Services (jaime.e.powers@dhhs.nh.gov, 603-856-1687) with any questions or comments.